

Counterpart International
In partnership with
Ahmedabad Municipal Corporation
and
Saath



Child Survival *Jeevan Daan*
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Midterm Evaluation Report

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Jeevan Daan Maternal and Child Survival Cost
Extension Program



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In addition, one cannot forget to mention the selfless dedication of the members of the Community Health Teams’ community-based health workers and community members themselves who are showing all of us the remarkable power of what empowered people in developing countries can achieve.

Acronyms and Abbreviations

AMC	Ahmedabad Municipal Corporation
AR	Annual Report
BCC	Behavior Change Communication
CDD	Control of Diarrheal Disease
CHT	Community Health Team
CDT	Community Development Team
CIMCI	Community Integrated Management of Child Illness
CO	Community Organizer
CPI	Counterpart International
CSHGP	Child Survival and Health Grants Program
CSP	Child Survival Program/Project
CSTS	Child Survival Technical Support Project
EBF	Exclusive Breastfeeding
EU	European Union
EIP	Expanded Impact Project
EOP	End of Project
EPI	Expanded Program on Immunization
FE	Final Evaluation
FGD	Focus Group Discussion
HIP	Hygiene Implementation Project
HQ	Headquarters
IIM	Indian Institute of Management
IMCI	Integrated Management of Child Illness
JD	<i>Jeevan Daan</i>
KPC	Knowledge, Practice, and Coverage
LQAS	Lot Quality Assurance Sampling
LW	Link Worker
MCH	Maternal and Child Health
MNC/H	Maternal and Newborn Care/Health
MTE	Midterm Evaluation
NFHS	National Family and Health Survey
NGO	Nongovernmental Organization
PCM	Pneumonia Case Management
POU	Point of Use (Water Treatment)
PVO	Private Voluntary Organization (U.S.)
RCH	Reproductive and Child Health
SCM	Standard Case Management
TAC	Technical Advisory Committee
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
WLCC	Ward Level Coordinating Committee

I. Midterm Evaluation Report

A. Summary

The Jeevan Daan Maternal and Child Survival Cost Extension program 2004-2009 (CS-XX) is an extension of Counterpart International's (CPI) original Jeevan Daan (JD) Child Survival Program (2000-2004) an urban child survival capacity-building and quality improvement methodology focusing on four additional municipal wards in Ahmedabad, and covers a beneficiary population of approximately 277,000. Urban slums were targeted by JD because of the stark contrast between the prosperity and relatively high economic performance in Gujarat state and Ahmedabad city and the high morbidity and mortality of women and children in the urban slums of the city. Five interventions are included in the CSP: Control of Diarrheal Disease (25% effort), Pneumonia Case Management (15% effort), Nutrition and Micronutrients (20% effort), and Immunization (10%) as well as a new intervention area, Maternal and Newborn Care (30%). The two main goals of the program are: (1) Sustainable reduction of maternal and newborn and infant mortality and morbidity in the urban slums (2) Capacity strengthening of partnering agencies to sustainably carry out selected maternal and child survival activities after the program ends. CPI plays a facilitative role with the two partners: the Ahmedabad Municipal Corporation/Ministry of Health (AMC) and Saath, a well established local community development NGO.

The addition of Maternal and Newborn Care intervention has required the project to become more involved with women of reproductive age and place more emphasis on children below three years old. The C-IMCI focus of the child health components in the program have increased the need to improve the contribution of health workers and increase their attention to the quality of maternal and child clinical practices to meet project goals and objectives.

Some of the specific accomplishments to date include: Mothers who can properly demonstrate ORS preparation rising from 33% to 62%; appropriate care seeking for children with danger signs of pneumonia rising from 37% to 57%; exclusive breastfeeding in the last 24 hours rising from 15% to 27%; fully immunized children within 1 year increasing from 48% to 66%; and measles immunization increasing from 51% to 81%. The high diarrhea prevalence rate in the program area (39%) highlights the importance of partner collaboration to address the multiple factors necessary to reduce the prevalence and prevent very high prevalence of chronic malnutrition in the program areas.

Significantly, the NGO partner Saath now has the measured capacity to assume the community components of the program as planned after the midterm evaluation. Saath will add additional development and income-generating activities to the Community Health Teams which will help them to be sustained after the project ends.

One major impeding factor to the program has been the almost complete turnover of program staff both at the PVO headquarters and in the field. Lack of actual policy support at the Gujarat state government also prevents introduction of zinc for diarrhea treatment as well as the introduction of C-IMCI to replace disease-specific standard case management. Doctors and other skilled health personnel in the AMC partner have received no technical updates since their initial training and this challenges CS quality of care efforts. Integrating PD/Hearth into the government's ICDS system deviates from the successful community-based approach of the first CSP and presents several technical implementation challenges which should be guided by technical specialists familiar with both approaches.

HBLSS and the Willingness to Pay studies described in the DIP have not yet been done, but there are plans to do the latter in consultation with the Indian Institute of Management and the Ahmedabad Municipal Corporation (AMC) after the MTE. CPI should contact USAID to ask if

dropping HBLSS from the workplan will require a modification of the Cooperative Agreement. Otherwise, there appear to be no major changes to indicate a modification is indicated.

Quantitative and qualitative assessments conducted during the MTE led the team to conclude that the project is making significant progress towards program intervention indicator targets and the NGO partner is ready for the turnover of the community components to them. Further progress towards indicators will require more attention towards improving health worker performance in the program interventions, and the training methodologies will need to be adjusted accordingly. More advocacy is needed for updated policies to support the interventions and collaboration with all key players to address the high diarrhea prevalence rates.

Recommendations include: 1) Proceeding with the turnover of the community components of the program to Saath as specified in the sustainability plan 2) Use statistical sampling or “mini-surveys” to distinguish high and low performing areas 3) Place greater emphasis on Counterpart’s capacity building efforts to building AMC child survival and maternal/newborn performance 4) Develop a policy advocacy strategy with project partners and the Technical Advisory Committee 5) Streamline project financial reporting between HQ and the field office and provide a clean slate for the new staff by conducting a financial audit. Additional recommendations for program partners and USAID are included at the end of the report.

An action plan developed collaboratively by the partners in response to the Midterm Evaluation findings is found in Section II of this report.

This report summarizes the analysis of quantitative and qualitative findings of the participatory midterm evaluation that took place between March and August, 2007. The overarching conclusions and recommendations are listed at the end of the report. Additional recommendations and suggestions pertinent to specific aspects of the program are included in individual sections.

B. Progress Made Toward Achievement of Project Objectives

1. Technical Approach

C-IMCI in the Jeevan Daan CS Expanded Impact Project.

C-IMCI was envisioned as the overall framework of the project in the DIP. While case management, care seeking and prevention strategies, as well as linkages between communities and health facilities consistent with C-IMCI are already included in the CSP strategy, health facility providers have no background in IMCI and it is not currently Gujarat State policy. Even without the policy environment, doctors working for the AMC have heard about IMCI and are interested in at least learning what it is. It is unclear whether the enabling environment is present for the requisite policy changes to be put in place by the end of the program. There are opportunities to introduce important elements of IMCI and C-IMCI into the project and to AMC health services overall but the project will need technical support and partnership with the Gujarat State health ministry to do this.

CONTROL OF DIARRHEAL DISEASES (25% EFFORT)

CDD prevention interventions in the program include: 1) increasing hygiene improvement primarily through the three key hygiene behaviors – hand washing with soap at 5 critical times, feces disposal, and improving/protecting quality of water; 2) increased access to clean drinking water, improved toilet and sewage facilities, regular garbage disposal; 3) improved Point of Use

through treatment and filtration of water, safe storage of water; 4) reducing susceptibility to diarrhea infection by promoting complete immunization, vitamin A and measles vaccine promotion, and immediate and exclusive breastfeeding; 5) promotion of measles vaccination and Vitamin A; PD/Hearth for children as an opportunity for demonstration of hygiene behaviors and nutritional management of diarrhea.

Diarrhea treatment approaches described in the DIP include: 1) Raising awareness about signs of diarrhea, danger signs of dehydration, dysentery and quick treatment; addressing issues of anti-diarrheal tablets; 2) nutritional management of diseases through ORT and continued breastfeeding; 3) promotion of ORS and its correct preparation, including encouraging ORS corners; 4) promotion of zinc supplementation.

The project appropriately targeted CDD as an intervention. Poor water and sanitation, consumption of contaminated foods from street vendors and poor hand washing and household hygiene were all identified as underlying causes of the diarrhea. The project has little control or influence to date on the quality of the water supply, but analysis of specific questions in the KPC results indicate behavioral changes have occurred at the household level. Giving (usually contaminated) water to breastfed infants continues to be a problem (see nutrition section) and the MTE team was able to identify that while mothers are washing hands after defecation at high percentages, far lower percentages were washing their hands before feeding the child, lowering the overall hand washing indicator. Point of Use (POU) water decontamination is promoted by the project, but needs to be significantly scaled up to have a measurable impact on diarrhea prevalence.

MTE KPC Indicator	Baseline	Midterm	EOP Target
% of mothers would be able to demonstrate correct preparation of ORS (or substitute) and explain its use	33%	62%	60%
Prevalence of diarrhea in children less than 2 years in the two weeks prior to the evaluation, as reported by mothers	36%	40%	30%

Diarrhea prevalence in the target population has not changed and is currently almost 40%. Members of the TAC were surprised to find the prevalence amongst babies to be so high. Increases in correct treatment with ORS (or substitute) is impressive and has almost doubled (to 62%), already exceeding program targets.

Treatment Interventions are limited technically because the Gujarat State government has not yet adopted the GOI policy promoting the new ORS formulation and administration of Zinc. JD/ CPI cannot train health personnel or promote these interventions until the policy is changed.

Significant portions of the DIP and the DIP review were devoted to Counterpart's plans to collaborate with USAID's new Hygiene Improvement Program, but the details were not elaborated upon at the time. Gujarat State is not a focus for USAID/ India's assistance in the health sector. At the time of the MTE, it was unclear if the CPI JD CSP would be able to access the technical assistance from HIP, even though there were several references to this technical assistance in the DIP review comments. Given the high child diarrhea prevalence, access to the technical expertise contained in the HIP continues to be very important.

Follow-up and next steps:

Given the seriously high diarrhea problem in the project area, Counterpart should:

Contact USAID and request their help in accessing CDD and Hygiene technical assistance to the project, either through the partners in HIP or other child survival technical assistance mechanisms in order to: 1) develop a policy advocacy strategy (possibly with help of the TAC) to change the Gujarat State policy and assist with training and implementation of the WHO/UNICEF guidelines on the CDD that include guidance about prescribing Zinc to children with diarrhea and consistently providing new low osmolarity ORS 2) involving all of the key players with the objective of improving the quality of water supply and community hygiene to project communities¹ 3) Include a state of the art CDD technical update for health officers in the AMC partner, TAC members and representatives of the Gujarat State government. (See Health System/Health Worker Strengthening sections of Capacity Building) 4) Ensure that promoting increased food and fluids are included throughout the diarrhea project activities 5) Increase exclusive breastfeeding messages to specifically discourage giving additional water (already accomplished during 2007 World Breastfeeding Week).

PNEUMONIA CASE MANAGEMENT (15% EFFORT)

Major program efforts in this intervention include: 1) improved caretakers' knowledge for recognition of pneumonia and improved decision making for immediate care seeking from an appropriate provider. 2) Promotion of early diagnosis and treatment on the same day and completing the doses of antibiotic. 3) Ensuring supply and availability of Cotrimoxazole in the AMC facilities. 4) Prevention of pneumonia through the promotion of immunization, breastfeeding, measles vaccine and Vitamin A. Improved nutritional management during and after pneumonia episode.

MTE KPC Indicator	Baseline	Midterm	EOP Target
% of mothers with children < 2 years of age would be able to recognize at least two IMCI danger signs indicating medical treatment	74%	87%	90%
% of mothers with children < 2 years would seek medical treatment from a qualified provider on the same day that the child shows danger signs of pneumonia	37%	57%	65%
% of children 6-23 months, having cough with fast breathing in the last two weeks were offered same or more to eat during the illness	29%	29%	65%

Monitoring data, the HFA and the MTE KPC indicates an impressive increase in recognition of danger signs and care-seeking for at-risk children with possible pneumonia. There has been no change in feeding behaviors for children with ARI and analyzing and modifying approaches to address this requires more emphasis in the BCC efforts for the remainder of the program (see nutrition section).

¹ This will need to be undertaken understanding the context of the "slum clearance" underway in Ahmedabad. Lack of action may be rationalized that infrastructural improvements can not be justified when the fate of the neighborhoods themselves can not be determined. CPI can only be a facilitator with project partners, but the TAC and other sympathetic advisors to the project should adopt advocacy for diarrhea disease reduction as a primary agenda for the remainder of the project, including setting up a continuing advocacy mechanism that will remain in place after the project ends.

The DIP planned for training and refresher training of MOH/AMC staff CHT/ TBA/ AWW/ AMC Link Worker and private practitioners. The plan was to continue to focus on prevention, WHO standard case management (SCM) of pneumonia and improved quality of care. This was to be supported with refresher "drip trainings" with updated skills and information. While training for the community level health workers and "Link Workers" has been done, the SCM component for clinicians has not happened. Refresher trainings for all target audiences should provide specific guidance on the importance and methods for seeking care for newborns with pneumonia. For the "drip" or cascade training methodology to be effective, Counterpart will have to organize a Training of Trainers approach in partnership with AMC health authorities.

NUTRITION AND MICRONUTRIENTS (20% EFFORT)

Nutrition and micronutrient interventions in India are exceptionally challenging. In spite of outstanding economic performance in Gujarat, chronic malnutrition levels, even in urban areas, are higher than in many African countries. To date, the government program, the ICDS, has not achieved the hoped-for demonstrable impact on childhood malnutrition but remains the main venue for government efforts to address malnutrition. The national program is currently discussing modifications to the program to make it more effective. The CSP originally targeted increasing attendance as a program process indicator. Even though it has doubled, and will probably reach the modest target of 20%, it is unclear how emphasizing this approach will address malnutrition for the majority of program beneficiaries. Government policies prevent the CSP from acting on (the appropriate) effort to expand access to deworming for preschool children. One reason for associating the PD/Hearth with ICDS was the availability of the Aganwadi centers as venues for CSP community mobilization activities. While there is no reason not to organize community activities in this way, the CSP must ensure that the focus on preventing and treating malnutrition in children is not compromised.

The 20% point increase in Vitamin A coverage is impressive, but the project is only able to measure children 2 years or younger, where Vitamin A supplementation is indicated for children up until 59 months of age. With the extremely high diarrhea rates in the project area, the project should continue with strong partner efforts towards meeting program targets. Participating in advocacy to meet and sustain Vitamin A supplement coverage for all children in the target group for this intervention should be included as part of the technical sustainability approach.

MTE KPC Indicator	Baseline	Midterm	EOP Target
% increase in the coverage of children less than 2 years under the ICDS program, as compared to the baseline levels	7%	14%	20%
% of children less than 2 years that are de-wormed during the last 6 months	11%	10%	30%
% of children between 9 months and 2 years have received Vitamin A doses according to GOI recommendations, once every 6 months	24%	44%	60%
Children 0 - 5 months exclusively breastfed during last 24 hours	15%	27%	No target

Lesson learned:

The project appropriately has devoted significant efforts to EBF BCC efforts, and increased early initiation of breastfeeding as well as feeding colostrum to newborns. A valuable lesson was learned in interpreting KPC data for monitoring and impact purposes in this most important child survival and nutrition intervention. The more robust

measurement for EBF (24 hour recall) showed an impressive increase between baseline and midterm, while the more general self-reported Exclusive Breastfeeding rate actually reduced. This could be due to mothers actually understanding EBF better and answering the question more truthfully. True EBF increases are extremely challenging to attain and support the effectiveness of the program approach.

MTE KPC Indicator	Baseline	Midterm	EOP Target
% of newborns are breastfed within one hour after delivery	24.70%	41.51%	40%
% of newborns that are fed with colostrum at birth.	55%	72.64%	75%
% of infants 6-9 months of age who receive appropriate supplementation/weaning in addition to breast milk.	78.40%	74.44%	85%

While the breastfeeding indicators have shown impressive gains in coverage of key behaviors, introduction of complementary foods in addition to breast milk, as well as feeding during illness (identified in the pneumonia intervention) indicate that BCC efforts and training messages need to be strengthened to promote appropriate behaviors in this area. Adjustments in the BCC approach will include broadening the target audiences for the messages to key influential members of the community, including grandmothers (especially mothers-in-law), husbands and community leaders.

Using Data to adjust Exclusive Breastfeeding BCC Approach

MTE quantitative and qualitative findings revealed that self-reported EBF levels of coverage levels were not supported by mother's 24 hour recall. The 24 hour recall findings (comparing baseline to the MTE KPC) showed that the program is having significant positive effects on the indicators that more accurately measure actual exclusive breastfeeding behavior. This is very important for a few reasons. First, the high diarrhea prevalence rate (including in babies less than 6 months of age) indicates that EBF levels were extremely low at the beginning of the program (15%). Second, EBF was cited by the Bellagio Child Survival studies to be the single most important intervention to decrease infant and child mortality. Follow-up qualitative investigation by the MTE community field teams revealed that mothers-in-law are pressuring mothers to give water (which is usually contaminated) during hot weather to satisfy the perceived "thirst" of the baby. As a result of these findings, the program staff has already expanded EBF BCC messages and activities to target influential members of the communities, mothers-in-law as well as the mothers themselves. The understanding that water is not perceived as "food" and therefore not reported by mothers is also important information that will be used to modify the BCC approach.

PD/Hearth modifications in the EIP

The introduction of PD/Hearth to the urban Indian environment was considered one of the key achievements of the CS XVI Jeevan Daan CSP—one that was hoped could be scaled up in the EIP. Adding PD/Hearth to ICDS significantly modifies the methodology. This is worrisome because none of the original managers who oversaw PD/Hearth in the first JD still work for Counterpart and there are no nutritionists with PD/Hearth training associated with the project. This could make maintaining the key components of PD/Hearth more difficult. Full analysis of the pros and cons of this modification goes beyond the scope of this evaluation, but should be done by an expert with knowledge of PD/Hearth, the ICDS, and how ICDS fell short in addressing malnutrition in the CSP target group: children <2 years of age. In addition, there was mention of a Hearth for pregnant women in the DIP, but it does not appear that they have been started. Mother's employment is a major factor in low ICDS participation in the project area. For several reasons it is extremely difficult to access enough pregnant women in one community to pilot this approach and is appropriate for CPI not to pursue this, as yet unproven strategy unless framed as an operations research study. CPI currently does not have the human resources to make this a priority at this time. It is not known whether introducing PD/Hearth into ICDS centers will affect participation in the centers themselves.

USAID/Washington and USAID/India should provide guidance to Counterpart International about whether the successful community-based PD/Hearth slated for scale-up from the first CSP can/should be modified to be included in the ICDS program. If the answer is yes, then technical assistance will be required to assure that what is being called "Hearth" does not deteriorate into only growth monitoring and cooking demonstrations such as has occurred in some other CS programs in other countries.

The ICDS has many operational challenges and does not reach the majority of families of young children in the program area. PD/Hearth is labor intensive and the risks and benefits of this adjustment should be considered and documented. If this approach is pursued, the objectives and monitoring approach of such a change in the program approach should be clarified and included in the 3rd Annual Report. There are reports of successful ICDS-PD/Hearth integration activities in West Bengal that should be studied for lessons that are appropriate for the CPI PD/Hearth approach. There are technical specialists who are familiar with both ICDS and PD/Hearth who could be consulted about the best approach(s). CPI should budget for technical assistance from a consultant(s) with this level of expertise.

IMMUNIZATION (10% EFFORT)

MTE KPC Indicator	Baseline	Midterm	EOP Target
% of mothers who possess a vaccination card for their child below two years of age	69%	64%	80%
% of children 12-23 months infants who were fully immunized in the first year of life	48%	66%	75%
% of children 12-23 months of age who have received measles vaccination in the first year of life	51%	81%	75%

During the MTE, the results of the most recent National Health and Family Survey (NHFS - 3) were released. National immunization coverage has remained flat or actually decreased in many states, including Gujarat. The DPT drop-out rate seems to be the vaccination

responsible for the low coverage. Lack of vaccines does not seem to be the problem. The drop-out rate indicates that some of the fundamentals of immunization programs, especially addressing missed opportunities, of the successful global EPI program are not currently practiced in most of India.

CSP COs say that full immunization is not being achieved because mothers don't return for follow-up visits, this can be related to side effects, not being told when to return, and the need to have 10 children to open a vial of vaccine. The gender of the child can influence accessing preventive health services, including vaccinations. In some communities second and subsequent daughters are taken less often for preventative and curative services.

The project has worked with the local AMC health officers to mobilize communities and strengthen linkages to increase coverage. Some examples include organizing community immunization camps, assisting Link Workers to find defaulters, providing referral chits and promoting immunization to the community through the multiple communication channels in the BCC strategy. The CSP partners will all be part of the larger national effort to address the low immunization coverage as it is rolled out.

MATERNAL AND NEWBORN CARE (30 % EFFORT)

MTE KPC Indicator	Baseline	Midterm	EOP Target
% of mothers who possess a Maternal Health Card	32%	33%	60%
% of women 15-49 that receive three ante-natal check-ups from a qualified provider during their last pregnancy (CARD)	24%	87%	50%
% of women 15-49 that receive 90 IFA tablets as an iron supplement during their last pregnancy	46%	58%	70%
Mothers who can cite at least one danger sign during pregnancy that indicates the need to visit a doctor	32%	83%	60%

The MTE KPC analysis revealed the limitations of measuring MNC behaviors based only on government-issued maternal cards. During the survey only 33% of mothers had these cards and supplies had been extremely limited at the baseline and also during the entire time preceding the MTE survey. At the time of the MTE, however, the newly issued government MNC card started to become available. In addition, private OB/GYN doctors, including some of those who are working on contract to the government, issue their own cards. Given the small sample sizes of using only mothers with government-issued maternal cards, findings were recalculated to include self-reporting to determine the direction of maternal behaviors in the project area. The percent of mothers that either had a card available at the time of survey or reported to have possessed a card, but could not produce it when asked, was found to be 87%; percent reporting to have received at least 3 ANC checkups from a qualified provider was 78%; 59% reported to have received 90 plus IFA tablets during their last pregnancy and; 91% reported that they had received 2 or more TT injections during their last pregnancy.

The MTE team felt that these calculations more accurately reflected the true situation in maternal care. Institutional deliveries increased from 75% to 86%, but determining the

program effect is difficult. The GOI is motivated by the MDGs to increase skilled deliveries and is investing considerable resources to encourage women to deliver in health facilities.

Women can now deliver in private facilities and the government will pay for the delivery. It is unclear how much authority the government has over the quality of care in these private facilities. On the other hand, private facilities' maternity services are widely perceived to be of higher quality than those provided by public facilities.

ANC and IFA consumption have increased according to the MTE KPC findings, as has attendance at ANC visits. Original program efforts promoted AMC facility maternity and newborn care, but this has now shifted to all providers due to the high percentage of women who use private facilities and the cooperation that now exists between government and private facilities. The KPC measured postpartum and newborn checkups, even though they were not included in the original program indicators. In the second half of the project, promoting postpartum and newborn care should receive significantly more emphasis and measurement as this is the period when most infant and up to half of all maternal deaths occur.

Constraints to MNC intervention:

The lack of maternal cards resulted in a relatively small sample size of mothers in the KPC whose behaviors could be measured using only maternal cards. A more realistic picture appeared to emerge when self-reported behavior was included. Many women prefer to deliver at private maternity facilities, some are under contract to the government, and some are not. Lack of training to AMC personnel causes some of them to contradict the (correct) information promoted by the project and the quality of interpersonal relationships and staff motivation in government maternity centers continues to be a challenge. (See comments on AMC clinical training needs in the Capacity Building section)

Additional constraints identified by the MTE team include:

The majority of mothers work outside of the home and gatekeepers (usually grandmothers or older siblings) are not officially instructed by formal health system. Ways to increase their participation in future BCC activities need to be developed.

There are no OB/GYN, midwife or other maternal care specialists in the Counterpart staff, and the Project Director is the only clinical health/medical person on the staff.

Most mothers leave the maternity center with their babies within 24 hours after delivery. The government delivery payment system does not include return visits to the private maternity centers for postpartum or newborn complications. It is felt that this discourages poor women from returning to the place of delivery if there are complications during the newborn or postpartum period.

2. Cross cutting activities

a. Community Mobilization

Community mobilization strategies used in JD have been thoroughly described and documented in previous reports and evaluations². They are widely viewed as extremely innovative and effective. The EIP appeared to have been funded largely on the strengths of the combined Community Mobilization and BCC approaches applied to the urban South Asian environment and the confidence that these approaches could be scaled up to a much larger population.

² Counterpart Jeevan Daan Midterm and Final Evaluations, Jeevan Daan Cost Extension first and second Annual Reports

At the time of the MTE, project monitoring process indicators for community mobilization are presented in the chart below.

Program Community Mobilization Monitoring Data			
Process Indicator	Baseline	Midterm Evaluation	End of Project Targets
# of communities in the target area with trained and functioning CHTs by the end of the program.	30 communities under Jeevan Daan CS XVI Program	67 CHTs have been trained on nutrition and MNC	60 CHTs
# of CHT members who continue to volunteer their time one year after their initial training.	300 CHT members under CS XVI	522	600
# of AMC/MOH health facilities in the target area with “core” trainers in.	6 AMC Health facility staff trained in all interventions, except MNC under CS XVI	10 facilities' staff trained on MNC & Nutrition	10 AMC Health facility staff trained in all interventions, including MNC

These community mobilization methods and techniques used in the current JD expansion program were described and evaluated in detail in the CS-XVI Final Evaluation that was led by Donna Sillan³. All qualitative and quantitative evidence from the MTE field work indicates that the COs and CHTs, led by Counterpart India staff have been able to extend these techniques to the newer areas of the project. Process indicators have already met or exceeded many of the DIP targets. Communities, both new and old have responded well to these techniques. Thus, community mobilization remains strength of Counterpart India’s program approach.

CHTs have been extended into the new areas and their roles will be expanded in Community Development Teams (CDT) once Saath assumes responsibility for the major portion of community activities. Included in the partnership with Saath into larger development and civil society activities to improve the overall quality of life in the communities and provide support for the changes effected by the project.

While limiting CHT membership to women only certainly has raised the profile and respect of women in decision making and influence in the communities, continuing to leave men out of this mobilization process entirely would inhibit further MCH impact. Men’s cooperation (especially husbands) is needed to change certain key care seeking and treatment behaviors and encourage them to provide the resources and “protection” while seeking emergency delivery and sick child services particularly during nights and weekends. This is particularly true in the culturally and religiously conservative communities involved in the project. The CHTs could remain predominately female, but men should be considered for membership wherever possible. Current CHT members agreed that adding some men to the CHTs would be a good idea.

Some very positive impacts of other activities involving men in the project’s community mobilization involved rickshaw or “three-wheeler” drivers, many of whom live in the targeted slum communities. Some of these rickshaw drivers advertise that they are

³ Sillan, D. „Jeevan Daan CSP CS-XVI Final Evaluation Report,2004.

available to provide transport during the nights, many times free of charge. In some cases, the drivers have been motivated to provide their mobile phone contact numbers in case of emergency. These initiatives apparently have emerged from the “ground up”, indicating that the community is truly motivated to address increasing access to life saving services.

Barriers to participation in community activities are largely due to the need for employment of the target women (the mothers), and their husbands who are absent from the communities during the day when they have to work. JD partners are piloting various approaches of providing programs during times when mothers and fathers are available. There are also pockets of “resister” communities, primarily the culturally conservative lower caste Patni communities and very religious Muslim areas where daughters (especially the second daughter and after) are often not taken for care when they are sick as quickly as boy children or first daughters. The Patni communities have many superstitions and traditional practices related to sick child care. They resist taking children with pneumonia to health facilities and don’t believe in treating them with antibiotics. Team members found however, that inroads toward changing these behaviors were in process in these communities, but were happening more slowly.

Community mobilization has stimulated strong community demand for additional development activities, specifically employment and income-generation. Saath (the local NGO partner) has a lot of experience in this area, as do some members of staff. As mentioned elsewhere in this report, the CHTs are evolving into CDTs. This is consistent with the sustainability plan of the project and responds to the demands of the community. Care will need to be taken, however, not to lose the health emphasis that caused the CHTs to be created in the first place as well as to continue the health impact achieved through the program. Program staff noted that the work to maintain the work of CHTs has continued in the last seven years without any cash or in-kind incentives. The level of motivation of these unpaid health workers has remained high, which clearly demonstrates their genuine interest and dedication to their communities.

Political, cultural and religious tension still remains in some of the program communities and is always a consideration in project planning. Fortunately, JD and partners have good relationships in these areas and activities are usually not interrupted. As long as the partners are active there, many of the structures established can continue. Gender analysis undertaken during the MTE revealed that mobilizing women to advocate for community change (e.g. improved water and sanitation services) is significantly less threatening to authorities than when men become mobilized over the same issues. JD partners plan to use this information in training communities to effectively advocate for change. JD has succeeded in drawing attention to the needs of the slum areas and the second half of the project will continue to build partner and community skills to make sure that these areas are not ignored after the project ends.

b. Communication for Behavior Change

Counterpart India’s BCC approach in Ahmedabad was also thoroughly evaluated in the previous project and recognized as a both innovative and effective approach particularly suited to the urban slum pocket environment⁴. The approach has been expanded and modified as the program has moved into new and different types of slum pockets. Improvements in program behavioral indicators in the MTE related to individual and household behaviors provide additional support for the approach.

⁴ Sillan, D. Jeevan Daan CS-XVI Final Evaluation, 2004.

Written and oral messages are given in Gujarati and spot checks during the MTE indicated that messages were up to date within the limitations of current policy. These policies still promote a “stove-piped”, single intervention approach according to illness (diarrhea, pneumonia) and do not allow for some evidenced-based behaviors such as postpartum vitamin A supplementation or zinc for diarrhea to be promoted.

Counterpart has already been recognized for creative and innovative dissemination methods. The results of the KPC, along with the qualitative follow-up have pinpointed specific areas that need additional *emphasis*, although they were already included. BCC staff have already targeted messages about avoiding water supplementation to breastfed babies less than 6 months and expanded their audience to grandmothers, fathers, and the wider communities. While hand washing behavior at critical times is already included, quantitative results from the KPC revealed that while a high percentage of mothers were washing their hands after defecation, the percentage washing their hands before feeding the child was relatively low. The program plans to increase emphasis on these other behaviors in the future.

Disseminating the same messages through multiple channels and reinforcing these message through COs to Link Workers and CHTs has gone beyond message dissemination to influence social and behavioral norms as measured by the KPC, direct observation and focus groups discussions held with mothers, health workers and community members. AMC authorities have measured increased care-seeking at government clinics and at early stages of the child illness and attribute these increases to the JD CSP.

CHT BCC and Community Mobilization activities have raised the profile of women as community change agents and empowered them to start making requests of program staff for more involvement in community improvements and greater access to means of generating income. JD, especially Saath plans to build on this enthusiasm as the CHTs evolve into CDTs in the second half of the program. Fortunately, the cultural / social norm in Gujarat allows women to move about freely. This has made many BCC activities more feasible than they would be in other parts of the country. .

c. *Capacity Building Approach*

i. Strengthening the Grantee Organization

Extensive work has been done in building both Counterpart India and partner capacities in community mobilization, information systems, BCC approaches and integrating health into community development in poor slum environments. Much of this work was done in the first program and carried over with the staff for the first year of the EIP. Staff turnover and new employees' needs for orientation to the complex design and implementation methodology of the JD EIP have not left as much time for attending conferences and workshops as was spent in the first program. But after the MTE there are plans for additional opportunities for professional development in child survival programming for Counterpart staff members. Plans for attendance at workshops and classes is now included in field office employee annual reviews.

The TAC has not been as active in providing specific technical guidance about the details of project implementation as was envisioned in the program design and DIP. Some of the expertise that is needed (primarily in updated child health and maternal/newborn care approaches) is not available within the members of the TAC. On the other hand, TAC members are well-respected health professionals within the project area and if their role in

advocacy were expanded, this could be of great benefit to removing some of the barriers toward CS intervention implementation. This would require Counterpart to provide technical updates to TAC members along with facilitating TAC meetings to develop the advocacy strategy.

The overall design of the program focuses primarily on building partner technical capacity. Several of the technical assistance inputs envisioned in the DIP, and described in the first annual report⁵ however, have not yet taken place may no longer address the current needs of the project. For example, specific training such as HBLSS⁶, Rational Drug therapy for private practitioners, and operations research for maternal and newborn care have not been developed. Given the priorities, approaches and budget, it is unclear whether these activities remain the priority technical considerations for the project. Counterpart intended for these particular types of activities to serve the local partner capacity building focus of the extended program. Technical assistance and collaboration are needed for Counterpart to assume the Child Survival technical leadership and capacity building of the second phase of the program. Details of these needs are listed later in this report.

Earlier staff were very active in trainings and attending conferences. The impact of the loss of institutional memory due to the more recent staff changes is not yet apparent, since some of the new staff members have been in place for only a few months. They appear to have all of the necessary background to carry the BCC, CM and HIS requirements of the program forward. Technical expertise in the clinical and treatment aspects of the child survival interventions rests with the Program Director, who also is responsible for supervising overall organization operations of the project and for the PVO in the country. The new Program Coordinator attended the 2007 CORE annual meeting; This provided him with exposure to other global child survival program managers as well as multiple presentations in PVO child survival interventions. The training officer attended the training on rational drug usage and the M&E officer took a course on research methodology

The specific challenges of the expansion aspects of an urban CS program have been brought to light by the MTE discussions. There are only two USAID urban child survival projects that follow earlier projects, and there have been very few urban child survival projects since the beginning of the CSHGP. In a sense, these two projects are “writing the book” in scaling up urban CS and MNC programs. There is relatively little outside capacity building expertise specific to these environments that can be imported intact from other programs. Counterpart India CSP staff could benefit from exposure visits to the nearby Concern Worldwide urban program in Bangladesh, though those municipalities are smaller and organized differently from the “mega city” of Ahmedabad. CPI also has valuable experience to share with Concern Worldwide, so an exchange program could benefit both organizations. In addition, the annual Urban Health conference held in Baltimore, MD is now expanding to include international urban health. This conference may be worthwhile for Counterpart India employees to attend in the future.

⁵ First Annual Report, p. 32

⁶ A proprietary program owned by the American College of Nurse Midwives that requires use of ACNM trainers and materials.

ii. Strengthening Local Partner Organizations

An NGO capacity assessment for Saath was conducted at the baseline and again just prior to the MTE. Saath is a strong local NGO with experience in many development sectors. Involvement in the CSP has added community-based health programs to the wide array of their activities. The integrated implementation approach of the program has strongly contributed to the results. Saath COs have been integrated into the program work from the beginning.

AMC has received much capacity building support. But since it is the public health system in the project area, please see comments on health worker and health facility strengthening sections for discussion on capacity building for the AMC.

iii. Health Facilities Strengthening

A Health Facilities Assessment using the Basics/WHO tool was used at the beginning of the project and again at the MTE. Many of the elements that encourage client behavior change and/or linkage with community based providers (including Link Workers and Aganwadi workers) have worked very well. The tool measures, however, many facility aspects over which the JD CSP has neither control nor specific expertise (e.g. ambulance, equipment procurement, maintenance, infection control). In addition, a very large percentage of the population relies on private health facilities and these facilities are not included in the study.

The project has modified its assumptions since the beginning of the program. Rather than focus on motivating communities to use government health facilities rather than go to private facilities, CPI is working with AMC and communities to involve private health providers (formal and informal) and facilities as well as government health facilities to deliver the same messages and increase access to appropriate health care services. This is especially important because private doctors and NGOs are now receiving contracts to provide services in place of the government. In addition, some informal providers (RMPs, homeopaths) etc. are more trusted by communities and are important sources of information for the population as well as referrals to the formal sector. JD has linked all of these providers together through their referral chits that are now highly prized and adopted into the AMC system. (See Program Highlight)

iv. Strengthening Health Worker Performance

The interface between the community and AMC health services has been significantly strengthened by the CSP through building the capacity of health workers who are now bringing more, and higher quality preventive and first line treatment through the Link Workers, COs and CHTs to the community. Quantitative and qualitative measurements during the MTE field work were triangulated with health workers, field workers and clients to verify that this is the case. At the same time, further progress towards implementation of the technically-sound approaches elaborated in the DIP are constrained by the barriers presented by outdated national and state policies. These policies are largely outside of the CSPs control, but could be influenced by a coordinated partner advocacy approach.

Ahmedabad is a city of stark contrasts in health care. As a center for “medical tourism” in India, some private hospitals have global state of the art tertiary care facilities that attract patients from around the globe seeking affordable health services for open heart, cataract or plastic surgery. The economic boom in the state has made high quality health services available for those who have the resources to pay for them. But basic public health services for the most vulnerable population have not received adequate attention or resources. AMC is the primary provider of public health services for the poor, but is subject

to policies determined at the national and state governments and lacks the decision making autonomy necessary to make major changes in health protocols, regardless of the justification for doing so.

Gujarat's strong economic growth is generally considered to be positive, but this high economic status means that USAID and other donor-funded programs do not target the state to receive much attention, equating resources with capacity. As with the rest of India, AMC doctors have not received any professional training upgrades since they graduated from medical school. Human resource weaknesses that were identified in the local government primary health care are the same as those in the rest of the country.

On several occasions during the MTE, AMC and Gujarat State authorities volunteered that lack of money was not the major barrier to upgrading health systems outcomes. Progress is stymied by the policy environment and poor technical training capacity within the health system itself. There is no program for government health worker human resources technical/clinical skills development, no in-service training, and no routine technical updates in maternal and child health. Without any epidemiologists at the local or state level, both AMC and Gujarat state health authorities are challenged to set priorities and provide medical technical training to address priority public health needs.

CPI can not address these formidable challenges alone, but is in a position to leverage the good will and reputation gained through *Jeevan Daan* and to bring the technical experts to provide subject matter inputs to technical training that is organized by Counterpart, assisted with advice from the TAC. Counterpart's partnership with USAID could facilitate access to the technical experts in each of the project's focus interventions. Counterpart can organize the training with financial support from AMC and Gujarat health authorities.

IMCI is not currently the policy of Gujarat State and that hinders progress in developing the child survival framework of the project. AMC doctors have heard of IMCI, and are interested in learning about IMCI but were aware of no current plans to provide this training. Child health services are not integrated. To improve access to medical services, the AMC has contracted with some private doctors, specifically OB/GYNs and pediatricians, but no specific supervisory role is assigned to of the AMC doctor at the health center. Therefore it is unclear how the quality of services provided by these private doctors will be assured by the AMC. CPI does not have any direct responsibility for this arrangement, but their role in drawing attention to the quality of services means that the project will need to assist community members to monitor the quality of services and develop mechanisms to provide feedback to the health system as these changes are implemented.

The project has worked extensively with the AMC "link workers" and strengthened their roles as liaisons between the formal health centers and the communities. This has been a major accomplishment of the program. They have been trained in child survival activities as well as how to work at the household and community level to increase coverage in the program interventions. CHT member volunteers will receive priority when new link workers are hired by the AMC.

v. Training

Counterpart India staff are experienced training professionals and they employ well established adult learning techniques, including evaluating participant performance. Most training activities in both the current and previous programs have been focused at the community, community-based health worker and community organizer level. Undoubtedly,

this has helped move many of the target household and community behaviors forward and contributed to the increases in behavior-related project indicators. Even though specific process indicators are behind the schedule in the workplan, increased coverage in several key indicators attest to the training effectiveness in these specific areas. Facility-based health providers have received training support in some quality assurance, interpersonal skills, BCC and recordkeeping and this has improved client-provider relationships.

Since the CS-XX project, is by definition an extension of successful methodologies, the cascade, or “drip” training approach has been equally effective in the current program for the community based intervention activities. In addition, health facility-community linkages are much stronger as a result of capacity approaches of the CSP.

Related to the previous section on Health Worker Strengthening, the training gap rests with the CS and MCH health provider technical/clinical skills. Although highlighted in the DIP reviewers’ comment at the beginning of the program, the project has not devoted enough effort to bringing health worker intervention capacity to the level needed to support the targeted client behaviors. This was specifically addressed by the DIP reviewers when they said:

“Training AMC personnel to be trainers will ensure a greater level of sustainability and also strengthen the capacity to extend training opportunities to other personnel outside the project area. AMC trainers should also be involved in the development of materials and curriculum.”

The project responded by saying:

“It is clarified that the program follows a cascading model of training plan and that requires that all the training has the component of TOT, including the community based trainings designed for the community health workers so that they can carry forward the knowledge and train the mothers in healthy behaviors”

The MTE evaluation team findings concurred with those of the DIP reviewers and supports CSP developing an AMC clinical health worker Training of Trainers. The drip training at community level does not address the skilled health providers need for training in the intervention program areas consistent with the guidance in the CSHGP TRMs. Addressing this gap should be Counterpart’s major focus for the remainder of the program after the bulk of the community work is transferred to Saath.

While sufficient human resource capacity to organize trainings exists within the project, the only clinical health staff person is the Project Director. While it is true that government policies have not kept up with the state of the art in child health and maternal/newborn care, the project could make more use of the TAC to develop an appropriate advocacy strategy to move the Gujarat State policies forward enough to allow the CSP to provide CS and MNH training for AMC health facility staff.. This training is valuable enough that partnering with the AMC, it is possible that additional clinical health personnel mentioned in the DIP reviewer’s comments could be trained and thereby scale-up the impact of these technical updates to additional areas of the city. This could be a major contribution of the CSP to sustainable health improvement to poor mothers and children in Ahmedabad.

As attention shifts from developing community capacity after Saath assumes the major responsibility, Counterpart will need to pay much more attention to health worker case

management skills. Specific approaches that are both appropriate and acceptable to health workers (including AMC doctors) clinical behavior change is needed and should be included in this major area of emphasis in the second half of the program. Working with the Indian Institute of Management may provide valuable guidance on how to approach the training methodologies for AMC, and possibly Gujarat state health officials.

d. Sustainability Strategy

A detailed handover strategy with benchmarks, along with partner capacity assessments was developed early in the program. This plan, and updated assessments have been reviewed and the handover strategy will commence soon after the MTE is completed. Saath is on target for assuming primary responsibility for the sustainable community mobilization and is slated to integrate health into their on-going community development activities, including expansion of the CHTs into Community Development Teams CDTs. This transition should include methods for safe-guarding the CS and MNC behavior change functions of the CHTs.

AMC has integrated the referral chits (see Highlight) into their programs and will scale them up across the city. Since there are remaining technical elements of the program that have not been implemented, largely due to state and national policy barriers, these elements are not ready to be turned over.

The MTE team was satisfied that partners know about the phase-out strategy and the schedule.

It is unclear how the new integration of PD/Hearth and ICDS will be sustained since the integration has just started and is not yet fully developed. The percentage of families who participate in the ICDS program is very low. Even very poor families prefer to use private day care services because they are available for longer periods of time during the work day and the quality of the food is perceived to be better. Using the CSP to increase ICDS utilization is probably not a wise use of project effort. These activities are taking place in the context of the overall redesign of the ICDS program which may not be completed by the time that the project ends. This alternate approach has caused the program to delay scaling up the community-based PD/Hearths that were considered so successful in the previous program. Technical specialists, who are familiar with both PD/Hearth and the ICDS program, are available. The USAID-supported FANTA project, implemented by the Academy for Educational Development (AED) should be consulted for further advice on this aspect of the program.

At the community level, CHT members say that they have been empowered to address community health problems and are now ready to tackle the broader community development and poverty issues. Members are demanding project staff develop income generating activities for them and they are responding by expanding the CHT to be a Community Development Team (CDT). Saath is a multi-sector NGO with linkages to income generation and microcredit. The turnover of JD activities to Saath will facilitate CHT member's access to these programs. The AMC has said that CHT members will be given preference for hiring when openings for Link Workers occur.

The GOI and AMC are making significant investments in increasing demand for skilled delivery with financial incentives for the first two deliveries. It is unclear if commensurate investments are going to be made in increasing quality of services and capacity to address this increased demand in government facilities, though private skilled health providers are now under contract to the government for antenatal and delivery services.

Saath also receives funds for direct service delivery in slum areas of the city through the RCH program. Most of these services are not provided in JD areas. They attempted to initiate very modest cost recovery (2 rupees (\$0.05), but this was discontinued when the government objected. A "Willingness to Pay" study to be conducted by the project was included in the original DIP, but unless coordinated with the government the value of such a study is questionable at this time. It is unclear how the project would use the findings of such a study. The GOI has their own plans for financing primary health and maternity services to poor families. If CPI decides to go forward with the study, the potential application of the findings should be clarified. AMC has sufficient financial capacity to upgrade staff training and improve equipment, facilities and information systems. Providing the technical expertise to guide AMC through the process of upgrading staff and facility capacity is the gap for establishing quality services in the first place, and then later sustaining. The MTE team agreed that this should be an emphasis of the second half of the program. As mentioned in the training system, if CPI and AMC teamed up and offered the CS technical updates through workshops organized by CPI, perhaps in collaboration with IIM, but financed through GOI resources (including AMC) the sustainable impact could be substantial. If CPI were able to influence AMC and Gujarat State health policies through advocacy (possibly spearheaded by the TAC) even greater sustainable, and scaled up benefits could be achieved.

The launch of the EU funded Urban Reproductive and Child Health (RCH) program in April 2004, has increased AMC focus on RCH issues and complements the Jeevan Daan program goals. In addition, the urban Reproductive and Child Health program has ensured improved facilities at NGO centers, regular supplies of ORS, stocks and increased outreach through immunization camps. The new initiative 'National urban Health Mission' (NUHM) is now in the planning process with AMC. The implementation of this new initiative is expected to be up and running in the middle of 2008. In principle this will help to address many of the gaps identified in the midterm evaluation. It will be important for CPI to be engaged as these changes are made and advocate for things that will support the *Jeevan Daan* goals and objectives.

How the remaining child survival intervention activities that have not yet been introduced can be implemented and at the same time sustainability integrated into the health system remains a large question and justifies bringing in technical assistance to carefully develop future plans in those areas. Early project documents, including the DIP and DIP review comments, implied that CPI would introduce Zinc to the project area as part of the CDD intervention, but later documents seem to imply that the project was dropping this effort due to lack of uptake of the national policy by the Gujarat state government. As of the MTE, there were no apparent efforts by any national or international organization to advocate for the Gujarat State government to adopt the new GOI policy that now complies with international (WHO/UNICEF) recommendations. Clearly CPI can not achieve this policy and implementation shift alone. The options should be discussed and resolved between CPI HQ and USAID/Washington, possibly with USAID/India's assistance, and the final decision clarified in the next Annual Report. This will allow the Final Evaluation team to be clear about the criteria by which the CSP is to be measured at the end.

C. Program Management

1. Planning

Partners meet on a regular basis and are involved in establishing workplans and schedules. After the MTE, Saath will assume more responsibility for developing plans and

Counterpart will decrease direct responsibility for managing the community-based components of the program. AMC is involved with specific planning for the government health system involvement. The AMC Health Director has requested CPI involvement in additional public health and HMIS, but some areas where support has been requested go beyond the scope of the CSP and would need to be funded through other sources.

Planning is participatory and integrated, especially with Saath staff. Staff turnover, both within Counterpart and to a lesser extent within Saath have required a reorientation to the DIP (which took place late in 2006). The DIP was very complex and the staff has had to devote considerable time to “getting up to speed” with all of the requirements of the program. This was hindered by poor archiving of program records, both in the US and in the India office. To their credit, the staff in India went to great lengths to reconstruct information during the second year of the program. Some specific process indicators are behind schedule, but the project will need to reexamine which of these activities are still necessary to meet project goals and objectives in light of the progress already attained towards some of the indicators. Despite the fact that program is lagging behind in terms of the process targets, based on the MTE KPC findings and qualitative assessments, less program effort was needed to accomplish some of the output performance indicators than was anticipated. This should allow for shifting of program efforts to the more problematic areas.

The second HQ project technical backstop and the acting HQ technical representative both cited the challenges to program planning and management presented by lack of program records in the HQ office mentioned above. The India office can do little to improve this situation; it will need to be addressed by the new HQ technical manager when she assumes her duties in October 2007.

CSP partners examine monitoring data and use it to plan capacity building activities and progress towards program process targets. Quantitative assessments undertaken during the MTE were compared with baseline studies and program implications were decided upon jointly with the NGO partner. Since involvement with AMC health facility management staff has been limited in terms of direct capacity-building for health personnel, they have not participated as much as Saath. But the AMC Health Director and the New CSP Program Director have been meeting on a regular basis and planning integration of CSP activities into the AMC health system. Since AMC health worker capacity building will constitute a large part of program effort in the second half the project, joint planning with them will, by necessity, increase significantly. Appropriate monitoring approaches will need to be developed to track implementation of these new activities.

Piloting of the social and verbal autopsies mentioned in the DIP⁷ has not started. When the emphasis shifts to AMC capacity building in the second half of the program, this may be an appropriate time to begin this activity. It is unclear as to whether Counterpart already has capacity to introduce this, or whether outside technical assistance will be required.

2. Staff Training

Staff turnover from the experienced and well established team in the first project to an almost brand new team has made assessing staff training needs especially challenging and a process that is continuing. As part of the employee performance review, training needs are being identified and planned. Until the budget pipeline and line item funds available for training are clarified as part of stream lining the budget, it is hard to answer

⁷ DIP M&E plan, p. 27.

whether or not sufficient staff training funds are available. But since the relative percentage of program funds expended compared to elapsed time appears to be on target, it is assumed that sufficient funds will be available to meet the needs that are identified by the Project Director and the staff themselves.

In preparation for the changing emphasis on program priorities, Counterpart India and Counterpart HQ could benefit from an updated Human Resources technical and management skills inventory and developing plans for matching future CSP training plans with program needs.

3. Supervision of Project Staff

When the new Project Director assumed his position, there were job descriptions for the existing staff but they had not been updated to reflect the new program. Program Coordinator and M&E Manager positions were vacant for close to two years, and job descriptions for those who were hired into those positions were revised. Roles and responsibilities and HR policy documents were also reviewed and updated after the new Project Director came in, reporting systems were clarified. These activities have seemed to relieve many of the apprehensions that staff had during this time.

Staff appraisals, extension letters, job contracts, increments etc are now reported to be up to date. CPI currently has a legal advisor reviewing all of these documents to ensure compliance with the national and State labor laws. Prompt and timely recognition about staff performance is acknowledged and rewarded by means of sending them for courses which are appropriate to the work they do and to their professional growth. Continuous education has now reported to have become a routine activity.

The CSP Program Manager, who also serves as the *de facto* CPI Country Director is also the only clinically trained public health professional in the Counterpart Staff. Saath has now recruited someone to fill their medical director position; the position was vacant at the time of the MTE, but is now filled. The health worker capacity building components of the program indicate the need for additional project personnel with health facility and clinical child health and maternal/newborn professional working and program management experience. This may require hiring additional personnel, either as PVO staff, or contractors.

4. Human Resources and Staff Management

A significant shift in management processes took place when the HQ technical backstop and designer of the original Jeevan Daan project left Counterpart to take a position with another organization. For approximately 6 years, many decisions were made, or strongly influenced from the headquarters in the US. This changed when the new Project Director came and much more decision making authority has now been delegated to the CPI India office. This facilitates the day to day management as decisions are made closer to where they will be acted upon. At the time of the MTE, all key CSP positions were filled, but a high percentage of the staff had been in their positions for 9 months or less. As mentioned in the earlier section, the partner Medical Director position was vacant at the time of the MTE, but Saath was in the process of recruiting a replacement.

The MTE team did not review personnel management systems at the headquarters, but turnover in the health positions at the headquarters, coupled with scarcity of program

records in the US have challenged everyone managing the program. CPI headquarters managers should review the health backstop personnel situation and determine ways that the organization can provide additional support to them to reduce turnover, maintain institutional memory and support continuity within the health program.

At the country level, staff work together well and are dedicated to the objectives of the program. As mentioned elsewhere, many of the key staff had worked for the project for 9 months or less at the time of the MTE and there were vacancies in key positions at Saath. In spite of the newness of the evaluation experience, these new staff all worked together and coordinated partners and communities efficiently. Very little documentation was left by the staff that resigned from the program and could not be recreated from headquarters' files. Staff members have had to spend time familiarizing themselves with the project methodology, but now seem to be caught up. Health technical capacity is under-represented in the PVO staff and the partner NGO. The TAC has not been actively engaged in the details of the program, and therefore does not provide enough support to make up for the imbalance. The Project Director will be very challenged to implement child survival technical capacity building activities with staff who do not share the same professional background.

Staff retention in the original Jeevan Daan project was unusually high. But staff turnover at both the country and at headquarters has been a dominant factor influencing the CSP EIP. The turnover after the first year of the Cost Extension Project did not seem to be the result of poor morale, but rather experienced staff moving on to better positions. Some ex-employees continue to maintain relationships with Counterpart. If the rate of turnover were to continue, however, it could have detrimental effects on implementation of the more technical and highly complex activities slated for the remainder of the project, as well as the delicate relationship-building required to build an effective advocacy strategy. The Project Director has taken many steps to make management more team oriented and to ensure full participation and consensus building and promote staff morale. This appears to have had positive effects and this type of support will be needed as the project undergoes changes in the second half of the program.

The future of Counterpart India is a concern for the entire staff. Staff members who have left the project have gone on to other jobs of equal or greater levels of responsibility. At the time of the MTE, the future of the office and employment of the staff after the program ends was uncertain. The CSP is Counterpart's only project in India. Without bringing in additional funding, the office will have no choice but to close when the CSP ends. To provide stability in the office, Counterpart should address the future of its operations in India as soon as possible and discuss this with Counterpart India staff.

5. Financial Management

Counterpart India managers state that financial reports flow to and from the India office to CPI HQ regularly. The external evaluator found the financial pipeline report provided by CPI HQ for the MTE to be unusually confusing. This made commenting on the spend-down of the budget and balance of USAID resources available for the rest of the Cooperative Agreement virtually impossible. This was further complicated because a copy of the original approved program budget from the Cooperative Agreement was not available in the field office at the time of the MTE. When a pipeline was obtained from CPI HQ office, it is not clear why budget figures from the previous Cooperative Agreement (that ended in 2004) were included on the spreadsheet. It was not possible to determine whether or not funds from the CS XVI project were carried over into the current Cooperative Agreement budget. (Detailed budget analysis goes beyond the scope of the CSP MTE)

To provide budget clarity and allow for forward planning and resource allocation for the remainder of the project, however, CPI should streamline and simplify budget pipeline spreadsheets and provide the entire budget pipeline to the managers responsible for project financial management. These reports should include only those funds allocated to the CS-XX Cooperative Agreement

To provide a “clean slate” to the new CSP managers at both HQ and the field, and comply with GOI NGO requirements, CPI should contract with a nationally-recognized accounting firm to conduct an audit of the current project funds. This audit should be repeated before the end of the current Cooperative Agreement. USAID/India can be contacted for names of reputable firms. It is not recommended that a firm that is solely operational in Ahmedabad be selected for this contract. CPI HQ should conduct an audit using a US audit company

Project partner organizations and TAC representatives stated that GOI has laws pertaining to foreign NGO financial reporting. Verifying this goes beyond the scope of this evaluation, but should be checked by Counterpart International to make sure that the organization is in compliance with all required national regulations. USAID/India may be able to provide guidance on GOI and Gujarat state requirements.

Saath has been working in the CSP on a cost-reimbursement basis. Reimbursements have been on a timely basis for the most part, but at the time of the MTE some funds were said to be delayed from CPI to Saath. Payment procedures were reviewed with CPI managers and the processes for future disbursement approvals were clarified to prevent future delays. Timely disbursement of funds to partners should be included in management monitoring systems and reviewed during partner meetings.

6. Logistics

Jeevan Daan is primarily a capacity building, community mobilization and quality improvement program. Very few materials and commodities are provided directly by Counterpart. The MTE team did not review CPI's in-kind contributions as part of the project match.

The project office, which is also the country office, is located in a different area of the city than the project slum pockets. Transportation can sometimes be challenging and would require significant number of vehicles if the office were the only center for operations. This has been largely alleviated by opening two satellite offices in two different locations closer to the project communities. This office is highly used and decreases the need for large numbers of project vehicles. Saath is a large enough NGO that CPI does not need to provide them with routine project supplies and equipment.

7. Information Management

All partners are involved in data collection and are able to use the data to assess progress towards objectives. Routine reports are provided to AMC and Saath. JD's HIS and monitoring systems were extensively reviewed in the previous program and were determined to be of high quality. In fact, copious amounts of data are collected by the project. Two full time staff members are devoted to maintaining these data bases, but when tested during the MTE data retrieval was timely and appropriate. On the other hand, staff members acknowledged it was sometimes hard to see “the forest for the trees” and led them to conclude that they should “collect less data, but analyze more.” Over the next year, JD managers and partners should determine what data collection is essential to program effectiveness and what data can be dropped, especially as community program components are turned over to Saath.

Assessing program data and documentation during the MTE was constrained by the commingling of print and electronic materials with the previous CSP that ended in 2004. The current MTE covers only the period beginning October 1, 2004. Although valuable as reference materials, it would be advisable to archive documents from the CS XVI program and keep them separate from current project documents. The same recommendation pertains to electronic project records.

Two versions of the DIP were circulated to members of the evaluation team. This caused some confusion and lost time in planning. The field team has always been working with the revised (i.e. correct) DIP. To avoid confusion at the FE, project managers should inventory all documents and delete those documents that are no longer in use.

The new staff is developing new documentation and dissemination systems to improve institutional memory and provide easier opportunities to build on past experiences. The current data base allows for quick electronic retrieval of the sub-elements of the KPC, rather than only the aggregate figure and hence contributes to retrieving more information to explain aggregate quantitative findings. For example, not only was hand-washing behaviors overall measured, it was possible to pinpoint *which* of the behaviors were low and should be emphasized to increase the overall percentages to meet the target.

The MTE process and analysis was the first opportunity for some of the newer staff, many of whom had little or no child survival experience, to see how the data that is collected should be used in programmatic decision making. They proved up to the task and generated many ideas on how the data could be presented and used effectively for decision making.

JD makes extensive use of capacity assessments and process monitoring tools to determine if process indicators are being met and keep the program moving in the right direction. In addition, student interns conducted several "Mini-KPCs" at the individual slum pocket level. While their findings seem to indicate wide variations in performance when individual indicators were assessed. Regrettably, their work was not intended to be used for the purposes of monitoring the project, but were rather a learning exercise for participants in the intern program. The JD team is encouraged to collect similar, but more technically sound and usable data, based on the models followed by the interns. This can be done with "mini-KPCs" or using LQAS methodology. In either case, this monitoring capacity should be developed alongside with the program partners, who should be capable of using it after the program ends. This disaggregated data collection approach shows promise for helping the program to target areas for focused efforts in particular interventions. M&E staff of JD could consider applying LQAS, or "mini-KPCs" to determine which of the lower-performing areas, or program components, could benefit from additional attention from the project. CPI can contact the CSTS monitoring and evaluation advisor if further guidance is needed.

Project data is shared with the AMC health department and Saath as well as the communities (through the CHTs) on a regular basis. The AMC health department is making extensive use of JD reports and the development of a referral system, through "chits". This is an innovative sustainable contribution of the program and should be seriously considered for replication in other urban (and possible) rural areas in the country. (See Results Highlight). As the project becomes more involved with AMC child survival and maternal health technical programming, information systems should be revised to incorporate useful data into the AMC HIS.

8. Technical and Administrative Support

The Technical Advisory Committee (TAC) was envisioned in the original JD to play a more active role in guiding the technical direction of the child survival interventions than has proven to be the case. Members of the committee are all well known and respected professionals in their areas of expertise but many are not familiar with the details of the project, nor are they up to date with the latest developments in the CS/MNC interventions. The TAC also does not meet often enough to realistically expect them to provide significant input on the day to day operations of the program. Current staff say that the TOR for the TAC does not require them to participate in technical day to day guidance, but without them there were no staff members with clinical expertise to manage the technical child survival interventions, especially at the level of clinical health facility personnel, until the current Project Director was hired. JD managers should continue to consult members when issues that are in their areas of expertise arise, but should not rely solely on them for all aspects of the technical content of the program. On the other hand, the TAC as a whole, or as individual members could be very valuable in providing a bridge to AMC and Gujarat state health system decision makers to advocate for the necessary policy changes that are required to implement some of the evidence-based CS/MNC strategies included in the DIP.

Technical assistance from the Hygiene Improvement Project to the JD CSP was discussed at length during the DIP review. Diarrhea and Hygiene/Water quality issues are critical elements in the CSP and technical assistance to Counterpart and partners is needed to address the shockingly high diarrhea prevalence in the program area. Gujarat is not a USAID/India focus area, so HIP will not be starting new programs there. But there is technical expertise within the project that could provide significant help in strengthening both the CDD and nutrition components of the project. USAID/Washington should provide assistance to help CPI to obtain the TA that was envisioned at the beginning of the program.

The new CSP Project Director is a medical doctor with postgraduate public health and child survival training and experience. He has also served as Counterpart's India Country Director since he began working more than one year after the program began and approximately 9 months before the MTE. He is the only staff member working for Counterpart with a health technical background in the program interventions who could lead the technical updates envisioned in the DIP. On the other hand, as the only staff member with clinical MCH experience, additional clinical expertise, such as from midwives or other public health doctors may be required to complete the remaining activities of the project. (See Recommendations).

Strengthening the child survival and maternal/newborn intervention-specific components of the program needs to be Counterpart's priority in the second half of the program. Technical assistance is needed on how to build AMC health worker capacity in the interventions, given the policy environment constraints of the GOI and the Gujarat State. Partners need to have their capacity built to be advocates to facilitate adoption of key child survival policies and provide access to training of AMC health workers. If planned correctly, CPI could be the catalyst to assist AMC to upgrade training throughout AMC, hence having scale-up impact beyond the CSP area. The CSP, however, should not be expected to pay for all of this training.

The program will need specific assistance to develop a training needs assessment and program for:

1. **PD/Hearth scale-up** in CS-XX CSP. Technical PD/Hearth expertise is needed to make sure that the PD/Hearth implemented through the Aganwadi interface

maintains the principles of PD/Hearth. This TA would also address the feasibility of introducing Pregnancy Hearths. If not feasible, then CPI should request that USAID allow them to drop it. PD/Hearth is labor intensive and the current project staff members do not have the technical background to supervise introduction of two very challenging modifications of the community-based PD/Hearth approach.

2. **Policy advocacy** strategy at the Gujarat State and AMC level to support program interventions and develop a Training of Trainers (TOT) approach for training the AMC (and interested private health providers) on at least the following topics:

a) **C-IMCI** approaches (and advocate for facility IMCI supported through other programs). Providing technical capacity building following the outdated “stove-piped” intervention approach is not a wise use of resources and should be avoided unless absolutely necessary. TA is needed to design the intensive training programs that will be needed in the second half of the program. It is not foreseen that basic facility-based IMCI training should be supported through the JD, especially for areas not served by the CSP

b) **Zinc and implementation of the new low osmolarity ORS.**

Assistance is needed to change state policy to align with national policy, CPI would have to make a case for not pursuing an advocacy strategy for introduction of zinc and the low osmolarity ORS, given current international technical standards and extremely high diarrhea prevalence in the project communities.

c) **Technical and policy updates in maternal and newborn health**, including new research results within India, even though they have been done in rural areas. HBLSS is unlikely to be the appropriate training approach without introducing a whole cadre of MNC supervisory positions at this late stage of the program. HBLSS requires using specific US-based ACNM trainers. USAID CSHGP should be contacted about removing this specification from the program description. If HBLSS is pursued, sustainability and financing for the training from ACNM will need to be addressed and coordinated with CPI HQ

d) **Improving poor EPI coverage.** Although EPI coverage is better in the CPI program areas than elsewhere, remaining challenges are similar to those experienced in the rest of India. The NFHS-3 results have made this a national priority and it is assumed a national strategy will be developed to address the poor coverage. Copies of *Immunization Essentials* were provided to CPI staff, but government policies and procedures will have to change in order for the project to promote best practices in EPI. AMC has resources, but not expertise to provide this training. Even though donors are unlikely to focus on Gujarat, USAID/India can secure invitations for AMC and state officials to attend national conferences dealing with improving EPI coverage and quality. CSP funds can legitimately be used for this purpose.

CPI and AMC can collaborate to organize training to reach beyond the areas covered by the CSP, and expanded to include key medical staff in the state health department. The Indian Institute of Management and other training institutions in Ahmedabad are available as venues and have experts who can also provide guidance. This is a wonderful opportunity for USAID/GOI collaboration to leverage a relatively small investment of resources to update the knowledge and skills on CS and MNC that will impact on a wide

population since government health workers have had no refreshers in those areas at all. CPI training specialists can design the training activities themselves, but need the technical expertise to work with the Project Director for organizing the content, and much of the funding to come from AMC and the state.

Counterpart Headquarters Support to the Field Office.

Significant project resources were devoted to HQ health backstopping of the project in the first year of the program. The original health technical backstop visited the program several times and maintained regular contact with the project via telephone and e-mail. She is a native of Ahmedabad, designed most of the original *Jeevan Daan* CSP and has longstanding relationships with many of the individuals and organizations associated with both the first and the current programs. At the time of the MTE, however, both the HQ health backstop and the CSP Project Director had changed within the previous year, with the most recent HQ health backstop resigning from the office just before the MTE field work began. New HQ staff members were unable to locate trip reports from these earlier visits. Training records of BEHAVE and BCC training provided by the previous HQ backstop, however, were available.

Ms. Negina Sawez, who received her MPH 2 years before the MTE, stepped in at the last minute and served as the HQ representative for the MTE fieldwork. She provided valuable support and input to the team during the fieldwork. As of the time of this report, another HQ health backstop has been hired and began work in October 2007. CPI HQ was reminded by the team leader that, according to the terms of the USAID Cooperative Agreement, changes in key project personnel need to be approved by USAID.

Additional HQ staff members are scheduled to visit the project in October 2007 after the MTE results and Action Plan are finalized.

9. Mission Collaboration

Counterpart India and USAID India have collaborated extensively during both CSPs. Counterpart/India's new Project Director has also applied the principles that led to formation of the CORE group within the US to begin collaboration with other Child Survival PVOs working in India, including forming a journal club and organizing periodic meetings. India is a large country, and face to face meetings require significant travel. There is much enthusiasm for this collaboration and all are hopeful that the logistic challenges for those organizations centered outside of Delhi can continue to be involved. USAID/India could explore the feasibility of developing electronic conferencing, possibly via internet, similar to the conference calls and Elluminate sessions used by CORE members in the US.

CPI is considering opening a Delhi office, but no decision has been made. This would increase chances that CPI would have access to information about additional sources of funding for their India programs and encourage additional collaboration with other implementing partners.

USAID/India is undergoing restructuring, but child survival and maternal health will remain priorities. Urban health is also a mission priority. Globally, much more attention has been devoted to rural child survival and MNC programs than in urban areas and JD has valuable lessons to share in this emerging focus area.

USAID/India Mission partners are addressing maternal, child and newborn policy issues at the national level and within their focus states. It is unclear which donor or

international organization will support advocating for systematic changes across the states that are not currently any donor's priority. This could potentially lead to huge disparities in the quality of maternal/newborn and child survival programs between individual states, with the economically better-off states actually lagging behind the poorer ones.

JD is in the position of needing to show that it is a "model" of how to raise the status of the poorest and hardest to reach urban poor without pouring large amounts of external financial support into activities. USAID/India is not prepared to support small, "boutique" projects, but is interested in lessons learned that can be applied elsewhere. JD has much valuable to teach that satisfies this desire on USAID/India's part. In this sense, Counterpart and USAID/India are at a cross-road as to the potential contribution that can be made to the Mission's goals and objectives by including lessons learned from JD in planning for scaling up successful strategies elsewhere in India. Significant lessons learned about upgrading quality of public health services and making positive impact on key maternal, newborn and child health services have been developed in the JD project, but it is unclear how these lessons will be captured and scaled-up without significant planning and coordination with the other USAID/India projects/programs and partners.

Counterpart should not be expected to spend significant amounts of the CS-XX CSP funds to share the lessons learned that would be used to impact on programs in other parts of the country. On the other hand, AMC and other partners have verified how some of the cost-effective approaches developed by JD address problems that are prevalent through out the country, especially in extremely poor urban areas.

Members of the USAID/India mission staff have been very involved in CSP design and evaluation activities. Dr. Rajiv from USAID India's health programs participated in the MTE at the field level and organized the MTE results debriefing with USAID PHN staff in Delhi in July 2007.

D. Other Issues Identified by the Team

No other issues were identified by the evaluation team.

E. Conclusions and Recommendations

In spite of almost complete turnover of headquarters' and field project staff since the beginning of the CS-XX phase of Jeevan Daan, quantitative and qualitative assessments indicate that significant increases have been made in most of the project CS indicators. In some cases, planned CS approaches have not yet been introduced. These are largely hindered by a combination of outdated government policies and lack of partner technical capacity, and are primarily related to the technical aspects of the child survival interventions

Major Recommendations

Counterpart International:

- 1) Proceed with turnover of community-based aspects to Saath as outlined in the sustainability plan. Financial reimbursement from Counterpart to Saath should keep pace with the turnover to prevent delays.
 - 2) To supervise performance and identify areas of the project needing additional support or attention, train staff and partners (including AMC) to use sampling techniques, such as LQAS or "mini-KPCs" to identify high performing versus low performing project areas according to project target indicators. These competencies for monitoring and supervision should be included in the sustainability plan. The CSTS Monitoring and Evaluation advisor may be contacted for additional guidance.
 - 3) Significantly more attention needs to be devoted to building AMC Child Survival and Maternal/Newborn Health technical capacity, including implementing a training program for AMC skilled health personnel as highlighted in the DIP review comments. As was also pointed out during the DIP review, this will require much more collaboration with the Gujarat State health authorities. Counterpart should assess whether sufficient health technical human resources are available within the CSP partnership and use project funds to obtain any needed technical assistance.
- Saath and appropriate TAC members should be included in developing a clear and comprehensive advocacy strategy to pave the way for AMC and state policies that will support building AMC skilled health personnel technical capacity in the program interventions. Where national policy is involved, Counterpart should collaborate with USAID/India and their partners to identify policy barriers and contribute to developing ways to overcome them. Technical assistance plans as described in the DIP, including the role of the TAC, should be revisited and adjusted to meet needed technical inputs, including orientation to C-IMCI and MNC. This may require a revised program description, but probably not a modification to the Cooperative Agreement unless IMCI is dropped from the program entirely.
- 4) Counterpart International Headquarters should clarify their plans for the future of Counterpart India with their field office as soon as possible. This significantly impacts on sustainability planning. Legal status of Counterpart India as a national NGO also needs clarification. Current CSP staff will be extremely busy managing the workplan for remainder of the project. Staff retention issues may continue if future existence of the office is in question.
 - 5) To facilitate planning the use of resources for the remainder of the program, financial reporting between HQ and the field should be simplified and streamlined, removing any references to funds from the CS XVI CSP. CPI should also consult USAID/India for advice about complying with the Indian national laws related to the routine financial reporting requirements for foreign NGOs. Due to turnover both at HQ and the field

office and subsequent institutional memory gaps, CPI should strongly consider conducting a financial audit using a reputable firm recommended by USAID. This is a routine practice in many CSHGP PVO programs and should take place soon after the MTE, and again before the end of the project. In addition, all references to funds from the previous CS-XVI project (2000-2004) should be closed out and removed from the current CS-XX financial reports.

Partners

Counterpart and AMC should document the successful implementation and future scale-up plans for the referral chits. Ideally, this would be presented at global forum such as the CORE group Annual Meeting, Global Health Council. Counterpart, AMC and Saath should include assessing the effectiveness of the CSP and MNC technical updates after the CSP ends in their sustainability planning.

For USAID

USAID/GH/HIDN/NUT/CSHGP should assist Counterpart HQ to interface with the Hygiene Improvement Project (HIP) to provide the needed technical assistance to address the severe diarrhea prevalence problem in program communities. Technical assistance was implied, but not elaborated upon during the DIP review.

USAID/India has offered to provide some limited technical assistance to the project through its Mission-funded MCNH programs. Counterpart India and USAID/India should clarify the amount and the type and include this assistance in the workplan for the remainder of the project. Agreements should be documented and shared with Counterpart Headquarters and USAID Washington to better coordinate technical assistance to the project.

F. Results Highlight

Strengthening Linkages between Urban Slum Communities and Ahmedabad Municipal Corporation (AMC) Government Health Services through the introduction of Referral Chits

Early recognition and appropriate care seeking for danger signs in sick children and pregnant women has been included in PVO and other Child Survival and Maternal/Newborn Care programs for many years. Protocols in global community-based programs usually specify that the volunteers or health workers should refer serious cases, or those that don't improve, to health facilities. This advice has served to strengthen the linkage between communities and the formal health sector in many programs, but relies on an effective referral system to be in place.

Until recently, however, relatively little attention has been devoted to the quality of design, evaluation and documentation of effective referral systems. One factor has been the lack of a "paper trail" that tracks the referral from the source (community, health worker, health facility) to the referral point (health center, clinic, and hospital) and then assessing the impact of this referral system from beginning to end. This documentation has been even more challenging in large urban areas where families can choose to seek care from multiple providers, both private and government. In addition, there are also multiple informal providers whose advice is often sought early in the course of illness, when referrals are far more likely to be easier, more effective and less costly.

The Jeevan Daan Child Survival project in Ahmedabad India developed a series of color-coded "referral chits" that are used in the urban "slum pockets" of Ahmedabad the "mega city" where the project is located. These chits have provided the much-needed documentation to the government health partner, the Ahmedabad Municipal Corporation (AMC) that the community mobilization and provider capacity-building components of the program have been effective in directly improving key child survival and maternal/newborn health indicators. This system has resulted in the referral of mothers and children to health centers and hospitals by a wide array of community members and providers. By issuing referral chits, the first CSP (CS-XVI) was able to increase access to AMC facilities and create a demand for AMC services. Referral chits have also been issued to immunization "drop-outs" through Community Organizers, Community Health Teams, AMC Link Workers, Traditional Birth Attendants, and Aganwadi Workers and adolescent volunteers. Some of these same health workers and community members also provide referral chits to pregnant women for key preventive services such as ANC checkups, tetanus toxoid immunization, iron/folate tablets, skilled deliveries and postpartum and newborn checkups.

The CS-XX Expanded Impact CSP, now targeting 277,000 beneficiaries, continues to strengthen the partnership with AMC as it extends into new slum areas of the city and establishes critical linkages between public, private providers and communities in both the old and new project areas. Introducing innovative monitoring systems, such as the referral chits and regular supervision have helped give the AMC health authorities a much clearer picture of health care seeking behaviors and services needs in the city's poorest communities.

Results

The number of appropriate referrals increased significantly. The AMC health director attributed these increased referrals directly to the project. The AMC was so impressed by the effectiveness of the referral chits that they have been incorporated directly into the entire city-wide AMC health system. Same day care seeking at a health center for children

with pneumonia symptoms rose from 37% to 57%, 3 ANC visits rose from 24 to 87% and complete immunization coverage by age 12 months increased from 48% to 66% in the first half of the program. The AMC has adopted the referral chits into the entire municipal public health system that serves over 3.7 million people.

II. Action Plan

A. Action Plan on Overarching Issues

Recommendations	Action Plan based on recommendations	Dead-line
i. Proceed with turnover of community-based components of the project to Saath as outlined in the sustainability plan. Financial reimbursement from Counterpart to Saath should keep pace with the turnover to prevent delays.	1. Field based components, financial reimbursement according to DIP and the human resources would be handed over to Saath (BCC process documentation, print based material, best practice advocacy conference—sharing the lessons learnt with fraternity, budget)	Oct 2007
	2. Orientation of field staff to be completed	Oct 2007
	3. Joint decision making mechanism between CPI & Saath through 2 meetings of the entire JD team a month	Ongoing
	4. Develop the inventory of equipment and resources and the same to be handed over to Saath	Oct 2007
	5. Revisit the existing MoU between CPI & saath and revise if necessary	Oct 2007
ii. To supervise performance and identify areas of the project needing additional support or attention, train staff and partners (including AMC) to use sampling techniques, such as LQAS to identify high performing versus low performing project areas according to project target indicators. These competencies for monitoring and supervision should be included in the sustainability plan.	1. Line managers supervise performance of the staff closely and provide feedback so as to re-adjust/address weak areas	Ongoing
	2. Identify thematic areas which are weak and reinforce with appropriate measures to have a greater impact	Ongoing
	3. Performance on key indicators-monitor closely and set up feed back mechanism for AMC	April 2008
	4. Design training curriculum and impart trainings to CPI staff and its partners including AMC on sampling techniques like LQAS to identify high performing versus low performing project areas	June 2008
	5. To evidence that JD monitoring and supervision activities are leading towards program sustainability, activities will be listed and included in sustainability plan	Oct 2007
iii. More attention needs to be devoted to building AMC Child Survival and Maternal/Newborn Health technical capacity, including implementing a training program for AMC skilled health personnel as highlighted in the DIP review.. The DIP review also pointed out that this will require significant collaboration with the Gujarat State health officials. Counterpart should assess whether sufficient health technical human resources are available within the CSP partnership and use project	- Come up with a training plan for AMC doctors and other skilled workers with main focus on technical thematic areas - Design curriculum in conjunction with Dr. Kulkarni - Set dates for trainings during second Saturdays and other days that AMC staff can devote for trainings.	January 2009
	- Use consortium to identify policy barriers and develop ways to overcome them	ongoing

<p>CSP partnership and use project funds to obtain any needed technical assistance. Reference to HBLSS training for TBAs should be removed, as this is unlikely to be appropriate at this stage of the program.</p> <p>- Saath and appropriate TAC members should be included in developing a clear and comprehensive advocacy strategy to pave the way for AMC and state policies that will support building this technical capacity. Where national policy is involved, Counterpart should collaborate with USAID/India and their partners to identify policy barriers and develop ways to overcome them. Technical assistance plans as described in the DIP, including the role of the TAC, should be revisited and adjusted to meet needed technical inputs, including orientation to C-IMCI and MNC. This may require a revised program description, but probably not a modification to the Cooperative Agreement.</p>	<p>1. Collaborations with MOH Gandhinagar shall be extended; AMC commissioner shall be requested to recommend CPI to MOH in Gandhinagar for possible collaboration and scale up activities in other parts of the state. CPI shall attempt sincerely to have better understanding on Govt. policies esp. in the area of health care delivery; the current capacity of technical people in the program shall be assessed and the ways to address those gaps within the available frame of resources shall be worked out</p>	<p>Oct 2008</p>
	<p>2. JD's advocacy strategy: need felt to understand what other advocacy groups are doing in the city. CPI shall come up with a cohesive and comprehensive package to address advocacy issues relevant to the program to implement and monitor the impact. USAID Delhi shall be involved and their assistance shall be sought in this regard</p>	<p>Nov 2008</p>
	<p>3. CPI presence in Delhi would help address policy barriers, influence decisions made by the government, information gathering and advocacy both at state and at the national level</p>	<p>OFFICE IN DELHI???</p>
	<p>4. TAC involvement in JD shall be reviewed; program approach will be revised & TAC would meet as & when required and not on regular basis as originally mandated by DIP</p>	<p>Nov 2008</p>
	<p>5. Need felt to revise program description; current program description may change based upon the TAC's recommendation/advice...[since TAC would meet as & when required,</p>	<p>N/A</p>
<p>iv. Counterpart International Headquarters shall clarify their plans for the future of Counterpart India with their field office as soon as possible. This will significantly influence sustainability planning. Legal status of Counterpart India as a national NGO also needs clarification. Current CSP staff will be extremely busy managing the workplan for remainder of the project. Staff retention issues may continue if future existence of the office is in question</p>	<p>1. Raj shall visit HQs to discuss issues pertaining to future of Counterpart India program, staff retention, CPI as national NGO, Budget, and presence in Delhi etc.</p>	<p>Dec 2007</p>

<p>v. To facilitate planning the use of resources for the remainder of the program, financial reporting between HQ and the field should be simplified and streamlined, removing any references to funds from the CS XVI CSP. CPI should also consult USAID/India for advice about complying with the Indian national laws related to the routine financial reporting requirements for foreign NGOs. Due to turnover both at HQ and the field office and subsequent institutional memory gaps, CPI should strongly consider conducting a financial audit using a reputable firm recommended by USAID. This is a routine practice in many CSHGP PVO programs and should take place soon after the MTE, and again before the end of the project. In addition, all references to funds from the previous CS-XVI project (2000-2004) should be closed out and removed from the current CS-XX financial reports.</p>	<p>1. The financial reporting between the field and the HQ will be simplified through regular pipe line analysis, ensuring that the figures tally at both levels,</p> <p>2. monthly financial reports and reviews, ensure that the current program funds are from CS XX and contains NO reference from CS XVI.</p>	Dec 2007 [TO BE COMPELTED BEFORE AUDIT IS CALLED]
	<p>3. CPI's legal advisor shall look into the certifications, notices and renewals from the RBI and Central ministry of home affairs etc. to ensure that CPI are up to date with the current laws of GOI and their compliance is to the fullest for program sustainability and future course of CPI</p>	Dec 2007 [TO BE COMPELTED BEFORE AUDIT IS CALLED]
	<p>4. CPI shall order an audit after consulting the HQ. Raj will bring this up during his visit to the HQ</p>	[to be decided by Raj...][THIS WILL HAPPEN AFTER THE ABOVE 2 STEPS ARE COMPLETED]
<p>vi. (Partners) Counterpart and AMC should document the successful implementation and future scale-up plans for the referral chits. Ideally, this would be presented at global forum such as the CORE group Annual Meeting, American Public Health Association, Urban Health Conferences or the Global Health Council Annual Meetings. Counterpart, AMC and Saath should include accessing the effectiveness of the CSP and MNC technical updates after the CSP ends in their sustainability planning.</p>	<p>1. One presentation already done at Washington in April 2007; shall be done on different areas more frequently across the country to increase CPI's visibility; scale up activities/plans with other actors shall be drawn and presented in such a way that it appeals donors awarded a grant.</p>	Sep-2009
	<p>2. Plan on taking AMC senior staff to these conferences shall be chalked out and they shall be encouraged to represent CPI as permitted by budgetary provisions/opportunities. Relevant training opportunities that CPI may come across shall be passed on to the AMC staff as part of their capacity building endeavor.</p>	Ongoing
	<p>3. Institutionalize certain USAID strategies that they advocate on MCH into AMC as an institution and document the success stories for dissemination – enroll AMC on the CORE mailing group so that they have access to latest international MNC updates plus CPI shall see that AMC become a part of MNCHN consortium.</p>	Sep-2009

<p>vii. (for USAID) USAID/GH/HIDN/NUT/CSHGP should assist Counterpart HQ to interface with the Hygiene Improvement Project (HIP) to provide the needed technical assistance to address the severe diarrhea prevalence problem in program communities. Technical assistance was implied, but not elaborated upon during the DIP review.</p> <p>USAID/India has offered to provide some limited technical assistance to the project through its Mission-funded MCNH programs. Counterpart India and USAID/India should clarify the type and include this assistance in the workplan for the remainder of the project. Agreements should be documented and shared with Counterpart Headquarters and USAID Washington to better coordinate technical assistance to the project.</p>	<p>1. The HQ backstop person will work with USAID DC and seek guidance and support from them in order to support field activities. The HQ backstop staff will utilize resources to its program that are made available by USAID to all its CS programs and PVOs.</p>	<p>Ongoing</p>
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B. Action Plan on Technical Interventions

Technical Intervention: MNC	
Indicator	Action-points
Percentage of mothers possessing MH cards	<ol style="list-style-type: none"> 1. All MH cards will be considered based on certain criteria 2. Advocacy at Ahmedabad Municipal Corporation level for providing Plastic jackets to retain the cards 3. Advocacy at Ahmedabad Municipal Corporation level for allowing the Chiranjivi Schemes' doctors to distribute Mamta cards, distribution at filed-level through LWs
Postpartum Vitamin-A dose as per WHO Protocol	<ol style="list-style-type: none"> 1. Current State-policy for Vitamin-A supplementation be studied- for postpartum care
Why few people still prefer home deliveries	<ol style="list-style-type: none"> 1. Reinforce our old strategies for this indicator- continue what we are doing 2. Identifying the TBAs in Jeevan Daan areas, make them Community Health Team member and gather information 3. Cross-visits of positive TBAs to other areas' TBAs 4. Focus on gate-keepers for promotion of institutional deliveries 5. Identifying the areas where prevalence of home-deliveries is high
Private facilities are preferred over public facilities for deliveries	<ol style="list-style-type: none"> 1. To drop this concept and just concentrate on promotion of "institutional deliveries"
Observance of 5 cleans during home-based delivery	<ol style="list-style-type: none"> 2. Observation of the delivery at Ahmedabad Municipal Corporation facility by third party- Ahmedabad medical association then devise a training / orientation program through the DHOs/AMA
Investigate gate-keeper's role in decisions on matters related to pregnancy & delivery	<ol style="list-style-type: none"> 1. Focus on male involvement to be increased
Postpartum check-ups	<ol style="list-style-type: none"> 1. Preparation of technical checklist 2. Providing the list of pregnant women of all trimesters to COs for reminding them about the post-partum check-ups for follow-ups by LWs/COs/CHTs 3. Awareness in gatekeepers through trainings, campaigns and meetings- of positive deviants 4. Technical checklist- strategy to be revised
IFA tablets	<ol style="list-style-type: none"> 1. Verify that IFA tablet has 60 milligram of iron and 400 micro units (5 ml) of folic acid

Technical Intervention: CDD	
Indicator	Action-points
Almost 40% incidence of diarrhea. Why?	<ol style="list-style-type: none"> 1. We will have holistic approach-including- source of water, POU, storage of water, exclusive breast-feeding 2. More male involvement to be promoted through HHV
Max cases in age group 4-11 months. Discuss.	<ol style="list-style-type: none"> 1. Focus on promotion of exclusive BF- focusing on gate-keepers' counseling (more emphasis on not giving water to the child of age under 6 months) 2. Inclusion of exclusive BF concept in the training module of training of Ahmedabad Municipal Corporation staff-MOs 3. Advocacy at AMA level
Community's understanding of ORT	<ol style="list-style-type: none"> 1. "to continue what we are doing" 2. Promotion of keeping ORS packets in house through the HHV
Appropriate supplementary feeding	<ol style="list-style-type: none"> 1. Refresher session for program staff on supplementary feeding to child
Investigate gate-keepers, role in decisions on matters pertaining to diarrhea control	<ol style="list-style-type: none"> 1. Convincing husbands for promotion of exclusive BF 2. Ward-level meeting of mother-in-laws for correct practices involving positive mother-in-laws 3. Males can go to muster-station for registering the complains related to water supply
what is done if child refuses to eat	<ol style="list-style-type: none"> 1. Promotion of feeding practices to mothers through HHV 2. Focus on mother-in-laws and husbands through HHV
hand-washing behavior	<ol style="list-style-type: none"> 1. More emphasis on hand-washing before cooking and before feeding the child through HES and HHV 2. Monitor the results of hand-washing practices after every 3 months- M&E 3. Preparation of poster for promotion of hand-washing practices and using it during HHV –Dhriti and Dr.Raj
After the child recovers from the illness, should he be fed more/less/same as usual?	<ol style="list-style-type: none"> 1. to remove the indicator about the food during illness- less/equal/more – since we found it no more effective related to our program, and replace it with the food during recovery- less/equal/more

Technical Intervention: PCM	
Indicator	Action-points
Fast/difficult breathing is recognized by 17% mothers as danger sign. Why?	<ol style="list-style-type: none"> 1. 2. focus on gate-keepers for counseling- mainly mother-in-laws 3. counseling on prevention- promotion of Measles and DPT vaccine, Excl. BF, vitamin-A, nutrition 4. training on case management and on rational drug usage to Ahmedabad Municipal Corporation-through DHOs (Dr.Raj) 5. community level training to COs on the same subjects 6. preparation of action-plan for intensive HHVs for this intervention
Delay seeking care after identifying danger signs	<ol style="list-style-type: none"> 1. Counseling on recognizing the danger signs
Are there any barriers to taking the child for care to qualified provider	<ol style="list-style-type: none"> 1. Continue doing the activities we do- providing them knowledge
Investigate gatekeeper's role in decisions on matters pertaining to pneumonia management	<ol style="list-style-type: none"> 1. mobilize the CHTs and other stake-holders for follow-ups for the pneumonia cases' treatment (treatment adherence) 2. more CD-shows on PCM 3. Focus on rational drug usage/standard case management

Technical Intervention: Nutrition and Breast-feeding	
Indicator	Action-points
Meaning of exclusive Breast-feeding as understood by community	<ol style="list-style-type: none"> 1. mobilize gate-keepers for the correct practices 2. counseling on not to give water- promotion of the message that if your child go thrice for urine in a day then he is having enough water and no need to give him additional water if he is under 6 months age 3. advocacy at Ahmedabad Municipal Corporation level and also at AMA level
Low excl. BF during past 24 hours (27%). Why?	<ol style="list-style-type: none"> 1. Promotion on the messages related to BF during breast-feeding week's celebration
De-worming? Do people know about it.	<ol style="list-style-type: none"> 1. To ask Ahmedabad Municipal Corporation about their policy about de-worming- Dr.Raj will do it , also ask Ahmedabad Municipal Corporation about antenatal deworming, suggesting Ahmedabad Municipal Corporation for conducting campaigns on the same intervention 2. At filed-level- referrals will be done for symptomatic cases 3. To develop BCC material on de-worming
Hearth approach as viewed by community	<ol style="list-style-type: none"> 1. 2. We will revisit the figure decided for AWW-hearth 3. We will continue doing AW-hearths 4. Non-Saath AWs will be taken up to test out the model of AW-hearth interface (where cooked food is supplied)

Technical Intervention: EPI	
Indicator	Action-points
DPT drop-out rate is quite high (94%-72%). Why?	<ol style="list-style-type: none"> 1. Preparation of list for follow-ups of vaccination by COs during their HHVs , handing over the same list to UHC and also to the LWs/AWWs/CHTs, also during CHT meetings 2. Focus on side-effects after vaccination 3. Focus on gatekeepers' counseling to alter their beliefs
Despite measles coverage being 81%, rate of complete immunization is 66%. Why?	<ol style="list-style-type: none"> 1. Information gathering and advocacy at Ahmedabad Municipal Corporation level
Investigate gatekeeper's role in decisions on matters pertaining to vaccination	<ol style="list-style-type: none"> 1. Mass-level activities- poster-campaign on the photos of diseases that occurred due to lack of immunization

Others	
Issue	Action-points
Training of staff	<ol style="list-style-type: none"> 1. session on specialized subject by each staff member after each 6 weeks from August 2. In house trainings for program staff from time to time 3. Preparation of content of the Training- referring all TRMs and information on internet or through distance learning (Elluminate sessions, etc.)
Issues with supervision	<ol style="list-style-type: none"> 1. Joint-monitoring (Counterpart-Saath) should be started 2. Ensure keeping the Program coordinators in loop in all the decisions and activities related to field
Referral-chits	<ol style="list-style-type: none"> 1. More focus on the entire referral-system
Impact of Jeevan Daan	<ol style="list-style-type: none"> 1. Activity for getting visibility of program 2. - Program's visibility by providing name-plates and ID-cards to CHTs

III. Attachments

a. Baseline Information from the DIP

Please see report narrative above.

b. KPC Survey

Please see attached full KPC report.

1. BACKGROUND

A. Project overview

Counterpart International received a grant under the Child Survival Health Grant Project (CSHGP) funding from the USAID to implement a Child Survival program in Ahmedabad, Gujarat, India in collaboration with Ahmedabad Municipal Corporation⁸ and partner NGO Sanchetana in the year 2000. The JeevanDaan Child Survival Program (CS-XVI) funded by USAID commenced in October 2000 covering 6 out of the 43 Municipal wards (now 55, due to recent inclusion of adjacent rural areas in municipal limits) in Ahmedabad city. The program covered a slum population of approximately 177,400 and addressed the four key technical interventions of Control of Diarrheal Diseases, Pneumonia Case Management, Nutrition and Immunization.

On basis of the demonstrated successful stratagem of the CS-XVI program, and with respect to the unmet maternal and child health needs of the slum population living in Ahmedabad as cited by the implementation partner Ahmedabad Municipal Corporation, JeevanDaan program was awarded the Cost Extension grant for the period of 2004-2009 in partnership with local NGO Saath and Ahmedabad Municipal Corporation. A new thematic area namely Maternal and New born Care was also appended to original manifesto of the program.

B. Characteristics of the target population

For the cost extension program, it was proposed to include the additional indigent slum pockets situated in the other four adjoining municipal wards of Ahmedabad as a scale up endeavor. The grant was awarded for five years beginning w.e.f. October 1, 2004 to September 30, 2009 to cover more than 300,000 population. The details of the population covered under the **JeevanDaan Maternal and Child Survival Cost Extension Program (CS-XX)** as estimated at the time of phase-in have been outlined in table 1.

Thus, at the time of commencement of Cost extension phase, the CS-XX Program area had a total population of 308,445 including 55,519 children under five of which approximately 11,104 were infants. There were approximately 80,196 women of reproductive age in the CS-XX program area. However, due to various reasons administrative in nature⁹, the total population estimated at the time of Midterm study was 277,000 approximately.

⁸ The Ahmedabad Municipal Corporation, a statutory local self-government body, deriving authority from the provisions of the *Bombay Provincial Municipal Corporation Act, 1949*, is responsible for the provision of health and hygiene services. It provides health care in the form of preventive and promotive services, curative services, medical education, and other services including the registration of births and deaths.

⁹ The Municipal Corporation is currently implementing an urban infrastructure renewal project under which the selected existing slums are being removed and rehabilitated elsewhere to improve upon the basic amenities in the heart of city.

Table 1: Details of the population covered under the JeevanDaan Maternal and Child Survival Cost Extension Program (CS-XX) at the time of phase-in

Sr. No.	Municipal Ward Name	Population / JeevanDaan CS XVI Program 2000-2004	Population / JeevanDaan MCS Cost Extension Program 2004-2009	Children < 5 years ¹⁰ ; JeevanDaan MCS Cost Extension Program		Women of Reproductive age (WRA); JeevanDaan MCS Cost Extension Program		Total Beneficiaries; WRA and Children < 5 served during LOP; JeevanDaan MCS Cost Extension Program
				Current Estimate	Estimated addition during LOP	Current Estimate	Estimated addition during LOP	
1.	Danilimda	41,300	38,850	6,993	6,713	10101	1,426	25,233
2.	Behrampura	55,000	49,210	8,858	8,503	12,795	1,806	31,962
3.	Raikhad	25,500	36,125	6,502	6,242	9,393	1,326	23,463
4.	Raipur	3,000	2,125	382	367	553	78	1,380
5.	Jamalpur	15,000	21,860	3,935	3,777	5,684	802	14,198
6.	Dudheswar	37,600	49,920	8,985	8,626	12,979	1,832	32,423
7.	Bapunagar	-	24,415	4,395	4,219	6,348	896	15,858
8.	Saraspur	-	32,670	5,881	5,645	8,494	1,199	21,219
9.	Kankariya	-	29,710	5,348	5,134	7,725	1,091	19,297
10.	Maninagar	-	23,560	4,241	4,071	6,126	865	15,302
	TOTAL	177,400	308,445	55,519	53,298	80,196	11,323	200,336

¹⁰ **The AMC calculates the under five population as 18% of the total population, and the infant population from the Crude Birth Rate x population.

C. Social, economic and health conditions within the project area

a. General account

Ahmedabad is the seventh largest city in India and is home to second largest textile industry in India. The city has an area of 190.15 sq. km and has well-developed commercial and industrial centers. The population of urban Ahmedabad¹¹ is 3,515,361 making it one of the most densely populated cities in the state. For administrative purposes, Ahmedabad has been divided into six zones which have been further sub-divided into 55 administrative units called Municipal Wards, with a population range of 80,000 to 90,000. The civic affairs of the city are governed by the Ahmedabad Municipal Corporation; apart from providing basic civic amenities to the people such as water supply, wastewater disposal, collection and disposal of waste, construction and maintenance of roads, provision of street lights etc., it also provides several other services to the urban poor such as schools for primary education, city transport, construction and maintenance of public hospitals and dispensaries, medical services and medical education through teaching hospitals and undergraduate and postgraduate medical colleges and other programs for public medical relief.

Since Ahmedabad is an industrial city, people migrate to the city in search of employment from other states including Uttar Pradesh, Bihar, Rajasthan, Karnataka and West Bengal. There is a Hindu majority with a substantial Muslim minority. In 1991, the work force in the city was 831,459 or a little more than 28% of the total population. Of these, 42.44% were engaged in manufacturing and construction, 56.13% were in the tertiary sector, and the rest were in other occupations. Its population has grown by an average of 37.6% every decade since 1901, mainly due to continuous immigration.

The immigrant population usually inhabits slums. At the time of phase-in, the city had 2,432 slum pockets, with a population of over 1.5 million. Slums, as defined by the United Nations Development Programme, are *“Buildings, groups of buildings, or areas characterized by overcrowding, deteriorating, unsanitary conditions or the absence of facilities or amenities, which because of these conditions endanger the health, safety or morals of its inhabitants or the community.”* Local conditions however, should be taken into account while defining ‘Slums’, as this term needs to be defined in the context of the general economic and housing conditions in the area. When large populations are residing in hut-like structures in urban areas, care has to be taken to identify the areas where conditions are relatively poor, and there is a greater need for community-based interventions. The Ahmedabad Municipal Corporation defines *Slums* as any structure that meets the following three criteria¹²:

¹¹ Urban Reproductive and Child Health and Primary Care Project in the city of Ahmedabad, Gujarat, India. August 2003 and as per the 2001 Census

¹² Urban Reproductive and Child Health and Primary Health Care Program in the city of Ahmedabad, Gujarat, India; *Ahmedabad Municipal Corporation report*, August 2003

1. It should be an unauthorized construction on a government, municipal or private plot.
2. It should be devoid of basic civic amenities (i.e. water supply, drainage, water closets, etc.)
3. It should not be in accordance with the building bylaws of the Municipal Corporation (such as the required plinth level and room size, etc.)

In addition to these types of housing, a *Chawl* is another form of structure, which has been identified as a slum by the Municipal Corporation. A *Chawl* is generally defined as an agglomeration of rows of rooms with common or shared sanitary conveniences. *Chawls* were originally constructed for housing textile labor. Over a period of years, conditions in many of these *Chawls* have worsened, due to over-population and a lack of basic services. These *Chawls* do have some basic infrastructure of services, such as water supply and community latrines, but they are generally inadequate. The community latrines are not sufficient to meet the needs of the current population in the *Chawls*, which is more than three times greater than the original population at the time of their construction. To add to the plight, the condition of public facilities has deteriorated to the extent that many public toilets are now unusable. The community and *Chawl* owners rarely provide the necessary funding for maintenance of these facilities, leading to deteriorating conditions and health problems in many *Chawls*. Therefore, for the purpose of health programs, most *Chawls* should also be included in the definition of urban slums. Both the categories of people living in huts and *Chawls* are therefore, identified as urban poor. It is estimated that 1.19 million people have been living in these huts and *Chawls*.

Most of the slums do not have adequate drinking water facilities, health care infrastructure, waste-water and sewage disposal systems. Conspicuous diversity is evident in program area in terms of customs, beliefs, traditions, language/dialect spoken and eating habits.

b. Demographics and socio-economic status

Table 2 presents the demographic profile of Ahmedabad city. As may be seen, the literacy for women aged 15-49 was 59% according to the Census of India 2001. The women literacy was further lower at 32.9%¹³ in Ahmedabad's urban slums, with generally lower rates for women married at a younger age. Unemployment is high in the program area with a per capita income estimated to be \$272, which is much lower than that for the state of Gujarat at \$487¹⁴. Most of the residents are engaged in unskilled labor such as vending, burrow pulling, flower and vegetable selling and auto-rickshaw driving whereas the daily laborers mainly work in factories, in construction and as garage mechanics with low paying incomes. The majority of the

¹³ Sample registration System Bulletin, Registrar General of India, 2001.

¹⁴ Source: Directorate of Economics & Statistics of respective State Governments (As on March 26, 2004), Ministry of Health and Family Welfare, Govt. of India; Rs. 21276 equal to \$487 @ 1USD = Rs. 43.70

women are engaged in home-based activities such as quilt making, garlic peeling, kite making, embroidery work, incense-stick making, and selling vegetables and *Rakhi*¹⁵, or they work as maidservants or as construction workers.

¹⁵ A holy thread tied by the sister on the wrist of her brother on occasion of a Hindu festival which is celebrated on the full moon of the fifth month in lunar religious calendar.

c. Health status: causes of morbidity and mortality

According to the NFHS 1998-99, the under-five mortality rate for India is 94.9 and urban Gujarat is 68.5 of which 28.8% deaths occur within the first year and 19.3% within the first month. It is note worthy that the NFHS/DHS data largely provides data of the entire urban population, whereas the situation in the urban slums is more stark and pronounced and is not reflected in the overall figure. The under-five mortality rate for Gujarat State is 85, compared to 101 nationally from Gujarat Institute of Development and Research. The IMR of Ahmedabad city is 76, while the IMR of the target urban slums is estimated to be 136.8 as per the UNDP¹⁶ formula that establishes that the mortality in the urban slums are 1.8 times higher than average for the cities in India. 28% of all child mortality is caused due to Diarrhea; ARI accounts for 22% of all deaths and 50% of deaths are due to poor sanitation and lack of access to clean drinking water.

According to the Sate Program Implementation Plan, Reproductive and Child Health phase 2, Department of Health and Family Welfare, Government of Gujarat, January 2005; 48% of children less than 5 years in Ahmedabad district had Pneumonia as per the data available from the district level household survey conducted at the end of RCH Phase 1 in 2002-2003, 30% of the children had diarrhea and only 1.3% of these children were given ORS. Additionally, Immunization was completed in case of 75.2% of children.

Inadequate and contaminated water supplies, poor sanitation, and sewage disposal lead to outbreaks of dysentery, and diarrhea. Low levels of literacy and cultural and traditional beliefs/behaviors contribute to poor preventive and care-seeking behaviors. The primary causes of under-five mortality in the urban slums are poor neonatal care, diarrheal disease, and respiratory infections (including pneumonia), followed by measles. Pneumonia is the leading cause of death among children under five, according to the AMC/MoH. A 1996 study conducted by the AMC showed that diarrhea accounted for 20% of child deaths in the urban slums.

¹⁶ Reflection Paper on Diversities and Disparities in Human Development, UNDP, 1998

Table 2: Comparative demographic and Health profile on women and children in India, Gujarat and Ahmedabad¹⁷

Parameter / Indicator	India	Gujarat	Ahmedabad Municipal Corporation (all Municipal Wards)
Area	11,95,600 sq. km	1,96,000 sq. km	190.15 sq. km
<i>Total population</i>	1,027,015,247	50,596,992	3,515,361
Male	531,277,078	26,344,053	1,863,886
Female	495,738,169	24,252,939	1,651,475
Density (per sq. km)	324	258	18,488
Total number of districts	593	25	1
<i>Literacy¹⁸ rate</i>			
Persons	65.38	69.97	83.03
Male	75.85	80.50	89.27
Female	54.16	58.60	76.10
<i>Population 0-6 years</i>			
Total	15.42%	14.19%	11.63%
Male	15.47%	14.51%	12.24%
Female	15.36%	13.85%	10.94%
<i>Sex Ratio</i> (No. of females per 1000 males)	933	921	886
Number of women of reproductive age (15-45 years old)	46.4%	48.8%	48.8%
Crude Birth Rate	26.1	25.5	21.9
Infant Mortality Rate per 1000 live births	73	63	64
Maternal Mortality Rate per 100,000 live births	45	39	14

¹⁷ Census of India 2001, Gujarat, and Statistical Department, Ahmedabad Municipal Corporation.

¹⁸ A literate as defined by The Census of India, "A person who can read and write in any language is literate. A person who can merely read but cannot write is not literate. It is not necessary that the person should have received any formal education or should have passed any minimum educational standard."

d. Health care delivery services

The health facilities of the Ahmedabad Municipal Corporation are classified into three categories based on the level of health care services that they provide. Primary health care services are provided through Urban Health Centers (one per municipal ward) and Maternity Homes, which are currently 10 in the city of Ahmedabad. The secondary-level health facilities are generally better equipped, and include Referral Hospitals and General Hospitals. Currently there are 4 Referral hospitals and 3 General hospitals in Ahmedabad. Specialized hospitals form the tertiary level of health care, and cater to specific health care requirements, such as curative care for TB, malaria, and other infectious diseases, eye hospital etc. Currently there are 3 specialized hospitals in Ahmedabad; one TB Hospital, one Infectious Disease Hospital and one Eye Hospital. The secondary and tertiary level facilities are intended to provide services for the entire population of Ahmedabad.

UHC is the first site of service delivery for primary health care in the urban areas. There are 10 UHCs, 3 maternity homes and 2 general hospitals in the CS-XX program area. They provide reproductive and child health and family welfare services including registration of births and deaths, registration of eligible couples, registration of antenatal mother, organization of antenatal clinics and antenatal care, distribution of IFA tablets to pregnant women, postpartum care of women and neonatal care of children, children immunization, etc. They also provide medical services like active and passive surveillance of fever cases, general out patient department (OPD), special management of diarrhea, ARI/ pneumonia and fever/ malaria cases. UHCs also provide outreach services to the urban slum areas, primarily for vaccination and family welfare services.

The following personnel staff the UHCs:

- A Medical Officer (MO), with overall responsibility for the UHC; conducts general O.P.D. clinic and provide family welfare and RCH services to the population covered under the urban health centre
- A Health Supervisor, who supervises Multipurpose Workers, assists in minor operations, supervises in/outpatient clinics, compiles local health data, supervises and guide the health workers in the delivery of RCH and Health Care Services to the community;
- 4-5 Multipurpose workers, who assists principally in pregnant women and children immunization and delivery of reproductive and child health to the population covered;
- 15-18 Link Workers; Each Link worker covers a population of almost 2000 residing in his/her own as well as the adjoining slum communities. The key function of the link workers is to increase the outreach of the Urban Health Centers and ensure that the entire slum population in that ward is covered and registered for all health services delivered through that health center.

According to grant guidelines, a baseline assessment was conducted in the entire CS-XX program area to establish the yardstick at the time of program commencement and set the targets accordingly for the life of the CS-XX program. As the program reached its half life mark, a mid term evaluation was carried out in May-June, 2007 to assess the progress in terms of performance of the indicators vis-à-vis their baseline values. As a part of the midterm assessments, a Knowledge Practice and Coverage Survey (KPC), a Health Facility Assessment (HFA) and Qualitative Assessments were carried out.

This report summarizes the findings of the midterm KPC Survey conducted in 2007 and compares the same to respective baseline values to draw a relative sketch to demonstrate intervention's impact.

2. *JeevanDaan* Maternal and Child Survival Cost Extension Program (CS-XX) Goals & Objectives

The CS-XX program has two main goals:

- 1) Sustainably reduce maternal, new born and infant mortality and morbidity in the urban slums of the AMC.
- 2) Capacity strengthening of partnering agencies to sustainably carry out selected maternal and child survival activities after the LOP.

These goals have been envisaged to be suitably attained through following objectives:

Objective 1: Strengthened caregiver, family and household knowledge and decision-making skills related to improved maternal and child health and prevent, recognize and manage diarrhea and pneumonia through adoption and practice of positive health behaviors.

Objective 2: Enhanced community capacity to form groups, associations and institutions that sustain health initiatives.

Objective 3: Improved quality and accessibility of services provided by AMC personnel and AMC health facilities/services and established critical linkages among community organizations (CHTs), and public and private health providers.

Objective 4: Strengthened capacities of AMC and Saath to plan, implement, and evaluate maternal and child survival programs in the targeted urban slums

3. Objectives of the KPC Survey: Quantitative assessment for the JeevanDaan Maternal and Child Survival Cost Extension Program (CS-XX)

The three main goals of the KPC survey were:

- (1) To strengthen Counterpart/India's and Saath's capacity to collect, analyze and use KPC information for decision making in the future.
- (2) To gather data on the CS-XX program indicators to establish its current performance status and compare it to the baseline values to assess the progress towards goals. This data will also allow Counterpart and Saath to identify and prioritize gaps in the program area and accordingly revise strategies.
- (3) To help build consensus between Counterpart, Saath, the AMC, and other stakeholders in terms of health programming priorities.

The midterm KPC survey was conducted on the five key program interventions for the CS-XX program:

1. **Maternal and New born Care:** Prenatal visits coverage and practices, Coverage of IFA Tablets and TT vaccination, Place of delivery and Delivery practices, Post partum visits coverage and practices.
2. **Control of Diarrheal Disease:** Prevalence of Diarrhea, Use of Oral Rehydration Therapy during a diarrheal episode, Knowledge of correct method of preparing ORS, Diarrheal prevention through appropriate hand washing practice.
3. **Pneumonia Case Management:** Immediacy of care seeking for child showing signs of pneumonia, Knowledge of two danger signs of childhood illness (IMCI) and knowledge of key pneumonia danger sign
4. **Nutrition/breastfeeding:** Breastfeeding practice, Early initiation within the first hour of delivery, Exclusive breastfeeding up to 5 months of age, Introduction of complementary foods, Prevalence of malnutrition
5. **Immunization:** Children 12-23 months fully immunized, Children 12-23 months received measles vaccine

4. Survey Methodology

1. Questionnaire Development

To develop the KPC questionnaire for midterm evaluation, the questionnaire that was used during baseline study was modified. The latter was

formulated after being subjected to a series of alterations to the generic KPC 2000+ and RapidCATCH questionnaire developed by CSTS.

During the MTE questionnaire development process, the format of the questionnaires was altered to offer clarity and understandability to the person administering it. Certain items were ameliorated to suit the current requirements and were in line with discussions amongst key project officials across the partner agencies. The changes made to the original baseline KPC questionnaire have been annexed to this report (refer annex 4).

Once the draft questionnaire was prepared, it was pre tested to check if it fulfilled the purpose it purported to serve vis-à-vis language, sequencing, coding categories, etc. After incorporating the changes that emerged past pre-testing exercise, the second draft of the questionnaire was shared with the external consultant-cum-team leader and Counterpart HQ Director of Health and Child Survival Programs for their approval.

Finally, the questionnaire thus arrived at was then translated to Gujarati and then back-translated to English to ensure that the items do not lose their original meaning in this process of repeated translations. Utmost precaution was observed while phrasing the questions such that they would be understood by the primary target audience without the meaning of the question being changed. The final questionnaire was administered in Gujarati due to the fact that all of the respondents in the targeted slums spoke Gujarati.

2. Core Team for KPC Survey

The Core Team for the midterm KPC survey of the CS-XX program was constituted by the key program staff that provided technical guidance and backstopping during pre-KPC preparations, questionnaire review and finalization, training of supervisors and data collectors, data collection, data processing and the finalization of the Baseline KPC Survey Report. Members of the core team included Manager (Monitoring & Evaluation) and MIS Officers from both Counterpart India and Saath.

The Core Team was involved in the following pre-KPC preparations:

1. Finalization of the CS-XX program midterm KPC Survey Questionnaire;
2. Translation of the questionnaire from English to Gujarati and back translation to English to ensure that there is no change in the meaning of questions in the process of translation;
3. Pre-testing of the questionnaire;
4. Devising the 30-cluster sampling frame and selecting survey sites;
5. Selection of investigators;

6. Preparing the KPC Survey Training module for the Supervisors as well as the investigators and preparing a detailed training plan;
7. Planning for Transportation and Logistics for the data collection as well as for the field practice before the final data collection;
8. Printing and Photocopying of questionnaire;
9. Developing the computer programs for the database management, and
10. Identifying ways to ensure the quality and accuracy of data collected and keyed into the database.

The core team was also responsible for conducting the KPC training, overseeing the field data collection coordinators and database management coordinators.

3. Partnership building

Developing partnerships and fostering strategic alliances are an integral part of any development approach and are the overarching strategies linking the programs. The participatory, bottom-up approach is at the core of Counterpart's philosophy, thus, stakeholders were involved in the design of the CS-XX program. Partners and stakeholders were involved in a participatory design process, and in the implementation, monitoring, and evaluation of program activities and interventions. This participatory process has been used so as to develop stakeholders' capacity to sustain and replicate these skills to address their self-defined development needs. Counterpart brought to the program its strengths in partnership development with local NGOs, while at the same time enhancing its own capability and its partners' to promote and deliver child survival services that are technically and logistically feasible, high quality, and culturally acceptable.

System of referral chits, innovated by *JeevanDaan* program has been adopted by partner AMC mainly to be able to (1) encourage community members to access public health services and; (2) to monitor the performance of field workers. This was an excellent example of partner's capacity building. It is the first time that AMC experienced such a positive and integrative relationship with a US based PVO.

The partners were also involved in the survey process from the very beginning. During the process of questionnaire development, inputs were solicited from AMC as well as Saath; suggestions from the community members were also incorporated in the questionnaire that emerged during pre-test. After the survey, the findings were shared with stakeholders and dialogues were held soliciting their views to decide upon future strategies. Workers from AMC participated in the KPC survey which helped enhancing the institutional capacity to conduct and utilize the survey findings.

4. Personnel for the KPC Survey

To conduct the survey within stipulated timeframe, it was planned to appoint 10 survey teams with 3 persons on each team - one supervisor and two investigators. The investigators for the survey were externally hired whereas the Community Organizers of Counterpart and Saath were nominated as supervisors. The KPC participant selection process was highly selective, with an emphasis on finding those who had requisite experience. All the external investigators were Post-Graduates, well conversant with the local Gujarati language and had prior experience of administering surveys.

5. Sample Size Determination and Selection of 30-Clusters for the KPC Survey

The sample size for this survey was calculated using the following formula:

$$n = Z^2 (p \times q) / d^2$$

where n = sample size; Z = statistical certainty chosen; p = estimated prevalence / coverage rate; $q = 1 - p$; and d = precision desired.

The value of p was defined by the coverage rate that requires the largest sample size ($p = .5$). The value d was the precision, or margin of error, desired (in this case $d = 0.1$). The statistical certainty was chosen to be 95% ($Z = 1.96$). Given the above values, the following sample size (n) needed was determined to be:

$$\begin{aligned} n &= (1.96 \times 1.96)(0.5 \times 0.5)/(0.1 \times 0.1) \\ n &= (3.84)(.25)/.01 \\ n &= 96 \end{aligned}$$

Since the baseline KPC Survey carried out for the CS-XX program used the 30-cluster sample survey methodology, this survey also followed suit. This method involves organizing the population into “clusters” and several individuals within each cluster are selected to reach the required sample size. In order to compensate for the bias that enters the survey from interviewing persons in clusters, rather than as randomly selected individuals, experience has shown that the sample size used in a 30 cluster survey should be approximately double the number of that required for a simple random sample (calculated using the formula above). Thus a minimum sample of 210 (7 per cluster) should be used given the values of p , d , and z above (Henderson, et. al., 1982). Moreover in the case of cluster sampling for a KPC survey, a sample size of 300 (10 per cluster) is generally used to ensure that sub-samples (e.g., children with diarrhea) are large enough to obtain useful management type information.

The population covered under the CS-XX program is divided into **Slum Clusters**, with the smallest definable unit being the slum pocket. The urban slum pockets are group of houses, which are present within a geographically definable boundary, which are in some cases as small as even 50 houses (approximately 250 people) and in some cases as big as

1000 houses (approximately 5000 people). If the smallest definable unit is taken as one slum pocket, then at times it becomes difficult to find ten households within such slum pocket, which have children less than 2 years for the survey. For this reason, the slum pockets that are located in geographical proximity to each other are clubbed to form a slum cluster. In the slum clusters thus formed there is a sizeable population within these units making it possible to select 10 children less than two years from within one slum cluster. Care is taken to avoid the grouping of such slum pockets within one cluster that have significantly different behaviors and practices, and which belong to different socio-economic strata of the society.

There are 94 such “clusters” in *JeevanDaan* program area with population ranging from 1,300 (Kankaria Cluster 7) to 6,825 (Kankaria cluster 3). These slum clusters are formed from several small slum pockets located within the program area. Thirty clusters were randomly selected from this list. In order to be able to achieve equated sample size from each of the clusters, 10 interviews from each of the cluster were to be conducted. However, to account for no-response or invalid responses, one extra interview per cluster was conducted so that in the event of discarding of some cases at the time of office editing, stipulated sample size doesn’t get affected. Thus, 11 mothers having children aged less than 24 months were interviewed in each of the selected clusters, with the first household for interview being selected randomly. The sample size achieved was 322.

The following selection protocols were used in the survey:

- a. “Household” was taken to represent a dwelling with an independent kitchen.
- b. “Mother” was a woman with her youngest child less than 24 months of age at the time of survey, who had been residing in the area for at least a period of six months at the time of survey. In the event of two mothers in the same household, the investigators were asked to ascertain first if the household had one kitchen used by both mothers. If this was so, they were asked to randomly pick one of the two mothers for interview.

If the mother had more than one child under the age of 24 months, investigators were asked to randomly pick one child as the subject for interview, so as not to bias the survey towards younger children.

6. KPC Survey Training

The training for the KPC Survey was carried out at two levels:

1. Training of supervisors:

The first round of training was carried out for the Supervisors of the KPC Survey. A few of the incumbents had previous experience of carrying out the KPC survey. A participatory training was carried out for all the supervisors which involved the discussion on goals & objectives of program, discussion on questionnaire, survey methodology, identification of clusters, identification of boundaries of primary sampling units, the selection of the first household and discussions on roles and responsibilities of the supervisors and investigators.

2. Training of investigators:

The main KPC survey training for the Supervisors as well as the investigators was carried out for a period of 3 days; including 2 sessions of field based practice in program areas where the midterm KPC survey data collection was not supposed to take place. This training mainly focused upon helping the participants understand the basis of the KPC survey, ability to select the first household in a given cluster, administration of the KPC questionnaire to a mother with a child 0-23 months of age, and good interviewing techniques. The focus of the training was to hone the probing skills of the investigators. Two practice sessions were organized with an objective to familiarize the investigators with the process of administering the questionnaire in an actual set-up. Role-playing was liberally used, and the training was designed to be as participatory as possible, with more and more emphasis on practice sessions.

7. Data collection

Data collection was spread over three days May 31, 2007 to June 2, 2007. A total of 10 data collection teams were constituted comprising of one supervisor and 2 investigators each and 11 interviews were completed by each team of investigators each day in a selected cluster. The duration of the interview varied between 25 and 35 minutes. In order to compensate for anticipated non-response or invalid responses, it was planned to increase sample size by 10% and finally, a sample of 322 could be achieved.

8. Selection of the respondents and precautions taken to avoid selection bias

Interviewers asked an adult in each household the ages of the children that lived in the household. If only one child under two lived in the household, the interviewer proceeded with the consent form and determined the age of the child. If more than one child under two was found, one mother was chosen for the interview at random by assigning a number to each child and drawing lots or flipping a coin. If no children of requisite age group were found in a given household, the interviewer proceeded to the next nearest door to find the next mother to be interviewed.

If no one was found to be home, the interviewer asked a neighbor about the composition of the household to determine if a mother of a child under two

lived in the house. If there was a mother under two, but she was not in, the interviewer asked what time she would most likely be in, and planned a return visit if the mother would be returning before the end of the survey. Interviewers were given prior instruction to finish their cluster of 11 mothers even if several mothers were not at home that would need to be interviewed later.

9. Quality control procedures in data collection

The following were the procedures to ensure quality of data collected:

- Supervisors selected the first household to survey in all clusters using an approved random technique
- Supervisors observed at least 2 interviews for each of the interviewer each day.
- Supervisors checked all filled-in questionnaires for completeness and consistency prior to leaving the cluster
- Survey monitors checked all completed questionnaires prior to data entry.

10. Data Processing

The computer based data entry was carried out through a tailor-made software package developed in CPro 3.1 – a software, which finds widespread application to manage data. The CPro enables the data manager to introduce pre-defined consistency checks so as to restrict data entry to ensure accuracy.

Prior to the data entry, the completed forms were checked for any inconsistency by a team of 3 office editors. This team also provided a unique identification code to each of the forms in order to facilitate computer entry.

Data entry was done by a team of 3 persons. It took them less than 15 hours to key-in 322 questionnaires. During data entry, a 20% random sample of records were checked for correct entry by comparing the actual questionnaires with the entries made on the computer by the Manager (M&E). This was done for every lot of 50 questionnaires entered. The rule used was that any error found in the 20% checked would mean that the entire lot of 50 would have to be re-entered.

After the data entry was completed, the electronic data set was subjected to cleaning. The keyed-in responses were checked for correctness by running logical checks on the data set. This was done using SPSS 12.0.

As the last step in data processing, analysis of selected indicators was done using SPSS 12.0, with frequency distributions being adequate for most of the other indicators and questions for which analysis was done. Confidence intervals were calculated using MS Excel.

5. Key findings of KPC survey

1. Description of sample

- A total of 330 mothers were interviewed with 11 interviews in each of the 30 clusters, however the legible sample finally achieved was 322. All of the mothers interviewed had a child less than 24 months, on the day of the survey. The age of the mothers ranged from 18-45 years, with the average age being 24.7 years (SD = 4.17) and the median being 24 years. The percent distribution of mothers by their age is presented in table 3.

Table 3: Percent distribution of respondents by age group

<u>Age group (Years)</u>	<u>Percent</u>
--------------------------	----------------

Less than 20	6.2 (20)
20 – 24	46.9 (151)
25 – 29	30.7 (99)
30 – 34	13.4 (43)
35 and above	2.8 (9)
n=	322

- Table 4 sheds light on the educational profile of the respondents. As may be seen, 29% of the respondents had passed middle school while 28% were illiterate.

Table 4: Percent distribution of respondents by education status

Education status	Percent
Less than primary	11.8 (38)
Primary	12.1 (39)
Middle school	29.2 (94)
Secondary	13.4 (43)
Senior secondary	3.7 (12)
Graduate	2.2 (7)
Illiterate	27.6 (89)
n=	322

- Majority of households were under annual income group of INR 20,000 to 50,000 (51%) while 21% reported to have annual income of INR 10000 to 20000 and 16.5 % had annual income of less than rupees 10000. A little less than 10% were found to be under income group of INR 50 to 100 thousand while 2% reported to have annual income more than INR 100,000 (table 5).

Table 5: Percent distribution of respondents by annual household income

Income group (INR)	Percent
Less than 10,000	16.5 (53)
10,000 – 20,000	21.4 (69)
20,001 – 50,000	50.6 (163)
50,001 – 100,000	9.6 (31)
More than 100,000	1.9 (6)
Total	322

- Out of the 322 children that formed a part of the survey, 176 (54.7%) were males whereas 146 (45.3%) were females; sex ratio being 829 per 1000 males. The age distribution of children 0-23 months is as per table 6:

Table 6: Percent distribution of children by annual household income

Age group	Percent	
	Male	Female
0 – 5	50.0	50.0

	(42)	(42)
6 – 11	60.2	39.8
	(71)	(47)
12 – 17	50.8	49.2
	(31)	(30)
18 & above	54.2	45.8
	(32)	(27)
n=	176	146

2. Maternal and newborn care

i) Antenatal care

Antenatal care seeking practices have been far-flung throughout the program area. Figure 1 reveals that percent of respondents who sought at least 3 ANC visits by a qualified provider was 79% at the time of baseline which registered a slight increase and found to be 87% (93 out of 107) at the time of midterm review (as confirmed by the maternal health card).

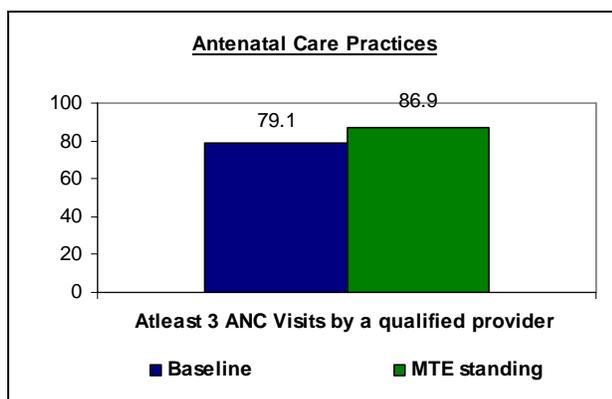


Figure 1: ANC seeking behavior: confirmed by maternal health card

Table 7 sheds light on the ANC seeking behavior of the respondents by verbal report. Nearly 94% respondents reported that they had availed atleast one ANC checkup by a QUALIFIED PROVIDER during their pregnancy with last child while 78% reported to have visited the qualified provider atleast thrice for ANC.

Around 48% respondents reported that they had received atleast one ANC from an AMC service provider while 41% enunciated to have availed ANC checkups atleast thrice from AMC provider. Overall, ANC seeking behavior has improved from baseline and awareness among the community is evident.

Table 7: ANC seeking behavior (verbal report)

ANC seeking behavior (verbal report)	Percent
Atleast 1 ANC visit from a qualified provider	93.8 (302)
Atleast 3 ANC visits from a qualified provider	77.6 (250)
Atleast 1 ANC visit from an AMC provider	48.4 (156)
Atleast 3 ANC visits from an AMC provider	41.0 (132)
n=	322

ii) Place of delivery

One of the major concerns of the state Reproductive and Child Health (RCH) Programme was the low percentage of institutional deliveries. Various schemes were promulgated to promote institutional deliveries including cash assistance schemes such as *Janani Suraksha Yojana*. Under this scheme, all urban women aged 19 years or more and fall Below Poverty Line (BPL) who deliver at the Government health facilities are eligible for monetary assistance of Rs. 600.

The midterm review found that the percent of respondents reporting to have undergone institutional delivery at the time of their last pregnancy has increased from the baseline value 76% to 86% (figure 2a). This is an indication of constant promulgation of awareness regarding importance of safe motherhood and that the process of behavior change has already started off. The findings are commensurate to the findings of National Family Health Survey (NFHS) – III, 2005-06, according to which, 78% institutional deliveries were registered in urban Gujarat. *JeevanDaan* program has been able to contribute its bit to this effect.

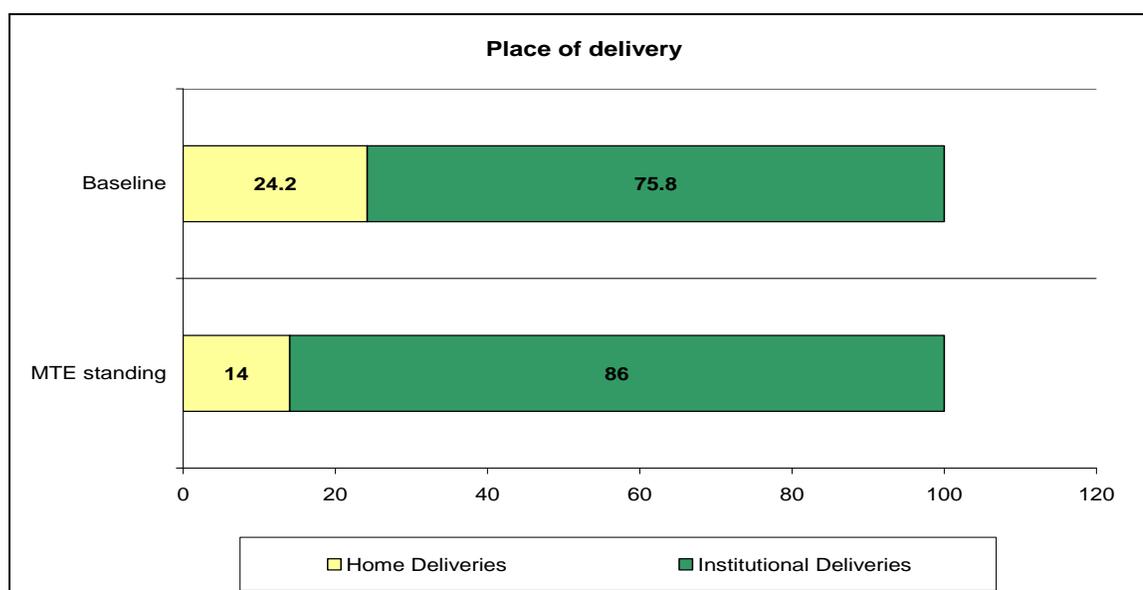


Figure 2a: Place of delivery

Gujarat State has implemented the “*Chiranjeevi Yojana*” to improve access to institutional deliveries with an objective to reduce maternal mortality and at the same time providing financial protection to poor families. The scheme involves private health service providers in provision of maternity services through contracting-out and use of voucher type of mechanism. The private provider is reimbursed the expenses incurred during a delivery by the government on capitation fee basis.

Further analysis of the MTE data reveals that out of the total institutional deliveries reported, nearly 48% were reported to have taken place at AMC facilities while 52% occurred at other facilities (figure 2b). This indicates that people still have slight preference for private facilities over the AMC facilities in general despite various schemes under operation.

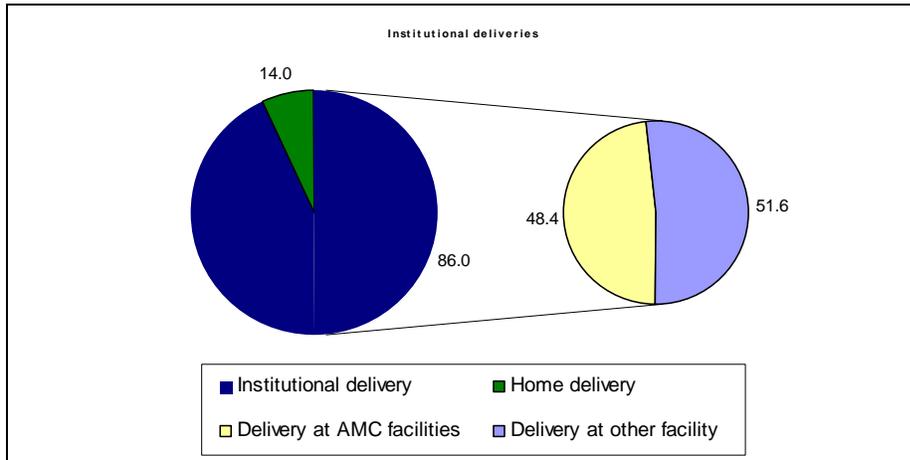


Figure 2b: Breakup of institutional deliveries

iii) Post partum care

Post partum care is yet another important, safe motherhood indicator. Several studies have been conducted worldwide to determine nature and extent of maternal morbidity which have been instrumental in raising awareness regarding the magnitude of postpartum morbidity. Postpartum haemorrhage is the single most important cause of maternal death. It kills 150,000 women each year and nearly nine out of ten of these deaths take place within four hours of delivery¹⁹. Puerperal sepsis & eclampsia are yet other major causes of maternal mortality in many developing countries. However, the same is often neglected when it comes to practical terms.

Raising awareness regarding importance of seeking postpartum care is at the core of *JeevanDaan* program. Around 78.6% (253 out of 322) respondents reported to have received first postpartum checkup immediately after the delivery. Figure 3a sheds light on postpartum care seeking behavior of the respondents. The tendency to seek postpartum care shows an inclining trend with percent of respondents seeking at least one postpartum checkup from a qualified provider rising to 96% from 65% at the time of baseline. According to baseline standing, nearly 55% of the respondents had reported that the checkup included the examination of newborn which was found to be 77% during midterm study.

¹⁹ Source: WHO

Similarly, percent of respondents reported to have received at least one postpartum checkup from an AMC provider has also increased from 41% to 55% and the percent reporting to have received the checkup that included examination of newborn has also risen from 33% to 43% (figure 3a).

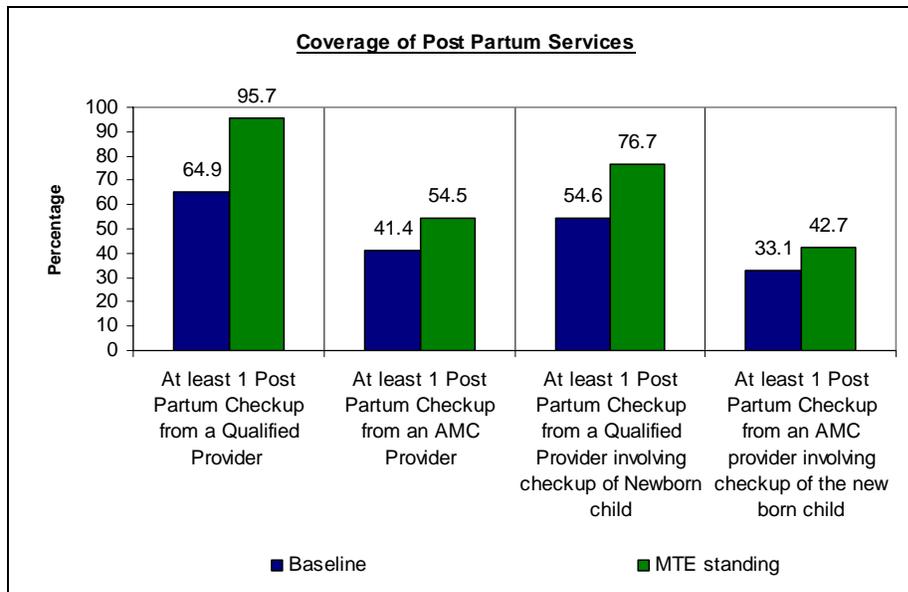


Figure 3a: Postpartum care seeking behavior

First week after delivery is critical for the mother. Eclampsia typically presents in first days postpartum. A study reports that more than 50% of their postpartum cases initially presented 3 or more days postpartum (Lubarsky et. al., 1994). Eclampsia is the third most important cause of maternal mortality worldwide. As per the accepted international standards, 3 postpartum checkups are prescribed – first being within six hours of delivery; second within six days and; third after six weeks after delivery.

The midterm review of *JeevanDaan* revealed that percent of respondents reported to have sought second postpartum checkup was 31.1% (100 out of 322). Practices regarding seeking second postpartum checkup have been presented in figure 3b. As may be seen, percent of respondents reporting to have received second postpartum checkup from qualified provider has shown exorbitant rise from its baseline value 32% to 98%. The postpartum checkup including examination of newborn by a qualified provider was reported by 19.5% respondents during baseline which has risen to 50%.

Similarly, indicators related to postpartum checkup received from AMC provider have also registered an increase (figure 3b). The figures presented here however should be interpreted with caution. The wide confidence intervals arising due to small denominator size are liable to be wrongly interpreted.

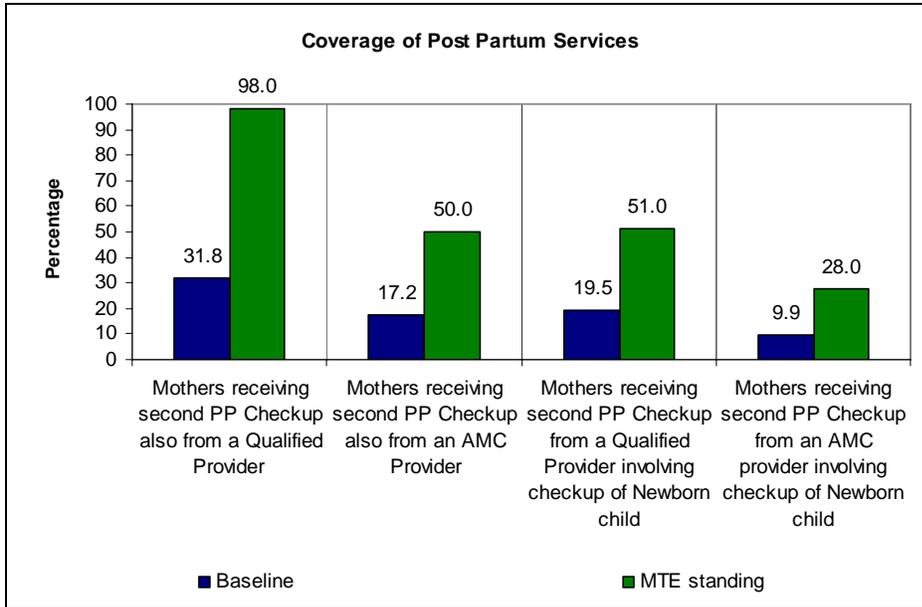


Figure 3b: Second postpartum checkup

iv) Other crucial maternal health indicators

Figure 4 sheds light on other crucial indicators related to maternal health. There was overall performance rise across all indicators. As may be seen, the percent of respondents found to be in possession of maternal health cards at the time of survey was 31.5% at the time of baseline while it displayed a slight hike (33.2%) during midterm review.

At the time of baseline 89% respondents had reported to have received two tetanus toxoid vaccines during the term of pregnancy while 91% had reportedly received the same at the time of midterm review. Similarly, the coverage of IFA tablets also rose from 46% to 62% (figure 4).

The efforts of the *JeevanDaan* program appear to translate into practice through the indicator pertaining to placement of child adjacent to mother immediately after birth. It registered an exuberant increase from 21.5% at the time of baseline to 81.4% in the midterm study (figure 4).

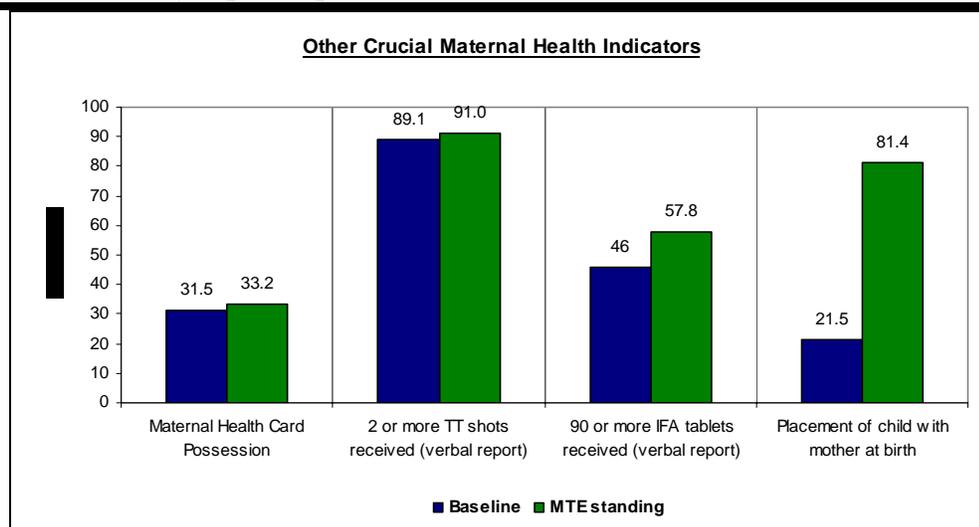


Figure 4: Other crucial maternal health indicators

Despite the fact that maternal and newborn care was a new addendum to the port folio of the previous phase of the program, it appears to be doing well with regard to translation of knowledge to practice.

3. Control of diarrhoeal diseases

The under-five mortality rate for Gujarat State is 85 per 1,000 and the IMR of Ahmedabad city is 76 per 1,000. Nearly 28% of all child mortality is attributed to diarrhoeal diseases. *JeevanDaan* envisages improving the status of child morbidity due to diarrhoeal diseases.

Figure 5 sheds light on selected indicators for control of diarrhoea. The values have been calculated using the total sample size (i.e. 302 for baseline and 322 for midterm study) as denominator. It is revealed that the prevalence of diarrhoea has risen from 35.8 % at baseline to 39.8 % at midterm. This could be partly explained by the fact that the baseline study was conducted in the month of February while the midterm was conducted in the month June which is considered to be the peak season for diarrhoea.

Use of Oral Rehydration Therapy (ORT) has risen from its baseline value 12% to 25% at the time of midterm. The midterm study found that exactly 50% of the total respondents (161 out of 322) had heard of Oral Rehydration Solution (ORS). Of these, 31.1% (denominator being 322) were able to demonstrate the correct procedure of preparation of ORS. This indicator has registered a rise from its baseline value 16% (figure 5).

Figure 5 also reveals that the hand washing practices have also improved. Whereas 5% respondents had correctly mentioned all hand washing practices at the time of baseline, 9% reported the same at midterm.

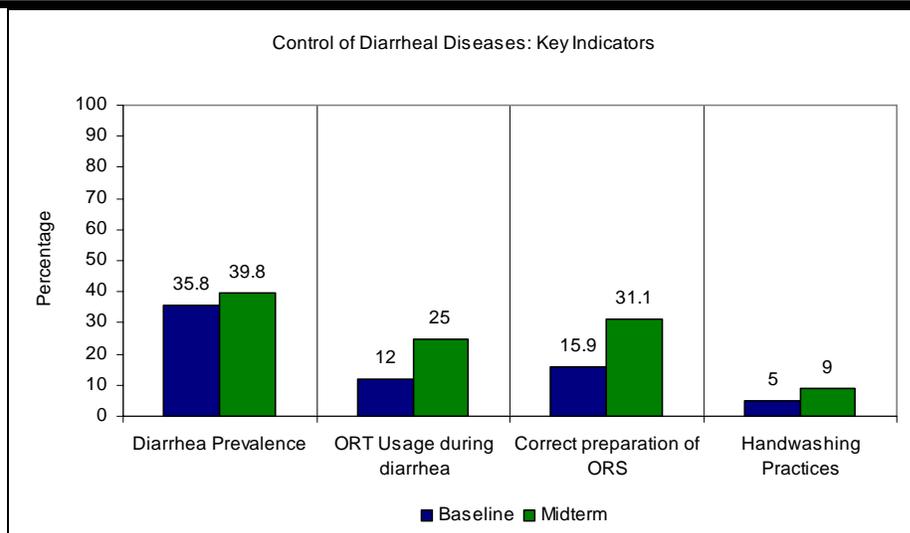


Figure 5: Control of diarrhoeal diseases

The program impact is evident in technical intervention for control of diarrhoeal diseases. Table 7 presents the indicators pertaining to preventive behavior against diarrhoea. As may be seen, nearly 91% of the households covered during the midterm study had special place for hand washing. As regards with the hand washing behavior, 84% respondents reported that they wash their hands after defecation; nearly 62% reported to wash hands before eating; 60% before preparing food; 52% after attending to a child who has defecated and; remarkably low percentage of respondents reported to be washing hands before feeding the child.

Table 7: Preventive behaviors against diarrhoea

Indicator	Percent
Special place for hand washing	91.3 (294)
Hand washing after defecation	84.2 (271)
Hand washing before eating	61.8 (199)
Hand washing before preparing food	60.2 (194)
Hand washing after attending to a child who has defecated	52.2 (168)
Hand washing before feeding child	34.5 (111)
n=	322

Indicators related to treatment of drinking water have been presented in table 8. It is revealed that 96% respondents reported to be treating the drinking water using one or the other method once it is in the household. Nearly 87% reported filtering and; 4% each reported boiling & treatment with chlorine.

Table 7: Treatment of drinking water

Indicator	Percent
Any method to treat drinking water	96.0 (309)
Filtering	87.3 (281)
Chlorine treatment	4.3 (14)
Boiling	4.0 (13)
Treatment with alum	0.3 (1)
n=	322

4. Pneumonia case management

Pneumonia causes around two million deaths among children annually world over (20% of all child deaths)²⁰. Pneumonia case management (PCM) has been one of the thematic areas that *JeevanDaan* has been working on since the inception of previous phase. The present study attempted to shed light on performance of selected indicators pertaining to PCM.

Figure 6 presents an overview of performance of PCM indicators. Percent of mothers with children less than 24 months of age that would be able to identify at least 2 IMCI danger signs that indicate immediate medical attention has risen from baseline value of 74% to 87% at the time of midterm.

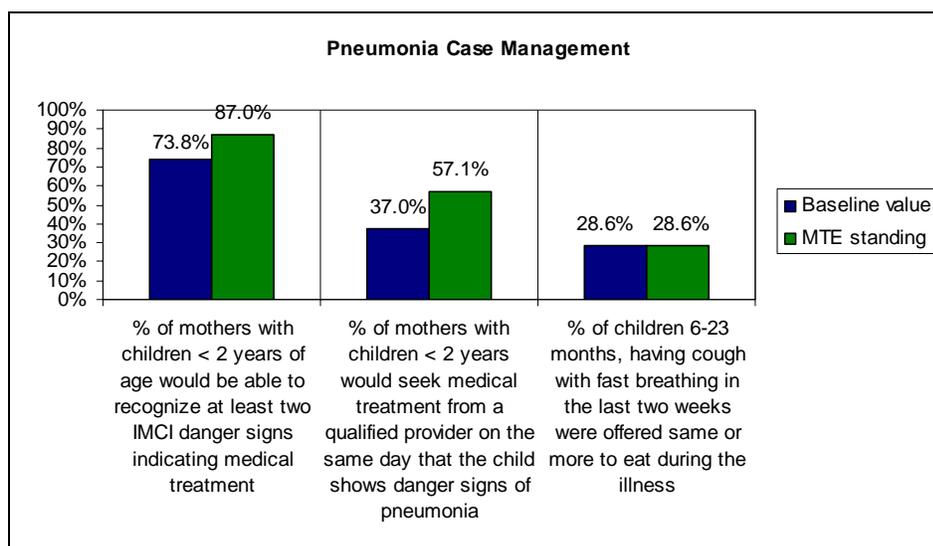


Figure 6: Pneumonia case management

²⁰ Sazawal, S. and Black, R.E.; Effect of pneumonia case management on mortality in neonates, infants, and preschool children: A meta-analysis of community-based trials; *The Lancet Infectious Diseases* 2003 (3):547-556

The percent of respondents reporting that they would seek medical treatment from a qualified medical service provider on the same day that the child presents danger signs of pneumonia was 57% as against its baseline counterpart 37% (figure 6).

Another important indicator i.e., percent of children aged 6-23 months, having cough with fast breathing in last 2 weeks that were offered same or more to eat during illness, failed to show an upwardly movement. In fact, the indicator didn't move at all from its baseline value and remained at 28.6%. This indicates a need to further strengthen the program strategies in this regard.

Table 9 presents other important indicators related to PCM. Nearly 17% respondents could cite *fast or difficult breathing* as a danger sign of pneumonia. Occurrence of pneumonia over 2 weeks preceding the survey was found to be 12.4% of which 50% respondents reported to have sought the quick treatment the very same day as the danger signs were detected.

Table 9: Pneumonia case management

Indicator	Percent
Percent of mothers who can cite <i>Fast or difficult breathing</i> as a danger sign	16.8 (54)
Incidence of Pneumonia during the last two weeks	12.4 (40)
n=	322
Sought quick treatment on same day	50.0 (20)
n=	40

5. Nutrition/breastfeeding and growth monitoring

Nearly 4 million infants do not survive their first month of life; half a million women die in pregnancy each year leaving countless infants and children motherless; one child in six is severely hungry; one in seven receives no health care²¹. WHO estimates that malnutrition was associated with over half of all child deaths that occurred in developing countries in 1995. These are some perturbing findings that cast shadow on Millennium Development Goal that vows to reduce the mortality rate among children under five by two thirds.

²¹ Source: UNICEF

It is a well established fact that children who are breastfed have fewer illnesses and are better nourished than those who are fed other drinks and foods. If all babies were fed only breastmilk for the first six months of life, the lives of an estimated 1.5 million infants would be saved every year²².

The present study attempted to measure performance of the *JeevanDaan* program on indicators related to nutrition/breastfeeding. Figure 7 attempts to summarize the findings on breastfeeding/nutrition practices among the community. It is observed that the percent of the respondents that reported to have breastfed their last baby within one hour after delivery was 41.5% as against 24.7% at the time of baseline. Similarly, percent of newborns fed with colostrum at birth was found to be 72.6%, whopping increase from 55% at baseline. The percent of infants 6-9 months of age reportedly administered supplementary weaning in addition to breast milk, however, showed a downward movement from 78.4% at baseline to 74.4% at midterm (figure 7).

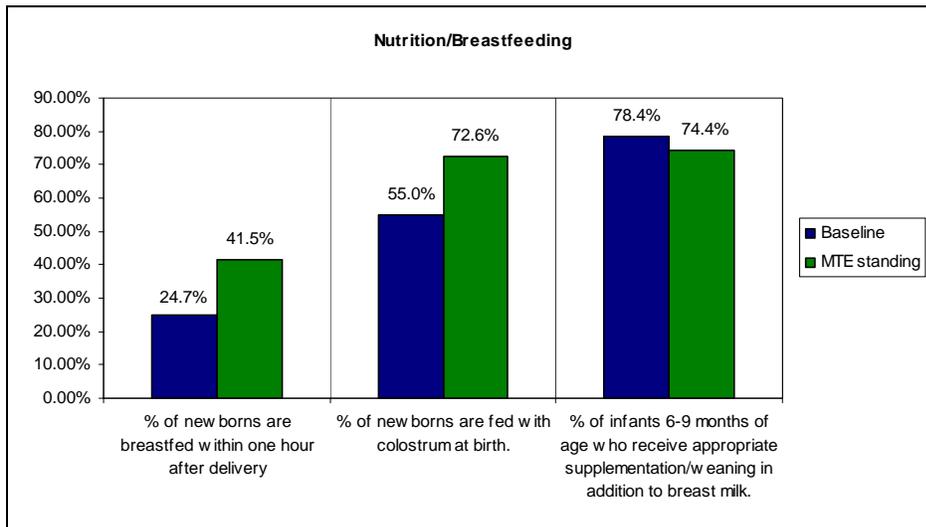


Figure 7: Breastfeeding/nutrition

Figure 8 draws comparison between baseline and midterm standings for children aged 0 – 5 months who were exclusively breastfed over past 24 hours preceding the survey. Program performance is manifested by this graph. While 15% were reportedly exclusively breastfed at the time of baseline, 27% were reported to be exclusively breastfed at the time of midterm study.

²² Source: UNICEF

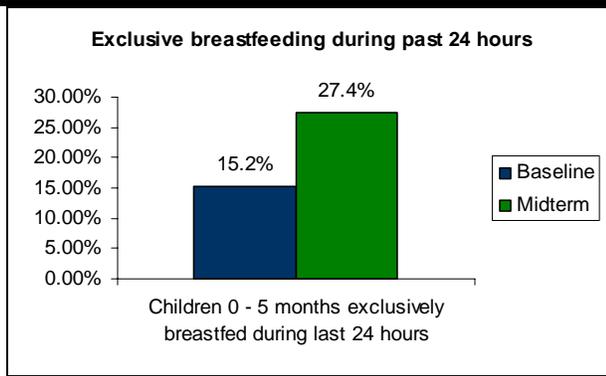


Figure 8: Exclusive breastfeeding

Figure 9 presents other important indicators pertaining to nutrition status of children in program area. It may be seen that % increase in the coverage of children less than 2 years under ICDS program has been able to register improvement from 6.6% baseline value to nearly 14% at the time of midterm. The % of children aged 9-23 months that had received vitamin 'A' doses as per Gol guidelines has risen from 24.3% to 43.5%. However, the % of children dewormed during past six months preceding the survey moved down slightly from 11% to 10%.

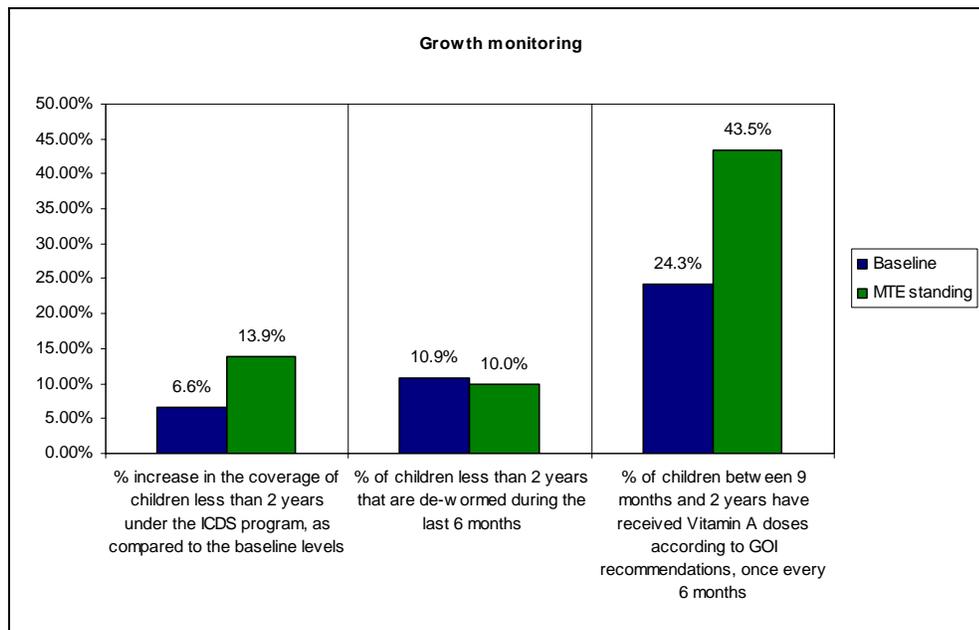


Figure 9: Growth monitoring

6. Immunization

Immunization is proven and cost effective public health intervention to mitigate proliferation of smallpox, measles and polio, and substantially reduce the morbidity and mortality attributed to diphtheria, tetanus and pertussis. WHO estimates that 2 million child deaths were prevented through vaccination in 2003. As per another estimation by WHO, four to five million annual deaths could be prevented by 2015 through sustained and appropriate immunization efforts, backed by financial support.

JeevanDaan program strives to improve the immunization coverage in its area of operation. The present study attempted to bring to the fore the immunization seeking practices of the community. Figure 10 reveals the status of immunization in the program area. It may be seen that the percent of children aged 12-23 months who were fully immunized in the first year of their life has increased from its baseline value of 48% to 66% at the time of midterm study (as confirmed by card).

Percent of children aged 12-23 months who received measles vaccination in the first year of their life was also found to be much higher (81%) than its baseline counterpart (51%). The performance of the program is much evident through immunizations status.

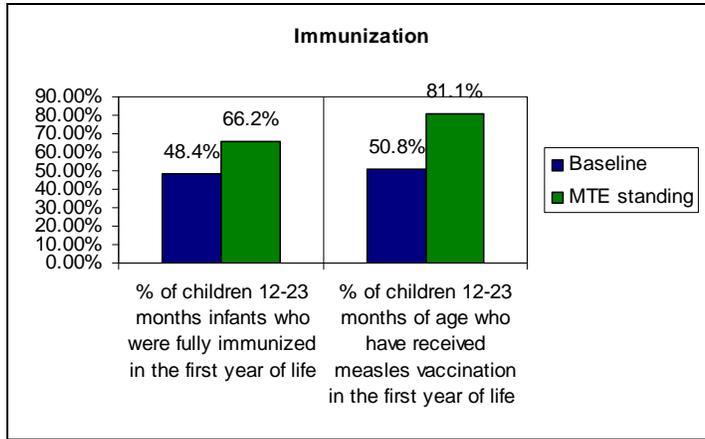


Figure 10: Immunization status

Figure 11 illustrates the status of coverage of individual vaccines. As may be seen, coverage of BCG was found to be 98.5%; that of OPV-1 was 94.6%; OPV-2 was 86.1%; OPV-3 was 72.8%; DPT-1 was 94.6%; DPT-2 was 86.1%; DPT-3 was 72.3%; measles was 76.8% and; vitamin A was found to be 57.9%.

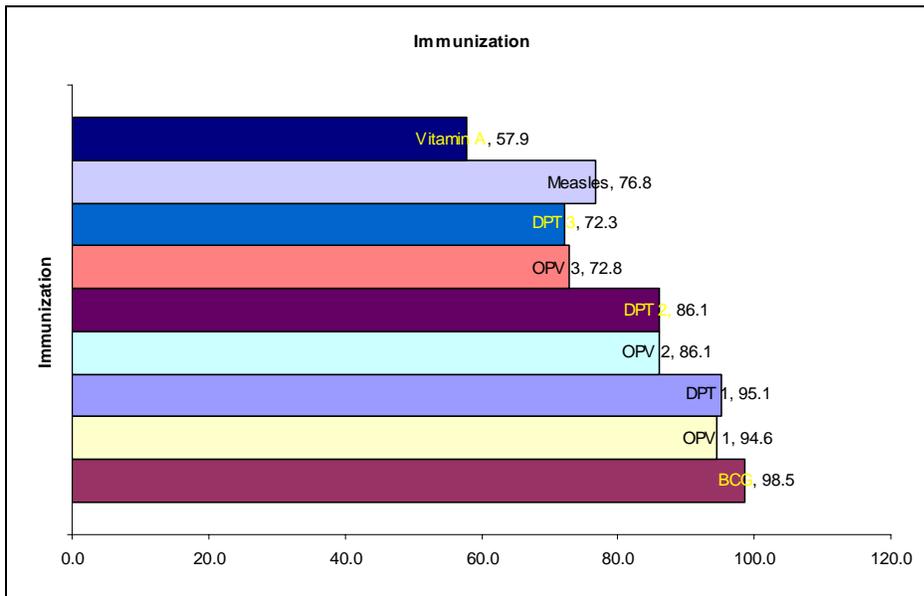


Figure 11: Vaccines coverage

7. Other RapidCATCH questions

MALARIA

- The *JeevanDaan* midterm study found that 39.8% households reportedly used bed nets.
- Nearly 48% respondents revealed that the child under investigation during the survey slept under the under the bed net previous night.

HIV/AIDS

- Nearly 49.4% respondents had heard of HIV/AIDS.
- Table 10 sheds light on knowledge of the respondents regarding methods to avoid HIV infection.

Table 10: Methods to avoid HIV infection as reported by respondents

Indicator	Percent
Abstain from sex	17.0 (27)
Use condoms	18.2 (29)
stay faithful to one partner	18.9 (30)
Avoid sex with persons who have many partners	5.0 (8)
Avoid intercourse with persons of the same sex	13.8 (22)
Avoid sex with persons who inject drugs intravenously	2.5 (4)
Avoid blood transfusions	15.1 (24)
Avoid injections	13.8 (22)
n=	322

6. Dissemination of KPC Findings

After the analysis of key indicators, the KPC survey findings were shared with the key stakeholders of the CS-XX program and the development initiative fraternity operating in Ahmedabad city on July 2, 2007 at a local banquet hall.

The dissemination workshop was attended by the external consultant & team leader, Counterpart India program staff, Saath program staff, key stakeholders from the Ahmedabad Municipal Corporation including the Medical Officer Health, Deputy Health Officers and Family Welfare Officer. The Technical Advisory Committee members were also present and the session was chaired by Mr. Amit Shah, Mayor, Ahmedabad city.

Among the others present were representatives from various agencies such as ICDS, IRC and UNICEF. The members from community Health Teams

and representatives from amongst private practitioners also participated in the workshop.

The dissemination workshop was followed by a debriefing before USAID Mission – India at New Delhi, India on July 3, 2007. The external consultant and Manager (M&E) took lead in presenting the findings to USAID officials.

7. Annexes

1. Training process documentation
2. Midterm KPC questionnaire (English)
3. Midterm KPC questionnaire (Gujarati)
4. Changes made to baseline KPC questionnaire
5. List of selected KPC indicators
6. Midterm KPC survey sampling frame
7. Map of the program area

c. Evaluation Team Members and Titles

	Name	Title
1	Ms. Jean M. Capps	Team Leader
2	Dr. K. Raj	Prog. Dir. Jeevan Daan
3	Dr. SP Kulkarni	TAC member, Medical Officer Health, AMC
4	Dr (Mrs.) K. Mehta	Family Welfare Officer, AMC
5	Mr. Rajendra Joshi	TAC member, Director, Saath
6	Dr. Rajiv Tandon	Advisor Child Survival, USAID Mission India
7	Dr. Kshitij Sharma	Manager (M&E), CPI
8	Ms. Negina Sawez	Counterpart International HQ technical backstop person, USA
9	Mr Sanjay Joshi	Prog coordinator, CPI
10	Ms. Payal Rajput	Prog coordinator, Saath
11	Ms. Nirali Pancholi	Training Officer, Saath
12	Ms. Bijal Bangdiwala	MIS Officer, Saath
13	Ms. Dhriti Bhattacharjee	Training Officer, CPI
14	Ms. Seema Joshi	Program Officer, field
15	Ms. Megha Shah	MIS Officer, CPI
16	Mr. Narendra Vyas	Finance Officer, CPI
17	Prof. Dilip Mavalankar	TAC member, IIM Ahmedabad
18	Prof. Arvind Sinha	TAC member, MICA
19	Prof. S. Iyengar	TAC member, VC (Gujarat Vidyapeeth)
20	Dr. Ashok Bhargava	TAC member, IDEAL
21	CHT members	MTE participants (29)
	Aanganwadi workers	
	Private practitioners	
	Multi Purpose workers	
	Link Workers	
	Community Organizers	

d. Evaluation Assessment Methodology

Literature Review

- Midterm Evaluation Guidelines
- Detailed Implementation Plan
- Baseline KPC and HFA reports
- DIP Review Comments
- CS XVI Midterm and Final Evaluation Reports
- First and Second Annual Reports
- Intervention TRMs
- Intervention Technical Updates

Surveys and Assessments

- Knowledge, Practice and Coverage (KPC) survey
- Health Facilities Assessment
- Project Timeline
- Key informant interviews
- Focus group discussions: mothers, TBAs, health workers, local leaders, COs, CHTs, Link Workers,
- Group synthesis sessions

Key Informant Interviews

- Counterpart Senior Management
- USAID/India Health Manager
- AMC Health Officers
- AMC Health Director

Management Reviews

- Meetings with Counterpart India Managers
- Budget Pipeline Reports (HQ)
- Staff interviews
- Feedback sessions between evaluation consultant and management staff
- Local and national level stakeholder meetings

Stakeholder Meetings

- Local Dissemination Presentation in Ahmedabad
 - National level dissemination meeting with USAID/India in Delhi
 - Key Informant Interviews with Partner Managers
- Expectations shared with TAC and USAID CS Representative

f. HFA Report

Background Information

This report summarizes the findings of the Midterm Health Facility Assessment (HFA) conducted for the Counterpart International/India *Jeevan Daan* Maternal & Child Survival Cost Extension Program.. The Program is funded by USAID for a period of five years (October 2004- September 2009), and focuses on five thematic areas namely maternal and newborn care, pneumonia case management, diarrhoea case management, nutrition/breastfeeding and immunization. The *Jeevan Daan* program is being implemented in the slums of ten municipal wards in Ahmedabad city. Counterpart is working with the local non-governmental organization Saath as an implementing partner, and also collaborating with the Ahmedabad Municipal Corporation. As part of the midterm study, the Midterm HFA survey was jointly conducted by these three organizations.

Objectives of the Midterm HFA

The objectives of the Midterm HFA included:

- Assessing the current knowledge and practices of health workers at AMC outpatient clinics regarding the assessment and management of sick children
- Assessing the availability of pharmaceuticals, vaccines and equipment in AMC facilities

The Midterm HFA survey results were used to inform the program about the progress made in the following areas, including:

- Improvements in the quality of care at AMC outpatient health facilities, including staffing, clinic organization, and case-management practices.
- Improvement in the availability of equipments as per the requirements, continuity and regularity in drug and material supplies etc.

Methodology

The Health Facility Assessment was conducted in 10 Corporation facilities located in the program area.

The AMC facilities selected for the Midterm HFA were classified in the following three categories:

1. Urban Health Centers
2. Maternity Homes
3. General hospitals

Table 1: Municipal Health Facilities covered during Midterm HFA

Sr. No.	Facility Name	Facility Type		
		Urban Health Center	General Hospital	Maternity Home
1.	Urban Health Center, Jamalpur	✓		
2.	Urban Health Center, Raipur-Khadia	✓		
3.	Urban Health Center, Kankaria	✓		
4.	Urban Health Center, Raikhad	✓		
5.	Urban Health Center, Bapunagar	✓		
6.	Urban Health Center, Vasna	✓		
7.	Urban Health Center & maternity home Danilimda			✓
8.	Urban Health Center & maternity home, Dudheshwar			✓
9.	L.G. Hospital, Maninagar		✓	
10.	Shardaben hospital Saraspur		✓	

The Midterm HFA was conducted during June 4 – 8, 2007. For the assessment of the 10 facilities, a total of 5 survey teams were constituted. Each survey team comprised of two investigators, one supervisor and one team leader, the latter being the in-house team members of *Jeevan Daan* program.

Orientation for data collection

A two-day orientation for investigation teams was conducted before commencement of the actual field work for HFA. The training included sessions

on the purpose and methodology of the HFA, interview and observation techniques, correct recording of data, reviewing the questionnaires. Two data collection tools were used for the HFA, including the Observation Checklist for health worker observation and the Equipments and Supplies Checklist. In house expertise was used to impart training; The Program Director, who is a qualified medical doctor, took intense sessions for the data collection teams to orient them towards the medical procedures and protocols to help them to be able to conduct the assessments without a hitch. A detailed note on the process of HFA training has been annexed to the report on midterm KPC survey as part of process documentation on trainings given during midterm review (annex-1; Midterm KPC survey report, 2007).

Procedure

The checklists used in the Midterm HFA were the same as those used during the baseline HFA and were adapted from the BASICS Integrated HFA Manual, translated from English into the local language (i.e. *Gujarati*). All interview forms were checked manually for errors before data entry. Data set was compiled and analyzed using MS Excel. The field teams were given clear instructions not to fill in the assessment items in the observation checklists because they needed to be assessed for correctness by a qualified professional. This was done by the Program Director after bringing the filled up checklists back in office.

Summary of HFA Results

10 Municipal Health facilities were assessed for Equipment and Supplies. A summary of findings has been given in following sections. Following sections compare the midterm standings of the 10 health centers to baseline standings with regard to general facilities available.

Table 2: General Facilities available

Facilities	Baseline standing	Midterm standing
Adequate seating for patients.	9	8
Covered waiting area.	8	10
Potable water.	6	5
Functional toilet or latrine.	9	7
Functional waste disposal area/pit.	9	9
Health information posters are displayed.	8	10
Posters written in the local language.	8	10
ORT corner present and being used.	1	0

Table 3: Equipment and Supplies

Equipment & supplies	Baseline standing	Midterm standing
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Adult weight scale	9	10
Baby weight scale	3	4
Salter	1	2
Thermometer	8	8
Stethoscope	9	9
Regular	9	4
Obstetrical	6	3
Otoscope.	3	10
Tongue depressor	7	5
Watch with a second hand or other Timing device	6	8
Steam sterilizer	7	7
Cooker or stove	8	5
Measuring and mixing utensils	6	5
Cups and spoons	3	10
Refrigerator	9	9
Working thermometer inside	6	8
Temperature chart.	7	7
In the last 30 days, temperature record up to date.	7	7
Ice packs.	9	10
Vaccination Carrier in good condition	10	10

Table 4: Antibiotics and other Supplies

Drugs	Baseline standing	Midterm standing
Penicillin /Ampicillin/ Amoxicillin/ Ciprofloxacin tablets/syrup	8	8
Cotrimoxazole/Metrogyl tablets/syrup	5	7
Nalidixic acid	1	2
Chloroquine tablets/syrup.	10	9
Fansida	1	3
Injectable quinine	2	3
Injectable chloramphenicol	1	1
Paracetamol	10	10
Tetracycline/ Chloramphenicol eye ointment	3	5
Gentian violet (Blue medicine)	6	8
Iron tablets/ syrup	10	9
Vitamin A	10	9
Mebendazole	10	9
Sterile water for injection	8	6
ORS	9	10
IV solution for severe dehydration	3	4
Needles	10	10
Syringes	10	10

Expired drugs in the health facility.	2	0
BCG	10	10
OPV	10	10
DPT	10	10
Measles	10	10
Tetanus toxoid	10	10

With one or two exceptions here & there, all of the facilities were found to be maintaining all records and registers up to the mark. Stocks were also found to be adequate and storage of inventory keeping was also satisfactory. A summary of midterm HFA results has been annexed to this report (annex 1).

Health Worker Practices

The screening and clinical examination process at the health facility by the medical officer in charge was observed to assess the IMCI skills. Table 4 sheds light on findings of the observation exercise. As may be seen, the health care providers are seldom able to meet the IMCI mandates. Although, in approximately 90% cases observed by the assessment team, the provider prescribed the medication which was appropriate to the condition. This percent was found to be 75% in the cases of diarrhoea management.

Table 5: Observation of Health care service provider		
Assessment tasks performed	Frequency	%
All danger signs assessed	2	4.08
All main symptoms assessed	5	10.2
n=49		
No of diarrhea assessment		
For how long	4	20.0
Is there blood in the stool	7	35.0
Is he/she able to drink or breastfeed	1	5.0
Pinch the skin on abdomen	9	45.0
Look for sunken eyes	1	5.0
n=20		
No of ARI assessment		
For how long	5	55.6
Raise the shirt	8	88.9
Count breaths per minute	8	88.9
Look out for chest indrawing	1	11.1
n=9		
No of fever assessment		
For how long	16	50.0
Look or feel for stiff neck	5	15.6
Look for generalized rashes	2	6.25
Look for runny nose or red eyes	1	3.13
n=32		
Severe Malnutrition status correctly assessed	5	10.2
n=49		
Medication appropriate For the diagnosis	44	89.8
n=49		
Diarrhea cases appropriate Medication	15	75.0
n=20		
Pneumonia cases appropriate Medication	1	11.1
n=9		
Malaria cases appropriate Medication	3	9.38
n=32		
No. of treatment tasks performed		
Explain how to administer medications	13	32.5
Demonstrate how to administer medications	23	57.5
Q-K-3	4	10.0
n=40		
Atleast 3 messages given to parient for home-based treatment	10	20.4
n=49		

Table 6 reveals the knowledge of the care taker with regard to home based illness management skills and correct knowledge of administering the medications. As may be seen, a vast majority of the respondents (86%) were able to tell correct procedure of administering medication. This in turn implies that the health care providers explain the methods very well so that they are retained well by the caretakers. Similarly, % of caretakers who could tell atleast 2 aspects of home based management of the case was 69%, while 67% were

aware of atleast 2 danger signs which would be an implication of deteriorating condition of the child (table 5).

Table 6: Exit interview of the caretaker		
care taker knows how to give all essential medications correctly	42	85.7
care taker knows at least 2 aspects of home case mgmt	34	69.4
care taker knows at least 2 signs of child getting worse at home	33	67.3
child is up-to-date	5	10.2
		n=49

g. Project Data Sheet Form

Child Survival and Health Grants Program Project Summary

Oct-31-2007

Counterpart International
(India)

General Project Information:

Cooperative Agreement Number: FAO-A-00-00-00028
Project Grant Cycle: 20
Project Dates: (9/30/2004 - 9/29/2009)
Project Type: CostXT

Counterpart Headquarters Technical

Backstop:
Field Program Manager: David Kurth
Midterm Evaluator: Kamal Raj
Final Evaluator: Jean Capps
USAID Mission Contact: Rajiv Tandon

Field Program Manager Information:

Name: Premanjali Society
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E-mail:
Sanjay
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9

Funding Information:

USAID Funding:(US \$): \$1,499,923

PVO match: (US \$) \$1,314,595

Project Information:

Description:

The Jeevan Daan Maternal and Child Survival Cost Extension Program's goal is to build on the previous project to sustainably reduce maternal, new born and infant mortality and morbidity in the urban slums of the AMC.

Also to strengthen the capacity of partnering agencies to sustainably carry out selected maternal and child survival activities.

The major program interventions are: diarrhea, pneumonia, immunization, nutrition and maternal care. The project will build upon the strong foundation laid through the original child survival, utilizing the experience gained to refine and further strengthen the program. Program strategies will include community mobilization through the formation of Community Health Teams and behavior change communication, through the BEHAVE Framework.

Location:

Ahmedabad, Gujarat State

Project Partners	Partner Type	Subgrant Amount
Saath	Collaborating Partner:	
Ahmedabad Municipal Corporation/Ministry of Health	Collaborating Partner:	

General Strategies Planned:

- Private Sector Involvement
- Advocacy on Health Policy
- Strengthen Decentralized Health System
- Information System Technologies

M&E Assessment Strategies:

- KPC Survey
- Health Facility Assessment
- Organizational Capacity Assessment with Local Partners
- Organizational Capacity Assessment for your own PVO
- Participatory Rapid Appraisal
- Participatory Learning in Action
- Appreciative Inquiry-based Strategy
- Community-based Monitoring Techniques
- Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

- Interpersonal Communication
- Peer Communication
- Support Groups

Groups targeted for Capacity Building:

pva	Non-Govt Partners	Other Private Sector	Govt	Community
USHQ (General) US HQ (CS unit) Field Office HQ	PVOs/NGOs (Int'l./US) Local NGO	Traditional Healer	National MOH Dist. Health System Health Facility Staff Other National Ministry	Health CBOs Other CBOs CHWs

Interventions/Program Components:

Immunizations (10 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Polio
- Classic 6 Vaccines
- Vitamin A
- Cold Chain Strengthening
- Injection Safety

Nutrition (20 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Compo Feed. from 6 mos.
- Weaning
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition

Pneumonia Case Management (25 %)

Control of Diarrheal Diseases (25 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Water/Sanitation
- Hand Washing
- ORSi/ Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mgmt./Counseling

Maternal & Newborn Care (20 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Emerg. Obstet. Care
- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Birth Plans
- Emergency Transport

Target Beneficiaries:

Infants < 12 months:	21,763
Children 12-23 months:	21,763
Children 0-23 months:	43,526
Children 24-59 months:	65,289
Children 0-59 Months	108,815
Women 15-49 years:	91,519
Population of Target Area:	308,445

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHOINCHS reference population)	0	0	0.0%	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0%	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	0	0	0.0%	0.0
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0%	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	0	0	0.0%	0.0
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	0	0	0.0%	0.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	0	0	0.0%	0.0
Percentage of children age 12-23 months who received a measles vaccine	0	0	0.0%	0.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0%	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	0	0	0.0%	0.0
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	0	0	0.0%	0.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of	0	0	0.0%	0.0

reducing the ri- ofHIV infection				
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Percentage of mothers of children age 0-23 months who wash their hands with soap/a~ before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0 . 0
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