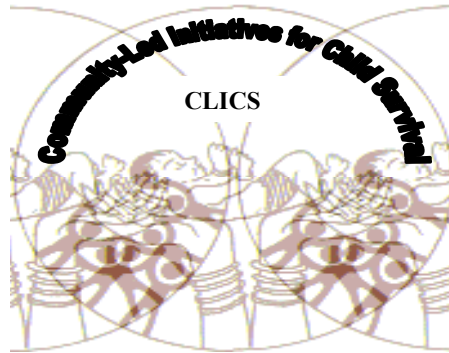


# **COMMUNITY LED INITIATIVES FOR CHILD SURVIVAL PROGRAM – (CLICS)**



## **ANNUAL REPORT** (Narrative)

**Report prepared for: The United States Agency for International Development**

**Name of PVO: Aga Khan Foundation, USA**

**Local Partner: Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha, India**

**Cooperative Agreement Number: GHS-A- 00-03-00015-00**

**Program Location: 67 villages in Wardha District, Maharashtra State, India**

**Start & End Dates: October 1, 2003 to September 30, 2008**

**Period Covered: October 1, 2005 to September 30, 2006**

**Date of Submission: 15<sup>th</sup> October, 2006**

**Report Prepared by:**

Dr. BS Garg; Program Director

Dr. Subodh S Gupta; Member, Technical Support Team

Dr. Shib Sekhar Datta, Assistant Program Coordinator (Documentation & Dissemination)

Dr. Abhijit Boratne; Assistant Program Coordinator (BCC & Training)

Mr. Manoj Chaudhuri, Program Officer (BCC & Training)

Mr. Atul Gandhi; Program Officer (Management Information System)

## Contents

<b>List of acronyms</b>	<b>... 4</b>
<b>List of local terms</b>	<b>... 6</b>
<b>Executive Summary</b>	<b>... 6</b>
<b>Introduction</b>	<b>... 8</b>
<b>1.1 Goal</b>	
<b>1.2 Objectives</b>	
<b>1.3 Beneficiaries as per the baseline survey</b> <b>(Source: CLICS Baseline Survey, 2004)</b>	
<b>1.4 Strategy</b>	
<b>Progress during the current reporting period</b>	<b>... 11</b>
<b>2.1 Overall progress</b>	
<b>2.2 Overall program achievement</b>	
<b>2.3 Key activities</b>	
<b>2.3.1 Community Mobilization</b>	
<b>2.3.2 Capacity Building Activities</b>	
<b>2.3.3 Health Care through Effective Partnership</b>	
<b>2.3.4 Research, Documentation &amp; Dissemination</b>	
<b>2.3.5 Behavior Change Communication</b>	
<b>Program Monitoring and Evaluation</b>	<b>... 29</b>
<b>3.1 Management Information System</b>	
<b>3.2 Future Plan</b>	
<b>Challenges and Lessons Learnt</b>	<b>... 30</b>
<b>4.1 Challenges</b>	
<b>4.2 Lessons Learnt</b>	
<b>Plans for the next six months</b>	<b>... 32</b>
<b>Annexure</b>	<b>... 33</b>

=====

## LIST OF ACRONYMS

AKDN	Aga Khan Development Network
AKF, India	Aga Khan Foundation, India
AKF USA	Aga Khan Foundation United States of America
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APMAS	Mahila Abhivruddhi Society, Andhra Pradesh
ARI	Acute Respiratory Infection
AWC	Anganwadi Center
AWW	Anganwadi Worker
BCC	Behavior Change Communication
CARE	Cooperative for American Relief Everywhere
CLICS	Community-led Initiatives for Child Survival
CO	Community Organizer
CSTS	Child Survival Technical Support Group
DCM	Department of Community Medicine
DIP	Detailed Implementation Plan
ECD	Early Childhood Development
FGD	Focus Group Discussion
GOI	Government of India
GOM	Government of Maharashtra
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IHMP	Institute of Health Management Pachod
IMCFSC	Integrated Model of Communication for Social Change
ICDS	Integrated Child Development Scheme
IEC	Information Education Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMI	Institutional Maturity Index
IMR	Infant Mortality Rate
IR	Intermediate Result
ISA	Institutional Strengths Assessment
KAP	Knowledge, Attitude & Practices
LHV	Lady Health Visitor
LOE	Level of Effort
LOGFID	Logical Framework for Institutional Development
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MGIMS	Mahatma Gandhi Institute of Medical Sciences
MIS	Management Information System
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoHFW	Ministry of Health & Family Welfare, India
NFHS II	National Family Health Survey II (1998-1999)
NMR	Neonatal Mortality Rate
NGO	Non Government Organization
ORS	Oral Rehydration Solution
PHC	Primary Health Center
PHC MAP	Primary Health Care Management Advancement Program
PNC	Post Natal Care
PRI	Panchayati Raj Institution

PVO	Private Voluntary Organization
QA	Quality Assurance
RCH	Reproductive and Child Health
RH	Reproductive Health
RTI	Reproductive Tract Infection
SHG	Self Help Group
SO	Strategic Objective
SRS	Sample Registration System
STD	Sexuality Transmitted Disease
TIPS	Trials of Improved Practices
TNA	Training Needs Assessment
TST	Technical Support Team
TT	Tetanus Toxoid
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VCC	Village Coordination Committee
VHW	Village Health Worker
WHO	World Health Organization

### LIST OF LOCAL TERMS

Bal aahar or posh aahar	Energy dense food for children
Bal Suraksha Divas	Child Survival Days
Gram Panchayat	Local Self Governing Body at village level
Gram Swasthya Kosh	Village Health Fund
Kisan Vikas Manch	Farmer's Development Forum
Kishori Panchayat	Adolescent Girls Forum
Koshadhyaksha	Treasurer
Mulgi Wachawa Mohim	Save the Female Child Campaign
Panchayat member	Members of Local Self-Governing Body (Panchayat)
Suraksha Aaichi Aani Balachi Mohim	Safe Motherhood and Child Survival Campaign
Suraksha Aaichi Mohim	Safe Motherhood Campaign
Anganwadi Worker	Female worker, under the 'Integrated Child Development Services Scheme', responsible for managing the Anganwadi Center and related activities: pre-school education, growth monitoring, supplementary nutrition, etc.

=====

## Executive Summary

The Community-Led Initiatives for Child Survival (CLICS) program is managed by AKF and implemented by Department of Community Medicine (DCM), MGIMS in 67 villages of Wardha District, Maharashtra State, India. The five-year (2003-2008) program will serve a total population of 88,128 residents in three sectors in Wardha District, Maharashtra.

The major strategy of CLICS is to refine and scale up the collaboration between the Aga Khan Foundation (AKF) and the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (DCM/MGIMS) to build the capacity of the target communities to develop, manage and ultimately achieve “ownership” of village based child survival and health services. This scaling up is being advanced by applying the principles of “social franchising” to the processes undertaken by CLICS to change communities’ health behavior and demand for healthcare. DCM (the “Franchiser”) mobilizes villages and enters into a contractual arrangement with representative coordinating committees (the “Franchisees”) to build capacity and to develop, manage and sustain a package of high quality, affordable child survival & health services that addresses priority health problems (the “Social Product”).

This report covers the period April 2005 to September 2006. The key project activities during the current reporting period focused on program start up activities and community mobilization through the formation of women’s Self Help Groups (SHGs), Kisan Vikas Manch (farmer’s development association) and Kishori Panchayats (adolescent girls forum). A total of 263 Self-Help Groups, 64 Kishori Panchayats (Adolescent girl groups) and 71 Kisan Vikas Manch have been established in the program area as on September 30, 2006. The process of formation of Village Coordination Committee has been completed and at present there are 63 VCC in the program area. The selection of VHWs from all the program villages has also been completed. A total of 88 VHWs are in place now. The Social Franchise Agreement has been signed with all the 63 Village Coordination Committees.

Orientation of CLICS program for program staff and program partners has been completed. Training Needs Assessment (TNA) exercise was conducted for all Program Staff; Anganwadi workers and Auxiliary Nurse Midwives of Talegaon and Anji Sector and Anganwadi workers of Gaul Sector followed by development of training plan. Training for program staff has been completed on Participatory Rural Appraisal and Community Mobilization, while training on Quality Assurance and technical interventions is ongoing. Capacity building activities are also being undertaken for Panchayat members and village committee members on a monthly basis.

One of the important achievements of the program during the reporting period is completing training for IMNCI for all level of providers. Initially, the Training of Master Trainers for IMNCI was conducted in two sessions for 31 program staff and partners. Later on, training was conducted for the government health workers, CLICS doot and Program Staff. A total of 61 Health Workers (Government Health Workers and CLICS ANMs), and 75 CLICS doot were trained in IMNCI. The training program was completed for all these categories of personnel by Aug 08, 2006. Following the training, IMNCI is being implemented in the program area by the CLICS doot and government health workers. WHO India country office and UNICEF, Mumbai provided technical support for the IMNCI training.

The training on ECCD was also undertaken for all Anganwadi workers in the program area. It included an initial training of 5 days and a follow up review of 1-day duration to ensure that the practice is in place.

The program facilitated *Bal Suraksha Diwas* (BSD) to ensure immunization for all the children through the Primary Health Centres in all the project villages. Twelve new Community Health Clinics (Talegaon – 5, Gaul – 5, & Anji – 3) were set up in the program villages; thus bringing the

total number of Community Health Clinics to 18. A total 51 parenting workshops were organized to sensitize young couples towards child health, immunization, nutrition, family planning etc.

Currently, four research studies are being undertaken. For three of these research studies, data collection has been completed and the preliminary report is available. Apart from this, an operation research is being undertaken to find out the effect of 'Social Franchise Model' on child health through qualitative and quantitative methods.

The process documentation of activities like formation of village committees, income generation activities, selection process of village health workers, training program etc is being undertaken regularly. Apart from this an overall documentation plan has been developed. The publication and distribution of newsletter 'Samvedana' has been continued to enable communities share and learn from each other's experiences.

A routine monitoring system is in place with Community Organizers submitting Monthly Progress Reports, data from which is collated at sector level and forwarded to Program Central Office. Database has been developed for data derived from Mother and (0-3 years) Child services records and Monthly Progress Reports. A village level household register to be maintained by VHWs has also been developed and training for the same has been provided to the selected VHWs. In addition, village information schedules have been completed for all program villages and reporting formats have been developed for VHW and Community Health Clinics. A reporting format has also been developed for Bal Suraksha Diwas and is currently in use in villages where the same is being organized. The computerization of the Monitoring Information System is near completion.

As for the institutionalization of systems, financial systems have been put in place, with routine internal audits of Quarterly expenditure and timely submission of Quarterly Financial Reports. There have been two annual financial audits without any adverse comment.

The CLICS MIS was earlier initiated using the internal resources. However, later on the task of software development was out sourced for computerization. The task is now in its final stage and is expected to complete in about 1½ months' time.

=====

## 1.0 INTRODUCTION

The strategy for the Community-led Initiatives for Child Survival Program (CLICS) has evolved from a collaborative pilot between DCM and AKF India in the Talegaon area, called “Partnering for Child Survival”. It introduced the concept of “community ownership” of a health clinic in villages without Government of India (GoI) facilities, as a model ensuring sustainable delivery of quality health services. To strengthen community participation, Department of Community Medicine (DCM) actively promoted the formation of self-help groups (SHGs), notably women’s groups, and partnerships with public and private practitioners. Results were encouraging: “community ownership” seems to be a valid approach to engaging a village to take responsibility for its own health. DCM's learning about ways to achieve “community ownership” has helped to define the social franchise principle proposed by CLICS. In the same way, DCM’s understanding of new behavior change communication techniques to improve the existing package of child survival interventions has been refined.

CLICS represents an opportunity for DCM, with AKF and USAID support, to build its capacity and that of its partners to implement new methods and techniques for both *organizing communities* and *addressing their health needs* in ways that are effective and sustainable. Furthermore, this program offers DCM and AKF an opportunity to *increase the scale of collaboration* and to monitor and evaluate the manner, in which services selected by villagers are implemented, financially supported and sustained. The intention is to *generate lessons* about the delivery model and the package of child survival interventions for *dissemination and replication through networks* of which both DCM and AKF are a part.

### 1.1 Goal

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

### 1.2 Objectives

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

The CLICS program is managed by AKF and implemented by DCM/MGIMS in 67 villages of Wardha District, Maharashtra State, India. To ensure long-term sustainability, the villages selected are part of the field practice area of MGIMS, which are used to impart community based training to medical and nursing students as well as conduct community-based research. The Program serves a total population of 88,128 residents in three sectors: Anji, Gaul and Talegaon.

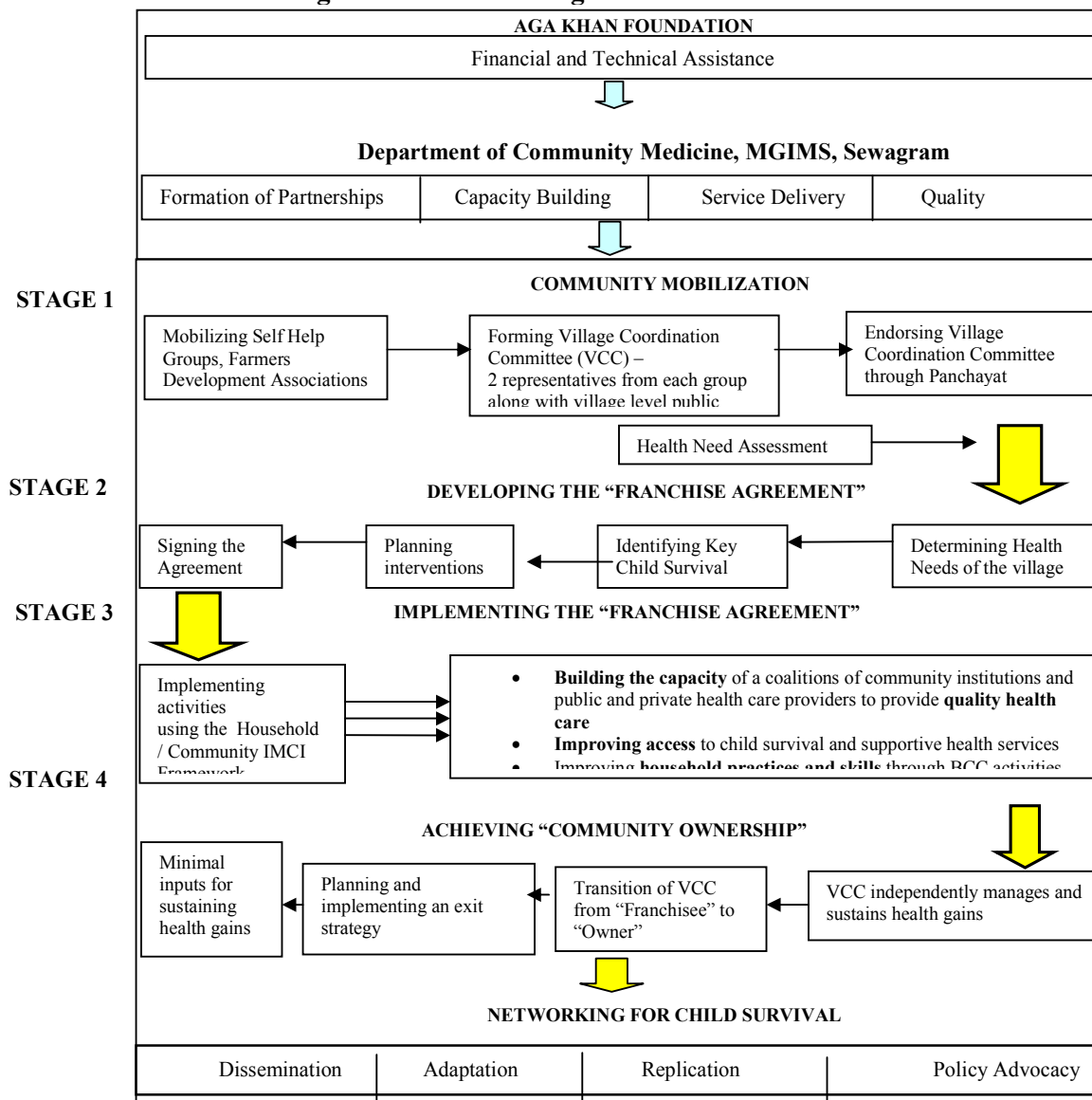
### 1.3 Beneficiaries as per the baseline survey Source: CLICS Baseline Survey, 2004

Description	Anji	Gaul	Talegaon	Total
Villages (under project area)	23	21	23	67
Total Population (under project area)	31482	18700	37946	88128
Total Households (under project area)	7783	4429	8699	20911
Beneficiaries: children (0-3 years)	1839	1039	2189	5067
Beneficiaries: women of reproductive age (15-44 years)	7524	4206	8955	20685
Beneficiaries: adolescent girls	2516	1492	3202	7210
<b>Total direct beneficiaries</b>	<b>11879</b>	<b>6737</b>	<b>14346</b>	<b>32962</b>

## 1.4 Strategy

The major strategy of CLICS is to refine and scale up the collaboration between the Aga Khan Foundation (AKF) and the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (DCM/MGIMS) to build the capacity of the target communities to develop, manage and ultimately achieve “ownership” of village based child survival and health services. This scaling up has been accomplished by applying the principles of “social franchising” to the processes undertaken by CLICS to change communities’ health behavior and demand for healthcare. As illustrated in Fig 1.1 below, DCM (the “Franchiser”) mobilizes villages and enters into a contractual arrangement with representative coordinating committees (the “Franchisees”) to build capacity and to develop, manage and sustain a package of high quality, affordable child survival and health services that address priority health problems (the “Social Product”).

**Figure 1.1: CLICS Program Framework**



## 2.0 PROGRAMME ACTIVITIES

During the reporting period, the program has successfully completed Stage I of community mobilization and currently, Stage 2 (Developing the Social Franchise Agreement) and Stage 3 (Implementing the Social Franchise Agreement) are in progress as outlined in the program framework above.

### 2.1 Overall Progress

The progress made towards achieving objectives in the current reporting period is summarized below:

**Table 2.1 Progress towards objectives**

Objectives	Progress towards objective on target Yes/No	Comments
To provide affordable, high quality health care through effective partnerships at the village level	Yes	<ul style="list-style-type: none"> <li>Community Mobilization through formation of community based institutions (SHGs, KVMs &amp; KPs) has strengthened.</li> <li>Monthly meeting of all the Community-based Organizations are continuing</li> <li>Nine Master trainers for KVM have been identified from the community.</li> <li>Sixty three Village Coordination Committees (VCCs) have been formed covering all program villages.</li> <li>Data has been collected regarding the quality of services through Bal Suraksha Diwas, Anganwadi centers, Sub centers and PHCs.</li> <li>Quality Assurance tools have been developed and tested.</li> </ul>
To build the capacity of coalitions of local partners to sustain child survival activities and health gains	Yes	<ul style="list-style-type: none"> <li>Program staff members, CBOs, Health care providers (public &amp; private) in all three sectors have been oriented to CLICS strategy-planning, implementation, monitoring &amp; supervision.</li> <li>Monthly training for Panchayat members, VCC members, public and private health care providers on various aspects related to program is continuing.</li> <li>Selection of VHWs has been completed in all the program villages; total 88 CLICS doot in place.</li> <li>Training of the VHWs is in process.</li> <li>Orientation training of Principals of all the high schools in the program area completed; Family Life Education started in all the High Schools in the program area.</li> <li>Training of AWW in ECCD completed.</li> <li>IMNCI Master Trainers' training completed in collaboration of GOI/WHO/UNICEF and Government of Maharashtra.</li> <li>IMNCI training completed for government health providers and CLICS doot</li> <li>First round of training on Quality Assurance has been completed.</li> <li>Training of Trainers completed on BCC.</li> <li>Training on BCC completed for the Program Staff</li> <li>MIS is in place.</li> </ul>
To refine and test a social franchising model for the	Yes	<ul style="list-style-type: none"> <li>Health needs Assessment exercises have been initiated in all villages where VCC has been formed.</li> </ul>

delivery of child survival interventions		<ul style="list-style-type: none"> <li>• Vision, Mission and Plan of Action has been prepared by all VCCs.</li> <li>• Social Franchise Agreement signed for all 63 VCCs.</li> <li>• New 'Community Health Clinic' has been started in 12 villages. At present, there are a total of 17 Village Health Clinics.</li> <li>• An Operational Research to find out effect of Social Franchise has been initiated. Baseline survey for this has been conducted.</li> <li>• Quality of services being delivered through the Bal Suraksha Diwas is being monitored by the Village Coordination Committees.</li> </ul>
To document, disseminate and share key program lessons and results to facilitate adaptation, replication and policy advocacy.	Yes	<ul style="list-style-type: none"> <li>• Regular publishing of monthly newsletter "Samvedana".</li> <li>• Progress of program activities has been shared with program partners.</li> <li>• Program brief contents have been finalized.</li> <li>• Case Studies on VCC, SHG, KVM, Sarpach, Village health clinic and CLICS doot is in process</li> <li>• Activities such as VCC formation, VHW selection are being regularly documented.</li> </ul>

## 2.2 Overall Programme Achievement

To study the effect of CLICS model thus far, it is imperative to compare the indicators at baseline with that at the mid-term. The tables 2.2 and 2.3 give the comparison of the important indicators in CLICS program.

**Table 2.2: Rapid Catch Indicators**

Indicators	Baseline	Current Status	Expected Mid-term
% children age 0-23 months who were born at least 24 months after the previous surviving child	64.4%	68.0%	-
% children (0-23 m) whose births were attended by trained provider	82.2%	97.0%	90.0%
% mothers of children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	83.3%	82.5%	-
% children (0-5 m) exclusively breastfed in the last 24 hours	80.1%	85.1%	90.0%
% children (6-9 m) given breast milk and complementary foods in the last 24 hours	72.0%	65.1%	80.0%
% children (12-23 m) fully vaccinated (against the six vaccine-preventable diseases) before their first birthday	62.4%	69.8%	80.0%
% of children age 12-23 months who received a measles vaccine	67.1%	83.8%	-
% children age 0-23 months who slept under an insecticide-treated bed net the previous night (in malaria-risk areas only)	NA	NA	-
% mothers with children (0-35 m) who cite at least two known ways of reducing the risk of HIV infection	9.2%	56.8%	50.0%
% mothers of children (0-35 m) who report that they wash their hands with soap/ ash			
a) before food preparation	9.1%	36.0%	30.0%
b) before feeding children	14.0%	40.6%	30.0%
c) after defecation	87.6%	94.2%	95.0%
d) after washing child after defecation	-	83.8%	60.0%
% mothers of children (0-23 m) who know at least 2 signs of childhood illness that indicate the need for treatment	30.5%	55.4%	40.0%
% sick children (0-35 m) with cough and/or difficult/ rapid breathing during the past two weeks who received			
a) increased fluids (after first 6 months)	1.3%	0.7%	40.0%
b) continued feeding among those who were breastfeeding	50.0%	82.1%	80.0%

**Table 2.3: Indicators for the Program Interventions**

Indicators	Baseline	Current Status	Expected Mid-term
<b>Indicators for 'New Born Care'</b>			
% mothers of children (0 - 11m) aware of care of the newborn			
a) Hypothermia prevention (at least one method)	84.2%	88.2%	90%
b) Low birth weight management (at least one method)	93.9%	91.8%	95%
c) Initiation of breastfeeding (Less than one hour)	0.6%	61.8%	40%
d) Recognition of danger signs (at least three signs)	11.3%	8.2%	30%
<b>Indicators for 'Safe Motherhood'</b>			
% mothers of children (0-11 m) who receive minimum ANC package (at least 3 antenatal checkups by a trained provider, 2 tetanus toxoid injections & 100 IFA tablets consumed) during last pregnancy	11.6%	10.9%	30%
% children (0-23 m) whose births were attended by trained provider	82.2%	97.0%	90%
% children (0-5 m) weighed within 24 hours of birth	73.5%	85.8%	90%
% adolescent girls attended a Health education/ Family life education session	2.1%	21%	30%
% adolescent girls (16-19 years) aware of 2 ways of delaying pregnancy	26.2%	41.0%	40%
% adolescent girls (16-19 years) who cite at least two known ways of reducing the risk of HIV infection	24.9%	71.0%	40%
# villages with emergency community transport plan in place	NA	79.4%	40%
% husbands aware of at least 3 danger signs of pregnancy	13.2%	18.0%	40%
<b>Indicators for 'ARI/ Diarrhea'</b>			
% mothers of children (0-23 m) who know at least 2 signs of childhood illness that indicate the need for treatment	30.5%	55.4%	40%
% mothers of children (0-35 m) who know at least 2 signs of childhood illness that indicate the need for treatment	29.5%	55.4%	40%
% mothers of children (0-35 m) who report that they wash their hands with soap/ ash			
a) before food preparation	9.1%	36.0%	30%
b) before feeding children	14.0%	40.6%	30%
c) after defecation	87.6%	94.2%	95%
d) after washing child after defecation	-	83.8%	60%
% children (0-35 m) suffering from diarrhea during the last two weeks, who received home available fluid / ORS	6.8%	39.4%	30%
% sick children (0-35m) presenting at clinics, advised to give fluids for child	0.0%	14.7%	30%
% sick children (0-35 m) with cough and/or difficult/ rapid breathing during the past two weeks who received			
a) increased fluids (after first 6 months)	1.3%	0.5%	40%
b) continued feeding among those who were breastfeeding	50.0%	82.1%	80%
% sick children (0-35 m) with watery or loose motion during the past two weeks who received			
a) increased fluids (after first 6 months)	1.4%	66.3%	40%
b) continued feeding among those who were breastfeeding	40.5%	89.5%	80%
<b>Indicators for 'Breastfeeding and Nutrition'</b>			
% children (0-5 m) breastfed within 1 hour of birth	0.9%	80.0%	30%
% children (0-5 m) exclusively breastfed in the last 24 hours	80.1%	85.1%	90%
% children (6-9 m) given breast milk and complementary food in last 24 hours	72%	65.1%	80.0%
% children (0-35 m) weighed in the last month	50.1%	79.8%	75%
% children (12-35 m) received a dose of Vitamin A in the last 6 months	53.6%	60.1%	70%
% children (12-35 m) received Iron and Folic Acid tablets in the last 14 days	6.0%	2.5%	30%
% mothers/ caretakers of children (6-35 m) who can name at least 2 iron rich foods	22.3%	24.4%	50%

Indicators	Baseline	Current Status	Expected Mid-term
<b>Indicators for 'Early Childhood Development'</b>			
# of parenting workshops organized	NA	71	1/village every 2 years
% mothers/caregivers of children (0-35 m) aware of at least five developmental milestones	89.3%	87.0%	95%
% mothers of children (0-35 m), who have been educated about early childhood development by VHW/ AWW/ other project functionaries	23.5%	70.0%	50%
% Anganwadi Workers trained in Early Childhood Development	NA	100.0%	80%
% Anganwadi workers aware of at least five developmental milestones	7%	100.0%	95%
% Mothers of children (7-35 m) who encourage, praise, play with their child to get them to eat	31.6%	76.0%	40%
<b>Indicators for 'Immunization'</b>			
% children (12-23 m) fully vaccinated (against the six vaccine-preventable diseases) before their first birthday (from card)	62.4%	69.8%	80%
% children (12-35 m) immunized during the last month where a sterilized needle / disposable syringe was used	-	10.0%	80%
% mothers of children (0-23m) with immunization cards	78.1%	93.1%	85%
<b>Indicators for 'RTI/ STD'</b>			
% females (15-44 years) who sought treatment for RTI/STD from a skilled provider in the last 3 months	49.7%	51.0%	75%
% females (15-44 years) with RTI/STD in the last 3 months whose partner was counseled	12.2%	13.0%	30%
% females (15-44 years) with RTI/STD in the last 3 months whose partner was also treated	4.3%	9.0%	30%
% mothers with children (0-35 m) who cite at least two known ways of reducing the risk of HIV infection	9.2%	56.8%	50%
<b>Indicators for 'Birth Spacing'</b>			
% children (0-35 m) born at least 36 months after the previous surviving child	29.3%	58.0%	40%
% mothers with a child (0-35 m) who are using any spacing method of contraception	25.5%	30.0%	40%

## 2.3 Key Activities

### 2.3.1 Community Mobilization

Community Mobilization mainly involved formation of community based organizations viz. women's self help groups (SHGs), Kisan Vikas Manch (Farmer's Development Association) and Kishori Panchayats (Adolescent Girls Forum). Based on experience, DCM fully appreciates the critical link between community empowerment and maternal and child health status and considers the involvement of community based organizations to be key to the success of the Program.

#### Self Help Groups

The CLICS Program has achieved the formation of an average of 3-4 groups per village. A total of 263 such groups were in place on September 30, 2006. The members have learnt to manage the group individually and have developed as member owned and member managed institutions over a period of time with the help of trainings. The program provide assistance to add a health action agenda to their primary financial function (finance +) so that the women are able to determine health priorities and to play a proactive role in health care delivery in their villages.

254 out of the 263(97%) groups are linked to banks, all the groups have updated member account books. 47 Self Help Groups have availed loan from the bank. The total amount with all the SHG under CLICS program in September 2006 amounted to INR 16,06,456.00. Members of 138 SHGs (52%) have got group health insurance policy of Kasturba Hospital, Sewagram for the year 2006. Apart from this, members of 33 SHGs are also getting benefit of health insurance from MGIMS, Sewagram as they are part of the village health insurance scheme of Kasturba Hospital, Sewagram. Thus, members of total 171 SHGs (65%) are availing the benefits of health insurance from Kasturba Hospital, Sewagram.

As a result of the continuous motivation of the project staff as well as the showcasing of successful income generation ventures during the Mahila Melawas (Women fair), many groups are now coming forward for income generation activities. Thirty seven income-generation activities have been started by the SHG members. The income generation activities include sale of vegetables, hiring out equipment required for marriages and other public functions, catering, embroidery, tailoring, dairy farming, grocery shop, sale of stationery, farming, herbal insecticide preparation, motor winding etc. The capital for these ventures has been acquired through loans from the groups or from the banks.

In Gaul sector, on experimental basis, two SHG coordinators have been selected from the existing members of SHGs in village Bhidi. These SHG coordinators have been assigned responsibilities to conduct meetings of SHGs, thus reducing the workload of Community Organizer working in that area. This strategy has been found successful in the village Bhidi.

#### Kisan Vikas Manch

The Kisan Vikas Manch have been formed to involve men in the health activities. A total of 72 Kisan Vikas Manch have been formed. The program provides learning opportunities for the members to improve their agricultural yield and in turn improve their economical status. The health action agenda is added to the primary purpose so as to empower them to actively participate in the health program.

A concept of 'Master Trainer' for the Kisan Vikas Manch' was started during this reporting period. A total of 9 Master Trainers were identified (Anji 4, Gaul 4, Talegaon 1). The Master Trainers will be assigned 4 to 5 program villages, where they will act as a resource person during the monthly training of the Kisan Vikas Manch. The Master Trainers were inducted the program in the month of Sep 05. They have started attending the meeting of 'Kisan Vikas Manch' since Mar, 06.

### Kishori Panchayats

The program has achieved the formation of 64 Kishori Panchayats (adolescent girl groups) in the program area till September 30, 2006. It has become a platform for the adolescent girls to share their idea, views, and problems and for personality development. The adolescent girls are provided training in income generation activities and on health. Apart from gaining knowledge for their future life, a number of group members have taken up responsibility of imparting health education to pregnant and postnatal mothers.

**Table 2.4 Existing groups in the Program area (as on March 31<sup>st</sup>, 2006)**

Groups	Anji Sector	Gaul Sector	Talegaon Sector	Total
Self Help Groups	76	65	122	263
Kishori Panchayats	20	21	23	64
Kisan Vikas Manch	24	22	25	71

### Formation of Village Coordination Committees

In addition to 32 village committees formed earlier, 31 new village Committees have been formed bringing the total number of VCCs formed to 63. All committees have their Gram Swasthya Kosh, which is deposited in Bank. On an average, there are of 21 members in each committee. To ensure the viability of the committees formed, a checklist and set of guidelines has been strictly followed.

**Table 2.5 Constitution of VCC**

Representative from	Members
SHGs	1(from each)
KVM/KP/Gram Panchayat (two each)	6
Influential leader (co-opted)	4
Ex-officio AWW	All
ANM and Gram Sewak and Community Organiser (one each)	3
Total strength of VCC (maximum)	25

**Table 2.6 Details of the Village Coordination Committee**

S. No	Sector	Number of Villages	Number of VCC
1	Anji	23	20
2	Gaul	21	20
3	Talegaon	23	23
	<b>Total</b>	<b>67</b>	<b>63</b>

Orientation of newly formed Village Coordination Committees was carried out through the monthly meetings. The members of the committees were informed about the various roles and responsibilities to be undertaken by the committees in the light of social franchise agreement. In addition, committee members were involved in village level program activities which also served as opportunities for orientation to the program.

Based on the suggestions of the Program Advisory Committee, to facilitate better planning and implementation of activities subcommittees were formed at ward level in large villages. The villages where sub-committee has been formed are Pawnsar, Anji, Bhidi, Talegaon, Salod, Waigaon. In these villages, Village Health Committee was formed after the formation of sub-committees by taking representatives from each subcommittee. This arrangement has proven to

be useful in getting increased participation from the community. It has also helped in ensuring that the marginalized communities are represented in the Village Health Committee and are part of decision making process.

All the village health committees have done village health needs assessment and have subsequently developed a village health plan. For implementation of the village health plan, subcommittees of the village coordination committees have been formed and delegation of responsibilities has been done.

#### Social Franchise Agreement

During the reporting period, Social Franchise Agreements were signed between the DCM/ MGIMS and the Village Coordination Committees of all the program villages. The Social Franchise signing ceremony was arranged on Nov 30, 2005; Jan 13, 2006; Apr 10, 2006 and Aug 25, 2006. The Sarpanch of these villages acted as witness to these agreements. Shri Dhirubhaiji Mehta, President, Kasturba Health Society graced the ceremony held on 30<sup>th</sup> November.

**Table 2.7: Signing of Social Franchise Agreement with date**

<b>Date</b>	<b>Villages signing Social franchise agreement</b>
30/11/2005	08
13/01/2006	10
10/04/2006	08
25/08/2006	37
<b>Total</b>	<b>63</b>

#### Village Health Fund

To implement child survival activities at the village level, the VCC has collected a *Gram Swasthya Kosh* (Village Health Fund) through community contributions, according to a fixed amount set per family member. As a prerequisite, at least 75% of households should contribute to the development of this fund.

Village Health Fund has been collected in 62 of the Program villages. In 32 villages, the collection of Village Health Fund is complete, while in rest 30 villages it is still in process. The total amount of Village Health Fund collected in the 62 villages sums to 2,08,986/-. Village Coordination Committees have deposited this fund in a local bank account. For the villages, where Community Health Clinic has been established, a part of this fund is utilized for revolving drug fund for the clinic. The funds is being replenished through user fees, annual membership fees and/ or a health tax<sup>1</sup> collected from all the residents of the village. In addition to the above, VCCs will encourage in-kind donations (built structure, furniture, etc.) from community members to implement activities.

**Table 2.8: Collection of Village Health Fund by VCC**

<b>Sector</b>	<b>Number of Villages</b>	<b>Total Collection (in Rs.)</b>
Anji	23	45960
Gaul	16	30120
Talegaon	23	132906
<b>Total</b>		<b>208986</b>

#### Selection of CLICS doot

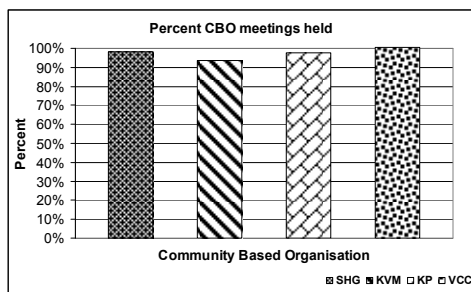
Another important achievement was identification of VHWs in all the project villages with VCC. During the current reporting period, a total of 45 new CLICS doot have been identified. Presently there are 88 CLICS doot working in all the program villages. Training of all the CLICS Doot has been completed.

<sup>1</sup> Recommendation from a Gram Panchayat representative during the DIP preparation stakeholder workshops.

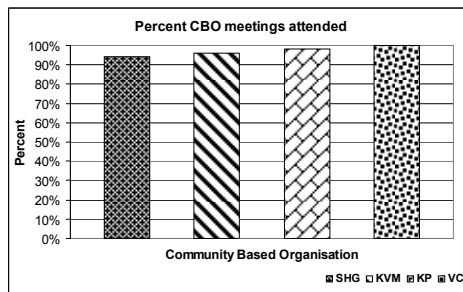
A special selection camp was organized in Sewagram Ashram from 28 February to 2 March 2006. For each position of Village Health Worker, three candidates attended the selection camp. The selection camp assessed the basic skills such as reading; writing; talking; addressing a gathering; ability to explain an issue; communication social behaviour; and interaction with group members. The camp was held in an informal atmosphere and special efforts were taken to ensure a fair and transparent evaluation. At the end of the camp, candidate with highest score was selected as CLICS Doot (Village Health Worker), while the candidate with the next highest score was kept on waiting list. At present, there are a total of 88 CLICS doot in the program; Anji sector – 29, Gaul sector – 22, & Talegaon sector – 37.

### Health and Social Initiatives by Community Based Organizations

Monthly meetings are held for SHG, Kishori Panchayat & Kisan Vikas Manch members. During these meetings, the SHG women get together and pool in their monthly contributions, discuss relevant issues and disburse loans. In the month of March 2006, the program staff attended 96% of all CBO meetings. These meetings are used by the Community Organizers as an opportunity for the delivery of key health messages related to the CLICS technical interventions. Every month, the Sector Coordinators provide training to the community organizers on key health messages to be delivered to Community Based Organisations during their meetings in the next month. The interest of the members in the child survival activities is reflected by their attendance in the monthly meetings of their respective groups. Fig 3 gives the attendance of members of Community-based Organizations in their monthly meetings. Fig 4 gives a comparative picture of meetings of Community-based Organizations attended by program staff.



**Fig 3: Attendance of Members of CBO in the monthly meetings of their group**



**Fig 4: Percent of CBO meetings attended by Program Staff**

The members Self Help Groups, Kisan Vikas Manch and Kishori Panchayat have started taking health and social initiatives across all three sectors. Majority of them have organized and participated in improvement of village sanitation and health activities such as organization of parenting workshop, collecting village health fund and setting village clinic (CHC), disinfection of drinking water, rallies for dissemination of health messages, Making the villages open defecation free village, adoption of malnourished children, sharing responsibility in antenatal care to pregnant mothers, getting the hand pumps repaired through Gram Panchayat, health insurance, painting health messages on walls etc.

### **2.3.2 Capacity Building Activities**

Capacity building of the program partners, including the community-based organization has been the thrust of the CLICS program. Training needs assessment exercise was conducted and training needs for all stakeholders (staff, VCCs, ANMs, ICDS functionaries) were identified with their participation.

### Community Based Organizations (CBOs)

CBO members were imparted information on important health issues by involving them in community level programs, melawas, cooking competitions and celebration of events like International Women's Day (8<sup>th</sup> March 2006). Besides these events, the Community Organizers

discussed and educated the CBO members on important health issues during their monthly meetings. Table 4.1 gives the monthly health topic for the three sectors.

**Table 2.8: Topics for health education**

Sector	Topics of health education for the reporting period
Anji	ANC, PNC, PPTCT, Breastfeeding, Nutrition, Contraception, malnutrition, Pneumonia, RTI/STD, New born care, Growth monitoring, Bird flue, Diarrhoea prevention, TB.
Gaul	Iodine deficiency, Malnutrition, Breastfeeding, Nutrition, Immunization, HIV/AIDS, New born care, RTI/STD, leprosy, safe motherhood, PNC, ANC, TB.
Talegaon	RTI/STD, Immunization, Breast feeding, New born care, HIV/AIDS, Malnutrition, PNC, Safe motherhood.

#### Kisan Vikas Manch (KVM)

Two special training programs for ‘Master Trainers’ were organized during the reporting period following which identified persons at village level attended the training programs.

The first training programme was organized in coordination with *Dharmitra*, a NGO working in Agricultural Development. The four days training was organized from 14<sup>th</sup> to 17<sup>th</sup> Dec 2005. Training programme was attended by six persons from the different Kisan Vikas Manch of the project villages. Training was mainly focused on sustainable farming, compost fertilizer, earthworm fertilizer, land, water and nature management. An exposure visit to village Dorli was organized during the training program to show remarkable work in natural farming.

Second training program for Master Trainers was organized with cooperation from the Government Agriculture School, Selsura, Wardha. Five Master Trainers attended the programme during Jan 3-5, 2006. The focus of the training was mainly on farming and supplementary professions. A demonstration of compost fertilizer was shown and also information on earthworm fertilizer was also provided during the training program. The ‘Master Trainers’ have started attending all the meetings of Kisan Vikas Manch since March 2006.

CLICS in collaboration with Acharya Shriman Narayan Rural Polytechnic, Pipari (Meghe) organized a 6 months training on ‘Motor rewinding and electrician’ for unemployed youths and KVM members. Two training program were done in the Gaul sector during the current reporting period and at present at third training program is going on. There were 20 & 19 trainees in the first two training programs and 22 trainees are attending the third training program.

#### Kishori Panchayat

Various training programs on nutrition, pregnancy and newborn care, health & sanitation, menstrual hygiene, Safe Motherhood First-Aid etc were organized for the groups. Understanding the intricacies of adolescent behavior, varied programs aimed at enhancing the level of awareness among the members of Kishori Panchayat on ‘Reproductive Health’ is being taken up under the CLICS programme. In Gaul Sector a workshop on “HIV/AIDS Awareness for adolescent girls” has shown a good response. During the current reporting period, five workshops for training of peer educators were conducted in Gaul sector. A total of 125 adolescent peer educators from the program villages were trained during this workshop. All these programs have witnessed an active participation from the members of Kishori Panchayat. These groups have also been instrumental in providing information on different health issues to the women at the village level.

A six-month training program in tailoring was organized for members of Kishori Panchayat in collaboration with Acharya Shriman Narayan Rural Polytechnic, Pipari (Meghe). 19 adolescent girls from Anji and neighboring villages are participating in this training program. A second training program in tailoring is undergoing in Bhidi village of Gaul sector currently. A total of 30

adolescent girls are registered for the training. These vocational courses are very popular with the adolescent girls.

#### Panchayati Raj Institution

One-day training program for the Panchayat members mainly focused on the role of PRIs and covered CLICS program issues and interventions as well as government health policy and relevant national health programmes. Since April 2006, the training of Panchayat members has been clubbed with the training of the members of Village Coordination Committee. This provides a common platform for the two groups so that they can do microplanning regarding the health activities to be implemented in the village.

#### Orientation of Health Care providers (Public, Private, ICDS, NGOs)

The system of routine monthly meeting with all Auxiliary Nurse Midwives, Anganwadi workers, PHC Medical Officers, Private Practitioners continued during the current reporting period.

#### ECCD training for the Anganwadi workers

Gram Mangal from Pune conducted Training of all the Anganwadi Workers from the program area in Early Childhood Development in three batches for three sector offices. The training included an initial training program of 5-day duration followed by a follow-up meeting of 1-day duration after 3 months of the initial training. The Anganwadi Workers were also provided a kit developed by the organization, Gram Mangal for in their Anganwadi center.

#### CLICS Personnel

The Program Staff and DCM personnel were encouraged to attend various conferences, workshops and trainings programs to build their capacities. Details of their participation are as follows:

**Table 2.9: Conference / Workshop / Training attended by DCM Staff / CLICS Staff**

Workshop / Training	Participants	Duration	Organized by
Financial Management workshop at Mount-Abu	Mr. MS Barambe	21/12/2005 to 23/12/2005	AKF New Delhi
Health Management Short Course PGIMER	Ms. Enakshi Ganguli	27/01/2006 to 13/02/2006	Health Management Short Course PGIMER, Chandigarh
Designation For Behavior BEHAVE Framework, workshop	Dr. BS Garg	23/01/2006 to 27/01/2006	The CORE, San Diego, California USA
3rd National Training on SHG Federation	Mr. PVBahulekar	06/03/2006 to 11/03/2006	APMAS, Hyderabad
2nd Short Course on" Design& Evolution of Behavior change Program on Reproductive & Sexual Health"	Mr. PV Bahulkar	13/02/2006 to 18/02/2006	Child In Need Institute, Kolkatta
Joint National Conference of IPHA & IAPSM	Dr. BS Garg Dr. PR Deshmukh Dr. Amol Dongre Dr. Savinder Kaur	21/01/06 to 24/01/2006	SV Medical College Tirupati
Training of Trainers on IMNCI	Dr. BS Garg; Dr. SS Gupta; Dr. PR Deshmukh; Dr. Chetna Maliye; Dr. Savinder Kaur Dr. Amol Dongre	13/02/2006 to 22/02/2006	CLICS Program, Sewagram
Financial Management workshop at Mount-Abu	Mr. SG Bhagat	21/12/2005 to 23/12/2006	AKF New Delhi
Workshop on BEHAVE Framework	Dr. BS Garg	23/01/06 to 27/01/06	San Diego
Short Course on" Design& Evolution of Behavior change Program on Reproductive & Sexual Health"	Mr. PV Bahulekar	13/02/06 to 18/02/06	Child in Need Institute, Kolkata
Short Course on Health Data Management Statistic Software	Ms. S Mokdam Ms. M Khetkade	27/02/2005 to 04/03/2006	Christian Medical College Vellore
3rd National Training on SHG Federation	Mr. VY Yenurkar Mr. PR Bhoi Ms. AO Kakde	06/03/2006 to 11/3/2006	APMAS ,Hyderabad
Communication and advocacy skills for health professionals	Dr. SS Gupta Dr. Savinder Kaur	27/02/06 to 03/03/06	Administrative Staff College of India, Hyderabad
Course on Planning, Monitoring and Evaluation of Community Health Programs, IHM, Pachod	Dr. S S Datta Dr. A Boratne	09/07/06 to 20/07/06	IHM, Pachod
UNICEF workshop on Microplanning	Dr. PR Deshmukh Mr. PV Bahulekar	01/06/06 to 02/06/06	Chandrapur
Process Documentation and Utilization of research findings	Dr. Chetna Maliye Dr. Savinder Kaur	06/06/06 to 14/06/06	CORT, Baroda
Exposure visit to CHETNA, Ahmedabad	Dr. Chetna Maliye Dr. Savinder Kaur	15/06/06	CHETNA, Ahmedabad
Exposure visit to UNICEF site in Chandrapur to learn 'Integrated Village Microplanning'	Dr. Chetna Maliye Mr. PV Bahulekar Mr. P Bhusari Mrs. Alka Kakade	28/08/06 to 29/08/06	Chandrapur
Conference of the network, 'Towards Unity for Health'	Dr. BS Garg	09/09/06 to 11/09/06	Belgium
Indo-US Workshop on 'Maternal and Neonatal Infections'	Dr. SS Gupta	19/09/06 to 20/09/06	ICMR, New Delhi

### IMNCI training for the Health Providers

One of the important developments during this period includes training workshop on IMNCI for the Master trainers identified for the program. Initially, a 10-day training workshop was conducted at MGIMS, Sewagram on Feb 13-22, 2006. WHO India Country Office and UNICEF Mumbai helped in conducting this training workshop. The training program was attended by 14 participants from the department of Community Medicine & department of Paediatrics, MGIMS as well as two were from Health Department Wardha..

Subsequently, two training programs were organized for the IMNCI training of the government health providers. 61 government health workers and CLICS ANMs participated in this program. The village health workers under the CLICS program, CLICS doot, were also trained in IMNCI in two training workshops. 75 CLICS doot participated in this program. A system of monitoring of the performance of IMNCI providers (government health workers and CLICS doot) is being developed.

A second training workshop for training of 'Master Trainers' was undertaken in July 2006. 17 'Master Trainers from Department of Community Medicine & Pediatrics, MGIMS, Sewagram and Government Medical Officers participated in this workshop.

**Table 2.10: Details of IMNCI training conducted under CLICS**

Date	Type of participants	Number of participants
<b>Training of Master Trainers</b>		
Feb 13-22	Master Trainers (Faculty members from Comm Med & Pediatrics; Public Health Nurse)	14
Jul 12-19	Master Trainers (Faculty members & PGs from Comm Med & Pediatrics; Govt. Medical Officers)	17
<b>Training of Government Health Providers</b>		
Jun 12-19	Government Health Workers, CLICS ANMs	28
Jun 27 – Jul 04	Government Health Workers, CLICS ANMs	33
<b>Training of Village Health Workers (CLICS doot)</b>		
Jul 03 – 06 & Aug 01-04	CLICS doot	42
Jul 08-11 & Aug 05-08	CLICS doot	33

### **2.3.3. Health Care through Effective Partnership**

This section focuses on role of effective partnership and participatory collective approaches in ensuring appropriateness, equity, accessibility, effectiveness, acceptability and efficiency of health care in program. It also highlights how enthusiastic collective performance stimulates intrinsic motivations for more focused and process oriented activities.

#### Bal Suraksha Diwas (BSD)

CLICS has promoted Bal Suraksha Diwas (Child Survival Day) on a monthly basis in the Program Villages. The Bal Suraksha Diwas, is an expansion activity of the immunization day, organized in villages through the Primary Health Centers. The CLICS Doot (VHW), members of SHGs and adolescent girls are being encouraged to participate actively during the Bal Suraksha

Diwas. The Village Coordination Committee of the village was entrusted with the responsibility of organizing the day and also ensuring that the beneficiaries access the services. The main activities taken up on the day are check up and weight monitoring of children of 0-3 age group, ANC and PNC check ups, nutrition and health education. During Bal Suraksha Diwas, growth monitoring and promotion is being done for more than 80% of children in the age-group 0-3 years every month. Table 2.11 provides information regarding the services provided through Bal Suraksha Diwas.

**Table 2.11: Villages with Bal Suraksha Diwas**

Sector	Number of villages	Villages covered	ANC service provided	PNC Service provided	Childhood Immunization administered
Anji	23	23	1634	331	2429
Gaul	21	21	1052	168	1642
Talegaon	23	23	1694	291	2587
<b>Total</b>	<b>67</b>	<b>67</b>	<b>4380</b>	<b>790</b>	<b>6658</b>

Attempts have been made to address the gaps between what was intended and what was actually done. Checklists and formats were developed to ensure physical and organisational quality of the service. To ensure smooth functioning, roles and responsibilities have been explained to respective VCC members. A system of quality assurance has been developed. Initially the quality of services provided through the Bal Suraksha Diwas was being monitored by the program staff. Since August, the responsibility to monitor the quality of services of Bal Suraksha Diwas has been taken by Village Coordination Committees.

#### Community Health Clinics

The project has four Community Health Clinics under the program before this reporting period. During the reporting period, total twelve new Community Health Clinics were started: 5 in Talegaon sector, 5 in Gaul sector and 3 in Anji sector. Thus, the total number of Community Health Clinic in the program as on Sep 30, 2006 is 18.



**Table 2.12 OPD services through Community Health Clinics**

Sector	No. of CHC	No. of Clinics	No. of patients
Talegaon	10	529	9124
Gaul	5	153	2442
Anji	3	33	907
<b>Total</b>	<b>18</b>	<b>715</b>	<b>12473</b>

#### Parenting Workshop

Parenting Workshops were organized in all three sectors. Parenting Workshops were held in 51 program villages during the current reporting period. The lesson plan and guidelines for the parenting workshop have been finalized. Innovative methods, e.g. group work, games, positive deviance method and other PRA tools, are being utilized to deliver the messages during the parenting workshop.



Community organiser explaining Growth chart to young couples

**Table 2.13 Sector wise Details of Parenting Workshop**

Sr.No	Sector	No. of Workshops	No. of Couples
1	Anji	15	84
2	Gaul	16	127
3	Talegaon	20	205
	<b>Total</b>	<b>51</b>	<b>416</b>

### Campaigns

During the current reporting period, 138 'Suraksha Aaichi Aani Balachi Mohim' and 58 'Mulgi Wachawa Mohim' were conducted covering all the program villages. The activities basically include community based events and programs in which the cause of the mother and child expounded. The Program staff took special efforts to involve local leaders, opinion makers, public and private health care providers and members from the media. The Suraksha Aaichi Aani Balachi Mohim and Mulgi Wachawa Mohim were organised in all the villages of three sectors of the program.



**Melawa for mother in-laws and males at Pipari sub-centre of Anji sector**

The Village Coordination Committees organized 'Gram Swachhata Diwas'. The sectors technically supported and participated with Primary Health Centre staff in field activities of European Commission supported Sector Investment Program, which is going on in Wardha district. Under this, Melawas for mother-in-laws and males were organised at each sub-centre. People were educated about problems of maternal and child health, immunisation, adverse sex ratio, PNDT act, HIV/AIDS, RTI/STD and Family planning.

**Table 2.14: Village-level activities in the program**

Sector	Suraksha Aaichi Aani Balachi Campaign	Mulgi Vachva Mohim	Parenting Workshop
Anji	94	41	15
Gaul	13	06	16
Talegaon	31	11	20
<b>Total</b>	<b>138</b>	<b>58</b>	<b>51</b>

### **2.3.4 Research, Documentation & Dissemination**

#### **Research**

The following are some studies which are being undertaken through the CLICS program:

- *Reaching the Unreached: A study to find out reasons for partial / non immunization in rural areas of Wardha district:* According to the baseline study, immunization coverage is lower than expected (of the 78% of card-documented children in the program area, 62% of children (12-23 months) are fully vaccinated (Wardha: 90%; Maharashtra: 62%). The remaining children who are not immunized are therefore higher than expected. This study will attempt to document the profile this unreached group for immunization in order to arrive at an understanding of the barriers and facilitating factors of immunization.
- *Morbidity profile of under three years children in rural area of Wardha district:* Though Infant mortality rate, child mortality rate are undoubtedly the extreme manifestations of poor child health, they are no more than "the tip of iceberg" because millions more suffer from ill health. In most of the available studies regarding child health status, the nutritional status, dietary survey, immunization coverage and micronutrient deficiency were assessed with a very few exception in which morbidity profile of the child was also included. Morbidity Profile of under three children is a sensitive indicator of community health, nutrition and accessibility & utilization of health services & the same is being documented in the study.

Data collection and data entry for this study is complete. The final report of this study will be ready by Dec '06.

- *Assessment of Health Care Quality in Primary Health Centers attached to M.G.I.M.S., Sewagram.* : The Quality of maternal and child health services and client satisfaction is the most vital in final outcome. Several methods are available for assessing quality of services ranging from direct observation, supervision, interview of target clients as also examination of records and facility surveys. The study has developed QA tools for different health care providers at PHC, Sc, CHC and private health facility. At present, the study is in an intervention phase where the health providers are being trained on Quality Assurance and the attempt is being made to put the system in place.

The preliminary finding of this study is being given in Annexure 1.

- *Role of Parenting Workshop in improving knowledge attitude behavior and practice regarding maternal and child health care:* A quasi-experimental study, with an objective to find out the role of 'Parenting Workshop' on improving the knowledge, attitude, behavior and practices related to maternal and child health care at family and community level will be conducted in 67 program villages.

All participants of the parenting workshops (during six-month period), are registered in the intervention group. A matching control couple for each intervention couple is identified from the same village. The registered couples are followed. Couples, where the wife becomes pregnant, were considered as another subset for study of practices related to antenatal and young infant care. These couples will be paid a three-monthly visit during their antenatal period and a monthly visit after delivery. A questionnaire for assessing the knowledge and attitude regarding maternal and child care practices at home is being administered to all the couples in both the groups, separately to the husband and wife. The same questionnaire is administered as posttest after a gap of 6 months from the completion of the 2nd day workshop to all the couples in the intervention and control group. At present, data collection for the study is going on. The baseline data collection and entry is complete for the study.

### **Operations Research**

As mentioned in section 2.2, an operation research to find out the effect of 'Social Franchise Model' on child health was undertaken in the program area as suggested in the mini university at the time of finalization of DIP in June 2004. For this, three control PHCs adjacent to the three program PHC areas have been identified. The control PHCs are Waifad, Vijaygopal and Kharangana (Gode). Both quantitative and qualitative exercises were conducted in the study and control area. The Table 6.1 provides the populations of the program and the control PHC area.

**Table 6.1 Population of the program and control PHC area**

<b>Program Area</b>		<b>Control Area</b>	
<b>PHC</b>	<b>Population</b>	<b>PHC</b>	<b>Population</b>
Anji	31482	Waifad	27212
Gaul	18700	Vijaygopal	17493
Talegaon	37946	Kharangana (Gode)	36771
<b>Total</b>	<b>88128</b>	<b>Total</b>	<b>81476</b>

### **Methodology**

As the sampling frame was not available for the control arm PHCs i.e. Waifad, Vijaygopal and Kharangna-Gode PHC areas, adoption of simple random sampling was not possible. So the 30 cluster sampling technique was adopted for the survey. However, using the baseline estimates of various indicators, sample size was first calculated and then the same was reconstructed

considering the design effect. To cover the requisite number of individuals cluster size was fixed as 10. A household with a child under age 3 years was selected.

In all 5 interview schedules were administered for data collection. The schedules are-

- Household Schedule
- Woman's Schedule (Woman with 0-3 yr child)
- Child's Schedule (child under age 3 years)
- Husband's Schedule
- Adolescent Girl's Schedule

It is to be noted that the areas which are very close to the urban or have grown urban were excluded from the CLICS Baseline. On the same lines urbanized area were also excluded from the control arm PHCs.

The qualitative survey was conducted in 60 clusters, 30 clusters from program area and 30 from control area. The qualitative method used for this purpose was Focus Group Discussion. In each cluster, the FGD was conducted with mothers, adolescent girls and men separately

### **Documentation**

'Documentation & Communication' is one of the important activities of the program. It is being seen as the "*Window to Child Survival Information*". Ms. Ila Vakharia, from CHETNA visited the CLICS programme on 8<sup>th</sup> and 9<sup>th</sup> March 2006 and helped CLICS project staff to firm up the documentation plan.

Processes of activities like formation of Village Coordination Committees, progress of Community Based Organizations, income generation activities, selection of Village Health Workers are being regularly documented. This includes key stages of forming groups, issues taken up, difficulties faced and strategies drawn. Case studies are being documented for the lessons learnt and problems encountered to capture the programme learning.

### Samvedana

At the village level, through its newsletter "*Samvedana*", DCM enables the community institutions to share and learn from each other. The CLICS personnel were also taken care about the information dissemination of Samvedana, through Community or Group reading activities. The publication and distribution of newsletter "*Samvedana*" was initiated since March 2004.

Two special issues of Samvedana from Gaul Sector and Anji Sector of the CLICS program have been published in the current reporting period. The 54<sup>th</sup> issue of Samvedana covered all the major activities of the sector including experiences and success stories. Some poems on CLICS program written by villagers were also included in the issue. The 55<sup>th</sup> issue of Samvedana from Anji Sector published innovative concepts of the Village Coordination Committees in the sector.

### Reporting

Quarterly Financial reports & half yearly narrative reports have been prepared and dispatched as per schedule. All the reports have been prepared as per the guidelines provided.

### Dissemination through Mass Media

Print Media was utilized to disseminate the message for masses and awareness creation. The news was published in most of the major Marathi news papers and received good impact. Most of news was related to different activities of CLICS programme; viz.: activities of Self Help Groups, Kishori Panchayat, Kisan Vikas Manch, Village Coordination Committees and Kiran Clinic..

### Development of documents

The following documents have been developed under the CLICS Program during the year 2005-2006.

1. “Gram Samanway Samiti (Village Co-ordination Committee) – a Community Led Initiative for Child Survival”; by – Shilpa Modi, an external consultant

This document is to explain the processes undertaken to form, operationalise and strengthen the ‘Gram Samanway Samiti’ or Village Co-ordination Committee as a focal point for implementing the ‘Social Franchise Model’

2. “A Qualitative Enquiry into the Functioning and Growth of the Kishoree Panchayats as an integral part of CLICS”; by – Anubhooti Arora from Tata Institute of Social Sciences; Intern, Aga Khan Foundation

This document is an attempt at documenting and recording the formation, growth and evolution of the adolescent girls groups or “Kishoree Panchayats”, as partners in the Community Led Initiatives for Child Survival (CLICS) program.

3. “Case Studies”

Two case studies are under process of publication in the CLICS program;

- a) Kisan Vikas Manch (KVM): Kisan Vikas Manch (Farmer’s Development Association) has been formed in all 67 villages under CLICS program. The present case study regarding a KVM tries to capture how sensitized community members and collective approach can bring changes in the community in child survival and related reproductive health activities.
- b) A Lady Gram Panchayat Sarpanch: The present case study regarding a ‘Sarpanch’ from one of the CLICS program villages tries to capture how a lady ‘Sarpanch’ discharges her responsibilities effectively and facilitates conducive environment for preventive and promotive health through VCC.

Apart from these documents, the following program documents describing program strategy have also been finalized under the program:

1. Documentation Plan
2. Communication Strategy
3. Behavior Change Communication plan
4. Behavior Change Communication Strategy
5. Human Resource Manual
6. Financial Handbook
7. Drug Costing Policy
8. Operating Cost of Kiran Clinic
9. Quality Assurance Plan
10. Formative Research
11. LOGFID and Draft of IMI
12. Training Needs Assessment (TNA) and Training Plan

### **Research Papers**

During the current

1. AR Dongre, PR Deshmukh, BS Garg. Impact of School Health Education Program on personal hygiene and related morbidities in a tribal school in Wardha. Indian Journal of Community Medicine 2006 April – June; 31(2): 81-82.
2. PR Deshmukh, SS Gupta, MS Bharambe, AR Dongre, C Maliye, S Kaur, BS Garg. Nutritional status of adolescents in rural Wardha. Indian Journal of Community Medicine 2006 Jan – Mar 31 (1): 26-27.

During the reporting period, four research papers have been submitted for publication in different recognized journals:

1. AR Dongre, PR Deshmukh, BS Garg. Danger signs among newborns: perceptions and health care seeking behaviors among rural mothers of Wardha. (Submitted to Indian Journal of Pediatrics)
2. AR Dongre, PR Deshmukh, BS Garg. Effect of socially marketed tap fitted to mud container and/or sodium hypochlorite solution on diarrhea prevention at household level. (Submitted to World Health and Population)
3. N Sinha, PR Deshmukh, BS Garg. Evaluation of WHO color scale and palmar pallor for screening of anemia among children (6-35 months) in rural Wardha, Central India. (Submitted to Tropical Pediatrics)
4. Enakshi Ganguly, PR Deshmukh, BS Garg. Quality assessment of private practitioners in rural Wardha, Maharashtra. (Submitted to 'The National Medical Journal of India')

### **2.3.5. Behavioura Change Communication (BCC)**

With the help of Dr. A. Dyalchand, a BCC macro plan was developed by the CLICS staff in a three-day internal workshop at DCM, MGIMS Sewagram during 16-20 January 2006. A framework for the BCC strategy was made during the workshop. It was decided that Dr. Dyalchand would conduct training programs for the Assistant Program Officers and the Community Organizers in the April – May, 2006.

Following the training, an internal programme staff meeting for a day was organized for development of BCC plan on 4<sup>th</sup> February 2006. The meeting began with the reviewing the BCC plan prepared during 16-20 January 2006. The meeting participants discussed and redefine the behaviors listed in the previous list. The house finalized the following 20 key behaviors for BCC:

1. Mother has ability to recognize the hypothermia and ensures that the baby is kept warm
2. Mothers recognize and take appropriate care to manage the LBW baby
3. Mother recalls the danger signs in new born and seeks appropriate medical help
4. Initiate and continue EBF immediately after birth until 6 months of age
5. Mother washes hands after defecation (self as well as of baby), before cooking food and before feeding the baby
6. Mother initiates appropriate complementary feeding at 6 months and continues breast feeding
7. Parents participate in growth monitoring and seek appropriate care in case of malnutrition.
8. Mother ensures child's primary immunization by the age of one year including first dose of Vitamin-A.
9. Mother ensures 5 doses of Vitamin-A by 3 years of age.
10. Mother takes proper care of child with ARI, recognizes danger signs and seeks appropriate medical help if needed.
11. Mother takes proper care of child with diarrhoea, initiates ORS, recognizes danger signs and seeks appropriate medical help if needed.
12. Pregnant mother seeks minimum 5 visits of which one is before 12 weeks, consume 100 IFA tabs & 2 TT injections. She is able to recognize complications during pregnancy and seek appropriate medical help.
13. Mother prepares for birth and plans (place, money, identify referral, transport in case of emergency)
14. Mother receives 5 PNC visits out of which 4 should be in first 28 days, able to recognize complications, take adequate diet and rest.
15. Mothers delay first pregnancy and keeps birth interval of 36 months
16. Women between 15-44 yrs ensure proper menstrual hygiene.
17. Women between 15-44 yrs recognize RTI/STI and seek appropriate care
18. Men recognize RTI/STI and seek appropriate care
19. Adolescent girls (12-19 yrs) consume iron rich diet
20. Child (0-3 yrs) has access to age appropriate toys at household level

According to the strategy developed, a doer and non-doer analysis is conducted for selected behavior at sector level. The sectors submit the findings of doer and non-doer study to the responsible team of members of Technical Support Team for each behavior. The team then analyzes the findings, discuss and finalize the BCC strategy for the particular behavior. This strategy is implemented in all three sectors. During the current reporting period, 'BEHAVE framework was utilized for the following five behaviors:

1. Initiate and continue EBF immediately after birth until 6 months of age
2. Mother initiates appropriate complementary feeding at 6 months and continues breast feeding
3. Mother washes hands after defecation (self as well as of baby), before cooking food and before feeding the baby
4. Mother takes proper care of child with ARI, recognizes danger signs and seeks appropriate medical help if needed.
5. Mother takes proper care of child with diarrhoea, initiates ORS, recognizes danger signs and seeks appropriate medical help if needed.

A sample BCC strategy developed using the above-mentioned approach for the behaviors 1) Initiate and continue Exclusive Breastfeeding immediately after birth until 6 months of age; and 2) Mother initiates appropriate complementary feeding at 6 months and continues breastfeeding; has been given in Annexure 2.

### **3.0 PROGRAMME MONITORING AND EVALUATIONS**

The objective of monitoring is to periodically assess the effectiveness of various program components. The monitoring system aims to ensure the compatibility and integration of different data – performance and impact to analyze the efficiency of the programme interventions.

#### **3.1 Management Information System**

CLICS intends to develop a Management Information System (MIS), based on *Information Equity*<sup>2</sup>, a practice which ensures that the level of awareness and knowledge of an issue, health problem or program is shared among different individuals within a group and among different groups in a community. The practice also ensures that the community has access to corresponding information sources. In general, communities in India have little or no access to reliable health information or sources. CLICS will ensure Information Equity by involving community institutions in the design, collection and use of data from the MIS. This enables community institutions to monitor and understand changes in health status, crucial for sustainability of Program gains.

Program MIS development strategy has been developed with the internal resources & with support of AKF (I). The CLICS MIS Development Plan was finalized in the first quarter of the 3<sup>rd</sup> year of program. The sets of indicators to be monitored through MIS have been finalized.

The routine data collection for monitoring of various program activities is already in place. However, the data collection formats observed some modifications depending on the need of the time and advancement in the program activities. At present, a comprehensive Monthly Progress Report for Community Organizers is being used to collect data and monitor progress of program activities. This data is collected at the village level. A comprehensive report is then prepared at the Sector level and forwarded to the Program Central Office. Using the internal resources, a software module has been developed to maintain the data of financial activities of Self Help Groups. The software module facilitates analysis of the data at different levels viz. group, village,

---

<sup>2</sup> Figueroa EM, et al: *Communication for Social Change: An Integrated Model for Measuring the Process and its Outcomes*, Communication for Social Change Working Paper Series: No. 1, Johns Hopkins University's Center for Communication Programs for the Rockefeller foundation, 2002.

sector and program. This data on financials of SHGs is collected every month for each group in the program area.

The computerization of the CLICS MIS was earlier initiated using the internal resources. However, later on the task of software development was out sourced. During the last six months, MIS team primarily worked for computerization of the system. The task is now in its final stage and the team is coordinating with the software development firm for pulling the existing data into the software and report testing. Some of the indicator driven reports from monthly progress report data are working, but need certain modifications for the better interpretation. The computerization of CLICS MIS is expected to complete in about 1½ months' time.

Apart from this the team is also working on Excel based analysis module for PHC monthly reports and developing a register for reporting of home visits and maintaining records of sick children and treatment as per IMNCI guidelines.

### 3.2 Future plans

- Further strengthening of MIS to capture BCC indicators.
- Strengthening monitoring of Cost Recovery Mechanism of CHC (will be completed by November 2006).
- Identifying indicators to help community to monitor the village level activities.
- Identifying person to build capacity for use of MIS at village level.
- Making software functional to its full strength by December.
- Appraisal of existing use of secondary data from existing Govt. MIS, as new MIS has been put in place.
- Convergence/modifications upon existing Government MIS.

## 4.0. CHALLENGES AND LESSONS LEARNED

### 4.1 Challenges

- **Non-availability of suitable candidates for Program Coordinator:** The major problem encountered by the program was not getting a suitable candidate for the post of Program Coordinator. Sewagram being a rural area, health professional with appropriate training and experience did not find it a good place for their personal growth. This resulted in the post of Program Coordinator being vacant for a long time.

DCM solved the problem by appointing two Post-graduate students in Public Health with two years experience as Assistant Program Coordinator in the CLICS program.

- **Difficulty in getting Consultants:** Difficulty in getting suitable consultant in BCC and documentation led to the delay in the development of BCC and Dissemination plan. However, the program was able to engage Dr. Ashok Dyalchand as consultant BCC and Ms. Ila Wakharia as advisor documentation during the current reporting period.
- **Preventing loss of institutional memory in a situation of high staff turnover:** The staff turnover in the program is high, especially for the positions of Program Officers. In such situation, the program needs to develop a mechanism for loss of institutional memory. At present, this is overcome by maintaining records and other documents of the activities and case studies in the field. The involvement of permanent staff from the DCM is also helping in preventing the loss of institutional memory for the program.
- **Keeping away from village politics/ conflicts among community members:** One of the challenges in any community-based intervention where community participation is the mainstay of the program is keeping away from village politics/ conflicts among the community members. CLICS, till now, has successfully avoided involvement in village

politics by proper training of the field staff and transparency in the program activities at the village level.

- **Convincing community that misappropriation of funds will not happen:** Although CLICS has successfully garnered community participation and has mobilized community contribution for child survival, the community initially looks towards such initiatives with doubt. Once they get convinced that funds will not be misappropriated, they actively come forward to contribute towards the program. This will remain a challenge for any organization which initiates such programs.

#### 4.2 Lessons Learnt

- **Delegation of responsibilities to subcommittees and individual members make people participate actively:** After formation of first 32 Village Coordination Committees had been completed, it was realized that the committees, in most of the villages, had become inactive and the attendance of members during the monthly meeting was gradually coming down. This issue was discussed with the members of Village Coordination Committee as well as in the meeting of Technical Support Team. It was realized that this has happened as proper delegation of work to the members of Village Coordination Committee has not been done. A training of the Assistant Program Officers and Community Organizers from all three sectors was done. A decision was taken to ensure that each VCC should have their Vision & Mission statement. They were also encouraged to form subcommittees (e.g. Health, Water & Sanitation, Information dissemination etc.) within the Village Coordination Committee and each member of VCC has specific task to perform.

Following the implementation of above-mentioned plan, the VCC members have started actively participating in the village level activities and the attendance in the monthly meeting has also improved significantly.

- **Support from the community and need-based training motivates government health providers:** One of the important strategies of the CLICS program is to empower the government health workers and improve the quality of health services provided by them at village level. During the initial phase of the program, there was lots of apprehension that the program may not be able to garner enough support from government health workers. However, as the program progressed, increased involvement of Government health workers in all the program activities was witnessed. During discussions with them, the health workers appeared interested in CLICS program and accepted that the training provided through the program and the support from the community during service delivery (especially Bal Suraksha Diwas) makes their task easy.
- **Innovative ideas and new assignments keep the staff interested:** While working in a program, the field staff often get bored and fatigued doing same thing again and again. CLICS program provides enough platform for its staff to share and implement their own innovative ideas in the community and thus is able to avoid boredom and fatigue of its staff.
- **Community members act as important vehicle for behavior change:** CLICS program is working on the concept of building the capacity of community members so that community is able to own their own health program at village level. During the initial phase of community mobilization, it has been realized that there is significant achievements in various indicators related to health behaviors. The credit for the behavior change in community goes mainly to the community members who acted as a vehicle for the behavior change message.

- **The responsibilities of program staff (community organizers) may be delegated gradually to community leaders/ volunteers:** Initially, the community organizers had to be present in each meeting of the Community-based Organization. Later on, it was decided that the Program will appoint 'Master Trainers' for Kisan Vikas Manch and on experimental basis 'SHG leaders' in a few villages. At present, 9 'Master Trainers' for Kisan Vikas Manch and two 'SHG leaders' for Self-Help Groups under the program are working. They are well accepted by the community. With their inclusion in the program, the Community Organizer has more time to work with the Village Coordination Committee.
- **Government health providers want opportunities for their skill development:** The CLICS program is trying to build the capacity of Government health providers. Initially, we had apprehension that the government providers will not be interested in the training programs to build their skills. However, the program staff were surprised to see the involvement of the government health providers in the training program. The government health providers are also using the skills learnt while providing service to people
- **Participatory evaluation of VCC activity helps to improve activities:** In Anji sector, during annual review, participatory evaluation of the health activities initiated by Village Coordination Committee was done. It was realized that when the community members participate in evaluation of the activities of Village Coordination Committee, they also show greater involvement in the program.
- **Working together with Government and Non-government organizations create new opportunities at village level:** CLICS program involved the local Non-governmental Organizations working in different domains from very beginning. These local NGO partners have helped to a large extent in the implementation of the program.

One of the key community-based organizations promoted through CLICS program is Kisan Vikas Manch. However, the capacity of DCM/ MGIMS, Sewagram in the field of agriculture is limited and therefore, it was getting difficult to conduct activities of Kisan Vikas Manch. The two local NGO partners, Acharya Shriman Narayan Rural Polytechnic, Pipari (Meghe) and Dharamitra, proved to be of great help in the capacity building of members of Kisan Vikas Manch. In collaboration with these NGO partners, nine master trainers for Kisan Vikas Manch were identified and they were provided training for the master trainers thus identified. With the help of these NGO partners, a few training programs for unemployed village youths and adolescent girls have also been organized.

## 5.0 PLANS FOR THE NEXT SIX MONTHS

The issues to be addressed during next year are:

- BEHAVE framework on 20 identified behavior followed by TIPS by end of 2007
- Capacity building of VCCs in planning, implementing & managing health interventions
- Implementation of IMNCI, home based management & SBA program
- BCC activities at village level
- Setting up of more Community owned health clinics & making sub centers operational
- Strengthening cost recovery mechanism for VCC activities
- Finalization of IMI
- Developing 2nd agreement for Ownership with few VCC based on their scoring n IMI

The detailed plan for next year is given in annexure 3.