“GIFT OF LIFE”

‘ JEEVAN DAAN' CHILD SURVIVAL PROGRAM

COUNTERPART INTERNATIONAL
in Partnership with
SANCHETANA and in collaboration with Ahmedabad Municipal Corporation
INDIA

Final EVALUATION REPORT
August 9 to September 13 , 2004

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A. Summary

A1.Program Description

The Jeevan Daan Child Survival program (JD) was initiated in September 2000. It is based in six urban slum areas of Ahmedabad city, and represents a partnership between Counterpart International (CPI), Sanchetana – an Ahmedabad based NGO and the Ahmedabad Municipal Corporation (AMC). The total population of the program area is 183,130. There are approximately 112,549 beneficiaries: 59,333 children under five years and 53,216 women of reproductive age.

The program aimed to sustainably reduce the morbidity and mortality among children under the age of five by improving caregiver childcare practices. It also aimed to strengthen the capacity of the NGO partner, Sanchetana and the AMC to enable them to plan, implement and evaluate Child survival programs in the targeted urban slums. The strategies of the program included the improvement of the capacity of the partners, the enhancement of the participation of the community and communicating for behavior change.

The main objectives were immunization of children and women, control of diarrheal disease, pneumonia case management and nutrition and breastfeeding. The main strategy was to increase family level protective behaviors through the establishment of Community Health Teams made up of local volunteers, intensive BCC activities including drama and puppetry and through extensive partnering.

Goals of Program:

- To sustainably reduce infant mortality in the urban slums of Ahmedabad through improved caregiver practices and increased access to quality care.
- To mutually strengthen the capacity of Counterpart and Sanchetana (partner NGO) to plan, implement and evaluate CS programs in the targeted urban slums.

A2 Technical Objectives:

1. **Improving EPI coverage: immunization of children and women**

The immunization rates for children aged 12-23 months have risen from 29% to 71.6% and for toxoid tetanus for women from 72% to 90.7%. This implies a strengthening of the MOH's capacity, as well as a large percent increase in coverage.

2. **Control of Diarrheal Disease**

ORT use has increased from 18% to 64% with correct preparation rising from 16% to 69.3%. Hand washing has increased from 9% to 75.3%.

3. **Pneumonia Case Management**

Pneumonia prevalence has reduced from 22% to 16%. Quick treatment on the same day has increased from 24% to 66.6%. The knowledge of two danger signs has increased from 54% to 98.3%.

4. **Nutrition and Breastfeeding**

The percentage of mothers who breastfed within one hour of delivery increased from 19% to 33%. Under-five children who were exclusively breastfed in the past 24 hours increased from 41% to 85.6%. Children 6-9 months received complimentary food in the past 24 hours increased from 65% to 78.6%.

A3. Summary of the Program's Main Accomplishments:

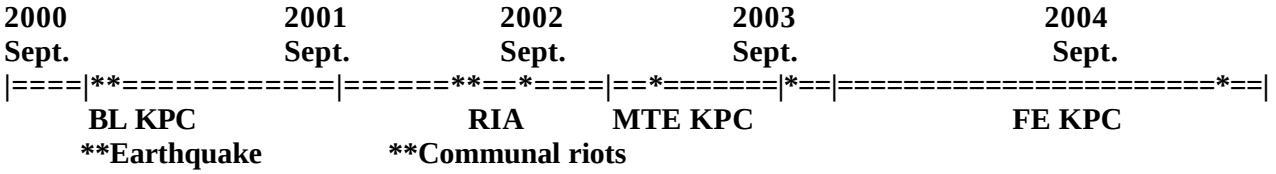
The program far surpassed its targets in all four interventions with the exception of coming within 3 percentage points within the nutrition/breastfeeding intervention of two of the sub- indicators.
Mobilized 400 community women to become volunteer members in Community Health Teams (CHT).

- The formation of 40 active CHTs is proving to be an effective venue for disseminating health messages and empowering communities to take charge of their health.
- Responded to two disasters: earthquake and communal violence
- Set up 10 Hearths which rehabilitated 169 Children under three.
- Leveraged funds for Humanitarian Assistance for $118,000 medical supplies and a second batch for $650,000 and third for $ 61,000.

The JD program has faced two major crises in its life. The first was a devastating earthquake in January 2001, which inflicted considerable damage to the state of Gujarat, and to the city of Ahmedabad. The second, in February 2002, was an outbreak of communal violence in the city, which caused immense physical, economic and mental damage to the people in the areas covered by the program. The program responded quickly and appropriately to both crises, by making an assessment of the situation and organizing for humanitarian assistance, which was the immediate need. This however, delayed the implementation phase of the program, with program activity being delayed by about 3 months following each crisis. The program resumed its baseline assessment activity in June 2001, and the detailed implementation plan was completed in December 2001. The program was able to function as normal in May 2002 following the second crisis.

In summary, there has been significant improvement in all of the measurable objectives from the baseline to the final. The objectives in which there has been the greatest increase in percentage points from the baseline to the final KPC are in the CDD intervention with ORT use and hand washing increasing 34 points and 55 respectively. Child immunizations (reported by mothers) also had great percentage point increases with the coverage rising from 15% to 80%.

A brief history of the major events:



January 2001	Baseline KPC
June 2001	Baseline Qualitative Assessments and FGDs
July 2001	Baseline Health Facility Assessments
December 2001	DIP Finalization
February 2002	Program Overview Workshop
March 2002	Communal Riots
June 2002	On-going trainings
August 2002	CHAP & Hearth training
October 2002	Rapid Impact Assessment
June 2003	Midterm KPC
August 2004	Final KPC
August 2004	Final HFA
September 2004	Final Evaluation

A4. Highlights of the Program:

There are several highlights of the program which include an innovative BCC component, which included kites, posters, games, song, and drama, the implementation of the Positive Deviance/Hearth and subsequent hosting of the Southeast Asia Regional Workshop, and a technical advisory committee has been formed and provides peer review and technical expertise to keep the program up to date and technically sound.

Sustainability was addressed by forming strong linkages between the slum area volunteers and the health facilities assuring greater demand, access and utilization of services. A strong community mobilization effort maintained enthusiastic volunteers throughout the life of the program. The formation of the CHT has created the missing link between the community and the government health system. The model that is being created has great potential for replication and possibly affecting India's Health Policy. Having a local Country Director and working with a local NGO and AMC are all sustainable strategies, which will lead to program continuity. The program focuses on behavioral change and through this approach seeks to facilitate new practices, which become internalized. MoH is now scaling BCC and other CS approaches into neighboring wards in the city as well as adopted into EC funded urban RCH program and partnered with Counterpart.

The Jeevan Daan program has excellent leadership in the Program Director who is well supported by a most committed Director of Health Programs at Counterpart International Headquarters in Washington, D.C. They supervise a capable and committed staff, whose potential has been unleashed. There is an unsurpassed team spirit.

A5. Priority Conclusions of The Evaluation Team:

A. The team successfully mobilized a network of community volunteers in Community Health Teams (CHTs) who were able to train community members in Child Survival actions and the measurable bringing about of behavioral change.

B. The team strengthened critical links between Community Health Teams and the Ahmedabad Municipal Corporation, and the Community Health Teams and Private Practitioners. The CHTs in time could be institutionalized by the government as it serves as an excellent model. Given that the Child Survival program has been awarded a cost-extension in the amount of $1.5 million, the strategy of registering CHT members with AMC, conducting a "CHT Convention with AMC", documenting and observing how the CHT evolves into Child Survival Plus, will continue.

C. The foundation on which the program rested was laid firmly by Darshana Vyas, Director Health Programs who adeptly included all stakeholders in the development of the program design, proposal writing phase, implementation phase and evaluation phase. The network that was formed by Darshana Vyas was inclusive and participatory.

D. In the face of two major crisis', the program staff responded in a professional and compassionate manner, which greatly facilitated its implementation, after the set backs. They built up a lot of goodwill which entrusted the community to Counterpart staff.

E. The BCC interventions were exciting, innovative and highly successful. Puppetry and street theatre were extremely entertaining and effective in message dissemination.

F. Leadership Development: As CHT formation strengthens, observe the emergence of leaders and support these leaders to facilitate their team meetings and phase out the role of Counterpart.

G. HMIS: An excellent HMIS was developed as a foundation. For the extension, institute more regular death reporting and post community data boards with simple graphics of the progress towards preventing under-five and maternal deaths and the progress towards program objectives. Share the data with the local leaders and train them to understand the measurable changes in their community.

H. Urban HEARTH: The urban hearth was highly successful and had high exposure in the crowed slum pockets. The Hearths developed under this program as a "living university" for the Asia/Pacific region.

I. Partnerships: Selecting a local NGO as a partner requires a lot of groundwork and preliminary assessments of work philosophy and style. This type of relationship is naturally complex and warrants much attention and nurturing. It was not until the two organizations began working together that some of the differences were revealed.

J. Good Management Matters: The management under the direction of Darshana Vyas, Director of Health Programs, and Counterpart International HQ was extraordinarily strong, participatory, transparent and supportive. Her finesse at responding to emergencies and as well as bringing the program on track was superb. In the country office as well, Ramesh Singh, Counterpart India Program Director, ran a tight ship, with a small management team. He supervised and guided the program to success through the creation of a highly empowered team.

B1. Assessment of Results and Impact

Summary Chart

Key Indicators	Baseline KPC %, Jan. 2001	Final KPC %, Aug. 2004	Targets KPC %, September 2004	Difference
DIARRHEA				
Prevalence of diarrhea during the last two weeks	**37**	**30.7**	**30**	**+.7**
ORT use during Diarrhea	**18**	**64**	**40**	**+24**
ORS prepared correctly	**16**	**69.3**	**35**	**+34.4**
Appropriate hand washing practice	**9**	**75.3**	**20**	**+55.3**
PNEUMONIA				
Prevalence of Pneumonia during the last two weeks	**22**	**16**		
Quick treatment on the same day	**24**	**66.6**	**35**	**+31.6**
Knowledge of two danger signs	**54**	**98.3**	**70**	**+28.3**
IMMUNIZATION				
Children 12 –23 months having a vaccination card	**39**	**78.0**		
Children 12-23 months fully immunized (Card)	**29**	**71.6**	**45**	**+26.6**
Children 12-23 months fully immunized (Mother's report)	**15**	**79.6**	**45**	**+34.6**
Children 12-23 months received measles vaccine (Card)	**37**	**73.3**	**60**	**+13.3**
Children 12-23 months received measles vaccine (Mother's report)	**39**	**69.4**	**60**	**+9.4**
Mothers who received at least 2 doses of TT	**72**	**90.7**	**85**	**+5.2**
NUTRITION				
Children breastfed within 1 hour of delivery	**19**	**33**	**30**	**+3**
Children who are fed with colostrums	**41**	**85.6**		
Children 0-5 months exclusively breastfed in past 24 hours	**41**	**57.1**	**60**	**-2.9**
Children 6-9 months received complimentary foods in past 24 hours	**65**	**78.6**	**80**	**-2.4**

B2. Assessment Of The Progress Made Towards Achievement Of Program Objectives- Technical Approaches

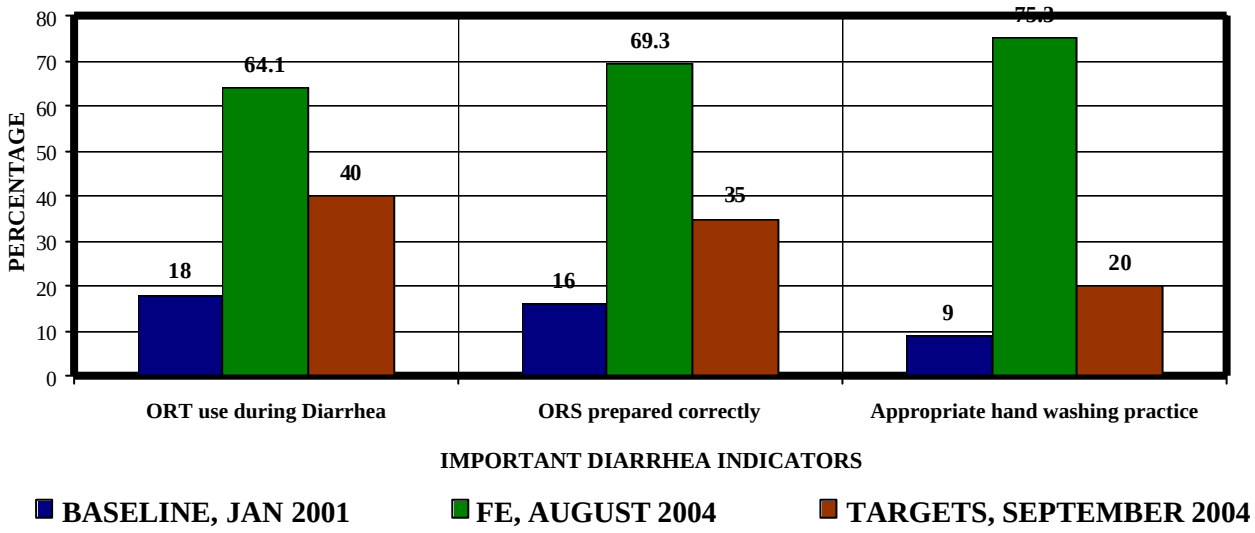
1. Control of Diarrhea Disease
2. Pneumonia Case Management
3. Immunization
4. Nutrition

1. Control of Diarrheal Disease

a. Objectives

1. Increased percentage of children with diarrhea in the last two weeks would be treated with ORT.
2. Increased percentage of mothers who are able to identify the signs of diarrhea requiring treatment. Improved hygiene and sanitation practices.
3. Diarrhea reduction in children under 5.
4. Increased number of health workers are able to correctly assess, treat, and counsel caregivers regarding diarrhea management.

COMPARISON OF FE KPC RESULTS WITH BASELINE AND TARGETS: DIARRHEA INDICATORS

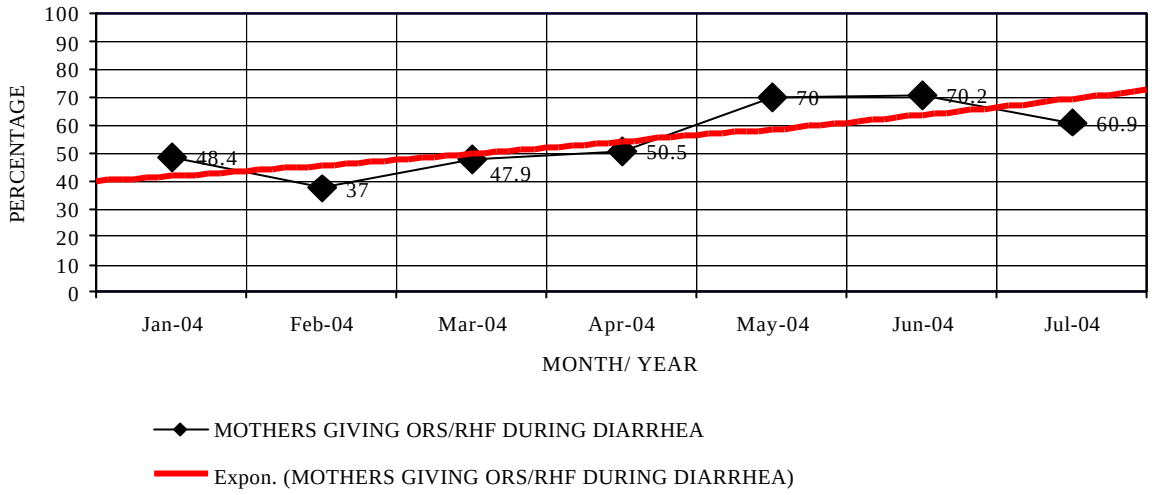


b. KPC data comparison: baseline and final

The ORT use during diarrhea dramatically increased from 18% to 64%. The ORS was prepared correctly 69.3% of the time compared to the baseline of 16%. Appropriate hand washing has increased from 9% to 75.3%. The prevalence of diarrhea reduced from 37 to 30.7%.

The evaluation team ranked this intervention on a scale from 0 to 10 (in terms of success) at 9.
The HMIS data confirmed the data, revealing an upward trend in diarrhea management knowledge and practices. In all seven indicators, the trend has increased consecutively each month for six months since December 2002.

TREND ANALYSIS OF IMPORTANT DIARRHEA INDICATORS



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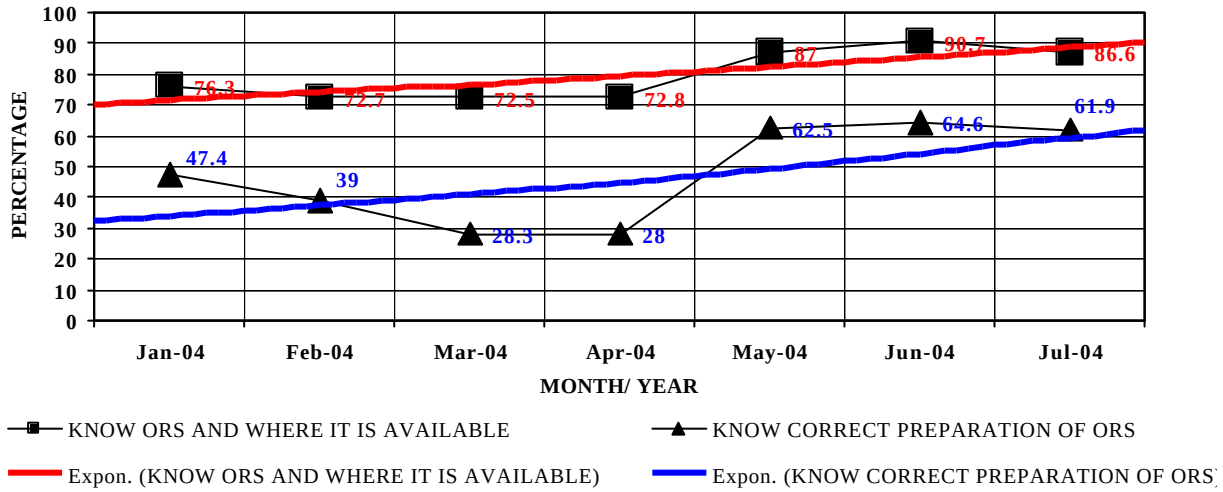

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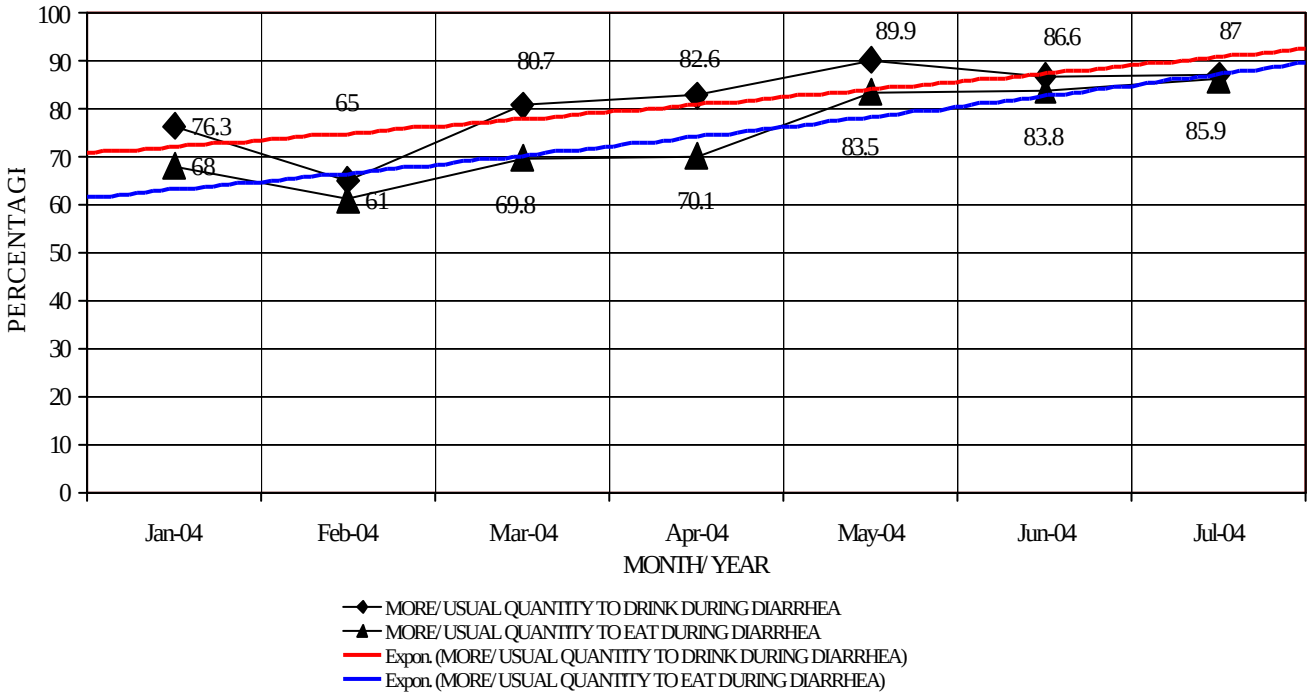


c. Results From The Qualitative Data

Home Visits Results: Interviews

- Mothers' knowledge levels about control of diarrheal diseases and home case management of diarrhea have increased and they can explain the correct preparation of ORS.
- People have started keeping ORS packets at home, unlike the scenario earlier when hardly any house-hold had ORS packets. Other members in the family have also started taking ORS packets during diarrheal episodes.
- During the diarrheal episodes, mothers have started feeding more than usual, unlike the behaviors adopted before the *Jeevan Daan* program.
- Due to continued feeding during diarrhea, mothers felt that the child didn't remain lethargic.
- Mothers have knowledge about the danger signs of severe diarrhea.
- Mothers don't give Rupee 1 tablet to the child during diarrheal episode, as they used to.
- If the child has severe diarrhea, they immediately take the child to a doctor.
- The general hygiene conditions within the households have improved. Mothers have correctly stated washing hands at all 5 critical times. Mothers have started using ladle for taking out water from the pot.
- Came to know through the street plays and counseling, how dirty hands and nails can cause diarrhea.

CHT and Hearth Participants Interviews:

- Lots of children saw the street plays on diarrhea, and many of them now wash their hands with soap before eating. Children also know the correct preparation of ORS and when to administer it. They also cut their nails regularly, do not eat uncovered food and remember the songs used in the street play.
- CHT members are clear about program's messages on diarrhea, and promote the same in the community to household visits.
- CHT members counsel the mothers and refer them to seek treatment from AMC health facilities. They also explain the importance of ORT during diarrhea and correct ORS preparation during home visits.
- Through the hearth lots of mothers have come to know about ORS and continued feeding during diarrhea. They have introduced this lesson to other mothers.
- Referral chits increase the accessibility to health services, and access is also made easier because of CHT members having the referral chits, and immediate action can be taken.
- The hearth participant mothers have learned to continue feeding and give more fluids to the children during diarrhea, so that these children do not get dehydrated.
- Street plays have been very beneficial in educating not only the mothers but also the children about preventive aspects of diarrhea and dehydration.

Successes:

- Communities have started utilizing AMC facilities more than they used to utilize earlier, before the program had initiated. Communities have gained confidence in AMC facilities, especially ID hospital etc., after the doctors in these facilities have made efforts to visit the communities and meet the target population.
- Doctors now have a full supply of ORS and give ORS to every case of diarrhea that comes to their facility.
- The CHT members have been proactive in putting pressure on the vendors to keep the food covered.
- The CHT members stock the ORS packets, and they feel happy when they can be of benefit to their community when they can supply an ORS packet to a child having diarrhea.
- CHT members have started practicing cleanliness and hygiene, so that they can be role models for others in the community for adopting positive behaviors.
- The CHT feels that the community now looks more clean and hygienic and that is the reason

for the reduction in the cases of diarrhea.

- The local leaders feel that ORS has become a community word and everybody has started to talk about it, a scenario, which didn't exist earlier.
- The vendors have realized the importance of covering food to reduce the incidence of diarrhea in their community. They have started to have hygienic food and have started to practice hand washing.

d. Factors Positively Affecting Achievement

1. Regular home visits by the CHT members to targeted households, provided individualized ORT training, using the available utensils when demonstrating how to mix ORT. Home fluids, such as rice water, which is readily available was also promoted. During the evaluation, mothers repeatedly referred to the fact that CHT members continued to visit them at their homes, even though when initially they were not receptive to the new messages. Mothers cited individual counseling as the most helpful BCC method. Appropriate follow-up was provided.
2. The Hearth provided a forum for ORS demonstration and learning.
3. At the household level, families are now making us of a water vessel ladle promoted to prevent water-borne illness. This is a new practice not found before in many houses.
4. Community leaders have noticed an improvement in sanitation practices. Local leaders have knowledge on diarrhea, ORS & ORT.
5. The availability of ORS is another important factor contributing to the success of this intervention. Supplies of ORS packets were abundant at all levels of the health system visited. By stocking the CHT members with ORS packets, it was much more readily available. It also gave the CHT members something tangible to offer to the families. Many mothers now keep ORS at home.
6. BCC efforts trained children in ORT messages so that the children could be supportive of home case management of diarrhea and further reinforce the practice at home. Children throughout the JD area were anxious to show everyone and anyone their clean-cut nails and were able to sing an ORT song verbatim!
7. Other BCC activities included a local cable carried strip on CDD, community boards show the way to prepare ORS, an ORS Rally with a celebration of ORS week and kites which carried messages about ORS.
8. The health facilities staff promoted ORS and provided ORS to patients at the clinics. Private practitioners had ORS stocks and provided patients with ORS. The unnecessary use of antibiotics and anti-diarrheal drugs is a significant problem in the urban slums. These drugs are perceived to provide a faster cure, so mothers often buy a 'diarrhea tablet' for one rupee (2 cents) from a nearby medical shop, before seeking treatment from an appropriate provider. The consumption of a tablet during diarrheal episodes has virtually discontinued.
9. The "referral chits" and the home-based health card that were jointly created by CPI. Sanchetana and AMC helped facilitate referral to the health facilities, for severe diarrhea cases and when home management failed.
10. The vendors that sold food outside the field-based training listened and learned to the health messages. A few vendors have stated that they would promote positive health behaviors like nail-cutting and hand-washing to all the children that come to buy food from them. They have started to cover their food with cloths. There is a plan to provide training and "certify" the vendors who are practicing healthy behaviors so that caregivers know which ones provide clean food for their children. The consumption of outside, uncovered food has been reduced to nil.
11. Private practitioners have been supplied with the WHO protocols but not all have displayed them. Most private practitioners have displayed BCC material in their clinics and also make use of them for counseling patients. Private practitioners have noticed the reduction in the seasonal diarrheal episodes, demand of ORS packets by mothers instead of medicine and increased knowledge of diarrhea among them.

e. Factors for Non-Achievement/Constraints:

- A few private practitioners do not follow WHO protocol - promote ORS - (although the knowledge about distribution of ORS packets by CHT members in the community is there), and continue to administer antibiotics during diarrheal episodes.
- Non-display and use of WHO and BCC materials by some reluctant private practitioners.
- The large issue of a basic lack of sanitation and clean water in an urban slum area.

f. Special Outcomes:

- Children have gained knowledge on correct hand washing practices and also implement them.
- Children groups have conducted household visits in the community and counseled the mothers on correct ORS preparation
- Adolescent girls are now making household visits to create awareness and supply ORS and trim the nails of all children of the community during home visits.
- Some private practitioners would like to get associated with vendors to aid in the reduction of morbidity and mortality.
- Vendors now earn more since sales have increased after selling covered, fresh food.

g. Lessons learned to be Applied to Extension Program:

- Gatekeepers needed to be targeted and counseled individually and in groups.
- Produce more CDs and video on diarrhea to be shown in community (very effective and enjoyed).
- Health Education sessions with live demonstration of hand washing in a bowl and how ORS helps in diarrhea was very effective.
- Involvement of male member of the community in program is very effective.
- Refresher training for private providers to emphasize correct classification and treatment, the proper use of ORS, simple household preventive behaviors, counseling and follow-up, and avoiding the use of unnecessary drugs for diarrhea. Help them to set up an ORT corner and administer ORS. The tendency to sell anti-biotic tablets to patients with diarrhea, as an incentive remains. How to make a financial incentive for ORS?
- Rally's of children can make more impact in the community and instill practices early in life.
- Adolescent girls will be included in the cost extension and other CPI health program activities in the active dissemination of health messages and as a tool to change the health behavior of the younger population.
- A few vendors have shown readiness, in stocking ORS packets, and freely distributing to the community to whoever needs it. Provide formal training to the vendors to encourage more of these behaviors.
- Surveying of the neighborhood drug sellers to see how many anti-diarrheal tablets they actually sell. Provide training to the drug sellers to promote ORS rather than anti-diarrheals.
- Involvement of slum leaders and men in the community is very effective and is necessary to combat the prevalence of diarrhea through more concerted efforts in community-wide preventive methods such as safe water supply and sanitation.

h. Scaling Up:

- For the scale-up, the program will need to look into more innovative methods to bring about community-wide hygiene and sanitation. Collaboration with AMC for garbage collection and drainage lines will help reduce diarrhea. Saath will address and strengthen this issue through their hygiene and sanitation program and will leverage resources.

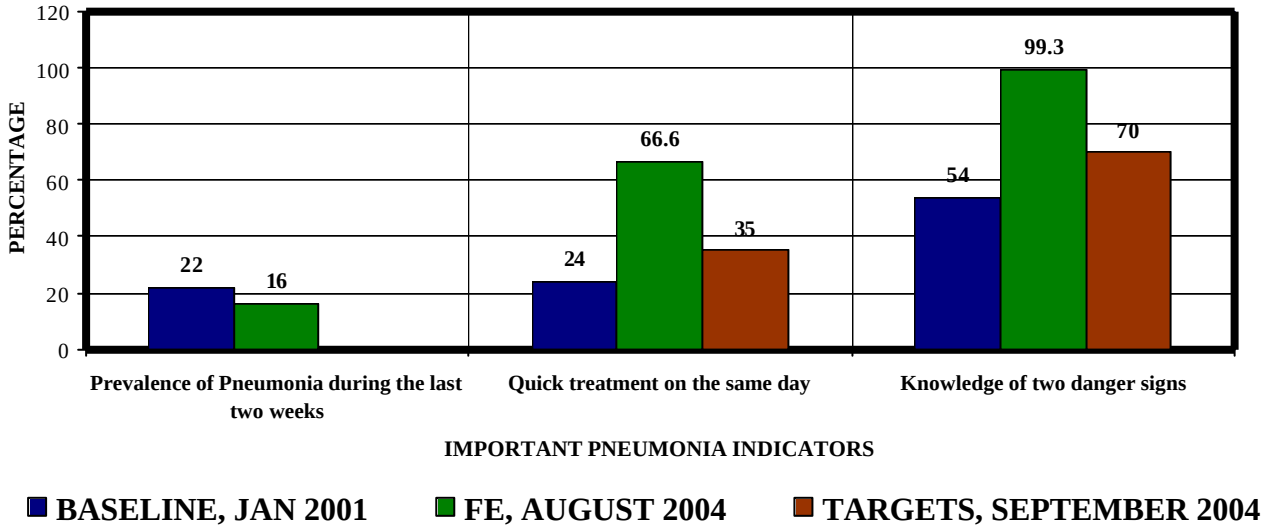
- A greater emphasis on the reduction in malnutrition will help reduce diarrhea and vice versa.
- Ensure the constant supply of ORS (both small and large packets) within the community independent form the AMC provision.

2. Pneumonia Case Management

a. Objectives

1. 70% of mothers with children < 2 years of age would be able to recognize at least two danger signs of pneumonia indicating medical treatment (baseline: 54%)
2. 75% of mothers/caretakers would be able to recognize the danger signs of rapid breathing /difficult breathing (baseline: 61%).
3. 35% of mothers with children < 2 would seek medical treatment from a qualified provider on the same day that the child shows danger signs of pneumonia (baseline: 24%)
4. 25% of children <5 years with cough/difficult breathing would be managed by a trained health worker following WHO/ IMCI protocols for SCM of pneumonia (baseline: 0%)
5. 45% of children < 5 years with cough/difficult breathing will have their respiratory rate checked when visiting the health facility (baseline: 27.6%)
6. 35% of trained health workers have received a supervision visit within the last 2 months that included an observation of case management of a sick child. (Assessment, treatment and counseling) (Baseline: 0%)

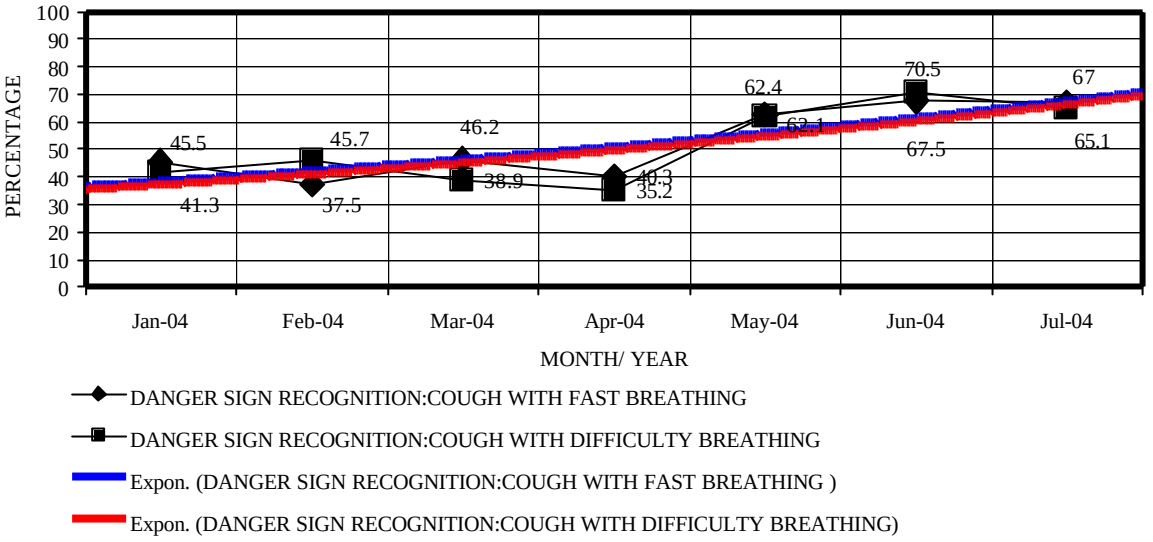
COMPARISON OF FE KPC RESULTS WITH BASELINE AND TARGETS: PNEUMONIA INDICATORS



b. KPC data and HMIS

The prevalence of pneumonia was reduced from 22 to 16 from the baseline to the final. Quick treatment on the same day was sought by 24% at the baseline and increased to 66.6 % by the final. Certainly, with more families adopting the behavioral change of seeking immediate health care more pneumonia could have been prevented. The evaluation team ranked this intervention on a scale from 0 to 10 (in terms of success) the highest of all interventions at **9.5**.

TREND ANALYSIS OF IMPORTANT PNEUMONIA INDICATORS



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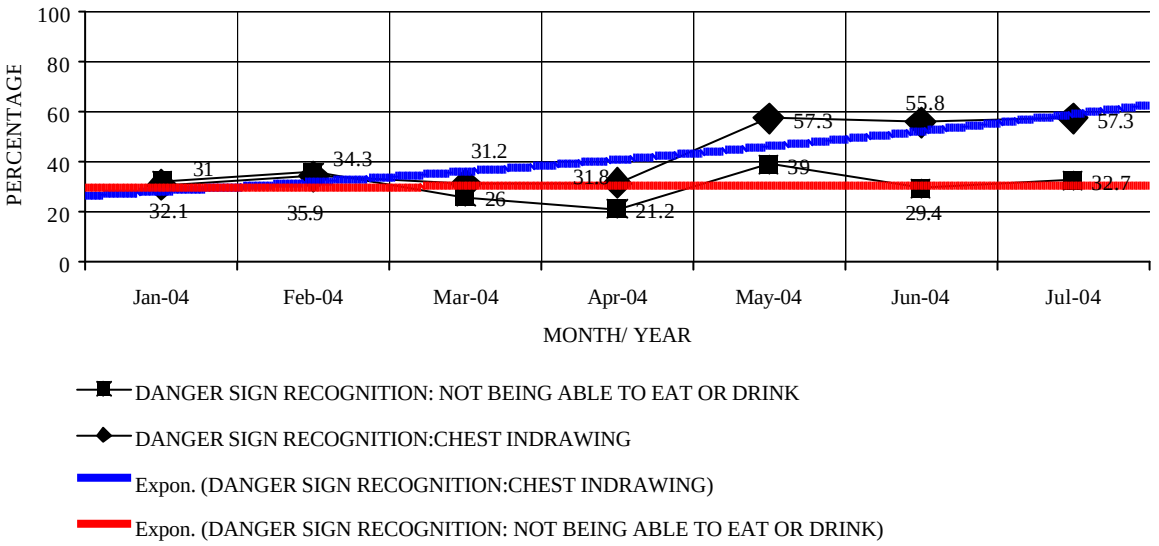

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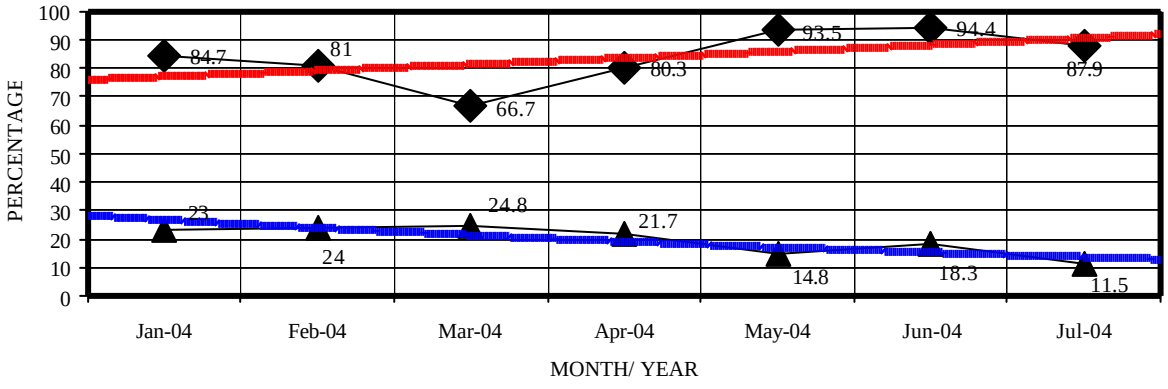
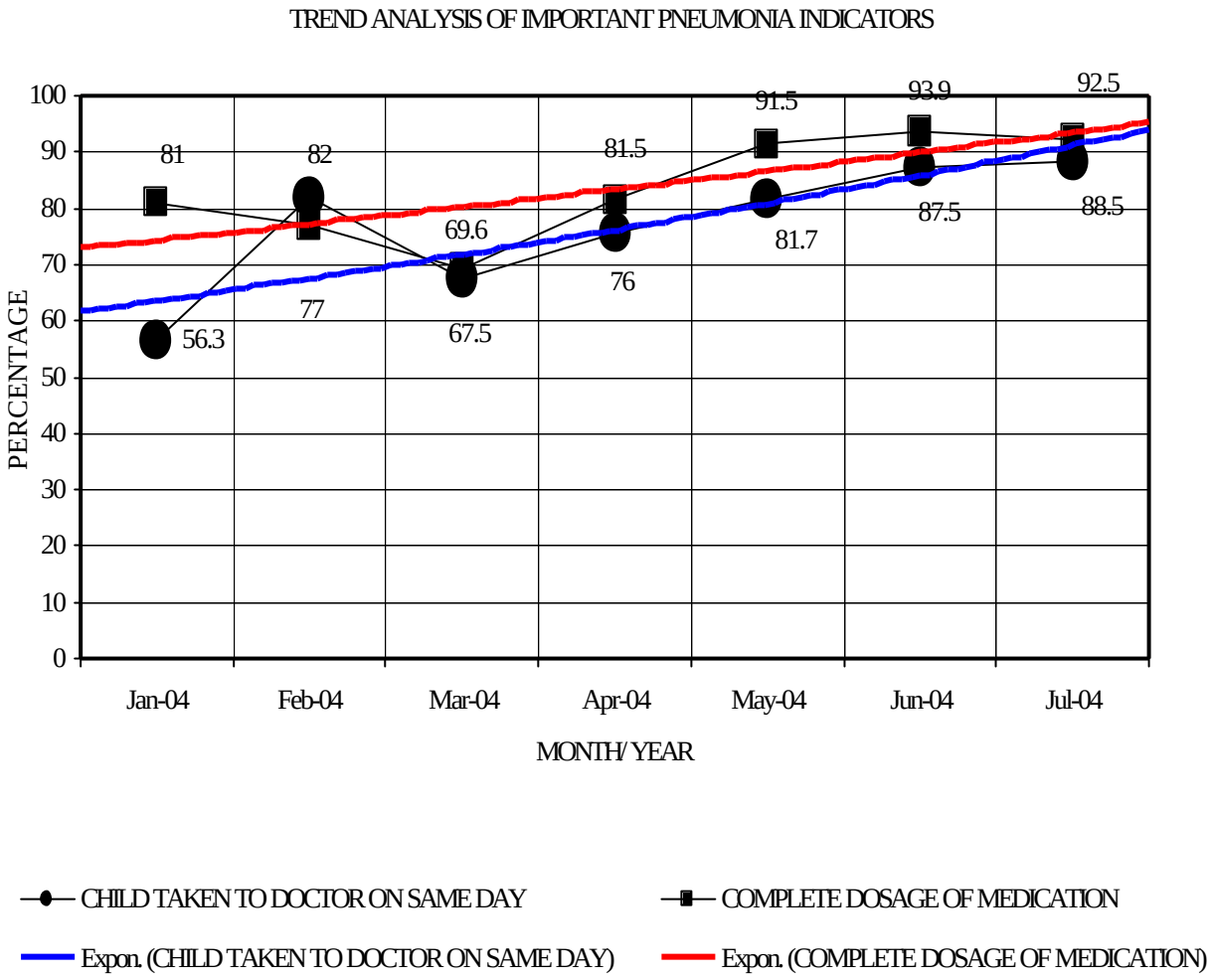




c. Results From The Qualitative Data

Community Interviews

- High awareness about danger signs and immediate treatment among mothers present.
- High awareness about danger signs and immediate treatment among CHT members present.
- Individual counseling have ensured clarity of understanding about Pneumonia
- Local leaders are aware about the CHT members' trainings on ARI and support the program.
- Practice- Mother bathes the child with hot water and applies Balm on chest before putting the child to bed, in rainy seasons.
- Mothers and gatekeepers no longer take their children to traditional healers.
- Referral chits have helped in easy access to the municipal hospitals and in proper and timely treatment. CHT members accompany the mother to the PHC with a referral chit and this, results in proper treatment at the PHC.
- Private practitioners recognize the decrease in number of cases seeking treatment from traditional healers and increase in number of cases seeking immediate care from a doctor. Acknowledges the impact of health education in increasing mother's knowledge on ARI.
- Vendors have been counseled on ARI who have volunteered to keep track of children falling ill with ARI and referring them to the CHT members or concerned CHP/A.
- Certificates of participation have increased CHT's confidence in their knowledge and the community's confidence in them.

d. Factors Positively Affecting Achievement

1. Access to AMC health facilities has improved and the service is considered better and is absolutely free.
2. A drastic change has occurred with reference to naming the Illness 'Pneumonia' which was a total taboo earlier. This makes the caretakers open to know more about the illness and take immediate action.
3. Better nutritional management of illness by increased feeding and breastfeeding. Some nutritious foods that were not fed earlier due to myths are now being fed to the children.
4. CHTs feel empowered in extending help to children with pneumonia.
5. CHT refer these cases to Health facilities and if required accompany the child with the caretakers.
6. Training of AMC MPWs/ ANMs on ARI has refreshed their knowledge on its cause and treatment.
7. Private Practitioners know and follow WHO Protocols for the Case management of ARI.
8. The illustrative and colorful BCC materials are easy to understand by all whether literate or non-literate.
9. Extensive individual counseling at house hold level
10. Health education in-group sessions have helped discuss and clarify the superstitions, myths and false practices regarding pneumonia.
11. FGDs with the community at the baseline and gave an idea about the myths and cultural beliefs about the issues of Pneumonia and formative research into the same before developing BCC materials and scripting for puppet and street plays have been effective.
12. The BCC messages focused primarily on simplifying the messages for ARI.
13. ARI posters have been posted at all health facilities and at private practitioners' clinics
14. Leaflets, video shows and poster have helped in increasing awareness, reducing myths and superstitions related to ARI.
15. CHTs have taken an active role in creating awareness about ARI and in counseling mothers about the same.
16. Increased use of referral chits for immediate care has helped in ensuring that children are taken care of.
17. Strong linkages among CHTs and Private Practitioners and CHTs with AMC staff has been effective in immediate treatment of cases
18. Traditional Healers have been involved in promoting immediate treatment and stopping harmful practices in some communities.

e. Factors Negatively affecting Achievement

1. The WHO Protocols were not posted at some of the health facilities for SCM of pneumonia.

f. Special Outcomes

1 Mothers know how to identify danger signs and demonstrated corrected knowledge.
2. Some of the private practitioners have started training community Health promoters as per the WHO guidelines in the community
3. AMC doctors are now regularly conducting ARI and other training in the community during their outreach sessions in assistance with the CHPs.
4, AMC has continued supply cotrimoxazole to all health facilities in the target areas and

g. Lessons Learned

1. Individual counseling by CHPs/CHAs have been very effective.
2. Mothers can recognize the danger sign of pneumonia and immediately go to the doctor, and complete dosage.

3. CHTs refer children for immediate treatment and promptly follow up on cases.
4. CHTs training on ARI through scientific inquiry have been effective. A video that was regarded as too scientific was readily understood and enjoyed by the CHTs. This has increased their knowledge and helped remove their myths and beliefs.
5. Local leaders can be promoters of immediate treatment of ARI among male members.
6. Deep-rooted beliefs of mothers-in-law have changed and they have started motivating women in their community to go to a doctor instead of going to traditional healers and have stopped harmful practices like branding.
7. All mothers of children under-five need to have ARI pamphlets with them.
8. More songs, flannel boards, stories on ARI may be developed.
9. Reduce gender bias to seek treatment for ARI, study this and involve the CHTs
10. Need to increase communication skills of doctors whereby they tell the reason of the illnesses, what has happened, and what to do and provide more clarity on dosage.
11. Increased participation of traditional Healers in CHT trainings on ARI.

h. Scaling Up

1. 100% coverage of ARI cases may be achieved through Link worker, CHTs etc.
2. Customer friendliness training to be given to AMC staff to improve chances that people will visit AMC health centers.
3. A counseling table at health facility once a week set by MPWs and Link workers.
4. ARI surveillance to be done, discuss it at ward level to see cases versus those that visited AMC hospitals.
5. Use adolescent girls and boys in counseling on ARI.
6. Between the months of November to February provide mass campaigns involving CHTs, and private practitioners for better pneumonia preparedness can be conducted since this is the season for greater incidence of ARI.
7. Street plays for Pneumonia to reduce taboo related to Pneumonia, simplifying it as a curable illness.

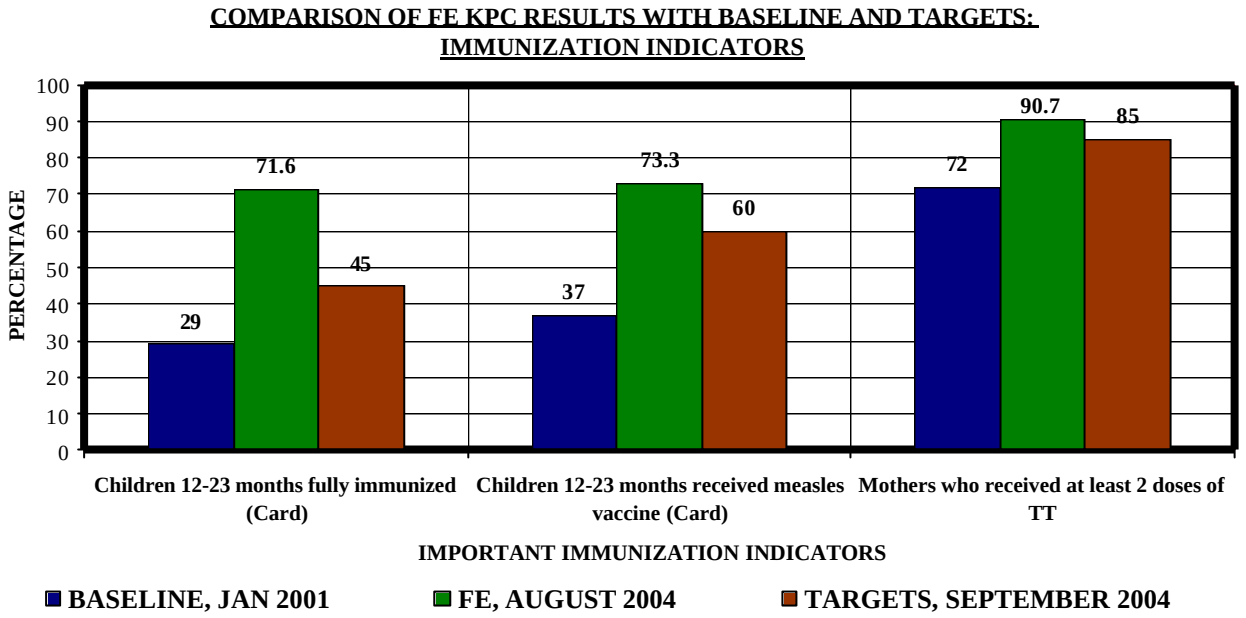
i. New Tools

Referral chits: The introduction of the jointly designed and produced AMC referral chit system was a tool that greatly improved access.

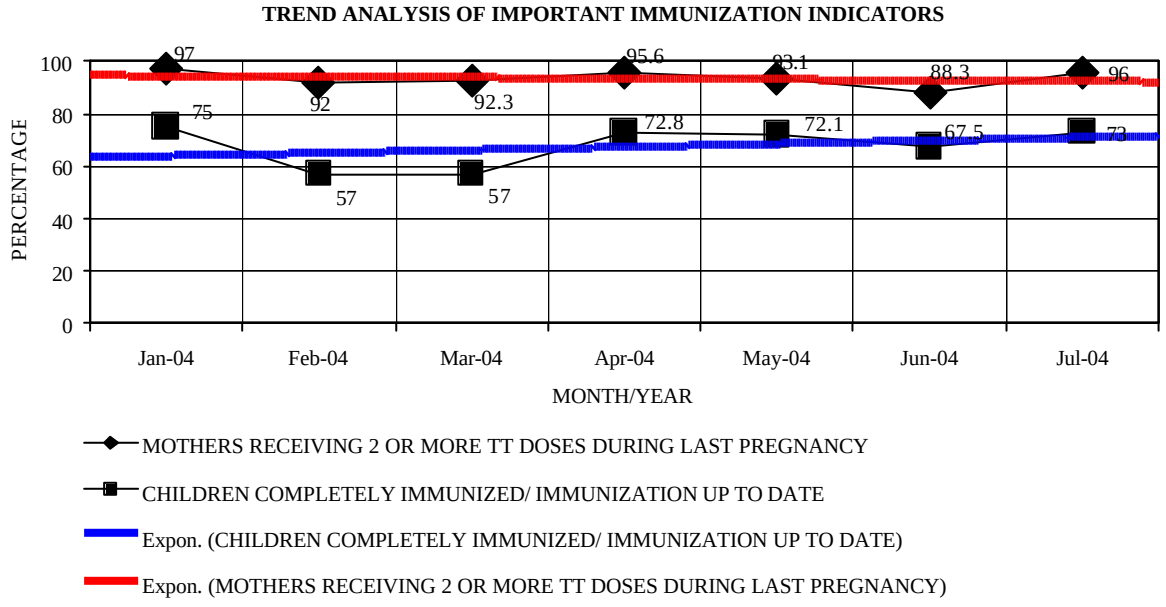
3. Immunization

a. Objectives:

1. Increased from 29% to 71.6% ***complete immunization*** of children 12-23 months.
2. Increased from 37% to 73.3% **measles coverage** of children under-two.
3. Increase from 72%-90.7% pregnant women who receive at least 2 doses of **TT.**



b. KPC data and HMIS



The evaluation team ranked this intervention at **8.5.**

c. Results From The Qualitative Data

Community Interviews

1. Myths and false beliefs regarding immunization have been addressed through the provison of technical understanding by training CHT members.
2. CHT members counsel mothers and mothers-in-law and accompany mothers to go for vaccinations with their children.

d. Factors Positively Affecting Achievement

1. CHTs and mothers have been made aware of vaccination card and vaccination schedules.
2. Extensive distribution of vaccination cards that are produced jointly with AMC that has its effect in community's understanding of timeliness of vaccinating their children. AMC is now using the card for the vaccination as well for the drop out children.
3. Referral chits have helped in enhancing the access of the community members to the AMC facilities also has helped in building good relations with vaccinators thereby, increased attendance of children in vaccination camps thus, increasing the coverage. Please see copy of referral chit Attachment O
4. BCC materials easy to understand and explanatory thus mikes easy for an illiterate CHT to counsel even an illiterate mother.
5. Reaching the target mother through multiple contact methods has made it possible to increase TT vaccine coverage amongst expectant mother.
6. Local leaders have been supportive in helping the CHT members to promote increasing the vaccination coverage and breaking false beliefs.
7. Infotainment programs like street plays, songs have been helpful in reaching men, youth and the gatekeepers of the community.
8. **EPI camps/Catch-Up:** Vaccinators of the AMC have begun penetrating into the slum areas, as a result of the efforts of the field staff of the program. Local leaders are often present during immunization camp. The camps are held at a CHT member's house. This new immunization strategy brings EPI services into the community through an outreach system. After the communal riots, AMC field staff asked CHP to accompany them for holding immunization camp. They have continued to attend.
9. **Linkage between AMC staff and CHT volunteers:** The AMC staff are well aware of the CHTs members since the CHAs and CHPs bring them when they meet. Since the vaccinators realize how the CHT's helped facilitate their work, there is a strong sense of mutual respect and appreciation. Each party encourages the other. When more children and women show up, an expectation is created and the vaccinators are more encouraged to come. When the vaccinators do not show up, the CHA/CHP along with a CHT member will go to the health center together to demand a reason for not showing. This is a very important relationship to build for sustainability. It was clear from interviews with the CHT members and local leaders that immunization was a "right" and that they were willing to demand the services if need be. This also works for referrals.
10. **BEHAVE framework:** The BCC activities have included messages on immunization to motivate the population to get immunized, included street theater and leaflets.

e. Factors Negatively affecting Achievement

1. The EPI technical training will be done after the demand has been created. The community has been motivated to receive immunizations, yet the technical training in EPI hasn't been given yet to assure the quality of service during the community outreach camps. The HFS does monitor the quality of care at the facility, but the camps are not included in the surveying methods. Immunization, if not conducted properly, can be more dangerous than not having it done.
2. Cultural beliefs surrounding measles continue to believe that it is better to have measles rather than the immunization to prevent it.
3. There is a high prevalence of tuberculosis, which leads to questioning the effectiveness of BCG. CPI I snow implementing TB control program in the same targeted slums working with AMC to address this issue.

f. Special Outcomes

1. Adolescents are involved in taking children to immunization camps and counseling mothers.
2. The awareness generated through various BCC activities has made gatekeepers encourage their daughters-in-law and wives to go for vaccinations.
3. Easy and simple training programs have served as an eye opener to the CHT members to break the myth regarding measles.

g. Lessons Learned to Apply:

1. New EPI Training will focus on improving health workers' communication skills required for counseling and follow-up for both AMC and private practitioners. Training will also include injection safety issues, the safe use and disposal of injection equipment, and the use of mono-dose auto-disable syringes (if approved by the AMC).
2. Train CHTs in "Safe Immunization" including cold chain and injection safety. Emphasize with the CHTs "Bad Immunization is worse than no immunization" so that eventually they are able to discern a safe session from an unsafe one.
3. Post camp dates on the community board and the increase in COVERAGE rates so that the data is community-owned.
4. Once beginning death reporting, cross-check the effectiveness of the EPI intervention with the number of deaths from immunizable preventable diseases. Each death should be analyzed to find out if it could have been prevented.
5. Consider expanding the immunization camps to include a MO to check-up children and treat women with gynecological problems and possibly weigh children. The model from Indonesia, Pos Yandu, includes 5 tables: weighing, nutrition counseling and Vitamin A distribution, immunization, ORT corners and family planning. This model has already started by AMC and Counterpart and it is worth expanding into neighboring areas.
6. Other community groups beside CHT, like adolescent, youth, mother in laws, men to be involved to mobilize people for increasing vaccination coverage.
7. Sensitizing the gatekeepers more in regards to the health of the children, daughters-in-law and wives.
8. Private Practitioners to be sensitized to encourage mother to immunize their child for a better health. Train the vaccinator for client servicing and ensuring follow up visits so that the community is encouraged to go for immunization
9. Private Practitioners to be involved in community training/ health education sessions
10. Emphasize trust-managed hospitals to share immunization load of AMC through effective partnership and help them in mobilizing community to come for immunization. Also build their capacity in the maintainance of the records of the mothers and children immunized.
11. Provide client-service training for MPWs to improve their attitude towards urban poor.
    Improve the technical skills of the vaccinators through training

h. Scale-Up:

1. CHT member trainings for mothers-in-law and target mothers to break myths and encouragement in expanding immunization coverage.
2. More interactive health education sessions on immunization to be taken up during hearths.
3. The CHT members accompanying the pregnant women and target mothers to get vaccination.
4. Gatekeepers to be involved in the activities of the program activities. More audio-visual mediums used in training/health education sessions.

5. Improve the regularization of camps through AMC. Be sure that even if there is a holiday (there are many) that the camp must go on.

i. New Tools

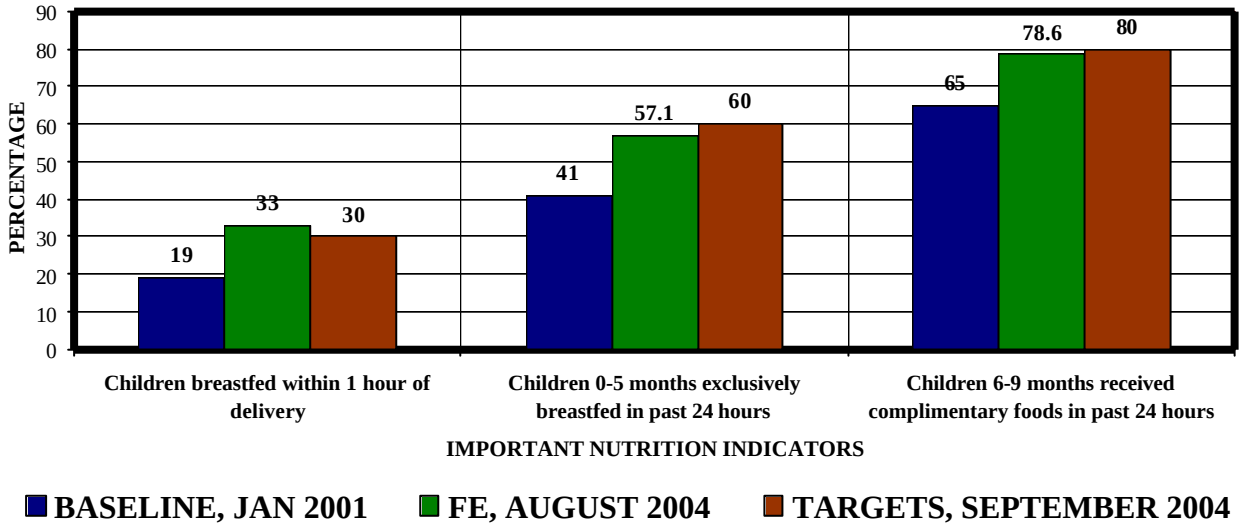
1. **Reminder system:** The registration of all under-twos for immunization was entered into EPI-INFO and monthly lists of children who need to be immunized are generated by date. It is updated monthly with the new antigens and dates received. As births are registered, newborns are added to the list. It has served to notify each CHP/CHA of the individual children who need to be immunized. This is shared with the CHT. They inform each caregiver to bring their child on the date their child needs immunization.
2. **Vaccination card**: By adding more visuals it is easier to understand and also encourages the caretaker to complete the immunization of the child.

4. Nutrition

a. Objectives:

1. 30% of newborns that are breastfed within one hour (baseline: 19.0%)
2. 85.6% of infants under-six months are exclusively breastfed and receive no other liquids or solids (baseline 41%).
3. 57.1% of children 0-5 months exclusively breastfed in past 24 hours (baseline 41%).
4. 80% of infants 6-9 months of age who receive appropriate supplementation/weaning (baseline: 65%)

COMPARISON OF FE KPC RESULTS WITH BASELINE AND TARGETS: NUTRITION INDICATORS



b. KPC data and HMIS

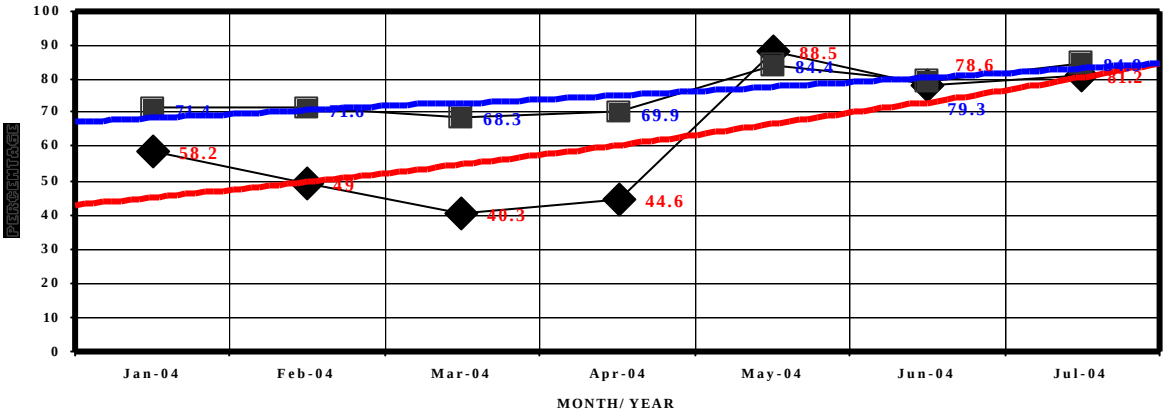
The major activities that have promoted nutrition have included:

1. Mobilization of CHTs: individual counseling and health education sessions.
2. BCC messages: promoting exclusive breastfeeding through community-based BCC initiatives, including BCC programs for mothers-in-law.
3. Hearth piloting

Thirty percent of children are now breastfed within 1 hour of delivery, up from 19%. And 85.6% are fed colostrums, more than doubling the baseline. Children 0-5 months exclusively breastfed increased from 41% to 57.1% and the percentage of children 6-9 months who received complimentary foods in the past 24 hours increased to 78.6% up from 65%.

The evaluation team ranked this intervention as an **8**.

TREND ANALYSIS OF IMPORTANT NUTRITION INDICATORS



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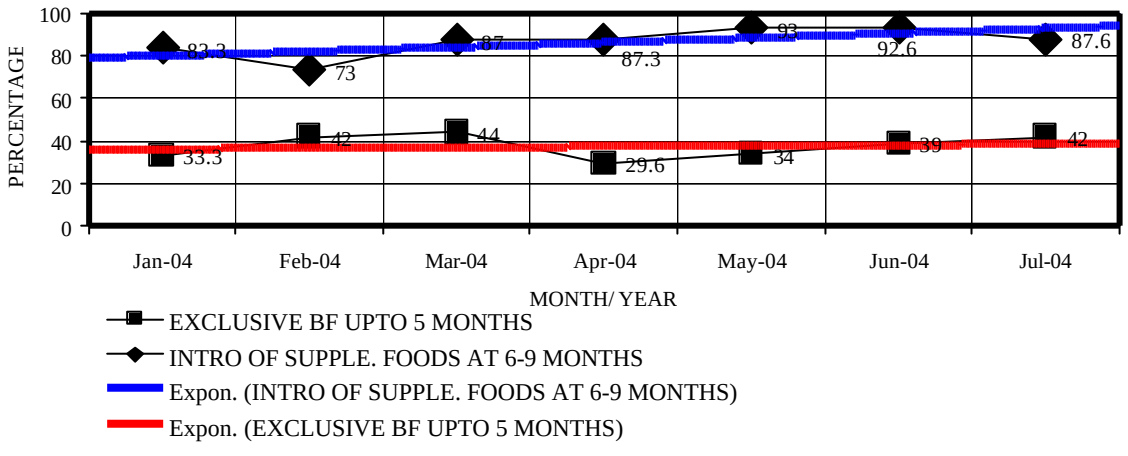

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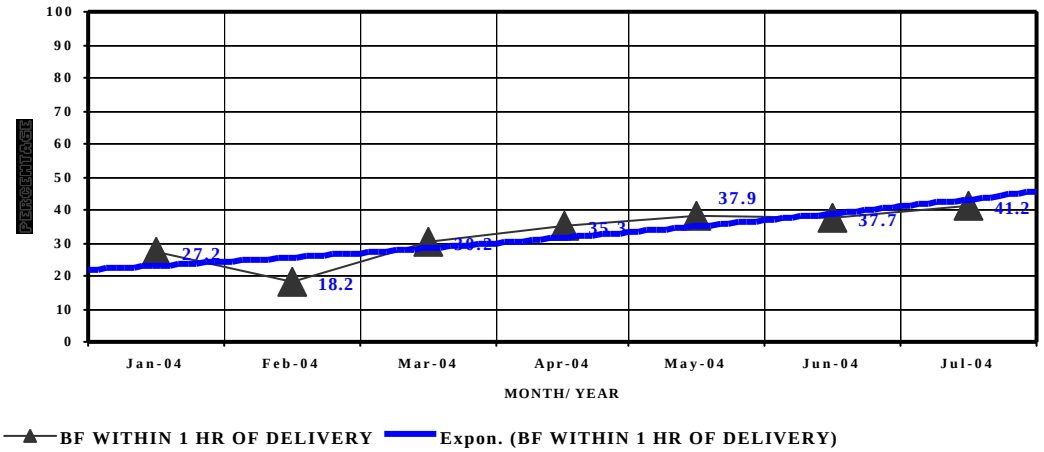
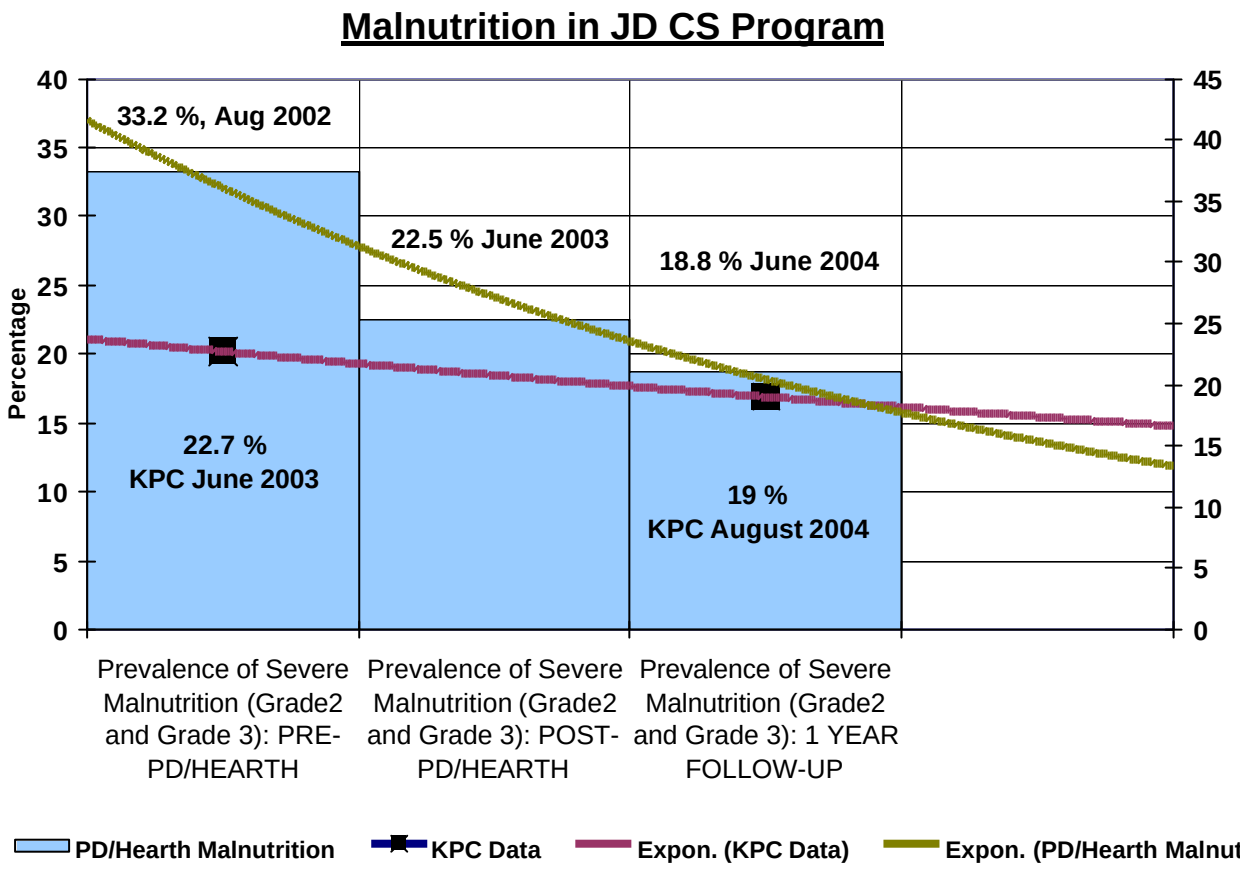


Quantization Results

The graphs display the change in nutritional status between the baseline KPC and the final KPC. Malnutrition (2nd and 3rd degree) fell from 22.7% to 19%. Within the slum pockets that implemented the Hearth, the prevalence of malnutrition dropped from 33.2% to 18.8% after completing two cycles and tracking one-year follow-up weights of Hearth participants only.



As far as the nutritional status of the hearth participants is concerned, the data is as follows:

- Prevalence of severe malnutrition amongst hearth participants before hearth: 64%
- Prevalence of severe malnutrition amongst hearth participants after two cycles of hearth: 31%
- Prevalence of severe malnutrition amongst hearth participants at one year of follow up of weights: 44.2%
- The prevalence of severe malnutrition in Hearth areas, one year later is 31% lower than at baseline.

c. Results from the Qualitative Data:

Home Visit Results: Observations
• Continued feeding during illness is a behavioral change from before the program started. • Mother knows importance of supplementary foods, if not on time, the babies will look malnourished. • Knowledge the importance of: nutritious foods during pregnancy, green vegetables and pulses, complementary foods, complete course of iron tablets and exclusive breastfeeding, vitamin A • Quote from one CHT: "No colostrum has been thrown away since *'Jeevan Daan'*

Gate Keepers:
• Elderly people know about colostrums as being healthy to give to newborns now. • Some Mothers-in-law counsel the young pregnant women on intake of nutritious food during pregnancy, continue 2 TT and iron and importance of colostrum

d. PD/ HEARTH:

The Hearth has been piloted in the urban area to try an approach, which depends on a large amount of community contribution and participation.

The implementation of the hearth was one of the first community activities after the violence, which served as a visible entry point and generated good will.

The Hearth Methodology using the "positive deviance" approach was started in selected neighborhoods in the slum pockets. As an alternative model to the "community kitchens" which have been set up in other urban slum areas, the Hearth was established to enable mothers of malnourished children to come together to cook and learn nutrition messages. Given the large cultural, religious and caste diversity within an urban slum, the Positive Deviance Inquiry (PDI) explored the differences and provided culturally specific nutrition education, through methods that were "discovered" in very specific groups. Direct observation of families with well-nourished children in the slum area was done to identify good feeding practices, good caring practices and good health seeking practices. The same three sets of practices were observed in families with malnourished children. The positive behavior differences were identified and shared among caregivers of malnourished children during the Hearth sessions.

Feeding PD food to the malnourished children at the Hearth

The PDI revealed behaviors such as hand washing, eating from street vendors, feeding practices, excreta disposal methods, and caring practices that make a difference in not only nutritional status, but incidence of diarrhea. PDIs were conducted among Muslims, Hindus, and various castes, allowing for the cultural differences to emerge in terms of "what is working today" for the support of well-nourished children.

This informed the Hearth sessions, which are conducted by local volunteer mothers. Groups of 5-7 malnourished children attend a two-week session with their caregiver, contributing food, cooking, feeding and cleaning up after each feeding demonstration. As most mothers' time is precious during the day, the timing of the Hearth was determined by the mothers to decide when they are available to attend a 1-2 hour Hearth session for a two-week period.

The hearth initiative has been received well by the staff and the community. Local leaders requested hearths in every neighborhood. There were women from neighboring wards who had heard of the Hearth and came to learn about it, wanting to replicate it in their area. The Hearth actually is not a "new" concept in India. Culturally in India, there is a tradition of gathering around the "chula". The chula is a community cooking fire. There is a value there for Hearth and introducing the Hearth was more of re-establishing a forgotten tradition.

The contribution of food brought by the participating mothers has not been a problem. The price of admission to the Hearth is food. If the practice does not begin with bringing the actual Hearth food itself from the start it would most likely not be practiced at home. The CHPs of one of the Hearths were surprised to find that the first mother to show up at one of the sessions with her contribution was from a beggar family. The issue of food contributions has not been a problem or questioned. CPI does provide vegetable oil. All the other foods are contributed. The addition of oil is to boost up the caloric value of the meal during the rehabilitation stage. Once the child

experiences "catch-up" growth, the intense calorie input will not be required, however, balanced healthy meals will continue to be needed.
Within 10 Hearths,169 children have gained weight. Twenty-two children have moved up from first degree malnutrition to normal. Ninety-five children have changed their nutritional status upward. Attendance has maintained an average over 90.8%. The dropout rate has been minimal, with only one or two per cycle. The average weight gain across 20 cycles has been 422 grams.

Hearth participants Quotes:
• "Now I know that poor people can also have healthy babies" • "We like the information about our babies' weights." • "Money is not important factor, can bring ingredients, and only need to have their child healthy." • "My child is playful and has chubby cheeks now." • "We are always happy to come back until really good weight and in the green." • "I like the follow-up visits by CHT (ex. 3-4 days after one cycle)." • "My child has started to consume more vegetables and demand food" • "I like to learn new recipes which are delicious and nutritious." • "Go-Grow-Glow knowledge is good". • "We can notice measurable and visible changes." • "My child started demanding food, and is more playful, used to be irritable, and cry a lot. Now she runs"
Gatekeepers:
• "Once the hearth, the young mothers are preparing nutritious food, not prepared earlier." • "I have motivated my daughter in law to send her children to hearth, if at all it could make them look healthy." • "I saw differences in my grand-daughter since Hearth. You can hold it at my place anytime".
Vendors:
• "You are working for the health of little children, so I also have given nutritious food so children do not fall ill." • "Started covering the food, better hygiene for children." • "You are working for the health of little children, so I also have given nutritious food so children do not fall ill."
CHT Members:
• "Colostrum feeding has begun." • "We counsel to give food during illness and continuous feeding to prevent malnutrition." • "Mothers are aware of good feeding practices so children look healthy." • "It is clear that malnutrition is not because of poverty." • "We are supervisors of the Hearth."
Local Leaders:
• Know about Hearth and are positive and encouraging. • Demanding many more Hearths in their area. • "Children look healthy now and do not fall ill, mothers know more about nutrition." • Appreciates HE session on Nutrition • "Mothers knowledge has increased."

e. Hearth Innovations:

1. Although the Hearth trainer had conducted separate PDs, one in a Hindu community and one in a Muslim community, the program evolved to bring both communities together into one Hearth, as the PD revealed similar findings. There was also a respect and accommodation of the Hindus by the Muslims for the prohibition of eating eggs and that has brought two communities together during communal carnage.
2. One of the Hearths recruited young girls as Hearth volunteers. They were implementing excellent Hearths with a clear understanding of the concept. One can be sure that they will become excellent mothers without any malnourished children at home.
3. A "Group" Road to the Health was posted at one Hearth with all the participants weights plotted on an enlarged Master Growth Chart poster. The weight changes were plotted. It was a graphic display of how the weights increased after one 2-week session and progress during subsequent sessions. Every mother said she wanted her child's weight to rise into the green (normal status) so it vividly displayed the weight changes and was understood by them.
4. Badges were pinned on children and caretakers at the time of the Hearth. This made the participant "official" and was a motivation for attendance.
5. Sort the food combinations by food group for the visual effect of seeing how each food group should be represented as it is contributed. Place it on a vinyl sheet or on a thali plate with 3 dividers for GO, GROW and GLOW foods.
6. Volunteers write up the recipes for the Hearth, reproduce them, and sell the book for income for the group of volunteers.
7. Use the on-going Hearth sites as a training site for the new Hearths.
8. Use of adolescent girls as volunteers is plus for the program and this should be continued

f. Recommendations for the Hearth:

1. Keep an index box with each Hearth participant's card and set up a tickler file to be sure to follow-up weight at 3 months and 6 months.
2. Consider a small contribution (3-5 rupees) per session by the participating mothers to give a small incentive to the volunteers and to encourage the participants to attend everyday of the session and value it more.
3. Hearth volunteers produce hand-made toys for the children, such as painted blocks and bottles, rather then buying toys.
4. Consider setting one of the pre-requisites for Hearth enrollment is up-to-date immunization.
5. Instill a sense of urgency to rehabilitate within one session. Hearth is not a permanent structure, but rather an itinerant, temporary rehabilitation. Caregivers should try to have their child graduate within one 2-week session.
6. Along with the participants, hearth volunteers, TAC and CHTs and JD staff, determine the criteria for graduation: gained "catch-up" weight (i.e. over 400 gms), or moved from sever to moderate, or moderate to mild or mild to normal, completed 3 Hearths.
7. Track the percentage of male/females of the hearth participants to be aware of gender bias with the hearth participant group and detect gender discrimination. Apply the "positive deviance" approach to the issue.
8. Use a split page register book to track a child over several Hearths.
9. Document the learning from the urban hearths. This can serve as a forerunner in urban Hearth experiment and provide a new model in India.

g. Factors Positively Affecting Achievement of Nutrition Indicators

1. Introduction of positive deviance approach to nutrition through the Hearth: testing the model in the urban slums

2. It is a high-profile intervention being in somewhat of a "fishbowl" in the slums. It created a stir among the community, since "seeing is believing" and children were gaining weight.
3. The Hearth brought Muslims and Hindus to eat together, and built peace.
4. Young adolescent girls were trained and became hearth volunteers with great enthusiasm and energy.
5. The BCC materials spread the message about breastfeeding and Vitamin A.
6. The ICDS program, through aganwadi centers provides supplemental food packets to those that fit an economic criterion. The Hearth is a different approach, which is antithetical to the supplementary feeding program. In the Hearth, mothers contribute the food and there is no reliance on outside resources except for some cooking oil from Jeevan Daan. The fact that AGW centers are not operating in the urban slum areas in which JD works, makes it somewhat more of a controlled experiment.
7. HEARTH- platform for Health Education on antenatal care, preparation on BF, cooking of nutritious foods, hygienic cooking, food groups. The CHTs feel that the nutritional status of the children in their community has improved due to the PD/hearth program.
8. Extensive individual contacts at homes and health centers have resulted in mothers adopting positive behaviors across this intervention.
9. Group health education with pregnant mothers, mothers of children less than 2 years, positive deviant mothers used as role models, TBAs.
10. Puppet shows, street plays, CDs – prepared by IDEAL, slide shows on how and why to Breastfeed and Lactation failure.
11. BCC aids- posters, pamphlets, and flipbooks have made the learning easier for the target audience. Even the illiterate CHT members can explain the nutritional messages through the pictures in the flipbook.

COMMUNITY MOBILIZATION

1. CHT formation-identification of pregnant mothers, new born babies, children ready to wean, malnourished children
2. CHTs have given special counseling to these groups
3. CHTS have trained TBAs in the above
4. TBA involvement in immediate BF and colostrum promotion
5. Involvement of Anganwadi Workers for counseling on nutritious foods
6. Involvement of Private Practitioners, Local Leaders, Youth groups in HEARTH

ORGANIZATIONAL CAPACITY

1. Systematic training
2. Percolation of trainings to community through CHT
3. Involvement of Private Practitioners and AMC staff in these trainings
4. In-house drip trainings on daily issues and challenges

h. Factors Negatively affecting Achievement

1. Iron deficiency anemia is a serious problem among women and children.
2. There is not a nutritional rehabilitation ward in the health facilities to isolate severely malnourished children who may require an intravenous insertion or naso-gastric tube.
3. Deep-rooted cultural beliefs regarding nutrition make it the most difficult to change behaviors in this intervention. Exclusive breastfeeding is not always truly exclusive due to religious and cultural traditions, which include small amounts of water, honey and jaggery
4. High amount of deliveries taking place at homes making initiating breastfeeding within 1 hour after delivery practically very difficult.
5. Growth monitoring is not institutionalized in the target communities. If this is done every month, it could be used as an opportunity to counsel mothers on good time for weaning foods and complementary feeding through the use of recipe books and pamphlets.

6. The Hearth was seen as a "social recipe" club. This is a good feeling, but also dilutes the impact and gravity of the messages and the rehabilitative goals.

i. Special Outcomes:

1. Emphasis early initiation of breastfeeding, explaining the benefits of starting fast!
2. Promoting the development of breastfeeding support groups through CHTs
3. Advocate to AMC the need for an isolation ward in the facilities for treating severely malnourished children.
4. Train doctors to assess nutritional status by asking to see the Growth chart of the patient or by weighing the child and determining the degree of malnutrition.
5. CHT of one of the communities collecting Rs. 2 per month per child as a token charge for weighing the child. This opportunity is used by the CHT to counsel the mother on nutritional needs of the child depending on its age. Moreover the money that is being generated can be used to administer the hearth in that community whenever the need arises.
6. Involvement of adolescent girls as hearth volunteers.
7. Involvement of adolescent girls, youth and children in the community to take nutrition related messages to the target mothers.
8. World Vision/India has visited the Hearth. This program offers a very good urban example that shines. CPI India staff went to World Vision India to train them in Hearth.
9. CPI hosted a CORE sponsored Asia Regional Training of Trainer's Hearth Workshop for 27 participants from 8 countries.

j. Lessons Learned

1. Regular Growth monitoring is necessary wherever Hearth is implemented for systematic follow-up.
2. More involvement of TBAs and a formal training of all TBAs to improve the breastfeeding behaviors of the community. At the end of the training, a "safe kit" could be given to the TBAs to practice safe deliveries.
3. There should be a more formal involvement of vendors in the program. There should be a training of all of these vendors on nutrition, food recipes and even diarrhea. At the end of this training they should be given a net as a memento to cover the foods that they sell.
4. There should be more activities at the Municipal schools in the program area, where the children are given explanations about various food groups, the importance of each food type and what effect eating outside open food has on their health.
5. Given that Maternal Health is clearly a future priority, consider setting up Hearths for pregnant and lactating women. Bringing women together to practice cooking and eating nutritious foods would be a jump-start to prevent low birth weights and early childhood malnutrition as well as improve lactation performance. A PDI would include observing those mothers who have healthy pregnancies as compared to those that are not, along with successful breast feeders, as opposed to those that are experiencing problems with breastfeeding. Health education messages would include: improved maternal diets, increased food intake, high calorie iron-rich menus, ferrous sulfate tabs, TT, malaria prevention (sleeping under ITNs), post-delivery Vit. A supplementation, HIV/AIDS and breastfeeding, etc.
6. Growth monitoring should be more formally institutionalized in at least the communities that are selected for the hearth intervention.
7. More hearths in the communities, as the communities perceive this as an activity that has a great potential to improve the overall health of the children in their community
8. Each and every malnourished child raises a red flag. It is a sign of dysfunction at the family level. The CHTs should act more as social workers and problem-solve as much as possible to understand the complex issues underlying malnutrition. A Hearth alone often is not enough.

Scaling-Up:

1. Do an in-depth analysis of the Hearth process before implementing it at a larger scale.
2. Implement regular growth monitoring
3. Involve the Anganwadi Centers in the Hearth training and find a middle path for collaborating with them.
4. Strengthen follow-up of all Hearth Participants and their siblings
5. Consider "hearth-like" sessions for pregnant and lactating women
6. Exhibitions at community centers and PHCs using slide shows, video shows to counsel the target audience.
7. TBAs increased involvement across all the selected communities
8. Increased involvement of AMC staff and paramedical staff for BF promotion
9. Forming strong partnerships and advocacy with private maternity homes to promote colostrums feeding and early breastfeeding initiation.

New Tools:

1. The Hearth Growth Card, specifically for Hearth participants
2. A large sized Growth chart displaying the growth data of participants was displayed during the hearth sessions to show the weight gains.

See attached special report entitled: "Piloting Urban PD/Hearth." It is an excellent analysis of the first 10 pilot hearths.

B3: Crosscutting Approaches

a. COMMUNITY MOBILIZATION:

Community-based programs have been a key strategy for many development and poverty alleviation programs in India. However, very little has been done in the area of community mobilization for health care and child survival, especially in the urban slum areas. The *Jeevan Daan* program mobilized local communities through Community Health Teams (CHTs). The role of the CHT is to mobilize community resources for child survival and other priority health issues, and to assist with program implementation and work to achieve the goals of the CS program. CHTs along with the CHP/CHA will be responsible for dissemination of BCC messages in the community. Tremendous progress was made in mobilizing the community and raising awareness of the four health interventions.

Groups Mobilized:

- CHT members (400)
- Formation of 47 CHTs
- AMC staff from the top to the bottom: MOH to health centers
- EPI teams mobilized to conduct monthly camps
- Local leaders mobilized to support and advocate for health activities.
- Vendors mobilized to learn about food hygiene and give messages
- Private practitioners to promote SCM of pneumonia and diarrhea.
- Hearth volunteers (93) trained to conduct the hearth approach to malnutrition

i. Effectiveness of Approach: Community Health Team Members (CHTs)

Community Health Teams (CHTs) have been formed within each ward, which are community-based and volunteer-driven. The Community Health Promoters (8) of CPI and Community Health Agents (4) of Sanchetana each supervise approximately 24 CHT members covering 2-3 CHTs. It has been an experiment in adding a new cadre of workers to the public health sector.

Rather than have community volunteers work independently, CHTs are organized into support groups. Each ward has a CHT with each CHT made up of between 10-20 members. The CHTs provide a venue for volunteers to work within a group structure, which is supportive and sustainable. The volunteers help their community "together." Each CHT member is responsible for 30-50 families.

Prior to the program, the community did not have volunteers (CHT members). There was a missing link between the community and the health system. With the introduction of a new cadre of front-line workers, the CHT members, the link was formed and proved to enhance and expand the interface between community members and health services. CHT members mobilize the target population to attend immunization sessions, seek services at the health centers and refer children with danger signs of dehydration or pneumonia.

ii. Objectives:

The CHT members are motivated by the skills training they have received. They have gained status and recognition from the community. With the observed and measured improvements in their neighbourhoods they have a sense of efficacy that they did not have prior to being trained. They are very eager to learn more and continue to be volunteers due to the intangible rewards they receive in terms of knowledge and helping others. The community mobilization approach was highly effective and the objectives have been successfully reached. The evaluation team ranked this issue at **9.**

Effectiveness

- Most of the community members have started assessing AMC health facilities due to the critical link formed between the CHTs and health facilities staff.
- The gatekeepers especially men are aware of the program and have a good rapport with the JD team.
- The mother-in-laws are open to daughter-in-laws participating in various activities of the Jeevan Daan program (Street Plays, Health Education Sessions, etc).
- CHT members are highly motivated and are committed to work for a better health of their community.
- Key community persons like local leaders, religious leaders feels child health has increased because of awareness generated through reaching people at individual as well as at mass level.
- The private practitioners feels very strongly about the interventions and qualifies it has an excellent program, has led to great change in the awareness of community.
- Gatekeepers are open for their daughter-in-laws and wives to be a part of the Jeevan Daan program.

How the Objectives were met:

- Multiple contacts have been made with mothers through individual counseling, group counseling using different media tools, which has resulted in bringing the program messages into practice.
    - The CHT members meet regularly, once in a month, maintain a register, in which they document their meetings' minutes and the accomplishments made by their team after joining the program.
- CHT meetings include pro-active discussion on: program interventions, pregnant mothers, breastfeeding promotion, cleanliness and hygiene, births and deaths in the community, water supply and sanitation, and other community specific issues
- CHT counsel mothers and help during the episodes of illness.
- CHT members accompany the patients to the health facilities when needed, and this results in them getting better treatment because of the doctors acquaintance with the CHT members'.
- CHT members have played a vital role in increasing the immunization coverage through not only mobilizing the community but also helping the AMC staff during immunization camps.
- Linkages between the CHT members and the local health facility staff have been established which has helped in a great deal of change in the outlook of AMC staff towards the community. The good relation and trust developed between AMC and CHT members has resulted in AMC involving CHT in their activities like the national polio eradication drive.
- Stock of contraceptive, ORS, etc are maintained by the CHT members and are distributed as required by the community.
- Each slum pocket has a community bulletin board, which is maintained by the CHT members with the support and help from the youth, local leader and other influential community members. The boards are updated regularly. Information regarding immunization camps, ORS preparation method, etc and other important health messages like information on seasonal diseases is put down on the boards so to reach a larger population.
- CHT members now taking a lead in the community in coming forward, and mobilizing the community for organizing and managing BCC activities like street plays and puppet shows.
- Hearth serves as a platform for the mothers to learn correct feeding practices and preparing nutritious recipes at a cheaper cost and also to ensure the children develop the habit of eating and gain weigh.

- The Private Practitioners have formally met CHT members and share a good rapport with them. The CHT members take the initiative and accompany patients to the doctor.
- The stationary vendors know about the JD program, its interventions and also the CHT in the respective community. Time and again they are counseled by the CHT and in most of the places they have started maintaining the health and hygiene practices.

Lessons learned-Successes

- The CHT is a mix of women of old age and young age, mother-in-laws and daughter-in-laws, thus being a dynamic team.
- Beside the trainings in intervention areas, the CHT has also been given made aware of other health and community related issues which, has made the CHT members have a holistic view of the community related issues and have made them proactive in going about in a more comprehensive approach to solve community problems.
- The issues emerged out in the CHT meetings are discussed with other influential members of the community.
- CHT has also taken up other issues in the community like problems related to drinking water and drainage line.
- The BCC materials (posters, health education Booklet, Flip Book) are being used effectively by the CHT members.
- The referral chit now given by the CHT members has increased community's confidence in the AMC system of health delivery.
- The relationship developed with the local leaders and the youth of the community has led to greater support to JD staff in carrying out BCC activities like street plays and puppet shows.
- The CHT members also actively take part in organizing BCC activities thus, now there is a greater self-confidence in them to take lead in the community.
- Targeting the gatekeepers in the various interventions has resulted in breaking certain myths, especially regarding immunization.
- CHT played a key role in hearth. They were involved from training to mobilizing the target mothers and also participated as a hearth volunteers.
- CHT members take the concept of Hearth to the entire community and thereby try to ensure that no children in the community are left malnourished.

Lessons Learned-Instructional Failures

- There is a need to more effectively divide work and houses between CHT members**.** Some CHT members are not assigned to a specific number of households to whom they are responsible. This dilutes their effectiveness, as it becomes less systematized and some households are left out.
- CHT needs to be developed more as community leaders (CS plus) and proactive in taking lead to work out other issues of community.
- More effort has to put in designing Hearth as the community can manage it on their own.
- CHT to be promoted in the community using different platform (e.g. street plays, puppet shows)
- At least one CHT members should be literate so that she can facilitate record maintaining, reminders, public messages, etc.

Is There a Demand For These, Was it measured?

- Local leaders are aware of the existence of CHT in his community as a formal structure, know its members and are confident about them. The local leaders feel "ownership" of the program since they have been involved from the start.
- Maintained purity of volunteerism without any cash incentives. CHT members are motivated by training. CHT is highly motivated, energetic and enthusiastic, from their collective strength would help it to continue to help the community in future.
- More and more mothers, who are not currently CHT members, have shown readiness to be

a part of the CHTs.
- Stocks for ORS, coltimoxazole and Chlorine Tablets are now available and demanded
- The AMC links are strong and will continue without CPI.
- The program has been successful to create linkages between the CHT and leaders in the community with other departments of the AMC like garbage disposal, water and sanitation etc. and helped the community to solve some of its problems like water contamination, etc.
- The introduction of Link Workers, from AMC's new Reproductive and Child Health Program, will continue the work of the CHTs and require their assistance.

Overall, the community response to the various mobilization efforts overall has been incredibly receptive. There is a high degree of community acceptance, recognition and a welcoming spirit towards the program. Health has become one of the top priorities in the community. The community wants program activities to continue, as measured by the creation of demand among women for the continuation of CHTs and a desire to learn more and participate in activities.

Sustainability Strategies for the extension:

- Invite private and public doctors to speak more in the community about public health issues.
- Expand a network of AMC doctors to provide additional training in health content to the CHTs.
- Advocate for the HFA tool to be institutionalized by AMC.
- Start selecting leaders within the CHT to facilitate their teams.
- Set up a plan for replacement/recruitment of new CHT members with local leaders and CHT members.
- Encourage more CHT members to become AMC RHC link workers. A few CHTs have already been adopted by AMC

See Attachment I document entitled**: "Community Health Teams (CHT) The Road to Sustainability"** which outlines the evolution of CHT, as a core strategy towards self-reliance.

b. BEHAVIOR CHANGE COMMUNICATION

The staff of the JD program is a strong team led by experienced BC C specialist Ms. Heer Choksi, well equipped to perform the BCC tasks of the program. Sanchetana plays a key role in the development of BCC activities bringing a wealth of experience to the table. Sanchetana has 18 years of experience in developing communication strategies and implementing community-based programs. The BCC focus is primarily on hygiene, breastfeeding and nutrition, proper administration of ORS, recognizing danger signs of ARI and diarrhea, appropriate home treatments, and care-seeking behavior. In addition, there is a special focus of the BCC to promote gender equality in all the messages.
It uses many forms of media, including kites, puppetry, community action theatre, posters, flipbooks, booklets, demonstrations, models and leaflets. The messages are clear and aligned with MOH/India, the IEC Bureau, UNICEF, WHO and TAC. The entire process is extremely well documented.

The evaluation team ranked this cross-cutting issue at **10!**

The effectiveness of the BCC strategy in the program has been due to the following:

1. **Using the BEHAVE framework:** The BEHAVE framework coupled with strong audience segmentation and detailed formative research into the key factors has been extensively used in planning BCC activities, designing messages and materials. This has been the success of the BCC strategy in the Jeevan Daan program and the fact that the

AMC has requested that Counterpart BCC materials be developed under the program for use in all the 43 AMC wards of the city and has requested that their staff be trained in BCC. The USAID local India mission has also appreciated the BCC materials and activities.

2. **Urban specific**: the program has developed an entire range of posters, pamphlets, flipbooks, booklets that are urban specific; culturally specific, in terms of clothing, food habits; community specific i.e. all materials have a good mix of images of members from the Hindu and Muslim communities; all materials have maintained a gender balance and promoted the girl child in key messages related to nutrition and care.
3. **Formative Research**: formative research has been conducted in the development of all BCC materials, messages and scripts, after which all have been pretested with the community and reviewed by members of the Ministry of Health, WHO, UNICEF and TAC members. Formative research was done to understand key practices and beliefs of the communities E.g. FGDs with the Traditional Birth Attendants and mothers-in-law was done to understand issues related to colostrum feeding and exclusive breast feeding, doer non-doer analysis was used to understand the hand washing practices in the community and trends of caregivers taking their children for immunization. Positive Deviance Inquiry was used to understand feeding practices of mothers and breastfeeding practices of mothers.
4. **Cost Effectiveness:** All the materials developed under the program have been developed at lower competitive rates than the IEC materials developed by other local NGOs and PVOs. This was achieved by conducting an informal market survey of the existing prices and cost of print materials and hunting for options to improve the quality of the materials and increase its dollar value. Conceptualizing and designing the print based materials in-house and getting them printed from service providers was another way the cost was reduced effectively. In the case of BCC activities like street plays and puppet shows, the program team developed all the scripts. Today the team has a collection of over 29 productions for puppet and street plays.
5. **Enabling Communities in using BCC:** the program has taken BCC to the community through Community Action Theater, youth groups and groups of adolescent girls. The program has formed a Community Action Theater group, trained ten boys and girls in puppetry and street plays, who have performed over 350 shows on varied interventions in the community. Over 60 young boys have formed 6 groups from 6 different communities, were trained in simple health education sessions on hand washing, preparation of ORS and basic hygiene. These boys of the youth group conducted 170 health education sessions in one month in their communities. Two groups of 35 adolescent girls have been formed who have also taken the messages of hygiene and nutrition to various communities through interesting health education sessions.

   This strategy of involving young community members to impart health education and disseminate health education in fun filled methods has been very effective in three ways. Firstly these youth are going to be the future parents and have already internalized positive health messages, which will equip them with the knowledge to make positive health decisions in the future. Secondly, the energies of this age group have been channelled in creative ways for their personal development. Thirdly, the community accepts health messages when given to them by members of their own communities.
6. **Training and capacity strengthening of program staff in BCC:** the effectiveness of the programs BCC strategy has been largely due to effective capacity strengthening of the key program staff and its translation to all program activities. Two members of the program core team have been trained in the BEHAVE framework and BCC by CORE workshops in S Africa and Cambodia. The Director Health Program- HQ's training in using the BEHAVE Framework for the entire program staff has also been very effective. (Please view Attachment K: Process Documentation of BCC activities and materials)

7. Involvement of AMC in BCC and adoption of BCC materials into the AMC system: Before developing BCC materials, all available BCC materials of NGOs, UNICEF, state IEC bureau and AMC were reviewed critically to avoid duplication and use of available resources. Wherever needed, BCC materials, contents were adopted. Program has critically developed and pre-tested BCC materials involving various stakeholders such as AMC education officer, ANMs, AMC other health staff, community members, NGO representatives have developed very effective materials. Now some of the materials are adapted by AMC and distributed into neighboring slums and there has been a request form AMC to train their out workers in BCC, TB and other programs. At AMC level, now program has established Core BCC team who provide constant guidance for the BCC materials.

The Innovations to BCC activities:

Puppetry:

One of the main features of the BCC component is the puppetry provided by JD staff members. This is a major venue for providing health messages in an entertaining manner to a youthful audience and the elders in the same fashion. Ranging from about 5 to 10 years old, the children learn many preventive health practices through the shows. The project has so far carried out 35 such shows having an involvement of almost 1750 children.

A Scene from a puppet story on Diarrhea.

Community Action Theater:

There were 350 shows performed during the LOP through practical demonstration. This is a very popular media enjoyed by the entire community. It is social entertainment with health messages. Counterpart has identified traditional performing groups and trained them in CS messages which are very effective and have created lasting effects.

Community Action Theatre Group that emerged from the community performs street plays on Diarrhea.

Melas:

Using culturally appropriate practices, the program has adopted the use of Melas as one of the BCC activities. There have been fairs for "healthy baby competitions," Breastfeeding day and ORS week. These events popularize a particular issue on which to focus attention in the community.

Kites:

Adopting cultural festivals: Colorful kites were produced with health education messages and displayed for 6 days during the kite festival each year. The kites are illustrative of looking upward towards the sky and keeping ones dreams high. This is a very innovative and creative approach to health messaging. Looking at Counterpart's success, the AMC traffic control division, education department and other departments have adopted this approach to educate the community in the city. In addition, kites were displayed in each slum with health messages.

Effectiveness

- The comprehensive BCC strategy and urban specific messages have reduced superstition, myths and harmful home remedies.
- Individual counseling through household visits have been very effective.
- Health Education Sessions helps in reaching many mothers in a group situation. The use of demonstrations, posters, flipbooks and video shows in these sessions has been very effective.
- Video Shows have helped women understand better about pregnancy, importance of Maternal, and Child Nutrition.
- CHT members feel empowered by the scientific knowledge gained by the video shows and this has helped them in disseminating messages to mothers.
- Most of the target population have participated enthusiastically or have witnessed street plays under the program. Street plays have also reached children, males, vendors, local and religious leaders. Street plays have also helped in making the communities aware about the program and its interventions, for example, understanding the dangers of harmful home remedies and importance of quick treatment.
- Messages of hygiene and nutritious foods have reached the community through street plays and puppet shows.
- Children have participated enthusiastically in street plays and puppet shows; and remember the messages of these shows easily.
- BCC tools like Posters, pamphlet, flipbook and snakes and ladders game have been effectively used to communicate to mothers and children.
- The BCC material like Posters, Pamphlets, especially the Flip Book has been a lot of help to CHT members in counseling mothers and gatekeepers.
- Posters have been largely appreciated and most people understand them.
- Non-literates have also been able to understand the messages of the posters and flip-books through their illustrations.
- Posters on ORS preparation, hygiene, and pneumonia have been very popular and easy to remember.

How the Objectives were met

- Excellent BCC strategy and materials developed.
- The execution of the BCC activities were fun, full of enthusiasm and culturally tuned to traditional media identifying community artist training them to perform CS Messages.
- CHT see Hearth as a platform for BCC.
- Private practitioners take initiative to enhance the CHT members' knowledge of childhood illnesses.
- Information about all four interventions has been effectively communicated by the extensive BCC activities and messages.
- Hired a dynamic street performer from the slum area as the BCC assistant.

Lessons learned-Successes

- The community most cherished the Street Plays, Puppet shows, Video Shows, Slide Shows, Individual Counseling and Songs. They enjoyed the multi-facets of the BCC effort and found it difficult to name a favorite.
- Through Street Plays the entire communities have been reached and are the most memorable of all BCC activities.
- Posters have been effective with both literates and non-literates.
- Communities seek immediate care for children's illnesses due to the BCC activities and messages.
- CS-plus messages like STD, Family Planning, etc. have been dealt with in addition which

have been helpful to the communities.

- The receptiveness to slide shows and video shows has been extremely high. The community wants to see more of this media. The use of a local NGO and TAC member that produces media (IDEAL) was an excellent resource.
- The Flip Book is easy to use for CHT members who are not literate as well.
- Hearth has been an effective platform for BCC.
- BCC activities have reached gatekeepers of the community who have started understanding and taking responsibility for their children and grandchildren's health.
- BCC activities and messages have lead to community harmony by bringing different groups together during communal violence.
- The local leaders are aware of the program through BCC activities.
- CHTs are equipped with all BCC techniques and materials and use them effectively.
- Private practitioners JD BCC materials to provide Health education.
- Rallies and Campaigns mobilize communities and promote health awareness
- Children, though they are not the primary target audiences, have become aware of health issues through BCC activities.
- Vendors are practicing positive behaviors like selling hygienic and covered foods after being aware of the BCC messages.
- BCC activities have lead to improvement in the hygiene and sanitation of community.
- In some areas where groups do not gather easily or where homes are cluttered, individual counseling is more effective than joint meetings.
- Individual counseling and video shows more effective in communities where mothers cannot go out in open in public places. (especially in Muslim community)

Lessons Learned-Instruction Failures

- In some areas where individual counseling was mostly done, there needs to be more group and community level activities.
- In areas where it is not possible to organize mass activities like street plays, activities like puppet shows and video shows can be done.
- Ongoing review of BCC materials present with CHTs members helped to adopt new information.
- The duration of Street plays and puppet shows may not exceed 20 minutes given the attention span of mothers, other chores that they need to attend to and external factors like heat and space constraints.
- Ensure that even those households that don't have children under five are involved in BCC activities like street plays, video shows, and puppet shows.
- BCC needs to be done more equitably throughout all the areas. There were certain areas that had less shows due to scheduling difficulties and religious reasons.
- Fathers are should be more involved in BCC activities.
- Traditional healers need to be involved more positively.
- More puppet shows need to be done in area where there are space constraints.

Is There a Demand for These, Was it measured?

- There is a demand for more video shows as noted during interviews.
- Street plays are requested through popular demand constantly. With the BCC assistant, on board from the community, the community has a sounding board with whom to state their demand directly, as he lives in the community.
- As requested by the District Medical Officer for AMC, Dr. Makwana, all wards in AMC have been sent JD Flip books (from the 6 wards of the program and neighboring wards, AMC requested flip books for all 43 wards. AMC has adapted BCC materials and are now using into their daily activities).

C. CAPACITY-BUILDING APPROACH

i. Strengthening of Counterpart International

This program represents Counterpart's fifth USAID-funded Child Survival Program. CS programs have been implemented in Vanuatu, Solomon Islands and Kiribati (1990-96), and Counterpart has also implemented child survival program in Uzbekistan (2000-2004) and a mission-funded MCH program in Turkmenistan that has similar interventions.

Counterpart has increased its capacity to document and disseminate impacts/lessons learned from child survival programs, by creating a computerized system for documentation in Counterpart's in-house library. Counterpart produced a series of working papers on child survival, as well as disseminated information on best practices and lessons learned to other NGOs in India working on child survival as well as shared information within the CORE PVO community. This sharing will help to ensure that the lessons of the *Jeevan Daan* program can be successfully applied to other child survival programs. Lessons learned will be exchanged, shared and disseminated within AMC/MOH, PVOs, and local NGOs working in health. CPI is a lead agency promoting KPC in the State of Gujarat and 6 NGOs and 2 research organization have adopted KPC into their system.

Counterpart has a set of Organization Assessment Tools and the TTAP (Technical Training and Assistance Plan) that have been developed out of 13 years work in Central Asia and other countries implementing NGO Capacity Building and Governance programs, under the Civil Society and Governance division. USAID invited CPI to share these tools at the PVO RFA conference in 2001. The tools have been shared with CSTS as well. The TTAP is modified and new tool will be soon in use.

ii. Strengthening of India Country Office:

Counterpart was implementing TB, HIV/AIDSs program on a small scale on pilot basis since 1997. This office began with this program, so a real CS country office was born where there was none. There is a vibrant staff that have implemented many new activities, such as KPCs, Rapid Impact Assessments, and Health Facilities Assessments, sustainability frame work, RRA, PRA, BEHAVE, and undergone much training.

The carefully planned inputs for the in house capacity building in terms of improved capacity to design implement and evaluate CS programs has been very successful and has strengthened the team not only in terms of having the capacity to design and implement but also to critically evaluate strategies , activities and the impact.

Due to the motivating policy of HQ under the leadership of Ms. Darshana Vyas and also emphasis on developing core competencies within the team so that the skills can be utilized, in the last four years of implementation the knowledge and skills for the country office staff has been systematically strengthened and improved and as result significant results have been achieved.

Inputs:

1) The Technical Advisory Committee has provided tremendous inputs to strengthen the program through regular dialogue for advice.
2) Sanchetana has enriched the new office, offering over 18 years of experience and a wealth of social research and community action development.
3) The office has a large network, Ms. Darshana Vyas, Director of Health programs was invited by EHP Washington to present a paper on Urban Health and the Director of Health programs and the Program Director of the CS program attended the Urban Health

consultation between EHP and MOH India in Bangalore in June 2003, and presented a paper entitled "Immunization Promotion in Ahmedabad".

4) The Country Director and Finance Manager received training in Finance at CPI's Kazakhstan program.
5) The JD team has received five days BCC BEHAVE training from the Director Health program, HQ and two day for Counseling and 2 days on conflict resolution and team building.
6) The JD team received training in trauma counseling from UNICEF.
7) JD Team has received many training such as BCC, ARI, CDD, conflict resolution and team building, communication and Counseling
8) JD CORE staff such as Program Director, MIS officer, BCC specialist and HMIS assistant, and BCC specialist have received numerous training in BCC, Counseling, Conflict resolution, team building, ARI and CDD training. In addition to this, HMIS officer (Jaydeep) received two trainings; BCC in Uzbekistan (he also acted as a co-facilitator for the BCC workshop in Uzbekistan) and BEHAVE training in South Africa. Heer (BCC Specialist) received BEHAVE training in Cambodia.
9) The Program Director participated in DIP defense and met with CSTS staff as well.
10) The Program Director, Finance Manager, HMIS officer attended the 2004 CORE Members meeting in Baltimore and presented on Urban Nutrition.
11) The program director, Finance Manager and HMIS manager were trained for one week in finance and other program management issues at HQ during May 2004.

Outputs:

a. The Finance Manager and HMIS manager have both been trained staff in CPI's CS regional office in Kazakhstan by the regional finance director along with the Uzbekistan CS program director and finance officer to maintain uniformity since both programs have similar financial procedures.
b. The Country Director co-facilitated BCC and counseling training with HQ Director Health programs and trained staff in BCC in CPI's MCH/CS mission-funded program in Turkmenistan.
c. The Program Manager provided training in Hearth World Vision/India
d. The office hosted the CORE Hearth TOT Regional Workshop
e. HMIS manager assisted the director of Health programs in BCC training in Uzbekistan CA program
f. HMIS manager and HMIS assistant have assisted Umir Nuri CS staff in revising HMIS system in CS program in Uzbekistan and share their lessons learned with the staff.
g. Finance manager has conducted finance training in Uzbekistan Umir Nuri CS program
h. Program director CS program has conducted one week Hearth training for the World Vision CS program staff in India
i. Seven NGOs were trained in Ahmedabad in KPC and now they are using KPC in their programs
j. HMIS manager has trained HMIS staff of AMC to incorporate MIS into their system and data collection

iii. Strengthening of Local Partners:

a. Sanchetana: PVO partner

What began as a seamless partnership between the two organizations slowly came apart at the seams. This is the first time in 18 years that Sanchetana is in partnership with another

international organization. Their capacity to implement child survival programs, including its technical and managerial capacity in areas such as program monitoring and evaluation, qualitative research, and the design and implementation of BCC activities has increased. This is also the first time they are partnering with AMC as well. Due to CPI's partnership they have started trusting AMC and the government system. This partnering has served as a bridge between service providers, community and a local NGO. There has also been an increased confidence for NGOs to work with the government system.

Sanchetana has been working in the targeted urban slums for over 18 years. It is a voluntary organization with extensive experience in community mobilization and health education, but the management felt the need to build the capacity of its staff in certain areas. During the program design process, Counterpart conducted a TTAP assessment to determine Sanchetana's capacity to implement child survival programs. Based on the results of this assessment, both organizations agreed that capacity-building assistance should focus on the following areas:

- ***Monitoring and Evaluation.*** Sanchetana has been actively involved from the inception of the program such as proposal writing, in the baseline, program implementation, joint training planning, DIP and the mid-term evaluation of health programs.

- Counterpart provided technical assistance and training to establish a Health Management Information System (HMIS), and trained Sanchetana staff in HMIS management, to enable Sanchetana to use data effectively. Additional training may be provided in operations research.

- ***Implementing Standard Case Management for PCM and DCM.*** Counterpart provides training and technical assistance in this area, and also trained Sanchetana CS team in the use of the quality of care assessment tool, the HFA,and to evaluate the quality of care at other facilities.

- ***Building partnerships with existing health care institutions of the AMC/MOH.*** Sanchetana has considerable experience in collaborating with the AMC/MOH, but the program has further enhanced their ability to cooperate on regular program monitoring and data analysis. By adding on Sanchetana's capacity to collect and analyze data, and by establishing a Health Management Information System (HMIS), Counterpart assists Sanchetana and the AMC to use these M& E tools. This will allow AMC to target interventions more effectively, and will also contribute to the long-term sustainability of the program interventions. AMC/MOH staff will be actively involved in all aspects of developing the HMIS, and trained in HMIS management, so that continued collaboration on data collection will continue beyond the LOP. Counterpart has created a single HMIS system which can be used in a collaborative manner by Sanchetana and the AMC/MOH, and avoid duplication of efforts in data collection and analysis.

- Sanchetana's Program Coordinator attended the ***BEHAVE Workshop*** in Cambodia to upgrade her BCC skills.

- Sanchetana's Program Coordinator and CPI jointly organized BCC and other trainings.

Sanchetana staff has already played an integral role in conducting the KPC and HFA surveys, designing the DIP, and co-facilitating training sessions. Sanchetana coordinates and implements BCC activities, and continues to participate in technical training activities. CPI provides skills transfer for PCM and DCM, Immunization, Malnutrition, Breastfeeding, HMIS, quality assurance, and overall financial and programmatic management, as well as monitoring and evaluation.

Sanchetana's capacity to mobilize local communities complements the skills of country-level staff, in building sustainability at the community level.

Although the first half of the program was blessed by a strong relationship with Sanchetana, after the midterm evaluation, the relationship slowly deteriorated. There are several factors that lead to this dissolution:

- It became more apparent with time that the vision and orientation of the two agencies are different. CPI in India was born with the Child Survival and Health programs and solely implements CS and other health activities. It is focused on key health program interventions, using the results-based approach. CPI's other partner; the AMC was strategically selected in order to work within the system to help institutionalize change from within.

- On the other hand, Sanchetana is an agency that concentrates on larger human rights and many other activities. They have immense experience in empowering slum residents in demanding their rights. Their approach has been to point out the gaps in the system and empower residents to demand services. There have been many charters and cases brought to the court, in order to get their rights heard. The Sanchetana staffs have felt that the focus on meeting CS objectives was too narrow and was at the expense of the larger developmental issues of fighting injustice. Thus, CS fits into a much broader development program, which addresses housing, education, reproductive health and violence.

- This difference in approach and focus caused tension between the health promoters from Sanchetana and CPI. The Sanchetana staff were involved in other activities beyond the scope of CS in their daily work, whereas CPI staff were full-time involved in CS program activities. Coordinating activities such as training and meetings was difficult as the Sanchetana staff were often not available due to their other job responsibilities. During CS field work, Sanchetana staff were spending time on human rights issues and other non health activities and as a result, CS activities suffered. Reports from Sanchetana were not submitted on time, which was difficult for the CPI staff to complete and meet the reporting deadlines. Lines of communication began to crumble. It became apparent that the TTAP needs to be revised in order to better detect such differences and provide more clarity in focus when selecting a local partner and CPI is now revising the TTAP.

b. AMC: MOH partner

AMC has fully supported their partnership with both CPI and Sanchetana. AMC was involved from the inception of the program in program design, proposal writing and site selection. This is an exceptional PVO/government partnership, which is greatly facilitated by total transparency with AMC staff and full-scale involvement. The partnership is not simply one of informing AMC of CS activities or simply seeking approval once the program was designed. Rather AMC sat down at the drawing table and pounded out the details of this program together with CPI and Sanchetana with the HQ Director of Health Programs Darshana Vyas from the start. This process has bred a tremendous degree of ownership. They are integral, important players in the program that form a necessary part of the tripartite partnership with the two other organizations.

Counterpart arranges and supports regular training for AMC / MOH service providers at targeted slums and other adjoining areas. Counterpart co-monitors interventions with AMC / MOH personnel. Counterpart organizes training with Sanchetana and AMC / MOH physicians (general practitioners, gynecologists, and pediatricians), Auxiliary Nurse Midwives and TBAs on BCC interventions for PCM, DCM, Nutrition and Breastfeeding, Immunization and communication skills. The MOH head of AMC goes down to the ward to visit the field. It is a win-win situation in that the link between the community and the AMC has been connected through the Jeevan Daan CS program. The Jeevan Daan CS team was invited by AMC assist them for the

immunization campaign and other health activities during communal violence as they were the only agency that remained during communal violence holding hands and organizing medical camps for the violence victims during crisis organizing camps and established a tremendous report with the community.

iii. Strengthening Health Facilities:

Using the health facilities assessment (HFA) at the baseline, midterm and final, it is clear that progressive improvements have been realized. From the health facility visits, interviews with the staff, and TTAP assessments the following observations were made:

- AMC/MOH facilities now implement WHO guidelines for DCM and PCM, and may also implement IMCI guidelines, depending on MOH policy.
- AMC/MOH facilities are accessed more with the referral chit system.
- BCC posters are found in every health facility visited.
- Essential drugs are available.
- ORT is more readily available and used.

iv. Strengthening health worker performance

One AMC MOH doctor stated that health worker performance has improved "from nil to being more duty conscious." The AMC/ MOH Doctors and Health Workers improved their skills and quality of care in DCM, PCM, immunization, nutrition, and breastfeeding promotion and in interpersonal communication through training by the JD team. The focus of capacity building within the clinics has been to improve their ability to provide preventive health care, and to collect and report accurate data required by the AMC/MOH. An area that needs further strengthening is patient care and counseling. This area will be addressed through refresher counseling training for health workers. TTAP revealed that almost 80% of ANMs are now able to communicate with their clients efficiently. Furthermore, ANMs have revealed that training in communication, BCC and community mobilization has certainly helped to increase acceptability of them within the community. They also have mentioned that immunization coverage has increased due to BCC and counseling skills and built the communities confidence into AMC health activities.

Data collection and quality of care are both serious weaknesses within the current health care system. In the areas targeted by the *Jeevan Daan* program, doctors and nurses have been trained as trainers, in order to strengthen the capacity of the Health Facility Staff to deliver effective preventive services and health education. The *Jeevan Daan* program Health Information Officer provided field-based technical assistance to Health Facility staff to improve the quality of data provided by facilities. Joint home visits also help health workers to improve their communications skills and on-the-job training on CS interventions. Joint planning sessions helped them to avoid duplication and strengthen their data collection methods.

iv. Training:

The development of the training plan for the CS program started with Learning Needs and Resources Assessments (LNRA), which were completed at different levels with all major program stakeholders, and integrated with the results of the other baseline assessments. In addition, the program also used Counterpart's Organization Assessment Tool and Technical Training and Assistance Plan tool (TTAP) for assessing various stakeholders' needs at the level of the AMC administration, at the clinic level, and at the program level for Sanchetana. A joint planning session was held with FHWs, other health workers, AMC doctors, key community leaders, partner NGOs and Counterpart field staff. Based on the initial needs assessment and planning workshop, the training plan for the CS program was developed, although it has been further refined during program implementation.

Training is supervised and coordinated by the program's Technical Advisory Committee (TAC) consisting of Counterpart's Director of Health Programs, the Senior Manager of Sanchetana, the

AMC Medical Health Officer, Dr. Dilip Mavlanker, Dr. Ajay and Rani Bang, Dr. Metha, and the local UNICEF representative. The role of the TAC will also include the review of technical modules, training curricula and other aspects of training.

For a complete matrix of training events, see Attachment H

Effectiveness

- Training was held as per seasonality (i.e. pneumonia training was held during winter season and diarrhea training was held prior to summer season).
- Training was held in the local language so that CHT members could understand.
- Training was technically appropriate – as per WHO protocols, UNICEF and MOH/India.
- Audio & visual training materials, posters, songs, demonstrations – ORS correct preparation and effectiveness of hand washing, role-plays, games etc. as per the interventions were used in the training.
- CHT members remember the video clippings, ORS demonstration, hand washing before eating, after defecation, before cooking, after cleaning the child, before feeding the child.
- CHT members remember that pneumonia is a bacterial disease and it affects lungs after seeing a scientific video on the disease.
- AMC staff – Medical Officer diagnoses patients as per WHO protocol.
- After receiving training CHT members can counsel mothers confidently and could relay all the correct messages.
- Training venue and time was suitable to the trainees.
  - Children were trained on Hygiene, sanitation, hand washing, nail cutting, ORS to be given during diarrhea, use of ladle for water thru street plays, Health Education Sessions, etc.
  - Local leader were aware of the training received by CHT members in Child Survival Program
  - Private practitioner is also aware about trainings imparted
  - Adolescent have received hearth training and has worked as a hearth volunteer
- Home visits conducted by adolescent girls / children on diarrhea, NASADO (Get rid of diarrhea), ORS preparation, hand washing, Hygiene Care etc.
  - Adolescent girl refer mothers to PHC after receiving training
  - After receiving Hearth and nutrition training; weighing and plotting is done by Adolescent girls in the community
  - Vendor has also received the training of all CS interventions
  - Gate keepers are aware about all the interventions
  - Community members are aware of CHTs functionality and seek their advise / assistance
  - Training of CHT members have helped in imparting messages to mothers
  - CHT members maintain register of their activities, discuss on problems and its solutions during the monthly meeting
  - Communication skills of the CHT members is developed after training

Objectives Met as evidenced by:

- Hand washing (5 times) a day – FIVE became the symbol
- For Immunization, also came to know that it takes FIVE visits to complete.
- Reduction in diarrheal episodes
- Mothers / community members have gained knowledge on all interventions
- Mothers are aware about danger signs
- Mothers take her child immediately to health facility
- Use of ORT & ORS is increased
- Increase in immunization
- Wrong beliefs and taboos are decreased
- During Measles episode mothers go to the doctor

Lessons learned- Success
• After nutrition training Community became aware about nutritious food. • Vendor attended the raining and now he sells quality food in the community • Hand washing is counseled by the children and practiced • CHT want to conduct hearth in their area.. She has started growth monitoring of children by charging Rs.2/- per child and this fund gathered would be used by her for hearth in her community • Community skills / Leadership training made them self confident, aware of their rights and capable to solve the problems • CHT refers mothers to PHC. • CHT also conducted vitamin A campaign in community • CHT assists in immunization camp. • CHT Maintain register of their activities and points of discussion • One of the mothers who was unable to conceive; took care of herself after watching CD on nutrition & pregnancy and after 12 months she become pregnant. • Training of staff could be short, intense efforts incorporated into regular meetings. • Training from AMC and private doctors have increased motivation of CHTs and this should be continued for the next phase • Drip training on common health problems of women would help staff address queries in this area and improve their credibility. • Original area CHTs can serve as demonstration sites for training new CHTs members for the newer areas, creating a "living university." • Use the strongest CHT members as "trainers" in the new area. Experienced peer trainers can be extremely effectual. • Drip training is effective in providing training over time with practice. • Those women who want to become a volunteer should be encouraged and mentored by the CG leader or another volunteer, to spread the news. • Involve community leaders in a "special training" to learn more about the technical training and give copy of lesson plans and IEC materials for reference for him. Train them how to train men
Lessons learned - Instructional Failure
• Training to be imparted to private practitioners on all technical interventions as per WHO protocols • Training through demonstration, and video is the most effective. • Formal training of vendors is needed rather than informal message transfer.
Demand
• Refresher training on all interventions fro AMC staff, private practitioners, community will continue in the expansion • CHT request more training on other health topics like T.B., Malaria, Family Life education will be included in the new program.

d. SUSTAINABILITY STRATEGY

i. Sustainability Objectives:

The sustainability objectives specified in the program are:

1. ***Build capacity in Sanchetana and AMC/MOH staff to implement CSP.***
   This objective was met through the joint implementation of CS for the past 4 years. Sanchetana still feels like they would like more skills developed in the formulation of proposals and budgeting.
2. ***Sanchetana and targeted health facilities improve skills and QOC.***

The HFA able to measure the quality differences during the life of the program.

3. ***Targeted CHTs and CBOs have the capacity to implement local health education interventions***
   The CHTs have appropriate skills to conduct home visits and facilitate health sessions in the community. The CBOs are now able to conduct health education sessions and working with AMC for immunization and other health activities. Their confidence will be boosted during the extension program.*
4. ***To establish long lasting, local institutions capable of sustaining systems for promoting positive change in health behaviors (CHTs).***
   The CHTs are solidly in place and are capable of conducting their monthly meetings on their own. AMC and private doctors are providing training on CS interventions on an on-going basis to the CHTs. During the extension, they will need to become more self-reliant, as the CHT/CHA's are expanding their scopes of work. This will be a true test of their independence.
5. ***Alternative funding and cost recovery system in place to continue interventions (i.e. community pharmacies)***
   During the DIP process it was decided that community pharmacies would not be possible however, so this was dropped. For supplies, AMC will provide provisions to the CHTs such as ORS and Vit. A, which are provided free of charge. The cost of running a Hearth are negligible as the community agreed to have 100% of the food contributed by the participants and the community offers the venue. The CHT members themselves are purely volunteers, so there are no recurrent costs, besides the need for refresher training. During the expansion, commitments for training from AMC (with or through the Red Cross) will be secured, so that the CHTs are provided training.

Other Steps taken toward Sustainability:

- The Country Director is Indian, who builds the capacity of local staff available in country.
- AMC is directly involved in program implementation and will take over many of the supervisory responsibilities of the program. CHT are pure volunteer groups that do not get paid.
- The Hearth nutrition rehabilitation and education sessions do not require tangible inputs (community contributes the food) and teaches new behaviors to caregivers to prevent further malnutrition within a family and for that child.
- The local leaders and private practitioners are directly involved in the program and feel as though they have ownership of the program.**
- Critical linkages between the CHT/local leaders and health providers are being established. AMC and private doctors have already started providing training in the slums and are providing regular training to CHTs on CS and other health intervention interventions that increase CHTs motivation.
- BCC activities aim to change behaviors and internalize new practices.

*** CHT Members Quotes:**

- "We shall continue to counsel the mothers and support one another".
- "We want to continue the noble tradition for years to come."
- "We started doing God's work, so we are in a position to save lives, biggest reward and we shall continue to do this."
- "When asked what was the first act you did as members? We changed ourselves."
- "Even if you are not there we will meet and discuss health issues." This benefits us and our communities.
- We are not doing this for the sake of money, so even if you are not there tomorrow why should we stop doing this." We are generating goof Karma. Even I do not have child under five, if I help my neighbor, she will help my grand chid!

- "We shall continue to counsel the mothers and support one another".
- "We want to continue the noble tradition for years to come."
- "We started doing God's work, so we are in a position to save lives, biggest reward and we shall continue to do this."
- Because of my work, I have gained respect within the community and from my own family. People ask my advice through I am not a literate person!
- ANMs and other health staff knows me well and I get good services for my own health care form them!
- Now we know about our health and that reduces our financial burden if we take prevention

****Local Leader**

- "I have never seen the change in such a short time. It is our responsibility to preserve this change."
- "People have started going to the Municipal hospitals to save money, we shall see that this continues."
- "After one more year, the community will be better positioned to do it on its own."
- "You are not forcing us to do this right now, so we'll do it on our own."
- This is the only program that involves us and asks our suggestions. This is our program, once you leave, we will continue.
- As a result of this program, we have now safe drinking water facility
- No one form Health department has ever visited before and now they come on their own to provide training.
- We are asked by AMC to participate in the immunization campaign due to Jeevan Daan program. Even you are not here tomorrow, we will continue this our own!
- This program has made us to realize that prevention is better than cure!
- "We want the Hearth in every ward."

ii. The phase-over plan:

The phase-over plan was on schedule and now that the program has received an extension, the program will continue to work towards sustainability over the next 5 years. The program design includes further working together in partnership with AMC to assure more quality enhancements of AMC facilities as the community is now accessing the facilities and have started to demand their services. CHT has safe drinking water and sewage repair to AMC and solved for their slums. Sanchetana has been very successful at mobilizing community members to demand their rights and has brought many cases to the court (malpractice, lack of access, etc). This demand of "equity and fairness" has empowered the community to protect their human rights.

Other steps that will be taken during the next phase include:

a. Conduct a joint CHT/AMC Convention to discuss sustainability issues and bring together the entire group of CHTs in one forum to build a movement.
b. Register CHT members with AMC to "institutionalize" their relationship and make them more official within the government system.
c. Explore other avenues besides community pharmacies for cost recovery.

iii. Financial sustainability:

Through the Counterpart Humanitarian Assistance Program (CHAP) , CPI has brought in over $833,000 worth of medical supplies and equipments under its humanitarian assistance program and donated to three hospitals and primary health centers in the targeted slums and upgraded

primary health care facilities. Perhaps some of these could be monetized for future program funding. This has amounted to more than 80% cost share through non-USAID funds as well as upgraded primary health centers and hospitals in to targeted slums.

iv. Demand for Services:

- The program has been successful in increasing the accessibility of the target population to the municipal facilities.
- The referral chits have increased the demand of health services by the target population and have resulted in increased patient flow at the AMC facilities as well as the private practitioners in the program area. (Attachment N)
- Most of the community members are aware of the existence of CHT in their community and approach them in case of any episode of illness in their family. The CHTs also get a lot of respect from their communities and they feel good if somebody from their community asks for their help.
- There is a demand to put the posters developed by the program at all the health facilities of Ahmedabad and at all the municipal schools in the program area.
- The husbands and mother-in-laws have shown an encouraging response to the *Jeevan Daan* program. They motivate their wives/daughters-in-law to be a part of the CHTs and attend the health education sessions and BCC activities organized by the program.
- There is a demand to form a team of Positive Deviant mothers-in-law who go and counsel those mothers-in-law who have still not shed their prevailing religious and cultural beliefs. This will sustainably improve the health behaviors of their community and lead to an increased programmatic impact.
- The CHTs will be able to continue their function even if the program comes to an end due to their effective linkage with the private practitioners and the Municipal Health personnel.
- The CHTs have evolved as a CS plus structure; through their active role in water, sanitation, waste disposal, and other social problems of their community like alcohol addiction etc.
- There is an increased demand for continued programming in the areas of maternal and reproductive health, TB, STD/HIV and AIDS.
- There is still a need to bring about further improvements in the attitude of the AMC Health personnel towards the slum population. Because of their negative attitude towards patients and in some cases even acts such as humiliating patients and shouting at them, patients prefer to visit the private practitioners and do not utilize the AMC health facilities
- In order to further improve the prospects of continuation, formal male groups should be formed, and they should be involved as far as possible in program activities.
- More demand for regular immunization in neighboring slums
- AMC requested CS, TB and HIV programs into all 46 slum pockets
- State MoH has requested Hearth and BCC training for the neighboring districts
- AMC requested BCC and CS intervention training under EU funded urban RCH program

v. Behavioral Sustainability

- The primary target audience, i.e. mothers are confident that they will remember the messages given to them by the program and would put them into practice. They will also use the health facilities in case of any episodes of illnesses in their family.
- The communities have become much more hygiene conscious than before and access the municipal hospitals for child deliveries
- The CHTs have played an instrumental role in making their communities shed religious and cultural beliefs.
- The local leaders see a positive visible change in the health status of their communities. They have observed that the accessibility of health services by their communities have greatly increased and prevalence of religious and cultural beliefs have fallen sharply. They have also

observed a reduction of diseases in the children in their community and also seen a sharp decline in the number of child deaths in their community.

- The mothers have started to make the PD/hearth recipes at home and have found them to be effective. However some of the recipes are difficult to make at home, since several ingredients are required. Care should be taken that only such recipes are used in hearth that can easily be replicable at homes.

vi. Organizational Sustainability (CHT, LL)

- CHTs effectively use the Referral Chits developed by the program and when needed also accompany the patients to increase the accessibility of the health services by the target population.
- The AMC has adopted CHT model form Counterpart and accommodated some of the trained CHTs under the EC funded urban RCH program
- AMC has requested Counterpart to be one of the strategic partners for the EC funded urban RCH program and requested to provide technical assistance and scale up BCC, community mobilization and health into the program in neighboring 46 wards.
- CPI is the only international agency that is now working with AMC under EC funded RCH programs in the city.
- The CHTs maintains records and registers of new births and deaths in their community, new pregnancies and episodes of illnesses and proactively follow-up on these houses for interpersonal counseling.
- The CHTs have also been successful in getting essential supplies like ORS, Mebendazole, Iron tablets and Contraceptives from the AMC and distribute them to their communities and also maintain a record of the same.
- The program has been successful in forming strong linkages of CHTs with private practitioners and AMC personnel making their work more effective and sustainable and giving better results.
- Several CHTs in the strong communities' feel that they can take charge of their communities' health needs even if the program comes to an end. They feel that the activities of the CHT can continue through their strong linkages with AMC.
- In order to strengthen the prospects of sustainability, all ward based AMC stakeholders (including field based personnel) should be brought together at a common platform at the program start-up, wherein the program strategies, types of activities and protocols are shared and discussed.
- Due to the proper training of the CHT members on Hearth, they will be able to supervise the hearth volunteers to organize and manage the hearth activities in their area.
- AMC staff are using BCC and CS communication skills into their routine work

CHTs have confirmed that behavior of ANMs and MPHWs have changed

C. Program Management

1. Planning:

Plans are only good intentions unless they generate into hard work. This program had a well-defined DIP, which served as a working map and guided the very small team to work very hard. Although it was de-railed twice by catastrophes, it picked up from where it landed and sped up in order to catch up. The planning process was as inclusive as it possibly could be, given the constraints of time and designing a field program without raising too many expectations before funding was assured. The initial proposal preparation, including the design and proposal involved all key stakeholders. Once the funding was secured, the MoH, TAC members, USAID mission representative at all levels were involved in the planning as well as the local leaders and Sanchetana staff.

- The *Jeevan Daan* program was designed using a participatory, bottom-up approach involving all stakeholders. This participatory approach has been an integral part of the initial program design process, as well as the baseline research and training for the program. Many of the same stakeholders who participated in the initial program design process were also available to participate in the development of the DIP, including senior health officials from the Ahmedabad Municipal Corporation (AMC) and Sanchetana. The DIP development process also actively involved the USAID Environmental Health Program, CSTS, and other PVOs working in India. Key stakeholders including community representatives, AMC health staff, Sanchetana staff, other CBOs working in the slum areas, and private practitioners were involved at every stage of the process. CSTS played critical role in reviewing and providing technical assistance during DIP process. Also Donna Espute from CSTS was present at the time of baseline KPC and provided technical insight. In February and March 2001, Counterpart conducted 12 focus group discussions (FGDs) in the targeted slum communities, involving AMC and private service providers, as well as in-depth interviews with community representatives and key informants. FGDs were used to discuss program interventions and approaches, and the findings were used along with baseline survey research to design the interventions for the program. Baseline assessments for the *Jeevan Daan* program were highly participatory, and involved a number of local stakeholders, NGOs, CBOs, and research institutions working in the targeted slum areas. Representatives from five local organizations -- SAMVAD, Gujarat Vidyapith, GSIDR, SAMARTH, and ISRD -- participated in the KPC Survey process as either Interviewers or Supervisors. Through their participation in the KPC training and survey process, the institutional capacity of these organizations to conduct and analyze KPC surveys was strengthened. These organizations have also expressed a desire to continue collaboration with the CS program and they have adopted KPC into their programs.

- Sanchetana staff participated actively in all stages of the DIP development process, and also served as trained interviewers for the baseline survey assessments. The KPC and FGD research was coordinated by the Sanchetana Field Officer, and conducted jointly by Counterpart and Sanchetana field teams. In addition, Sanchetana's Program Coordinator was involved in all consultation meetings and focus groups used for the designing of BCC strategies. Several community-level meetings were held jointly by Counterpart and Sanchetana, to discuss the findings of the baseline surveys and discuss their implications for CS program activities. Sanchetana staff and officers also participated in all DIP planning meetings with the AMC, and helped to build an even stronger partnership between the AMC, Sanchetana, and Counterpart program staff. Sanchetana's experience with community-based health programs in the targeted slums has been an important asset to the CS program and the DIP development process.

- A series of workshops, consultations and meetings were held with the local partner organization, Sanchetana, and AMC officials, to design program interventions and activities, and to clarify the partners' roles in the program. Counterpart's Director of Health Programs, Darshana Vyas, also met with the Gujarat State Minister of Health, Mr. Ashok Bhatt, and involved senior MOH officials and bureaucrats in the program design process. As a result of meetings with the AMC, health officials agreed to provide two offices (free of charge as a cost share) for program staff in the targeted slum areas. Counterpart's assistance with earthquake recovery programs and organizing medical camps communal violence also improved cooperation with the MOH and local community leaders, who expressed a desire to continue their work with Counterpart and Sanchetana on child survival activities.

Issues and Recommendations are received at the TAC meeting

- The program Technical Advisory Committee (TAC) was established, and several TAC meetings were held to

provide technical input into the DIP development process. The TAC is responsible for overseeing program activities and providing overall technical support to the program. Members include: the Medical Officer of Health for AMC; the Health Commissioner of Ahmedabad and Gandhinagar; Dr. Rani Bang and Dr. Abhay Bang from Maharastra, who are both very well known for their CS efforts in India; Dr. Dileep Mavalankar from the Indian Institution of Management; Professor Sudarshan Iyangar from Gujarat Institute of Development Research and Dr. Anjana Shah, Head and Superintendent, Pediatric Department AMC.

- A DIP Development Workshop was held with Sanchetana staff, other CBO staff working in the slum areas, AMC officials including Dr. P.K. Makwana, Medical Officer (Health), staff of family health centers, Technical Advisory Committee members, staff from the Gujarat Institute for Development Research, Ahmedabad Municipal Corporation chief pediatricians and interested private practitioners, and influential community members.

- Counterpart's Program Manager, Mr. Ramesh Kumar Singh, organized a series of meetings and workshops with UNICEF, PVOs including CARE International, and the USAID LINKAGES program staff, to receive their input into the development of the DIP, and promote coordination and collaboration in program activities. UNICEF representatives and Mudra Institute of Communication (MICA) have agreed to serve as members of the TAC, and CARE India agreed to provide technical assistance and training materials for CDD and PCM interventions, and for the planned adaptation of IMCI materials.

- In February 2001, the Director of Health Programs from HQ and Program Manager met with USAID Mission staff in New Delhi, and in order to plan changes in the program strategy and DIP development process following the January 2001 earthquake. Mr. Samresh Sengupta provided valuable suggestions regarding the course of DIP development, and program staff proceeded to develop an interim plan for program activities, which was submitted and approved by USAID. While in Delhi, the Director of Health Programs and Program Manager also met with the AED LINKAGES project coordinator, to discuss the program's BCC strategy for the nutrition intervention and plan collaboration on program activities.

- In July 2001, the Program Manager met with Dr. Anubha Ghose of CARE/India, in order to discuss the planned program activities and share strategies and lessons learned from CARE's other CS programs in India.

- The DIP Development process has also actively involved the USAID Environmental Health Project, which has reviewed the DIP and provided technical input, and will assist the program as part of EHP project activities in Ahmedabad at a later date.

- Ramesh Kumar Singh, CPI Program Director visited HQ to defend the DIP and spent two weeks, receiving orientation, and meeting with CSTS staff as well. The partner organization representative was also expected to join Ramesh. Unfortunately, the Program Coordinator from Sanchetana was unable to attend due to unexpected health reasons.

The program planning process continues to include the partners and stakeholders. As program-monitoring data is generated, the team as a whole is consulted along with the Program Coordinating Committee and the TAC meetings. The JD staff understands that the program is result-based and performance-based. The objectives of the program are understood by all. In spite of the two crises, the program has gotten back on schedule and will be able to complete what was planned in the DIP.

The JD team plans the program during their monthly meetings according to the outcomes that are presented through the HMIS data. The planning process is participatory and based on the field

reality. Hindrances are discussed by the group and problems solved together as a group. Therefore, the program is responsive to the immediate results that come in from the field.

The DIP work plan was mostly practical say for a few minor things as community pharmacies. The DIP has been guiding document for the entire program life and all the micro plans that has been chalked out in the field and implemented the DIP has been the source. It has been appreciated by the local Mission as well written document and was referred for the development of urban RCH program.

There have been incidents (Earthquake, after the baseline and before the DIP) and due to the earthquake the DIP submission for this program was delayed and an interim plan was formulated to cater o the immediate need of the community as well as all creating and strengthening the community structure for the CS work later; the communal violence in (more than 700 people died) was however after the DIP and it did destabilize the initial training plan but again the time was utilized to building more bridges with the community which later paid off, also the staff time was mostly utilized for the BCC material development) and during the life of the program which upset the planned activities but the program coped with both very well.

During both the crises the supportive role of HQ under the leadership of Ms. Darshana Vyas and Lelei Lelaulu CEO and President has been especially encouraging. There was immediate release of $ 6000/- from the private funding from the HQ for the medical relief to the violence affected community.

2. Staff Training:

It is clear that each staff member found the training by the program to be practical, relevant and easily applicable. There is a very strong cadre of Child Survival practitioners on board, who are knowledgeable in the CS interventions and equipped to impart that knowledge to others. All of the Field Staff have a social development or health background. Twelve field staff members supervise 400 volunteers. The CPI/India Program Director has prior three years of Child Survival experience with CRS. The Director of Sanchetana is an expert in the development and health field.

The training needs are assessed through supervision and various issues that are faced in the field. For example, after the earthquake, the team received training from UNICEF in trauma counseling.
Adequate resources were available for training and the team members feel that they received appropriate and practical training.

The overall lessons learned about staff training are:

a) The more you invest in a person, the more they will invest in the program. It creates a win-win situation. The commitment among team members grew as their skills increased. It is not only because of the sense of self-efficacy rising, but also a sense that the program feels they are important enough to provide more training.
b) Rather than "buying" skills, and hiring people who were already trained in particular CS skills, this team was created by "building" skills. This worked well as all the team members started on the same page and were trained in the same messages.

3. Supervision of Program staff:

The in country Program Director adeptly supervises the team so that it was cohesive and strong. Three other senior staff are well trained, and also provides supportive supervision and support to the field staff. Team is carefully designed with the support of three senior staff and works on the principles of:

- Dialogue between the supervisor and staff member
- Accessibility and transparency

- Learning from mistakes leading to corrective actions, not punishment
- Problem-solving: practical
- Performance-based supervision keeps the program staff focused on outcomes and is based both on quantitative data and on qualitative processes.
- Everyone's job matters and fits into the whole

There is no sense of "checking up" trying to catch errors. Rather it is simply based on performance from measurable outputs. Supervision is provided for the staff by reviewing their monthly activity report. That report reflects how well the CHP/CHA is doing. Staff members not performing well are reflected in the data. This is then discussed and analyzed by the supervisor along with the staff member. When a staff member requires more support, and other supervision visit is carried out to mentor the person who needs more direction. Thus, supervision is performance based.

The organogram has flattened and there are basically two levels only. The Program Director and the Finance Managers (Finance, HMIS, counseling and BCC) can perform without an added layer of a "Program Manager" in-between them and the field staff. The CORE management team of BCC specialist, Finance manager and HMIS assistance are direct in contact with the field staff. This structure is more horizontal than vertical and makes the team more cohesive. The atmosphere among the team was like family and at the end of the program each CHP produced a scrapbook of the program, which included photos, stories, anecdotes, and experiences, since it was a program not be forgotten.

The participatory supervisory system has been signature management approach from HQ tot eh field for this program the flow of information and the line of controls has been functionally institutionalized. There has been a well established performance assessment system to track the performance of each staff member. The system has been developed from the HQ under the guidance of Ms. Darshana Vyas and the HR division and has been adapted after consulting Indian advisor.

In the field, the major program decisions are taken consensually with the CORE management team with approval from the HQ. This approach is working well and we have proposed similar management structure in other Counterpart Programs in other countries…….

4. Human Resources and staff management

The National Employees Guidelines developed by HQ has been in place since the beginning and has been refined looking at the India laws and precedents and practice in other US PVOs working in India.

Program personnel morale is high and key to the success of the program. This high morale runs from the leader at the HQ Ms. Darshana Vyas, director health programs to the office messenger at the field office, the high morale and motivation is common thread which binds the team together.

Essential personnel policies and procedures are in place for those activities, which will continue through the grant period. All layers of Indian manpower were consulted. Roles defined with the partners and clear MOUs are signed with the partners. Conflict management and team building training conducted by Darshana Vyas form HQ contributed as well to good partnerships and staff management. Secondly, Counterpart's approach is decentralized throughout and there are opportunities for staff to grow within the organization.

During the earth quake in January 2001, Darshana Vyas quickly assembled a team despite odds from Headquarters and led the team. She managed to get a tent from the UNDP and opened an office in the tent. She displayed a high degree of compassion and responsiveness. She

immediately built a team and worked alongside as one of the team members, not only working out of a tent, but also living in one during the crisis. She continually boosted staff morale and kept to measurable tasks in all the chaos. The earthquake and communal violence were true tests of a leader and her leadership abilities shone.

Furthermore, after the quake the CPI office was located in a building, which was damaged and the staff did not want to work in the 10th floor. Darshana approached the Gujarat Institute of Development Research where she used to work and requested them to give CPI office space for two months. In fact, Dr. Sudarshan Iyangar, from the same institute, who is also a TAC member, was instrumental for the development of this program and with his help Counterpart could operate from his institute during interim period.

During the communal violence, a CHPs and her family were threatened. Darshana mobilized political resources and quickly deployed an army in the slum pocket to secure the area. Darshana has responded to an unusual number of challenges and has faced them head on with fearlessness and efficiency. She is a true visionary who desires to generate significant urban Child Survival lessons and share them globally. Overall, she is a true "positive deviant" as an outstanding mindful manager. She has created and grown a strong team of talented Child Survivalists, who will rise to the new challenges presented in the extension program. All of the lessons of the past four years will not be lost, but rather directly applied by this team with rigor to the next program extension.

Ramesh Singh, who is the Program Director for CPI, is an extraordinary manager. Staff meetings are regular and based on the problem-solving approach and reaching group solutions. He has a vision which he maintains, yet is adept and patient at keeping to the day-to-day tasks. The BCC specialist, HMIS manager and the finance managers are very committed to lead the field team.

The staff turn over in this cycle of the program has been minimal in the last 4 years. Only a few of the staff left on the grounds that they were married to individuals in other cities and therefore had to relocate. Almost 90 % staff is going to continue in the CS program and this trained human resource pool is going to add to the effectiveness of the program

5. Financial Management:

a. Accounts were carefully monitored, were on time and on real time reporting and well-run by the finance manager, Narendra Ashokvyas . He was well-trained by his predecessor, Milesh Hamlai. Furthermore, Narendra was trained at HQ by the finance manager in April 2004.
This grant was $1 million over four years. The annual budget is approximately $ 250,000. A gross cost benefit analysis revealed that the cost per beneficiary is $ 8.88 over the life of the grant (4 years) and $ 2.22 per year (total direct beneficiaries: 112,549 women and children). The cost per total population (183,000) is $ 5.46 over 4 years or $1.36 per year. The average beneficiary population of PVO Child Survival programs is 47,000 children and 37,000 women. USAID provides each program, on average, $620,000 or $5.42 per program beneficiary per year. (Performance of PVO Child Survival Projects, April 1998). As compared to a centrally funded Child Survival grant, this program is not expensive, especially since the comparison is made with data from five years ago. The 25% match has been more than met through the addition of CPI funds through the CHAP funds. CHAP has provided $118,000 of medical supplies to the health facilities and a second batch was donated to the Civil Hospital immediately after the Midterm Evaluation worth $833,000.

The major cost was in personnel and training. The next program will reap the benefits of the initial investment in human resources and bring down the cost per beneficiary.

The cost accounting system, approved by USAID, met the test of audits, including source records, ledgers and job costs. It segregated costs between direct and indirect. Its design allows for reporting on a number of sub-levels, so Program Managers have access to both consolidated and detailed reporting on a variety of levels. Actual costs are captured for the reporting period, fiscal year to date and cumulative to date. Labor utilization reporting captures all direct salaries charged to a program. Finance staff has many years of relevant experience and are fully familiar with all applicable USAID regulations including A-133 and 22 CFR 226. Finance staff maintains permanent Grants and Cooperative Agreements files that contain all needed critical information from award to closeout.

Funds were disbursed to the local NGO partner, Sanchetana, after receipt of a Counterpart expense report, receipts, and timesheets detailing the staff time allocated to CS activities. Funds were disbursed on a monthly basis, from the program office in India, and reports are submitted back to Counterpart HQ along with the field office financial reports. Funds were disbursed to cover the previous month's expenses. The expenses of Sanchetana and the field office were tracked using Counterpart's cost accounting system. Separate financial reports and records are kept for Sanchetana and the program office in India.

b. As the program has been extended, there are adequate resources to finance operations and activities beyond this cooperative agreement.

c. Technical assistance to develop financial plans for sustainability were not planned into the original proposal and DIP, so that the TA was not sought.

6. Logistics Management

a. Logistics ran smoothly and were not a problem. Milesh Hamlai who managed logistics for the first 4.5 years did a remarkable job at setting up systems to assure logistics were not to be a distraction.
b. Part of this is due to the convenience of working in a large city with access to supplies, materials and communications. Overall, working in the urban slum area cuts down on transportation costs and logistics. Telephone lines and cell phones and Internet connections were well-established at the office. The other is the efficiency of the staff, who were incredible logisticians, all the way from the tea boy, Laxman, to the Program Director, Ramesh.
c. Logistical support is ready to rise to the challenge to handle the larger, more substantial and complex extension program. Many of the vendors are not familiar with the program, so the local suppliers and BCC materials producers will be readily available and seasoned.

The program may face a logistical challenge due to an irregular supply of child-survival related commodities, including ORS and pharmaceuticals such as cotrimoxazole in the future. Presently, there are adequate supplies as verified through the HFAs. Anticipating approval from the AMC, Counterpart plans to use its humanitarian assistance program (CHAP) to supply donated pharmaceuticals, supplies, according to WHO's standards and other medical equipment, based on the results of the HFA survey and other needs assessments of facilities in targeted area.

7. Health Information Management:

a. The HIS designed for this program, is an example of an urban community-based monitoring system. It should serve as a "model" for urban programs, as it is not burdensome, and effectively measures progress towards objectives.

Families, children and caretakers "at risk" are identified by the MIS and then targeted for BCC activities. The system, developed by the JD team and led by Jaydeep Mashruwala, is well

designed and efficient. Mr. Jaydeep Mashruwala, is a highly motivated, well trained HMIS person and has involved AMC and rectified gaps and designed the program MIS system. The system avoids duplication of information collection and complements AMCs reporting system rather than creating a parallel system. AMC and CPI and Sanchetana have introduced the forms as a joint system, endorsing the forms with three logos on top. The system is a part of the government reporting system, which gives it credibility. Jaydeep has introduced referral chits and reminder system in assistance with AMC that is working well and AMC is now adopting reminder system established by Jaydeep Mashruwala.

b. Realizing that a population-based system in a transient urban slum community would not be effective, the system targets those families that are at higher risk than others for home visiting. The system rests upon a foundation of total population coverage as a denominator, since each household in a ward is assigned to a particular CHT member. Rather than over-burdening the volunteer (CHT teams) with regular home visiting to every household, the CHT member identifies those families that are targeted for interventions. The CHP/CHA and CHT members visit those prioritized families. It is an excellent way to identify on an on-going basis the cases of diarrhea, ARI and malnutrition in under-five children, the number of pregnant women, the number of births and deaths that occur in the community and the number of mothers in the community with under-two years of age children. Through the information given by the CHTs, the prevalence and occurrence of diseases is knows, the vital events are tracked and the denominator known. This system does not depend on a literate cadre of health workers with a large set of registers and reports. It is rather a community-based, volunteer, literacy-free system. An epidemiological analysis of the data points the CHTs to priority diseases and priority households to visit. It is a "data for action" system, especially with the reminder system which creates a list of children needing antigens for immunization. The list is given to the CHTs and they in turn motivate specific children to attend EPI sessions. The immunization rates were not increasing as hoped for according to the monitoring data, so there was a campaign to boost the coverage and a push towards getting children fully immunized.

c. The program staff is sufficiently skilled to continue collecting program data and to use it for program strengthening. It is a result-oriented program, so the CHPs /CHAs are aware of their performance according to the health indicators. The HMIS Manger shares the collected information with the program staff, AMC staff and Sanchetana staff. The emphasis is place on feeding results directly back in to the planning process and adapting immediately. Necessary correction is made immediately for improved implement through CHTS and CHP /CHAs. It is a fine example of "less time collecting data, more time analyzing and the most time using the data."

d. The team conducted special assessments to test new approaches. They implemented growth monitoring in 10 slum pockets prior to the Hearth. Then one year later the same slum pockets were re-visited and the entire under-three population living in those pockets were again weighed. A comparison of the data was made. An on-going program assessment was done through Rapid Impact Assessment in October 2002 and again in June 2004 to understand and document the qualitative data in comparison to the quantitative assessments (Baseline KPC, MTE KPC and Final KPC). This was centered around extensive focus group discussions and interviews in the community. The findings were used to fine-tune the program activities and to determine where to focus the efforts.

e. As the HMIS was not a parallel system, AMC's system was complemented. The reminder system which was developed by Jaydeep Mashruwala, HMIS Manager was a tool to assure that all children eligible for immunizations were motivated to attend on particular dates. All of the data from the HMIS system was shared with AMC and helps them to understand the urban slum pockets.

f. Program staff, headquarters staff, local level partners and the community have an understanding of what the program has achieved, basically through the final evaluation process. All groups were represented and participated in the evaluation team. A feedback session to the community will be arranged upon submission of this final evaluation report.

g. Monitoring data from this program have been shared at various conferences and workshops. The Hearth Data has been shared at the Asia Regional Workshop and at the Annual CORE meeting in Baltimore. The immunization data has been shared at the EHP/USAID Lessons Learned Workshop in Bangalore.

h. The field team has committed senior manage team; the HMIS manager, BCC specialist, Finance manager led by Ramesh.

8. Technical and administrative support:

a. Technical assistance to the program that was provided included:

- ***Darshana Vyas, MPH,*** CPI Director of International Health (Washington, DC) visited the program five times (and more times, using non-USAID funds during the earthquake and communal violence to support staff morale) and was a member of the midterm and final evaluation team. She provided training in (five days of BCC based on BEHAVE Framework, 2 days Conflict resolution, 2 days team building and 2 days Counseling Skills). She also provided tremendous support during communal violence and visited field quickly. Ramesh specially requested her to make a field visit and she conducted conflict resolution workshop with Hindu and Muslim staff in the office. Because she provided tremendous support during communal violence, HQ released $ 6000 additional funds to organized medical camps and trauma counseling for the affected victims. She provides timely feedback, support and technical resource materials and conducted trainings. In addition to this, Ms. Vyas organized exchange trips with similar CS programs in Uzbekistan and Turkmenistan. CPI announced a special bonus called "hardship allowance" to the staff during the earthquake and communal violence. She provides timely feedback on program reports and finance for the smoother implementation of the CS program. She invited three people form the field to attend ***CORE and CSTS workshops***, and sent Jaydeep (M& E) and Heer (BCC) for ***the BEHAVE workshop in South Africa*** and Cambodia. Darshana provided supportive supervision and provided all needed technical assistance and facilitated trainings. She is an incredible asset being she is from India and understands the system, as well as the culture. She was able to use this to the program's advantage by attaining additional resources and tapping her widespread network of professional colleagues within India and neighboring countries.

- ***Tom Davis, MPH,*** conducted the KPC training and implementation at baseline in January 2001.

- ***Donna Sillan, MPH,*** independent consultant, conducted Hearth Training in August 2002 and the CORE sponsored Asia Hearth Workshop in December 2003.

- ***Dr. Arvind Kasthuri, MD,DNB***, Associate Professor, St. Johns Medical College, Bangalore, Rapid Impact Assessment, October 2002

- ***TAC Technical Advisory Committee*****:** There was an active and genuinely interested group of health professionals and experts in the field of development, public health, research, communication, training and organizational development who sit on the TAC and provide

technical assistance and training in ARI, CCD and breastfeeding and peer review on a regular basis. They met quarterly, to share their opinions, and offer "free" advice.

- ***BCC specialist and HMIS manager, Sanchetana Coordinator attended BEHAVE workshop in Cambodia and South Africa***

- Urban RPA training in New Delhi for the field staff.

- Trauma Counseling by UNICEF Gujarat

b. Technical assistance that was required was attained. See above section.

c. PVO Headquarter Support**:**
The Director Health provided excellent support through her participatory and transparent supervision style. This program was conceived by Darshana Vyas, Director Health Programs from CPI Headquarters, who came to India to start-up a program with Child Survival. She came with only USAID guidelines in hand and started to tap her contacts in the various health departments and health institutions. Her connections are extensive in India and Asia. Using her key contacts, she was able to involve many government players the Gujurat State MoH and Ahmedabad Municipal Corporation level, as well as from the Gujarat Institute of Development Research, Dr, Abay and Rani Bangh, Dr. Dilip Mavlankar from the Indian Institute of Management, Environment Health Program, Municipal Corporation level as well as from Dr. Sudarshana Iyangar from the Institute of Development Research, and from Sanchetana, the local NGO partner. They sat down together to design the program as rapid community appraisals were conducted within the slum pockets of Ahmedabad. The program they designed was a result of this highly participatory process.

Once the funding was granted, Darshana opened a CS office, the first CPI office in India. She set about to hire staff and hired Milesh Hamlai, as Administrator. A Program Manager was hired with three years CS experience from CRS, Mr. Ramesh Singh. His skills were perfectly suited for the job. Two more extraordinary staff members, who were young and inexperienced with Child Survival, but possessed the right attitude and talents, rather than "buy" capacity, Darshana "built"capacity, by offering many training opportunities and focused responsibilities. The investment in opportunities for them to learn through workshops and conferences was well worth it. They also provided training to other CPI offices (ie. Uzbekistan).

Darshana has been fully engaged in the program from start to finish. She lent a "day-to-day" touch, without micro-managing. She deferred to the local manager (Ramesh) while offering constant guidance and support. She has been the program's biggest advocate and was there at all the critical times in the unfortunate series of volatile historical events over the life of the program.

In spite of the two disasters, a silver lining was found through those enormous dark clouds. A large amount of goodwill was bestowed by the way the team responded to each crisis. The community saw that the Jeevan Daan team was responsive to their needs and ready to help. One quote which aptly describes the program approach is: *"Our brightest blazes are commonly kindled by unexpected sparks."*

After the second crisis, a program decision to pilot the Hearth methodology was well chosen. Seeing malnourished children thrive again, creates high visibility within the community and two disparate communities actually came together through this intervention. It was so well-executed, that it served as a "living university" in the region. The program hosted the first Asia Regional Hearth Workshop, which was sponsored by CORE in Dec. 2003 for 27 participants from 8 different countries. Without Darshana's advocacy in CORE's Washington office, the workshop

would not have been conducted. She convinced CORE that the CPI program would be a great training site, which it proved to be. Besides the Hearth TOT, Darshana facilitated PCI/ Bangladesh and World Vision's visit as well.

The program has constantly shared the lessons it has learned through various forums and workshops in the US and in Asia. It has also exposed their program staff to larger arenas to present and learn through participating in workshops and trainings, such as the CORE meetings and Behave Workshops.

This program has far surpassed the quantitative results it set out to accomplish, and it has accomplished these results through a high quality process. The process need not necessarily match the success of measured change. In this case, the qualitative results are well beyond any expectation, as it was properly managed, especially when faced with extraordinary challenges, and implemented with technical expertise, creativity and care.

Without Darshana Vyas, this program would certainly not have had the success it was able to achieve. Not only did she start with a vision, she worked tooth and nail to set up and establish CPI in India, and then did follow-up each step of the way. Without her relentless efforts and her fearlessness this program would have suffered. She was able to face all challenges presented to the program, and provide the necessary support, either moral or technical to keep the team on track. She provided professional guidance to each member of the team, and at the same time as she kept her networking contacts at all levels of the MOH in India and in the larger public health arena, breast of the program's situation and progress. She developed the staff so that each built up skills as Child Survivalists. She exposed the program in many different forums and invited guest to come to witness the program. She was a strong **advocate** of the program in a true sense of the word and this attribute is what a KEY factor to the program's success was.

In addition to this, there is a lot of support from the headquarters senior management team. The Program Director receives all Senior Management Team minute notes from CPI's CEO. There is a tremendous amount of agency transparency keeping the organizational structure extremely horizontal, avoiding any hints of vertical programming. This transparency from HQ to Field office contributed to a highly participatory approach.

9. Management Lessons Learned:

Overall, much of a program's performance comes down to management. This program was clearly well managed from HQ to the field. The HQ support was unique in that the pulse of the program was directly felt in HQ. It was not micro-managed from afar, but rather jointly managed with a true commitment and dedication from the HQ Director of Health Programs. There was not a schism between the HQ and the field, but rather a strong, working relationship between the two. During this final evaluation, the evaluator reflected on the factors that went into this program's model of management to start to glean the factors that made the difference.

1. ***Style***: The style of management in this program was one of openness, respect, and trust. It is fully participatory in the true sense of the word. There was a dialectical dialogue, whereby different….
2. ***Results-oriented***: It was also strictly run like a business to achieve measurable results. The limited time frame of a four-year program was motivation to accomplish. The eyes were on results, not on egos.
3. ***Structure***: The organogram was flat and non-hierarchical. This lead to a great spirit of team, as there was not a feeling of superiority or inferiority. Each and every team member mattered. Even the drivers attended the technical trainings and evaluations. They were part of the team and needed to be aware of the program activities.

4. ***Attitude:*** The attitude towards the team was one of "we're a family and in this together for a common cause. The goal of the program was clear and utmost in every staff member's mind. They did not waver from the goal of the program, which kept them on task.
5. ***Commitment***: The Headquarters Health Director, Darshana Vyas, backstopped the program unusually well. She was always available and provided the backbone support every step of the way, without micro-managing and provided every opportunity to Program Director and staff for training, motivation and growth. The Program Manager, Ramesh Singh, said in an evaluation exercise (which asked what each staff gave to the program), that "I gave himself to the program." He truly gave his full being to the program with thoughtfulness and vision. The entire team was also truly committed to the values of community development and worked towards self-reliance, respect and results.
6. ***Team size:*** The team was "lean and mean." Basically, the Manager and Heer, BCC specialist and Jaydeep, HMIS and the finance man and Ashish made up the management team. The team member skills set were complementary. Therefore, there was not a competitive nature surrounding work, but rather, fitting together their strengths to make a whole. It was extraordinary to have recruited such talented young people, who proved to work together like magic.
7. ***Healthy Team:*** Coming together is a beginning, keeping together is progress; working together is success. The team is at the level of "family," well beyond what group processes or dynamics can create.
8. ***Training the team:*** The program hired younger professionals who could be trained, rather than experienced staff, who had already developed set ideas and ways. This proved to be an excellent infusion of young blood. Through exposure to trainings and conferences and meetings, the investment in new staff was paid-off. The managers made a conscious decision not to "buy capacity" but rather to "build capacity"
9. ***Sharing the program lessons outside of the program:*** The exposure of the staff to sharing sessions and workshops brought presentation skills. This sharing not only benefited those outside the program, but provided the staff with the need to reflect and share. This was an "urban health experiment" that unzipped new lessons. There were no mistakes, only lessons.
10. ***Manageress's Motto:*** Although the managers did not specifically know this motto, they lived by it. The team members were given the space and encouragement to fulfill their goals within the goals and objectives of the CS program. Each team member had specific goals, which corresponded with their specialty. This proved to highly enhance the program.

D. Other Issues Identified by the Team

There were not any issues that were not covered by the evaluation questions that the team felt strongly about.

E. Conclusions and Recommendations

1. Objectives:

As the data speaks, the objectives were met with flying colors. The approach was well-chosen and the also well-executed. It was achieved through distinguished management, a talented and exuberant team, and a team of willing volunteers eager to learn, exciting BCC interventions, a simplified HMIS, and a clear vision.

2a. Major Achievements:

The most important achievements are remarkable results in the increase in ORT use, up percentage points, and the tremendous leap in hand-washing from 9% to 75%. Quick treatment on

the same day for ARI cases experienced an increase from 25% to 66%. Immunization coverage jumped from 3% to 79% for children 12-23 months. Colostrum was now fed to 85% of children, when just four years ago only 41% of newborns were fed it. The number of deaths prevented from the adoption of these new behaviors by parents of children in six wards of Ahmedabad is difficult to attribute to but one of these successes. Given the combination of these changes in a whole picture, the team can be proud to realize that their Child Survival program saved many lives! Through a combination of hard work to mobilize the community and the creation of culturally appropriate and informative BCC activities, the team performed a miracle.

2b. Constraints:

- Partnership with local NGO became difficult as the relationship evolved. This affected performance near the end, as the group cohesion was starting to break and the pockets outside of the CPI areas were not achieving results as expected. This was a matter of organizational mission differences, changed in organizational activities after communal violence which eventually led to communication barriers.
- The water and sanitation problems are city-wide and a larger issue beyond the scope of this program. This challenging environment naturally is a large force against child survival.
- Private practitioners are free agents and have not taken up the Child Survival track easily, being they are curative-oriented and market-oriented.
- Sustainability needs more time to organically develop and grow beyond 4 years.

3. Best Practices/Lessons Learned:

Jeevan Daan Team:
• "It takes a team and community to raise a child". The JD team was led by a skillful manager who instilled a set of common values.
Clear, measurable Goals and Objectives:
• Surpassed the objectives and reached the targets by the EOP.
Community Mobilization efforts:
• 400 volunteers in 47 care groups are highly motivated. • Maintained purity of volunteerism with virtually zero dropout rate.
HIS Community-based information system:
• Front-line data are collected by illiterate volunteers. • Did not create a parallel information system of service statistics, but rather focused on tracking behavioral changes. • HFS useful to the municipality to measure performance of their program. • JD managers used the data for program and performance-based supervisory decisions. The team was RESPONSIVE to the DATA.
Training focused on behavioral change:
• Drip training (training over time) was an excellent way to allow time for the new practice to be internalized by the trainee. • Investing in staff members in an excellent strategy to prepare the staff for the challenges, but also provides a new cadre of trained individuals within the country. • All training events have been clearly documented, leaving a full set of training reports to be used in the future.
Supervision:
• Supportive supervision system is in place as a strong follow-up to training • The supervision system was based on performance measured through the HIS. This allowed for pin pointing low performers and providing adequate support to remedy the situation.

Sustainability Strategy
• Partnership with AMC is strong and mutually beneficial. Working with and within the system to produce even small incremental changes is worth the effort in the long run. • The front-line workers are volunteers!
PD/Hearth
• Implementing the Hearth in an urban setting can be successful.
BCC
• The multi-pronged approach, especially through "info-tainment" brought the health messages to large audiences and the messages were remembered. • The inclusion of children and adolescents tapped into a large resource of new cadre of child survivalists! • Each and every BCC activity has been meticulously documented, capturing not only the content (street theatre and puppet show scripts are ready to be picked up by street troupes for more performances), but also their process and effectiveness have been analyzed and written up.
Counterpart's Organizational Culture conducive to CS
• Information sharing is institutionalized and regular from HQ and in the region. • CPI effectively cross-germinates from its successful Child Survival programs and shared lessons. • Strong commitment and advocacy role from HQ's Director Health Program. • Being part of a Child Survival program links the staff to the global health community and creates a network of worldwide child survivalists. This group cohesion is highly motivating and invigorating. • Weekly posting of issues on a list serve throughout the agency's programs to share lessons learned and stay abreast of other CPI program activities.
Program Exposure and Lessons Learned Dissemination
• The program was continually sharing its program lessons through conferences, workshops and meetings: The program staff presented at an India National Conference on Urban Health, at USAID/ANE Bureau on HMIS, at USAID/EHP on EPI, CSTS on Urban CS and HMIS, USAID/DC on CS response to crisis, hosted the Regional Hearth Workshop, Central Asia conference, CORE annual meetings presented on HMIS and Urban Child Survival… Strong support form USIAD India mission: Mission was always supportive and provided timely guidance during two crises. Representatives form USID mission visited program four times and provided technical guidance. Dr. Messay Bateman has provided continuous technical guidance and Dr. Meenakshi had participated in to final evaluation of the CS program.
Spill-over Effects:
• Communities are demanding health care and working for change • Peace-building between Hindus and Muslims, especially after a tense and riotous year.

4. Recommendations

As the program has a five-year extension, the recommendations of this final evaluation have a direct value and can be viewed more as "mid-course corrections." The evaluation was extremely useful to the team who wanted to reflect and glean all the lessons learned in the first phase before expanding their work into a larger population. This series of experimentation and then applying the learning in the next phase is an excellent opportunity to bring about much higher quality programming. As successful as this program was, the next program will be yet of higher quality due to the tremendous experience gained.

1. ***Partnership***: When working with a local NGO partner it is recommended that the following actions be taken from the start:

- Partner orientation: A full orientation to Child Survival programming and the requirements and expectations. Clarify ground rules in terms of work load, percentage of time given to Child Survival activities, priorities and lines of command.
- Recruit team members as a whole team, not separate hiring. Since the team will work as one, the partners should hire together, although the team members will be under one NGO or the other.
- Joint monitoring: Rather than have the lead agency be in charge of monitoring, have the responsibility of monitoring be a joint effort.

2. Dissemination Workshop: As the partnership with AMC was so fruitful and exemplary, hold a workshop with 4 or more other municipalities to share the learning. Bring MOs from AMC to others for peer education. The impact of the CS program is to take back to the system the new ideas experimented with, small though they may be, and institutionalize them. This step-by-step process, which takes time and patience, has great impact in the long run.

3. Training:

- Continue to encourage those mothers who want to become volunteers to be mentored by the CHT or another volunteer, to spread the news.
- Involve local leaders in a "special training" to learn more about the technical training and give copy of lesson plans and IEC materials for reference to them. Train leaders how to train men. The leaders have been involved in BCC and training and invited to distribute prizes. However, training specifically designed for the leaders and which provides skills to them to train men would supplement their knowledge.
- Certify the food vendors if they adhere to certain hygienic criteria, which would be included in a food hygiene training.
- Train local drug sellers, who continue to see anti-diarrheals and not ORS
- Provide TOT for CHTs on communicating to different audiences.
- CHT training on broader development issues such as Community Development, public health, group building, human rights, etc. from the start to put Child Survival in context.
- Clearly define the criteria for the selection of CHTs: they are role models for peer education and as trainers should be "practicing what they preach."
- Conduct "leadership training" for those CHT members who are emerging as leaders, so that the staff can phase over facilitation of monthly CHT meetings to its members.

4. HMIS:

- Bring the data back down to the community through a direct feedback loop. The KPC, HFA and DIP results have been shared with the community leaders through a series of workshops however, there is not a large degree of community ownership yet by local leaders..
- HIS data needs to be presented to the community at large, either posted by local leaders on community boards or explained at community-large meetings.
- Engage the CHTs in designing the presentation of data Design formats for posting at a community wall that utilize simple illustrations.
- Simple illustrated versions of the pie or roti charts and bar graphs would be more understandable. Post the data, in its simplest form, in a central location in the community, so that the entire community can see the measurable changes. Set up a scoreboard on the new bulletin boards in the community!

- Institutionalize vital events reporting, doing it more rigorously and regularly. Have the CHTs analyze all the deaths by age and cause. Consider using the "verbal autopsy" method for understanding the cause-specific death rates**.**

5. CHT:

- Hold the planned Convention to begin the registration of CHT members with AMC. This was in the pipeline, but luckily delayed as the extension program will be expanded, and the roles more clearly defined to fit the new situation.
- Shift the role and responsibility of a CHP/CHA into facilitator role rather than implementer from the start so as to cover the larger area and to make use of peer educators from the original areas instead.

6. JD team:

- Continue organizing cross-visits to other programs in urban settings for learning and sharing.

7. Technical Issues:

- Now that the team has been trained in the positive deviance approach, use the methodology in each audience category to reach the non-doers of any particular health issue beside malnutrition.
- Pressing health issues stated by the CHTs and community members include: TB, Maternal/Reproductive, Malaria/Dengue, and AIDS. The extension addresses maternal and reproductive health. Consider developing a TB program.

8. Groups to concentrate further outreach:

- Private practitioners: knowledge and attitude has changed, but not much practice. Build up the public/private partnership for collaborative efforts.
- Men: still not enough of the male population involved in the health activities.
- Drug sellers who sell in the market need to be brought on board.

9. Technical Assistance:

- Continue to build and utilize the TAC more.
- Request TAC members to give more time by assigning concrete tasks to each member so that they feel useful and have a clear sense of responsibility, making the sounding board stronger.

5. PVO Headquarters:

CPI HQ remains an active member of the CORE Group and utilizes this mechanism as a major means of sharing its best practices and lessons learned with the Child Survival and wider MCH community. CPI is also an active member of the Global Health Council, and uses this venue to share its experiences. CPI HQ also utilizes its Health Committee within its Board of Directors, and information systems, as means to ensure that experiences and data/information gained in any particular program are shared throughout its global health network. CPIs Director of Health Programs has already started promoting best practices, strategies and methods in to other non CS health programs. CPI is also planning a regional conference in Asia and central Asia to share lessons learned from the CS program.

6. Potential for scale-up and expansion of the Program:

This program has been extended for another 5 years and has used the midterm evaluation as a basis for designing the new program. Many of the "fresh" lessons learned will be able to be directly applied to the new program. The new program site includes all 6 wards from this program with the addition of 3 contiguous wards, increasing the population by 31 percent. The total

beneficiary population will be 132,000 (54,000 under-five children and 79,000 women of childbearing age. The staff is well-trained and positioned to take on a larger population and bring the program to a larger scale.

E. Highlights

Urban HEARTH Offers Nutrition and Peace: Builds a Bridge to Good Nutrition and Good Relations!

Counterpart International is piloting the Positive Deviance (PD)/*Hearth* approach in the urban slum areas of Ahmedabad, India. Hearth taps into the indigenous knowledge of the mothers that exists within the community. It looks for families whose children are well nourished, yet live under similar socio-economic conditions as their neighbors with malnourished children. The feeding, caring and health-seeking behaviors those mothers are practicing, which deviate positively from the norm, are shared with their neighbors and practiced in a Hearth.

A Hearth is a two-week cooking and feeding PRACTICE session for mothers of children with malnourished children for rehabilitation and education. The food that is prepared and fed to participating children is based on menus that are discovered in the homes of well-nourished children. Participants at the hearth are invited to learn how to feed, care and seek health care for their malnourished child, while rehabilitating their children through the preparation and feeding of a supplemental meal for 10-12 days. They must bring a contribution of the specified locally available, inexpensive food as admission to the sessions, to begin the practice of using that actual food.

In March 2002, riots broke out in Gujurat state, particularly in the slum areas of Ahmedabad. Muslims and Hindus took to the streets setting off a wave of extreme communal violence. There was killing and blood spilling among and between communities that lived together peacefully for generations. The Child Survival program activities were obviously delayed and shifted to respond to the crisis by setting up medical camps for women and children who were afraid to access health centers, terrified to leave their homes or neighborhoods.

To complement the nutrition intervention, which primarily focuses on BCC activities, the Child Survival team was trained in PD/Hearth in August of 2002. Two separate demonstration Hearths were set up during the training, one in each of a Muslim and Hindu community. The eating and caring practices of the two religious groups differed, but overall the Positive Deviance Inquiry revealed basic similarities in their child feeding behaviors.

Upon return a year later, the same Hearth trainer evaluated the program and was surprised to visit a Hearth that had both Hindu and Muslim children. Their mothers were interacting through cooking together. The Muslim Hearth participants had not added eggs out of respect for the Hindu adherence to a strict vegetarian diet, wanting to accommodate Hindu preferences.

The team had not dreamed of bringing the two groups together, as they were still healing from the horror of violence a year earlier. They usually did not sit together even in the best of times. To see how mothers not only came together, but also "broke bread together," was the most unexpected phenomenon. When it came to feeding their children, the mothers could overcome their differences and pain. They understood that they both shared similar hopes for healthy children. And they were willing to put down the "knives" and pick up the "spoons" to learn about nutrition and rehabilitate their children together.

Not only did the Hearth bring two divergent groups together into one small group, the results of the pilot studies surpassed everybody's expectations: every child registered gained weight and

those that have already graduated have sustained their growth after 2 months. There were 7 hearths conducted for 76 children, Muslim and Hindu alike. Now there is a demand from community leaders to expand the Hearth in neighboring slums.

Attachment A: Evaluation Team Members

- Ms Donna Sillan MPH Evaluation Consultant and Lead facilitator
- Ms. Darshana Vyas, MSW, MA, MPH Director Health Programs, Counterpart International HQ
- Ms. Darshana Vyas and Ramesh K Singh, jointly coordinated the evaluation process.
- Narendra Vyas, was in charge of the logistics for the evaluation process.
- Sandhya Sundarsas, program coordinator Sanchetana
- Dr. Kinnari Mehta, Family Welfare Officer, FHW AMC facility
- Dr. NK Patel, Immunization Officer and Registration of Birth and Death, AMC

List of participants for Final Qualitative Evaluation

Sr. No.	Name of the Participant
1	Darshana Vyas, Counterpart HQ
2	Ramesh Kumar Singh, Program Director
3	Jaydeep Mashruwala, Manager HIS
4	Heer Chokshi, Health Education Specialist
5	Ashish Yadav, Field Coordinator
6	Narendra Vyas. Officer Finance and Admin
7	Anupama Shah, Office Coordinator
8	Veena Patel, Community Health Promoter/ CPI
9	Padma Dalwadi, CHP/ CPI
10	Keyur Shah, CHP/ CPI
11	Seema Joshi, CHP/CPI
12	Hiren Makwana, CHP/CPI
13	Kinnari Vyas, CHP/CPI
14	Samana Tirmiji, CHP/CPI
15	Priti Gajjar, CHP/CPI
16	Nita Raval, CHP/CPI
17	Shahin Saiyed, CHP/CPI
18	Khushali Mehta, Data Entry Operator
19	Sandhya Surendradas, Field Officer, Sanchetana
20	Debasree Chatterji, Community Organizer, Sanchetana
21	Amita Shah, CHA Sanchetana
22	Heena Vaghela, CHA Sanchetana
23	Firoza Vora, CHA, Sanchetana
24	Shruti Trivedi, CHA, Sanchetana
25	Shardaben B. Jadav, CHT Member
26	Haseenaapa H. Rinchhdiwala, CHT Member
27	Gomtiben G. Solanki, CHT Member
28	Manjulaben R. Wala, CHT Member

29	Shantaben D. Pardhi, CHT Member
30	Jyotiben G. Makwana, CHT Member
31	Raziabanu N. Sheikh, CHT Member
32	Gitaben J. Panchal, CHT Member
33	Dr. Meenakshi, USAID
34	Dr. Rajendra Joshi, Saath
35	Dr. Nita Shah, Saath
36	Mr. Pradeep Deshmukh, MGIMS, Sewagram
37	Mr. M.S. Bharamba, MGIMS, Sewagram
38	Dr. N.K. Patel, Immunization Officer, AMC
39	Dr. M.A. Kazi, Private Practitioner
40	Dr. A.R. Rawal, Private Practitioner
41	Mr. Prakash Solanki, Local leader
42	Mr. Manoj D. Makwana, Local Leader

Attachment B: Assessment Methodology

Evaluation Objectives:

a. assess if program met the stated goals and objectives
b. the effectiveness of the technical approach
c. development of overarching lessons learned from the program
d. a strategy for use of communication of these lessons both within the organization and to partners.

Evaluation Process:

The evaluation team evaluated the program using a participatory approach. The team was comprised of experienced and expert primary health care specialists from the program, along with community members.

Upon an initial planning workshop to orient the staff and evaluation team to the evaluative process, the team, using the program goals and objectives as a guide, devised interview tools to be used in the programs. The set of evaluation tools for the persons to be interviewed, and focus groups to be facilitated is attached below.

The team was then divided into six sub-teams to cover the six wards in two days. Upon return from the field visits, the sub-teams consolidated their field findings through a "Post-It exercise." The main points were placed on the appropriate flip charts around the room according to the category by "Intervention" with the various players interviewed listed below the title and Cross-cutting issues with the various perspectives of the groups interviewed.

a) Quantitative Analysis:

- Comparison of baseline and final data
- Review progress through the health information and monitoring system
- Home-based records
- **Monthly reports**

b) Qualitative Analysis: Focus group discussions and key informant interviews:

Community:

a) Home visits: mothers/fathers
b) CHT interviews
c) TAG member
d) Local community leaders
e) Hearth volunteers
f) Hearth participant caregivers
g) Vendors
h) Private practitioners

Facility Level: *HFA conducted in August 2004

NGO level:

a) Headquarters CS Director
b) Director CPI India
c) All relevant CS staff: HMIS, BCC
d) Finance staff

Partners:

a) Sanchetana: Dr. Hanif, Sandhya, CO
b) AMC: Dr. PKM
c) TAC Coordination Committee

SCHEDULE:

DAY 1: Thursday, Sept. 2

1. Team meets: orientation to evaluation
2. Determine process: sub-teams and villages to be visited
3. Refine evaluation tools (11 guided interview sheets)
4. Review ***Quantitative*** data by intervention (small groups)

DAY 2: Friday, Sept. 3

FIELD VISIT: ***Qualitative*** Sub-teams each visit one neighborhood: Interview community leaders, volunteers, Hearth volunteers, mothers, make home visits.

DAY 3: Saturday, Sept. 4

FIELD VISIT Sub-teams each visit one neighborhood: same as above

DAY 4: Sunday, Sept. 5

- Compilation of data
- Interview MOH, Sanchetana, TAG members, CPI staff

DAY 5: Mon. Sept. 6

- Analysis of field data (qualitative data), presentation by groups
- Discussion of lessons learned
- Reach consensus on strengths, weaknesses, recommendations and lessons learned

DAY 6: Tues. Sept. 7

- Interview CPI staff, review documents

AREA: Six Wards in 2 Zones: 2 days of interviews

1. **Dariyapur C 7,000**
2. **Raikhad C 25,000**
3. **Raipur C 5,500**
4. **Behrampura S 67,000**
5. **Jamalpur C 9,000**
6. **Danilimda S 69,000**

Sub-teams

a) Each team goes to one area and asks all the questions to all the groups.
b) Day 1 & 2 in one community: interviewing and observations
c) 6 communities in-depth out of 41
d) Day 4: AMC, San, CPI interviews

TOOLBOX:

- Interview with Community Leaders
- Focus Group Discussion with CHTs
- Interview (FGD) with Hearth Volunteers
- Home Visit Guide
- Interviews with traditional healers/private practitioners
- TAG members interviews

- Partner NGO interviews
- Vendors interview
- Private practitioners interview

The team then reached consensus on the conclusions by:

a. Objective and Cross-Cutting Issue Ranking Scale: 0→10

- Review as a large group: The rank of each intervention. Discussion around has been done and how it was accomplished: what were the critical factors for reaching the objectives so far? What is needed to achieve 100%?

b. Staff Motivation Exercise:

1. What did you give to the program?
2. What did you get?
3. What would you like to work on in yourself for the extension?

A. Interview guides

1. Community Interviews:

- Mothers: FGD discussion guide
- Children: PLA games technique
- Local leaders: interview
- Vendors: interview
- Private practitioners: interview
- Gatekeepers of the house: fgd/interview
- CBO leaders/other NGOs: interview
- CHTs: FGDs & interviews
- Hearth mothers: FGDs
- Hearth volunteers: interviews

2. Facilities Staff Interviews:

** See HFA was conducted in August 2004*

3. Stakeholders:

- TAC committee members
- Sanchetana: Dr. Hanif, Sandhya, CO
- AMC: Dr. PKM
- Counterpart staff
- Coordination Committee

B. Focus Group Discussions

1. Mothers
2. Hearth Mothers
3. CHT Members
4. Hearth volunteers

ATTACHMENT D: LIST OF INTERVIEWS

NO	NAME	ORGANIZATION/DESIGNATION
	MOH	
1	Dr. PK Makwana, Director	MOH, AMC
	TAC MEMBERS	
1.	Dr. Sudarshan Iyengar	GIDR: Gurjurat Institute of Development Research
	In-house team members	
1.	Darshana Vyas, Dir.of Health, HQTRS	CII
2.	Ramesh Singh, Country Director	CII
3.	Dr. Hanif Lakdawala, Sanchetana Director	Sanchetana
4.	Jaydeep Mashruwala, Manager HIS	CII
5.	Heer Chokshi, BCC Specialist	CII
6.	Sandhya Surendradas, Sanchetana CS Man.	Sanchetana
7.	Narendra, Officer Finance and Administration	CII
8.	Ashish, Field Coordinator	CII

Documents and presentations developed reviewed:	
No	**Name**
1.	Detailed Implementation Plan
2.	Baseline Assessment- KPC Quantitative Report
3.	Baseline Assessment- Qualitative FGD Report
4.	Baseline Assessment- Health Facility Assessment Report
5.	MOU for AMC and Sanchetana
6.	Mid Term Assessment-Evaluation Report
7.	Annual report 2001
8.	Annual report 2002
9.	Process Documentation of BCC Activities And Material Development
10.	Process Documentation of Posters
11.	Process Documentation of Flipbooks
12.	Process Documentation of Snakes and Ladders Game
13.	Process documentation of Street plays
14.	Process Documentation of Puppet plays
15.	Community Action Theatre
16.	Role play Scripts
17.	Street Play Script On Diarrhea- Bhavai
18.	Street Play Script On Diarrhea
19.	Street Play Script On Nutrition
20.	Street Play Script On ORS Promotion and Handwashing
21.	Puppet Script On Nutrition- Chatur Vaniyo
22.	Puppet Script On Pneumonia- Varad Ki Ab Samaj Aa Gayee
23.	Puppet Script On Diarrhea- Saaf Rehne Ka
24.	Puppet Script On Nutrition – Bakriben Na Saara Divaso
25.	Songs Developed Under The Jeevan Daan Program
26.	CHT- Road To Sustainability
27.	Piloting PD/Hearth in Urban Programs
28.	CHT Training Report on Control of Diarrheal Diseases
29.	CHT Training Report on Pneumonia Case management
30.	CHT Training Report on Nutrition
31.	CHT Training Report on Immunization
32.	Programmatic Training on CDD
33.	Programmatic Training on PCM
34.	Programmatic Training on Nutrition
35.	Programmatic Training on Immunization
36.	Photojourney through the Jeevan Daan Program- English
37.	Photojourney through the Jeevan Daan program –Gujarati
38.	HMIS in the Jeevan Daan Program
39.	Monthly Reports

	PowerPoint Presentations
1.	Photojourney through the Jeevan Daan program
2.	Immunization Promotion- Urban Health Consultation
3.	Program Activities Till Midterm
4.	Midterm Evaluation Results
5.	Piloting Urban PD/Hearth
6.	CHT –Sneh Milan sharing presentation- Gujarati
7.	Sharing of outcomes of the Qualitative Analysis – Gujarati

8.	Behavior Change Communication Activities Of The Program
9.	Implementing Urban CS Programs
10.	Multi-stakeholders Involvement in MIS
11.	Story for Team Building
	Videos under the Program
12.	Behavior Change Communication Activities
13.	PD/Hearth –An Endeavor
14.	Street Plays of the Program- Nutrition and ORS Promotion
15.	Immunization- WBC's function in the body

A. CPI Program Documents:

1. DIP
2. KPC Baseline Survey Report: January 2001
3. Report on Health Facility Assessment, August 2001
4. First Annual Report: February 1, 2002
5. Rapid Impact Assessment, October, 2002
6. HMIS for Jeevan Daan Program
7. Jeevan Daan Child Survival Program, May 2003
8. Second Annual Report: February 2, 2002-December 13,2003
9. DIP Comments and response
10. USAID Expansion Proposal, December 4, 2002
11. Debriefing summary sheet with proposal comments for expanded program
12. Paper on "Immunization Promotion in Ahmedabad" presented at Urban health Consultation- EHP and MOH India in Bangalore 30 June –1 July 2003

B. Sanchetana Program Documents:

1. Jeevan Daan Child Survival Program: Annual Report 2003
2. "Ailing Medical System: Understanding the Medical System of Ahmedabad Municipal Corporation through the Perception of Receivers and Providers", April, 1999

C. CPI BCC Documents:

1. A Photo Journey through the Jeevan Daan Behavior Change Communication Strategy
2. Process Documentation of Developing BCC Material and Designing BCC Activities
3. Process Documentation of SAAPSIDI: Snakes and Ladders Game
4. The Pretesting Results of Saapsidi
5. Process Documentation of Puppet Plays
6. Process Documentation of Posters
7. Process Documentation of Flip Books
8. Community Action Theatre: April 2003

D. Training Documents:

1. Training on "Behavior Change Communication and Strengthening Basic Communication and Counseling Skills, 26-28, 2003
2. Hearth Nutritional Model using the Positive Deviance Approach, August 2002
3. Training on Control of Diarrheal Disease, Sept 27, 2002
4. Training on Pneumonia Case Management: Nov.11, 2002
5. Community Health Team Training: Control of Pneumonia Case Management, March 2003
6. Community Health Team Training: Control of Diarrheal Diseases, April 2003

E. Sustainability

1. A Journey towards Sustainability: Formation of CHTs

F. Other: Articles

2. Waters, Hugh, Hatt, Laurel, Peters, David, "Working with the Private Sector for Child Health," Health Policy and Planning, 18(2): 127-137, 2003
3. Luce, Edward, "Faith, Caste and Poverty," p. 14-21, Financial Times, July 5, 2003

ATTACHMENT E: Schedule of Activities

Wednesday, Sept. 1	Depart for India, Arrive in Delhi, India
Thursday, Sept 2	Fly to Ahmedabad: Planning Meeting with Full Evaluation Team
Friday, Sept. 3	Field Visits
Saturday, Sept. 4	Field Visits, Meet with AMC, interview Head
Sunday, Sept. 5	Analysis and Compilation
Monday, Sept. 6	Meet with Sanchetana, interview Director
Tuesday, Sept. 7	Continue interviews of Counterpart staff.
Wednesday, Sept. 8	Depart to US
Thursday, Sept. 9	Arrive in US
Week of Sept. 9-20	Report writing

ATTACHMENT F: TOOLS Developed

A. Community Interviews:

Interview questionnaire: Mothers

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?
2. Since when do you know her?
3. What does she do in your area?
4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?
5. How have you benefited by her? OR How have you benefited by the information she/he gives you?
6. What other activities did the CHP/A conduct in your area?
7. Which activity do you like the most? Why?
8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)
9. In what way do you think the CHP/A can improve these activities?
10. Has there been something in these activities/program that you don't approve of/ or don't like? Why?
11. Do you listen or practice all that the CHP/A tell you? Why?
12. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?
13. Did you know about the_____(nearest Municipal Hospital/center) and its facilities, before the CHP/A came to your area? Do you utilize these facilities now? Why?
14. What is your opinion about the facilities offered to you at the Municipal Hospital?
15. When the program is over, what will you do about the information you have received? What will happen to your community?
16. Do you want to share anything else about the program or the CHP/A's work?
17. Is there a Community Health Team in your area ? If she says yes, ask the name of the CHT member ?
    Have you met her / Out of all of y7ou, whose houses have been visited by any CHT member (Count the number of mothers)
18. How do the CHT members help you or how do you take the help of the CHT members?
    (Note the information in detail)
19. What do you, when your child is sick / not well, where do you take your child for treatment?
    a. When do you take the child for treatment (after how many days)?

b. Why do you take for treatment ?

20. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?
21. Any other health program you think should come which will benefit you and your community?

22. If we plan to expand / replicate this program in other areas, and then if _____(CHP / CHA name) cannot come to your area, then what would you do?

Interview questionnaire: ***Local Leader***

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?

2. Since when do you know her?

3. What does she do in your area?

4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?

5. How have you benefited by her? OR How have you benefited by the information she/he gives you?

6. What other activities did the CHP/A conduct in your area?

7. Which activity do you like the most? Why?

8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)

9. In what way do you think the CHP/A can improve these activities?

10. Has there been something in these activities/program that you don't approve of/ or don't like? Why?

11. Do you listen or practice all that the CHP/A tell you? Why?

12. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?

13. Did you know about the_____(nearest Municipal Hospital/center) and its facilities, before the CHP/A came to your area? Do you utilize these facilities now? Why?

14. What is your opinion about the facilities offered to you at the Municipal Hospital?

15. Is there a Community Health Team in your area ? If he/she says yes, ask the name of the CHT member ?
16. Have you met her/them ?

17. How & what kind of support you have offered do the CHT members?
    a. (Note the information in detail)

18. In partnership with CHT members what other issues would you like to address in the community?

19. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?
20. Any other health program you think should come which will benefit you and your community?

21. If we plan to expand / replicate this program in other areas, and then if
22. (CHP / CHA name) cannot come to your area, then what would you do to help sustain the CHT activities?

Interview questionnaire: **Private Practitioner**

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?

2. Since when do you know her?

3. What does she do in your area?

4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?

5. How have you benefited by her? OR How have you benefited by the information she/he gives you?

6. What other activities did the CHP/A conduct in your area?

7. Which activity do you like the most? Why?

8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)

9. The posters/ pamphlets given to you have been any use to you?

10. Has there been any change in the patient ratio after the Jeevan Daan program?

11. In what way do you think the CHP/A can improve these activities?

12. Has there been something in these activities/program that you don't approve of/ or don't like? Why?

13. Do you listen or practice all that the CHP/A tell you? Why?

14. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?

15. Is there a Community Health Team in your area? If he/she says yes, ask the name of the CHT member?
    Have you met her/them?

16. What changes have taken place in the cases of
    a. Pneumonia
    b. Diarrhea
    c. Immunization
    after the program has started/ since the CHP/A has started coming to your community?

17. How & what kind of support you have offered do the CHT members?
    (Note the information in detail)

18. In partnership with Local Leaders & CHT members what other issues would you like to address in the community?

19. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?

20. Have you been appraised by CHP/A on WHO protocols? Do you agree with them? Do you follow them?

21. Why do you support this program?

Interview questionnaire: Hearth Volunteers

1. Why did you participate in the hearth as volunteer?
2. What was your role in the Hearth
3. What did you learn at the hearth? What did you enjoyed doing most and why?
4. What is your view on Hearth as intervention?
5. What has been the benefit of hearth to you and to the community?
6. Do you think Hearth should be expanded in your area? If yes, will volunteer again?
7. Do you think Hearth should be done in other areas?
8. Did you follow up on the Hearth kids? Did you notice any changes in them?
9. Has there been any change in the Health status of children who participated in Hearth?
10. How can we improve hearths?
11. If the program discontinues in your area how will continue implementing Hearth?

Interview questionnaire: ***Hearth Participant Mothers***

1. Why did you take your child Hearth?
2. Do you think that in an economically not-well-to-do family also, it is possible to have a well-nourished child? How?
3. After participating in the Hearth Program, what changes did you notice in your child (If she says yes, ask what all changes and list them in detail)
   Have these changes also been observed / experienced by the other members of the family?
4. After coming to the hearth program, after the first cycle what was the change in weight of your child? (Increased / Decreased) why?
5. Did you come to the hearth with your child everyday? If not, then why? (List all reasons)
6. After the first cycle of hearth did anybody form the Jeevan Daan Program CHT member visit you?
7. After participating in the hearth program, what kind of changes did you make in taking better care of your child?
8. After participating in Hearth what changes did you noticed in your child?
9. If we plan to expand / replicate Hearth program in other areas and if we cannot do it in your area then what would you do?
   What would you practice? How?
10. How can we further improve the Hearth Program?

Note: Check the Hearth card and notice the progress till date and discuss why.

Interview questionnaire: **Gatekeepers**

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?
2. Since when do you know her?
3. What does she do in your area?
4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?
5. How have you benefited by her? OR How have you benefited by the information she/he gives you?
6. What other activities did the CHP/A conduct in your area?
7. Which activities do you like the most? Why?
8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)
9. In what way do you think the CHP/A can improve these activities?
10. Has there been something in these activities/program that you don't approve of/ or don't like? Why?
11. Do you listen or practice all that the CHP/A tell you? Why?
12. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?
13. Did you know about the_____(nearest Municipal Hospital/center) and its facilities, before the CHP/A came to your area? Do you utilize these facilities now? Why?
14. What is your opinion about the facilities offered to you at the Municipal Hospital?
15. When the program is over, what will you do about the information you have received? What will happen to your community?
16. Do you want to share anything else about the program or the CHP/A's work?
17. Is there a Community Health Team in your area ? If she says yes, ask the name of the CHT member ?
18. Have you met her / Out of all of y7ou, whose houses have been visited by any CHT member (Count the number of mothers)
19. How do the CHT members help you or how do you take the help of the CHT members?
    a. (Note the information in detail)
20. What do you, when your child is sick / not well, where do you take your child for treatment?
    a. When do you take the child for treatment (after how many days)?
    b. Why do you take for treatment?

21. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?
22. Do you allow you daughter-in-law/ wife to participate in program activities? Have you seen any changes her?
23. What is your contribution to your grandchild/ child's health?
24. How can we improve this Jeevan Daan program?
25. What other health activities will help you and your community?
26. If this program discontinues in your area what will you do?

Interview questionnaire: **CHT Member**

1. Since how long are you a CHT member?
2. Why did you become a CHT member?
3. After becoming a CHT member, what did you do for your community?
4. How frequently do you meet and what do you discuss during these meetings? Do you maintain any records or registers of meetings? What do you record in it? Does this come in use? What are the difficulties do you face in maintaining these records?
5. Have you received any training?
   What kind of trainings have you received and what all other trainings do you require?
6. Where and how did you use the trainings received?
7. The materials that have been given to you by CHP/A, how have you used it in the community? Which has been the most effective one?
8. After you become a CHT member, has there been any change in the attitude of people towards you?
9. After you become a CHT member, has there been any change in the attitude of Local leader towards you?
10. After you become a CHT member, has there been any change in the attitude of Private Practitioner towards you?
11. After you become a CHT member, has there been any change in the attitude of AMC Staff (Doctors & Vaccinators) towards you?
12. What difficulties do you face in doing your work? How did you overcome them? What other assistance do you require for the same?
13. Did you get the expected support from the CHPs? What kind? What kind of support do expect in future?
14. After formation of CHT what changes did you noticed in your community? What has been your team's contribution to this change?
15. What keeps you motivated to offer your services to the community?
16. What is your opinion about Hearth?
17. If the Jeevan Daan program people do not come to your area, what do you plan to do?

Interview questionnaire: **Vendor**

1. Are you aware of CHP/A of Jeevan Daan Program? Since how long do you know them?
2. What activities and programs have been done by the CHP/A?
3. What did you come to know through these activities?
4. What kind of information has the CHP/A given you? How have you utilized this?
5. What have started doing differently after the program?
6. Are you aware of CHT in your area?

Interview questionnaire: **Children**

1. Are you aware of CHP/A of Jeevan Daan Program?
2. What activities and programs have been done by the CHP/A?
3. What did you come to know through these activities? Which did you enjoyed most?
4. What kind of information has the CHP/A given you? How have you utilized this?

D. <u>Community FGD Guides</u>:

FGD with Mothers

1. What benefits have you received from the "Jeevan Daan" Child Survival Program? (What Information / probe for the answer to get detailed information)

2. Does _____ (CHP / CHA name) come to your area? What are the activities does he / she do in your area?

3. Are you aware of the activities carried out by _____ in your area / have you seen these activities / How did you find these activities?
   What did you learn from these activities?

4. (Based on the answer of the mothers in the previous question)
   Did you practice any of the behaviors promoted by _____ CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)
   What and how (For you, for your child, for neighbors) and did you take the messages further?

5. Is there a Community Health Team in your area ? If she says yes, ask the name of the CHT member ?
   Have you met her / Out of all of y7ou, whose houses have been visited by any CHT member (Count the number of mothers)

6. How do the CHT members help you or how do you take the help of the CHT members?
   (Note the information in detail)

7. When your child is sick / not well, where do you take your child for treatment?
   - When do you take the child for treatment (after how many days)?
   - Why do you take for treatment?

8. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?

9. If we plan to expand / replicate this program in other areas, and then if _____(CHP / CHA name) cannot come to your area, then what would you do?

FGD with Hearth Mothers

1. Why did you bring your child there? / Why did you bring your child to the hearth Program?

2. Do you think that in an economically not-well-to-do family also, it is possible to have a well-nourished child? How?

3. After participating in the Hearth Program, what changes did you notice in your child (If she says yes, ask what all changes and list them in detail)
   a. Have these changes also been observed / experienced by the other members of the family?

4. After coming to the hearth program, after the first cycle what was the change in weight of your child? (Increased / Decreased)

5. Did you come to the hearth with your child everyday? If not, then why? (List all reasons)

6. After the first cycle of hearth did anybody form the Jeevan Daan Program CHT member visit you?

7. After participating in the hearth program, what kind of changes did you make in taking better care of your child?

8. If we plan to expand / replicate Hearth program in other areas and if we cannot do it in your area then what would you do?
    a. What would you practice? How?

9. How can we further improve the Hearth Program?

FGD with CHT Members

1. Since how long are you a CHT member?

2. Why did you become a CHT member?

3. After becoming a CHT member, what did you do for your community?

4. How frequently do you meet and what do you discuss during these meetings?

5. Have you received any training?
    a. What kind of trainings have you received and what all other trainings do you require?

6. Where and how did you use the trainings received?

7. If the Jeevan Daan program people do not come to your area, what do you plan to do?

FGD with Hearth Volunteers

1. How long have you been assisting the Hearth?

2. What is the meaning of the Hearth?

3. Is this different than the way malnourished children were treated in the past?

4. How do you know a child is malnourished?

5. How is the menu decided?

6. Who brings the food?

7. Who cooks, feeds and cleans at the hearth?

8. How long will this Hearth continue?

9. Would you like to continue to implement the hearth?

10. What have been the results of your labors?

11. What is your opinion of the Hearth?

12. What is your biggest obstacle?

13. What is your greatest success?

C. PVO Interview Question Guides:

CPI Director:

1. Overall describe your opinion of the program.
2. What is the biggest achievement?
3. What is your greatest disappointment?
4. What are your dreams/vision for leaving a legacy in India?
5. Is it realistic to realize this dream?
6. What support is still required?
7. Staff development/training been enough?
8. Supervision style, frequency of supervision visits
9. TA needs met?
10. PVO support?

Manager HIS:

1. How does the program use the data you compile?
2. How are the assessments used?
3. Your needs?
4. What will you do differently?

BCC Specialist:

1. Are your messages up to date?
2. Any been omitted?
3. How are effects of BCC measured?
4. Who uses the data gathered regarding the effects of BCC?
5. How have communities used these data to reinforce of promote other behavior changes?
6. Any additional support you need?

PVO Headquarters

1. What is your opinion of this program?
2. What would you like to see happen next?
3. How many times have you been to the program?
4. What is your vision for it? Any legacy you want to leave?

TAC Members:

1. What motivates you to be part of this committee?
2. What are the changes you see?
3. How is this program different from others?
4. What features do you see as sustainable?
5. What is potentially replicable?

6. Where do you feel the program should go?

D. Partner Interviews:

MOH:

1. Why did you choose to work with CPI?
2. What is your perception of JD?
3. What are AMC's priorities? Do they match CPIs?
4. How have you been involved from the inception of the program "idea"?
5. Did you have a MOU that worked? Were the roles and responsibilities clearly delineated?
6. What is your comfort level with the partnership?
7. Do you have other examples of working with other INGOS? How is this different?
8. What changes do you see? What have been the benefits of working with CPI?
9. What are the challenges of working with CPI?
10. Has the data been shared?
11. What differences are there between the 6 wards of JD and the 37 other wards?
12. How has the TAC worked? The Coordination Committee?
13. How has the program affected your capacity?
14. What would you like to see continue?
15. What kind of future partnership do you want?
16. How do you see the role of CPI changing?
17. What are your future plans?
18. What aspects of the program are sustainable?
19. What are your suggestions?

Sanchetana: local NGO partner

1. What is your perception of the JD program?
2. How has it proceeded?
3. Were you involved in the designing and planning of it?
4. How has the funding finances proceeded?
5. What percentage of your child health budget is from CPI?
6. Obstacles?
7. How have you measured results? Have you shared the HMIS?
8. Has your agency's capacity changed? How?
9. How has your relationship with AMC changed since you worked with CP?
10. What aspects of this program can be applied to other programs beyond CS?
11. What are your recommendations for the second half of the program?
12. What are your plans for the future?
13. What would you say are the programs greatest achievements? disappointments?

ATTACHMENT H: List of Training

1. ATTENDED BY PROGRAM STAFF

NO	*NAME OF THE TRAINING*	*MONTH/ YEAR*	*FACILITATOR*
1.	*Training on KPC Survey Method*	*January 2001*	*Thomas Davis, Jr.*
2.	*Training on Focus Group Discussions*	*May 2001*	*Ramesh Singh, Sandhya Surendradas*
3.	*Training on Health Facility Assessment Survey Method*	*July 2001*	*Ramesh Singh, Jaydeep Mashruwala*
4.	*Program Overview Training*	*February 2002*	*Mr. Ramesh K Singh, Jaydeep Mashruwala*
5.	*Trauma counseling*	*March 2002*	*UNICEF*
6.	*Training on Behavior Change Communication, Strengthening counseling skills*	*June July 2002*	Ms. Darshana Vyas
7.	*Training on Nutrition / Positive Deviance HEARTH*	*August 2002*	*Ms. Donna Sillan*
8.	*Training on Control of Diarrheal Diseases*	*September 2002*	*Dr. Lata Shah and Mr. Ashok Bhargava*
9.	*Training on Rapid Impact Assessment; KPC Survey, and Qualitative Assessments*	*October November 2002*	*Dr. Arvind Kasturi*
10.	*Training on Pneumonia Case Management*	*November, 2002*	*Dr. Lata Shah and Mr. Ashok Bhargava*
11.	*Training on Nutrition and breastfeeding*	*April 2003*	*Dr. Lata Shah and Mr. Ashok Bhargava*
12.	*Training on Immunization*	*August 2003*	*Dr. Lata Shah and Mr. Ashok Bhargava*

2. Training provided by the Team:

NO:	*NAME OF THE DRIP TRAINING/ WORKSHOP*	*MONTH / YEAR*	*FACILITATOR*
1.	Diarrhea and Pneumonia	*January 2002*	*Ramesh Singh*
2.	6 Killer Diseases and Immunization	*January 2002*	*Rachna Sujay*
3.	HIV / AIDS	*January 2002*	*Rachna Sujay*
4.	Workshop on Developing Roles and Responsibilities of CHTs	*February 2002*	*Jaydeep Mashruwala*
5.	Nutrition	*Feb 2002*	*Rachna Sujay*
6.	Client Segmentation	*April 2002*	*Ramesh Singh, Jaydeep Mashruwala*
7.	*Workshop on Effective Planning of BCC activities through 7 steps of planning*	*April 2002*	*Ramesh K Singh*
8.	Basics of Designing	*May 2002*	*Heer Chokshi*
9.	Workshop on Dramatics and Bhavai	*h May 2002*	*Heer Chokshi*
10.	Puppet Workshop	*June 2002*	*Heer Chokshi*
11.	*Immunization*	*July 2002*	*Ramesh K Singh*
12.	MIS	*June 2002, November 2002*	*Jaydeep Mashruwala, Narendra Vyas*
13.	Report Writing	*May 2002 July 2002*	*Rachna Sujay* Ramesh Singh
14.	Refresher training on PD/Hearth	*April 2003*	*Ramesh K. Singh*
15.	Effective team building and functioning	*November 2003*	*Heer Chokshi Ashish Yadav*
16.	Effective CHT meetings	*December 2003*	*Heer Chokshi Ashish Yadav*
17.	Establishing linkages in the community	*December 2003*	*Heer Chokshi Ashish Yadav*

3. TRAININGS RECEIVED BY PROGRAM STAFF OUTSIDE INDIA

NO	NAME OF THE PROGRAM	MONTH / YEAR	FACILITATOR	RECEIVED BY
13.	*Finance Training as per USAID requirements, Kazakhstan*	*July, 2001*	*Financial Director for Counterpart Central Asia, Bob Abma*	*Ramesh Singh, Milesh Hamlai*
14.	*BEHAVE Framework: Behavior Change Programming, Johannesburg, South Africa*	*Feb 2002*	*CORE/ AED*	*Jaydeep Mashruwala*
15.	*Applying the BEHAVE Framework: Cambodia*	*Feb 2003*	*CORE/ AED*	*Heer Chokshi, Sandhya Surendradas*

4. TRAININGS GIVEN BY PROGRAM STAFF OUTSIDE INDIA

NO	NAME OF THE PROGRAM	MONTH / YEAR	FACILITATOR	RECEIVED BY
1.	*Finance Training as per USAID requirements*	*April, 2003*	*Milesh Hamlai*	*CS Program Director, Finance Officer, Uzbekistan*
2.	*BCC Training*	*April 2002*	*Darshana Vyas, Jaydeep Mashruwala*	*CS Program Uzbekistan*
3.	*MIS Training*	*April 2002*	*Jaydeep Mashruwala, Narendra Vyas*	*CS Program Uzbekistan*
4.	*BCC Training*	*October 2002*	*Darshana Vyas, Ramesh Singh*	*MCH Program, Turkmenistan* Ramesh, please add Turkemnistan and World Vision India

Attachment A: Evaluation Team Members

- Ms Donna Sillan MPH Evaluation Consultant and Lead facilitator
- Ms. Darshana Vyas, MSW, MA, MPH Director Health Programs, Counterpart International HQ
- Ms. Darshana Vyas and Ramesh K Singh, jointly coordinated the evaluation process.
- Narendra Vyas, was in charge of the logistics for the evaluation process.
- Dr. ARvind Kasturi for Quantitative Assessments. KPC and HFA.

List of participants for Final Qualitative Evaluation

Sr. No.	Name of the Participant
1	Darshana Vy as, Counterpart HQ
2	Ramesh Kumar Singh, Program Director
3	Jaydeep Mashruwala, Manager Field and HMIS
4	Heer Chokshi, Health Education Specialist
5	Ashish Yadav, Field Coordinator
6	Narendra Vyas. Finance Manager
7	Anupama Shah, Program Coordinator
8	Veena Patel, Community Health Promoter/ CPI
9	Padma Dalwadi, CHP/ CPI
10	Keyur Shah, CHP/ CPI
11	Seema Joshi, CHP/CPI
12	Hiren Makwana, BCC Assistant/CPI
13	Kinnari Vyas, CHP/CPI
14	Samana Tirmiji, CHP/CPI
15	Priti Gajjar, CHP/CPI
16	Nita Raval, CHP/CPI
17	Shahin Saiyed,
18	Khushalid Mehta
19	Sandhya Surendradas, Field Officer, Sanchetana
20	Debasree Chatterji, Community Organizer, Sanchetana
21	Amita Shah, CHA Sanchetana
22	Heena Vaghela
23	Firoza Vora, CHA, Sanchetana
24	Shruti Trivedi, CHA, Sanchetana
25	Shardaben B. Jadav, CHT Member
26	Haseenaapa H. Rinchhdiwala, CHT Member
27	Gomtiben G. Solanki, CHT Member
28	Manjulaben R. Wala, CHT Member
29	Shantaben D. Pardhi, CHT Member
30	Jyotiben G. Makwana, CHT Member
31	Raziabanu N. Sheikh, CHT Member
32	Gitaben J. Panchal, CHT Member
33	Dr. Meenakshi, USAID
34	Dr. Rajendra Joshi, Saath
35	Dr. Nita Shah, Saath
36	Mr. Pradeep Deshmukh, MGIMS, Sewagram
37	Mr. M.S. Bharamba, MGIMS, Sewagram
38	Dr. N.K. Patel, Immunization Officer, AMC
39	Dr. M.A. Kazi, Private Practitioner
40	Dr. A.R. Rawal, Private Practitioner
41	Mr. Prakash Solanki, Local leader
42	Mr. Manoj D. Makwana, Local Leader

Attachment B: Assessment Methodology

Evaluation Objectives:

a. assess if program met the stated goals and objectives
b. the effectiveness of the technical approach
c. development of overarching lessons learned from the project
d. a strategy for use of communication of these lessons both within the organization and to partners.

Evaluation Process:

Before starting qualitative evaluation, KPC and HFA were conducted following 30 cluster sampling methods by the external consultant Dr. Arvind Kasturi. The evaluation team evaluated the project using a participatory approach. The team was comprised of experienced and expert primary health care specialists from the project, along with community members.

Upon an initial planning workshop to orient the staff and evaluation team to the evaluative process, the team, using the program goals and objectives as a guide, devised interview tools to be used in the projects. The set of evaluation tools for the persons to be interviewed, and focus groups to be facilitated is attached below.

The team was then divided into six sub-teams to cover the six wards in two days. Upon return from the field visits, the sub-teams consolidated their field findings through a "Post-It exercise." The main points were placed on the appropriate flip charts around the room according to the category by "Intervention" with the various players interviewed listed below the title and Cross-cutting issues with the various perspectives of the groups interviewed.

a) Quantitative Analysis:

- Comparison of baseline and final data
- Review progress through the health information and monitoring system
- Home-based records
- Monthly reports

b) Qualitative Analysis: Focus group discussions and key informant interviews:
Community:

a) Home visits: mothers/fathers
b) CHT interviews
c) TAG member
d) Local community leaders
e) Hearth volunteers
f) Hearth participant caregivers
g) Vendors
h) Private practitioners

Facility Level: *****HFA conducted in August 2004

NGO level:

a) Headquarters CS Director
b) Director CPI India
c) All relevant CS staff: HMIS, BCC
d) Finance staff

Partners:

a) Sanchetana: Dr. Hanif, Sandhya, CO
b) AMC: Dr. PKM
c) TAC Coordination Committee

SCHEDULE:

DAY 1: Thursday, Sept. 2

1. Team meets: orientation to evaluation
2. Determine process: sub-teams and villages to be visited
3. Refine evaluation tools (11 guided interview sheets)
4. Review ***Quantitative*** data by intervention (small groups)

DAY 2: Friday, Sept. 3

FIELD VISIT: ***Qualitative*** Sub-teams each visit one neighborhood: Interview community leaders, volunteers, Hearth volunteers, mothers, make home visits.

DAY 3: Saturday, Sept. 4

FIELD VISIT Sub-teams each visit one neighborhood: same as above

DAY 4: Sunday, Sept. 5

- Compilation of data
- Interview MOH, Sanchetana, TAG members, CPI staff

DAY 5: Mon. Sept. 6

- Analysis of field data (qualitative data), presentation by groups
- Discussion of lessons learned
- Reach consensus on strengths, weaknesses, recommendations and lessons learned

DAY 6: Tues. Sept. 7

- Interview CPI staff, review documents

AREA: Six Wards in 2 Zones: 2 days of interviews

1. Dariyapur C 7,000
2. Raikhad C 25,000
3. Raipur C 5,500
4. Behrampura S 67,000
5. Jamalpur C 9,000
6. Danilimda S 69,000

Sub-teams

a) Each team goes to one area and asks all the questions to all the groups.
b) Day 1 & 2 in one community: interviewing and observations
c) 6 communities in-depth out of 41
d) Day 4: AMC, San, CPI interviews

TOOLBOX:

- Interview with Community Leaders
- Focus Group Discussion with CHTs
- Interview (FGD) with Hearth Volunteers
- Home Visit Guide
- Interviews with traditional healers/private practitioners

- TAG members interviews
- Partner NGO interviews
- Vendors interview
- Private practitioners interview

The team then reached consensus on the conclusions by:

a. Objective and Cross-Cutting Issue Ranking Scale: 0➔10

- Review as a large group: The rank of each intervention. Discussion around has been done and how it was accomplished: what were the critical factors for reaching the objectives so far? What is needed to achieve 100%?

b. Staff Motivation Exercise:

1. What did you give to the program?
2. What did you get?
3. What would you like to work on in yourself for the extension?

1. Interview guides

1. Community Interviews:

- Mothers: FGD discussion guide
- Children: PLA games technique
- Local leaders: interview
- Vendors: interview
- Private practitioners: interview
- Gatekeepers of the house: fgd/interview
- CBO leaders/other NGOs: interview
- CHTs: FGDs & interviews
- Hearth mothers: FGDs
- Hearth volunteers: interviews

2. Facilities Staff Interviews:

* See HFA was conducted in August 2004

3. Stakeholders:

- TAC committee members
- Sanchetana: Dr. Hanif, Sandhya, CO
- AMC: Dr. PKM
- Counterpart staff
- Coordination Committee

2. Focus Group Discussions

1. Mothers
2. Hearth Mothers
3. CHT Members
4. Hearth volunteers

ATTACHMENT C: Please insert next the TEAMS

ATTACHMENT D: LIST OF INTERVIEWS

NO	NAME	ORGANIZATION/DESIGNATION
	MOH	
1	Dr. PK Makwana, Director	MOH, AMC
	TAC MEMBERS	
1.	Dr. Sudarshan Iyengar	GIDR: Gurjurat Institute of Development Research
	In-house team members	
1.	Darshana Vyas, Dir.of Health, HQTRS	CII
2.	Ramesh Singh, Country Director	CII
3.	Dr. Hanif Lakdawala, Sanchetana Director	Sanchetana
4.	Jaydeep Mashruwala, Program/HMIS Manager	CII
5.	Heer Choksi, BCC Manager	CII
6.	Sandhya Surendradas, Sanchetana CS Man.	Sanchetana
7.	Ravindra, Finance and Adminstration	CII
8.	Ahsish, Field Coordinator	CII

Documents reviewed:

A. CPI Project Documents:

1. DIP
2. KPC Baseline Survey Report: January 2001
3. Report on Health Facility Assessment, August 2001
4. First Annual Report: February 1, 2002
5. Rapid Impact Assessment, October, 2002
6. HMIS for Jeevan Daan Program
7. Jeevan Daan Child Survival Program, May 2003
8. Second Annual Report: February 2, 2002-December 13,2003
9. DIP Comments and response
10. USAID Expansion Proposal, December 4, 2002
11. Debriefing summary sheet with proposal comments for expanded program
12. Paper on "Immunization Promotion in Ahmedabad" presented at Urban health Consultation-EHP and MOH India in Bangalore 30 June –1 July 2003

B. Sanchetana Project Documents:

1. Jeevan Daan Child Survival Program: Annual Report 2003
2. "Ailing Medical System: Understanding the Medical System of Ahmedabad Municipal Corporation through the Perception of Receivers and Providers", April, 1999

C. CPI BCC Documents:

1. A Photo Journey through the Jeevan Daan Behavior Change Communication Strategy
2. Process Documentation of Developing BCC Material and Designing BCC Activities
3. Process Documentation of SAAPSIDI: Snakes and Ladders Game
4. The Pretesting Results of Saapsidi
5. Process Documentation of Puppet Plays
6. Process Documentation of Posters
7. Process Documentation of Flip Books
8. Community Action Theatre: April 2003

D. Training Documents:

1. Training on "Behavior Change Communication and Strengthening Basic Communication and Counseling Skills, 26-28, 2003Hearth Nutritional Model using the Positive Deviance Approach, August 2002
2. Training on Control of Diarrheal Disease, Sept 27, 2002
3. Training on Pneumonia Case Management: Nov.11, 2002
4. Community Health Team Training: Control of Pneumonia Case Management, March 2003
5. Community Health Team Training: Control of Diarrheal Diseases, April 2003

E. Sustainability

1. A Journey towards Sustainability: Formation of CHTs

F. Other: Articles

2. Waters, Hugh, Hatt, Laurel, Peters, David, "Working with the Private Sector for Child Health," Health Policy and Planning, 18(2): 127-137, 2003
3. Luce, Edward, "Faith, Caste and Poverty," p. 14-21, Financial Times, July 5, 2003

ATTACHMENT E: Schedule of Activities

Wednesday, Sept. 1	Depart for India, Arrive in Delhi, India
Thursday, Sept 2	Fly to Ahmedabad: Planning Meeting with Full Evaluation Team
Friday, Sept. 3	Field Visits
Saturday, Sept. 4	Field Visits, Meet with AMC, interview Head
Sunday, Sept. 5	Analysis and Compilation
Monday, Sept. 6	Meet with Sanchetana, interview Director
Tuesday, Sept. 7	Continue interviews of Counterpart staff.
Wednesday, Sept. 8	Depart to US
Thursday, Sept. 9	Arrive in US
Week of Sept. 9-20	Report writing

ATTACHMENT F: TOOLS Developed

A. Community Interviews:

Interview questionnaire: Mothers

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?

2. Since when do you know her?

3. What does she do in your area?

4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?

5. How have you benefited by her? OR How have you benefited by the information she/he gives you?

6. What other activities did the CHP/A conduct in your area?

7. Which activity do you like the most? Why?

8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)

9. In what way do you think the CHP/A can improve these activities?

10. Has there been something in these activities/program that you don't approve of/ or don't like? Why?

11. Do you listen or practice all that the CHP/A tell you? Why?

12. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?

13. Did you know about the_____(nearest Municipal Hospital/center) and its facilities, before the CHP/A came to your area? Do you utilize these facilities now? Why?

14. What is your opinion about the facilities offered to you at the Municipal Hospital?

15. When the program is over, what will you do about the information you have received? What will happen to your community?

16. Do you want to share anything else about the program or the CHP/A's work?

17. Is there a Community Health Team in your area ? If she says yes, ask the name of the CHT member ?
    Have you met her / Out of all of y7ou, whose houses have been visited by any CHT member (Count the number of mothers)

18. How do the CHT members help you or how do you take the help of the CHT members?
    (Note the information in detail)

19. What do you, when your child is sick / not well, where do you take your child for treatment?
    a. When do you take the child for treatment (after how many days)?
    b. Why do you take for treatment ?

20. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?
21. Any other health program you think should come which will benefit you and your community?

22. If we plan to expand / replicate this program in other areas, and then if _____(CHP / CHA name) cannot come to your area, then what would you do?

Interview questionnaire: **Local Leader**

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?

2. Since when do you know her?

3. What does she do in your area?

4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?

5. How have you benefited by her? OR How have you benefited by the information she/he gives you?

6. What other activities did the CHP/A conduct in your area?

7. Which activity do you like the most? Why?

8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)

9. In what way do you think the CHP/A can improve these activities?

10. Has there been something in these activities/program that you don't approve of/ or don't like? Why?

11. Do you listen or practice all that the CHP/A tell you? Why?

12. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?

13. Did you know about the_____(nearest Municipal Hospital/center) and its facilities, before the CHP/A came to your area? Do you utilize these facilities now? Why?

14. What is your opinion about the facilities offered to you at the Municipal Hospital?

15. Is there a Community Health Team in your area ? If he/she says yes, ask the name of the CHT member ?
16. Have you met her/them ?

17. How & what kind of support you have offered do the CHT members?
    a. (Note the information in detail)

18. In partnership with CHT members what other issues would you like to address in the community?

19. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?

20. Any other health program you think should come which will benefit you and your community?

21. If we plan to expand / replicate this program in other areas, and then if
22. (CHP / CHA name) cannot come to your area, then what would you do to help sustain the CHT activities?

Interview questionnaire: **Private Practitioner**

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?

2. Since when do you know her?

3. What does she do in your area?

4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?

5. How have you benefited by her? OR How have you benefited by the information she/he gives you?

6. What other activities did the CHP/A conduct in your area?

7. Which activity do you like the most? Why?

8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)

9. The posters/ pamphlets given to you have been any use to you?

10. Has there been any change in the patient ratio after the Jeevan Daan program?

11. In what way do you think the CHP/A can improve these activities?

12. Has there been something in these activities/program that you don't approve of/ or don't like? Why?

13. Do you listen or practice all that the CHP/A tell you? Why?

14. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?

15. Is there a Community Health Team in your area? If he/she says yes, ask the name of the CHT member?
    Have you met her/them?

16. What changes have taken place in the cases of
    a. Pneumonia
    b. Diarrhea
    c. Immunization
    after the program has started/ since the CHP/A has started coming to your community?

17. How & what kind of support you have offered do the CHT members?
    (Note the information in detail)

18. In partnership with Local Leaders & CHT members what other issues would you like to address in the community?

19. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?

20. Have you been appraised by CHP/A on WHO protocols? Do you agree with them? Do you follow them?

21. Why do you support this program?

Interview questionnaire: **Hearth Volunteers**

1. Why did you participate in the hearth as volunteer?
2. What was your role in the Hearth
3. What did you learn at the hearth? What did you enjoyed doing most and why?
4. What is your view on Hearth as intervention?
5. What has been the benefit of hearth to you and to the community?
6. Do you think Hearth should be expanded in your area? If yes, will volunteer again?
7. Do you think Hearth should be done in other areas?
8. Did you follow up on the Hearth kids? Did you notice any changes in them?
9. Has there been any change in the Health status of children who participated in Hearth?
10. How can we improve hearths?
11. If the program discontinues in your area how will continue implementing Hearth?

Interview questionnaire: **Hearth Participant Mothers**

1. Why did you take your child Hearth?
2. Do you think that in an economically not-well-to-do family also, it is possible to have a well-nourished child? How?
3. After participating in the Hearth Program, what changes did you notice in your child (If she says yes, ask what all changes and list them in detail)
   Have these changes also been observed / experienced by the other members of the family?
4. After coming to the hearth program, after the first cycle what was the change in weight of your child? (Increased / Decreased) why?
5. Did you come to the hearth with your child everyday? If not, then why? (List all reasons)
6. After the first cycle of hearth did anybody form the Jeevan Daan Program CHT member visit you?
7. After participating in the hearth program, what kind of changes did you make in taking better care of your child?
8. After participating in Hearth what changes did you noticed in your child?
9. If we plan to expand / replicate Hearth program in other areas and if we cannot do it in your area then what would you do?
   What would you practice? How?
10. How can we further improve the Hearth Program?

Note: Check the Hearth card and notice the progress till date and discuss why.

Interview questionnaire: **Gatekeepers**

1. Are you familiar with _____(CHP/A) of the *'Jeevan Daan'* program?

2. Since when do you know her?

3. What does she do in your area?

4. Did you know about the information, that the *'Jeevan Daan'* CHP/A gives you, prior to her/his coming to your area?

5. How have you benefited by her? OR How have you benefited by the information she/he gives you?

6. What other activities did the CHP/A conduct in your area?

7. Which activity do you like the most? Why?

8. Did you practice any of the behaviors promoted by CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)

9. In what way do you think the CHP/A can improve these activities?

10. Has there been something in these activities/program that you don't approve of/ or don't like? Why?

11. Do you listen or practice all that the CHP/A tell you? Why?

12. Apart from the activities the CHP/A does in your area is there any thing else that you would like her to bring/do? OR What are your expectations from the program?

13. Did you know about the_____(nearest Municipal Hospital/center) and its facilities, before the CHP/A came to your area? Do you utilize these facilities now? Why?

14. What is your opinion about the facilities offered to you at the Municipal Hospital?

15. When the program is over, what will you do about the information you have received? What will happen to your community?

16. Do you want to share anything else about the program or the CHP/A's work?

17. Is there a Community Health Team in your area ? If she says yes, ask the name of the CHT member ?
18. Have you met her / Out of all of y7ou, whose houses have been visited by any CHT member (Count the number of mothers)

19. How do the CHT members help you or how do you take the help of the CHT members?
    a. (Note the information in detail)

20. What do you, when your child is sick / not well, where do you take your child for treatment?
    a. When do you take the child for treatment (after how many days)?
    b. Why do you take for treatment?

21. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?
22. Do you allow you daughter-in-law/ wife to participate in program activities? Have you seen any changes her?
23. What is your contribution to your grandchild/ child's health?
24. How can we improve this Jeevan Daan program?
25. What other health activities will help you and your community?
26. If this program discontinues in your area what will you do?

Interview questionnaire: **CHT Member**

1. Since how long are you a CHT member?
2. Why did you become a CHT member?

3. After becoming a CHT member, what did you do for your community?
4. How frequently do you meet and what do you discuss during these meetings? Do you maintain any records or registers of meetings? What do you record in it? Does this come in use? What are the difficulties do you face in maintaining these records?
5. Have you received any training?
   What kind of trainings have you received and what all other trainings do you require?
6. Where and how did you use the trainings received?
7. The materials that have been given to you by CHP/A, how have you used it in the community? Which has been the most effective one?
8. After you become a CHT member, has there been any change in the attitude of people towards you?
9. After you become a CHT member, has there been any change in the attitude of Local leader towards you?
10. After you become a CHT member, has there been any change in the attitude of Private Practitioner towards you?
11. After you become a CHT member, has there been any change in the attitude of AMC Staff (Doctors & Vaccinators) towards you?
12. What difficulties do you face in doing your work? How did you overcome them? What other assistance do you require for the same?
13. Did you get the expected support from the CHPs? What kind? What kind of support do expect in future?
14. After formation of CHT what changes did you noticed in your community? What has been your team's contribution to this change?
15. What keeps you motivated to offer your services to the community?
16. What is your opinion about Hearth?
17. If the Jeevan Daan program people do not come to your area, what do you plan to do?

Interview questionnaire: **Vendor**

1. Are you aware of CHP/A of Jeevan Daan Program? Since how long do you know them?
2. What activities and programs have been done by the CHP/A?
3. What did you come to know through these activities?
4. What kind of information has the CHP/A given you? How have you utilized this?
5. What have started doing differently after the program?
6. Are you aware of CHT in your area?

Interview questionnaire: **Children**

1. Are you aware of CHP/A of Jeevan Daan Program?
2. What activities and programs have been done by the CHP/A?
3. What did you come to know through these activities? Which did you enjoyed most?
4. What kind of information has the CHP/A given you? How have you utilized this?

D. <u>Community FGD Guides</u>:

FGD with Mothers

1. What benefits have you received from the "Jeevan Daan" Child Survival Program? (What Information / probe for the answer to get detailed information)

2. Does _____ (CHP / CHA name) come to your area? What are the activities does he / she do in your area?

3. Are you aware of the activities carried out by _____ in your area / have you seen these activities / How did you find these activities?
   What did you learn from these activities?

4. (Based on the answer of the mothers in the previous question)
   Did you practice any of the behaviors promoted by _____ CHP / CHA or the activities (Interpersonal communication, street plays, puppet show, health education sessions, songs etc.)
   What and how (For you, for your child, for neighbors) and did you take the messages further?

5. Is there a Community Health Team in your area ? If she says yes, ask the name of the CHT member ?
   Have you met her / Out of all of y7ou, whose houses have been visited by any CHT member (Count the number of mothers)

6. How do the CHT members help you or how do you take the help of the CHT members? (Note the information in detail)

7. When your child is sick / not well, where do you take your child for treatment?
   - When do you take the child for treatment (after how many days)?
   - Why do you take for treatment ?

8. (Ask everybody) How to further improve the "Jeevan Daan" Child Survival program?

9. If we plan to expand / replicate this program in other areas, and then if _____(CHP / CHA name) cannot come to your area, then what would you do?

FGD with Hearth Mothers

1. Why did you bring your child there? / Why did you bring your child to the hearth Program?

2. Do you think that in an economically not-well-to-do family also, it is possible to have a well-nourished child? How?

3. After participating in the Hearth Program, what changes did you notice in your child (If she says yes, ask what all changes and list them in detail)
   a. Have these changes also been observed / experienced by the other members of the family?

4. After coming to the hearth program, after the first cycle what was the change in weight of your child? (Increased / Decreased)

5. Did you come to the hearth with your child everyday? If not, then why? (List all reasons)

6. After the first cycle of hearth did anybody form the Jeevan Daan Program CHT member visit you?

7. After participating in the hearth program, what kind of changes did you make in taking better care of your child?

8. If we plan to expand / replicate Hearth program in other areas and if we cannot do it in your area then what would you do?
    a. What would you practice? How?

9. How can we further improve the Hearth Program?

FGD with CHT Members

1. Since how long are you a CHT member?

2. Why did you become a CHT member?

3. After becoming a CHT member, what did you do for your community?

4. How frequently do you meet and what do you discuss during these meetings?

5. Have you received any training?
    a. What kind of trainings have you received and what all other trainings do you require?

6. Where and how did you use the trainings received?

7. If the Jeevan Daan program people do not come to your area, what do you plan to do?

FGD with Hearth Volunteers

1. How long have you been assisting the Hearth?

2. What is the meaning of the Hearth?

3. Is this different than the way malnourished children were treated in the past?

4. How do you know a child is malnourished?

5. How is the menu decided?

6. Who brings the food?

7. Who cooks, feeds and cleans at the hearth?

8. How long will this Hearth continue?

9. Would you like to continue to implement the hearth?

10. What have been the results of your labors?

11. What is your opinion of the Hearth?

12. What is your biggest obstacle?

13. What is your greatest success?

C. PVO Interview Question Guides:

CPI Director:

1. Overall describe your opinion of the project.
2. What is the biggest achievement?
3. What is your greatest disappointment?
4. What are your dreams/vision for leaving a legacy in India?
5. Is it realistic to realize this dream?
6. What support is still required?
7. Staff development/training been enough?
8. Supervision style, frequency of supervision visits
9. TA needs met?
10. PVO support?

HMIS Manager:

1. How does the program use the data you compile?
2. How are the assessments used?
3. Your needs?
4. What will you do differently?

BCC Manager:

1. Are your messages up to date?
2. Any been omitted?
3. How are effects of BCC measured?
4. Who uses the data gathered regarding the effects of BCC?
5. How have communities used these data to reinforce of promote other behavior changes?
6. Any additional support you need?

PVO Headquarters

1. What is your opinion of this program?
2. What would you like to see happen next?
3. How many times have you been to the program?
4. What is your vision for it? Any legacy you want to leave?

TAC Members:

1. What motivates you to be part of this committee?
2. What are the changes you see?
3. How is this program different from others?
4. What features do you see as sustainable?
5. What is potentially replicable?
6. Where do you feel the program should go?

D. Partner Interviews:

MOH:

1. Why did you choose to work with CPI?
2. What is your perception of JD?
3. What are AMC's priorities? Do they match CPIs?
4. How have you been involved from the inception of the program "idea"?
5. Did you have a MOU that worked? Were the roles and responsibilities clearly delineated?
6. What is your comfort level with the partnership?
7. Do you have other examples of working with other INGOS? How is this different?
8. What changes do you see? What have been the benefits of working with CPI?
9. What are the challenges of working with CPI?

10. Has the data been shared?
11. What differences are there between the 6 wards of JD and the 37 other wards?
12. How has the TAC worked? The Coordination Committee?
13. How has the program affected your capacity?
14. What would you like to see continue?
15. What kind of future partnership do you want?
16. How do you see the role of CPI changing?
17. What are your future plans?
18. What aspects of the program are sustainable?
19. What are your suggestions?

Sanchetana: local NGO partner

1. What is your perception of the JD program?
2. How has it proceeded?
3. Were you involved in the designing and planning of it?
4. How has the funding finances proceeded?
5. What percentage of your child health budget is from CPI?
6. Obstacles?
7. How have you measured results? Have you shared the HMIS?
8. Has your agency's capacity changed? How?
9. How has your relationship with AMC changed since you worked with CP?
10. What aspects of this program can be applied to other programs beyond CS?
11. What are your recommendations for the second half of the program?
12. What are your plans for the future?
13. What would you say are the programs greatest achievements? disappointments?

ATTACHMENT G: List of Training

1. ATTENDED BY PROGRAM STAFF

NO	NAME OF THE TRAINING	MONTH/ YEAR	*FACILITATOR*
1.	Training on KPC Survey Method	January 2001	Thomas Davis, Jr.
2.	Training on Focus Group Discussions	May 2001	Ramesh Singh, Sandhya Surendradas
3.	Training on Health Facility Assesment Survey Method	July 2001	Ramesh Singh, Jaydeep Mashruwala
4.	Program Overview Training	February 26-27, 2002	Mr. Ramesh K Singh, Jaydeep Mashruwala
5.	Trauma counseling	27th March 2002	UNICEF
6.	Training on Behavior Change Communication, Strengthening counseling skills	June 26- July 1 2002	Ms. Darshana Vyas
7.	Training on Nutrition / Positive Deviance HEARTH	August 17- 25 2002	Ms. Donna Sillan
8.	Training on Control of Diarrheal Diseases	September 27 2002	Dr. Lata Shah and Mr. Ashok Bhargava
9.	Training on Rapid Impact Assessment; KPC Survey, and Qualitative Assessments	October 28- November 1 2002	Dr. Arvind Kasturi
10.	Training on Pneumonia Case Management	20th – 21st November, 2002	Dr. Lata Shah and Mr. Ashok Bhargava

2. Training provided by the Team:

NO:	NAME OF THE DRIP TRAINING/ WORKSHOP	MONTH / YEAR	*FACILITATOR*
1.	Diarrhea and Pneumonia	January 2002	Ramesh Singh
2.	6 Killer Diseases and Immunization	4th January 2002	Rachna Sujay
3.	HIV / AIDS	4th January 2002	Rachna Sujay
4.	Workshop on Developing Roles and Responsibilities of CHTs	4th February 2002	Jaydeep Mashruwala
5.	Nutrition	Feb 2002	Rachna Sujay
6.	Client Segmentation	18th April 2002	Ramesh Singh, Jaydeep Mashruwala
7.	Workshop on Effective Planning of BCC activities through 7 steps of planning	24th-26th April 2002	Mr. Ramesh K Singh
8.	Basics of Designing	10th May 2002	Heer Shah
9.	Workshop on Dramatics and Bhavai	15th May 2002	Heer Shah
10.	Puppet Workshop	12th June 2002	Heer Shah
11.	Immunization	July 2002	Mr. Ramesh K Singh
12.	MIS	June 2002, November 2002	Jaydeep Mashruwala, Narendra Vyas
13.	Report Writing	17th May 2002 30th July 2002	Rachna Sujay Ramesh Singh

3. TRAININGS RECEIVED BY PROGRAM STAFF OUTSIDE INDIA

NO	NAME OF THE PROGRAM	MONTH / YEAR	*FACILITATOR*	RECEIVED BY
11.	Finance Training as per USAID requirements, Kazakhstan	July, 2001	Financial Director for Counterpart Central Asia, Bob Abma	Ramesh Singh, Milesh Hamlai
12.	BEHAVE Framework: Behavior Change Programming, Johannesburg, South Africa	Feb 2002	CORE/ AED	Jaydeep Mashruwala
13.	Applying the BEHAVE Framework: Cambodia	Feb 2003	CORE/ AED	Heer Shah, Sandhya Surendradas

4. TRAININGS GIVEN BY PROGRAM STAFF OUTSIDE INDIA

NO	NAME OF THE PROGRAM	MONTH / YEAR	*FACILITATOR*	RECEIVED BY
1.	Finance Training as per USAID requirements	April, 2003	Milesh Hamlai	CS Program Director, Finance Officer, Uzbekistan
2.	BCC Training	April 2002	Darshana Vyas, Jaydeep Mashruwala	CS Program Uzbekistan
3.	MIS Training	April 2002	Jaydeep Mashruwala, Narendra Vyas	CS Program Uzbekistan
4.	BCC Training	October 2002	Darshana Vyas, Ramesh Singh	MCH Program, Turkmenistan