Counterpart International, in partnership with Saath, a national NGO and Ahmedabad Municipal Corporation (AMC - Department of Health), has been implementing the Jeevan Daan (JD) program since the year 2000. This program covers 364 slums (total population: 225,000) across 10 municipal wards in Ahmedabad city. The program is supported by USAID/India.

**Program Objectives:** JD program aims at – i) improving maternal and child health behaviours at household-level, ii) improving quality and accessibility of health services provided by AMC personnel/facilities, iii) establishing AMC linkage with community through facilitating formation of community groups, iv) community linkage with private providers, v) enhancing capacity of community groups to form institutions that sustain health initiatives and vi) strengthen capacities of AMC and Saath to plan, implement and evaluate the program in the targeted urban slums.

**Technical Interventions:** These include - Control of Diarrhoeal Diseases (25%), Pneumonia Case Management (15%), Expanded Program for Immunization (10%), Nutrition and Breastfeeding Promotion (20%) and Maternal and Newborn Care (30%). Thus, 85% of interventions are directly related to improving nutrition status of mothers and children.

**Target Groups and Delivery Channels:** The program targets pregnant and lactating women and children less than two years of age. At community-level, the key delivery channels are 12 Community Organizers (COs) and close to 550 voluntary community health team (CHT) members organized as 63 teams with each CHT having 5-16 members. The 12 COs are the employees of the partner NGO-Saath and get a monthly salary plus the local conveyance. CHTs are active slum women working totally on voluntary basis except that they are paid fare towards commuting to training venues whenever required. One CHT looks after 82 target households roughly. One CO looks after one ward (approximately 30 slums) and 25-50 CHTs. The COs and CHTs have been provided induction and biannual refresher trainings on all program interventions by staff of counterpart international. Other stakeholders at Ward level include: other NGOs, local leaders, street vendors, TBAs, private medical practitioners, Anganwadi workers, link workers (cadre equivalent to ANM in rural context).

In four wards (Raikhad, Danilimda 1 and 2 and Jamalpur), the more mature and active CHTs are being mentored as core groups to sustain their interest and increase their access to micro-credit and livelihood options of Saath / other NGOs. Forty four of close to 550 CHT members have been identified to be the members of core groups. The core group members are elected by each CHT themselves. The primary activity of core group is to liaise with the government and other agencies for the well-being of the community.

**Intervention Strategy:**

1. **Behaviour promotion:** Behaviours are promoted at household level by counselling of mothers and their family members by COs through 450-500 home visits per month. Additionally, health education sessions (HES) are also organized with groups of expectant and lactating mothers regularly by CHT/COs as per the needs identified. The process is facilitated through visual aids such as flip-books, pamphlets, posters, wall-hangings, torans, video shows, puppet-shows and street plays. CHT members play an important role here by assisting COs in conducting HES/counseling. CHT members record their work through simple pictorial formats.

2. **Outreach services/camps:** Though Jeevan Daan is not directly involved into service delivery, the field staff closely assists AMC in successfully conducting the weekly Mamta

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1 Counterpart international/India website
campaigns / immunization camps by providing counselling to the target group and increasing visibility/accessibility of the services being provided by AMC mostly through referral chits and word of mouth.

3. **Referral support through referral chit system:** Linking communities to the existing health systems is a key effort of Jeevan Daan. To encourage individuals to access the government health care services, the referral chit was introduced by Jeevan Daan. It was seen as an attempt to link the communities to the health system directly.

4. **PD/HEARTH Interface:** PD/HEARTH Interface is a nutrition education and rehabilitation program for malnourished children 6-36 months of age operational in 10 municipal wards where ICDS is also operational. The program is taking place through Anganwadis at the Anganwadi centres. First, the Anganwadi worker with assistance from the CHT member weighs all children 6-36 months at the Anganwadi Centre to identify malnourished children (Grade II and Grade III). Then, they (Anganwadi and CHT member) motivate mothers of malnourished children to participate in cooking demonstration and group feeding sessions. Simultaneously, mothers who live in the same slum pocket and yet whose children are not identified as undernourished (not Grade II or III) on weighing are also contacted and encouraged to volunteer to help the Anganwadi worker in these sessions to motivate others and share their secret of what are the behaviours they practice which is making their children healthy. A training and a planning meeting is then organized with the Anganwadi workers, their supervisors and positive deviant mothers. At the beginning of a hearth cycle, each child is weighed-in and the measurement is marked on a chart. They are also examined by the Medical Officer from the Government Urban Health Centre. The hearth cycle lasts over 12 days each followed by a gap of 15 days after which, another 12 day cycle begins. The demonstration/active feeding session lasts for 2 hours a day and has on average 8-12 mother-child dyads as participants. Participant mothers of undernourished children learn and practice good behaviours. In the spirit of learning by doing, on each of these 12 days participating child receives a nutritious meal prepared by two or more participant mothers in rotation. Conventionally, hearth approach mandates contribution from the participating mothers in terms of raw material. Same approach is followed here too, the only addition to it is the inclusion of supplementary food provided under the ICDS thereby ensuring the purposeful utilization of the same which otherwise goes unutilized. The participating mothers also volunteer and cook the food during the sessions. Each child and the mother is taught to learn about hygiene to make the intervention more meaningful. After 12 days, the children are again weighed. Then mothers are asked to practice these behaviours for two weeks. During these two weeks the Anganwadi and the CHT member is instructed to ensure that mother practices the behaviours and motivate her to do so. Those children who remain malnourished are included in the second hearth cycle. The community is made aware of results from the PD/Hearth Interface through street plays/group meetings. The program does maintain the weighing-in (at the beginning of a hearth cycle) and weighing-out (at the completion of the cycle) data to establish the effect of the hearth intervention. The Program employs a fulltime nutritionist entrusted with developing locally popular recipes ensuring that the nutrition content is not compromised and the food is palatable to the child. There are various Gujarati recipes including dal-dhokla, sukdi, upma, vegetable khichdi, kheer, sheera etc. Among all the interventions being implemented, HEARTH is most popular amongst the communities. It has also got full support from government and other NGOs hence virtually there are no problems as such. However, convincing the decision makers at household level (husbands and even more so, mothers-in-law) to allow the mothers to participate in HEARTH sessions is most challenging part of the process.
JD PD/HEARTH program has completed 20 cycles of Hearth. Data from 16 cycles shows that there has been remarkable improvement in nutritional status of children (Box 1)

<table>
<thead>
<tr>
<th>Pre Intervention (Weigh In)</th>
<th>Post Intervention (Weigh Out)</th>
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</thead>
<tbody>
<tr>
<td>Grade II</td>
<td>Grade II *</td>
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<tr>
<td>107</td>
<td>90</td>
</tr>
<tr>
<td>Grade III</td>
<td>Grade III *</td>
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<tr>
<td>43</td>
<td>27</td>
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Impact: Most recently, Counterpart is working on infusing hearth intervention into the ICDS and training ICDS staff on this approach.

Behaviour tracking and monitoring mechanisms: The community organizers (CO) visit the areas regularly to keep track of the behaviors prevailing in community and record them in simple formats. The program has a well defined monitoring and evaluation matrix with indicators outlined to track processes and outputs. Community-based activity report tracks processes. Household visit checklist tracks output performance and KPC surveys are conducted to assess effect. The recent evaluation of the program was conducted in May-June, 2007.

Key outcome and process indicators: Between 2000-07 (8 years) the immunization rates for children aged 12-23 months have risen from 29% to 66.2% and for tetanus toxoid for women from 72% to 90.7%. Quick treatment of children with pneumonia on the same day has increased from 24% to 57%. Percentage of children initiated breastfeeding within 1 hour of birth have increased from 19% to 41.5%. Links between health facilities and community have been established. Urban specific BCC materials have been developed and AMC has adopted them for all the 43 wards. There has been strong partnerships and cost share on the part of AMC. Recently Government of Gujarat has invited Counterpart to up scale the Jeevan Daan program in Surat & Bharuch districts of south Gujarat. The CDTs are slowly taking charge of the program, meetings of core groups takes place once every 3 months. The most important thing common to all the accomplishments of core groups is that the activities are entirely planned and coordinated by the members; staff from Jeevan Daan only played as facilitators. The next steps would be to enhance core groups relationship with the AMC’s health system and move towards ward level CBOs and finally to city-level federation.

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World Vision, India

World Vision India, is a Christian humanitarian national non-government organization. It works to improve lives of children, families and communities living in poverty and injustice in 105 districts across 24 states in India through its Area Development Programs (ADP), emergency response and disaster mitigation programs and advocacy initiatives.

ADP North Delhi, Jaipur and Kolkata have been implementing a PD/HEARTH program in slums to improve the nutrition and survival of severely malnourished children 6-59 months of age. While principles of implementation remain the same, strategies are contextualized as appropriate to context. PD/Hearth program in Delhi although initiated was withdrawn on account of lack of need and participation of community. ADP Kolkata had implemented this program and currently it’s ADP Jaipur which is implementing this program.

Briefly, ADP Jaipur is being implemented in 5 slums (pop: about 80,000). Initiatives of each slum are looked after by community development coordinator (CDC). Each CDC is supported by a health and nutrition coordinator. As of now, there is no health and nutrition coordinator. In each slum a cadre of volunteers, age 18 years or more, married/unmarried educated atleast about class five, are also identified and trained. Each volunteer is paid a monthly honorarium between Rs. 800-1,000/- and takes charge of 1,000-1,500 population. None of these CDC areas have an ICDS program. These volunteers are responsible for conducting timed home visits to homes of pregnant mothers for counselling (4/5, 6/7, 8/9th month) maintaining behaviour tracking records and implementing the PD/Hearth. To aid counselling and understanding, a contextually appropriate pictorial flip book is used. Each volunteer is trained in PD/HEARTH using 5 day theory/class room teaching and thereafter five day practical training when they conduct growth monitoring sessions and PDI. Community volunteers also provide mobilization support during outreach health services. ADP also does some district level coordination to ensure the population receives the health services and provides transport support to government ANM. Behaviour tracking of initiatives is done through cohort tracking registers which is used to complete Also through population based surveys. Project MIS developed in line with child survival programs.

PD/HEARTH Program in Jaipur Slums:

**Identifying poor families and PDs:** Each volunteer enlists all children aged 6-59 months from her cohort registers. She then conducts a wealth ranking exercise in homes of enlisted children to identify which of these households are rich or poor. The ‘not so rich’ are also categorized as poor. For wealth ranking parameters used are income, household conditions and assets. Once a list of all children and their wealth ranking is done, then a growth monitoring session is held at a common venue to identify malnourished children (Grade I, II, III). The weighing scale used is Salter’s weighing scale. The volunteer is provided a new scale each year by the ADP to avoid any weighing errors. Those enlisted children not weighed at the session are weighed through a home visit. The weight of each child is plotted on the WHO 2006 growth chart. Weighed children are categorized in one of the following four categories – positive deviant (poor and yet well nourished i.e., have weight-for-age above 0 SD or borderline between 0 and -1SD), non-positive deviant (poor and malnourished i.e., below -1 SD), negative deviant (rich yet malnourished) or none of the above. In the Jaipur program, across five CDCs, 2000 children were weighed and only 7 children were identified as positive deviants.

**PD Inquiry:** A PD inquiry (PDI) is then conducted in PD homes during which volunteers identify the feeding, hygiene, health seeking, caring practices of PD families. This is a one day interview and observation of such families deeply observing their environment and practices. A 24 hour dietary recall is used to identify the types, frequency and amount of local

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food fed to the child. PDI is also conducted in NPD to understand some of their practices and also some of the positive practices they follow. In Jaipur ADP program, the PDI found that PD children were fed in their own Katori, atleast 3-5 times a day a specific amount by their mother or elder sister. The food fed was local and comprised their daily staple diet. In one of the PDI by ADP Jaipur, at Nazzia’s home, a PD family, the observer saw that 15 year old daughter while making the garlic paste/chutney to add in the food, she washed the garlic bulb and divided it into sections and then grinded the sections but did not remove the papery protective peel, which other wise is considered non palatable. On asking she said-“this is helpful for the stomach”. She mentioned during the same for potatoes.

**Preparation for the hearth:** Post PDI both positive and negative practices – feeding, care, and health seeking, identified are noted. Through a community meeting results of PDI are shared. Participation of mothers of malnourished and local stakeholders is ensured in such meetings. Participation, consent and advice are sought on need to re-habilitate the malnourished children using HEARTH.

**Hearth sessions:** HEARTH (or hearth meaning surround of a fire place) is then implemented for 12 days with mothers of the identified malnourished child along with the child. The venue is selected and made available by the community themselves. Basically, this is a nutrition education and re-habilitation sessions’ venue wherein volunteer assists mothers of identified malnourished children in preparing meals for their malnourished children, using the beneficial, locally-available foods that were identified through the inquiry. Mothers/caregivers bring a daily contribution of food and/or materials to these sessions. They process, cut and cook the food and feed their children together. It is a two hour session, carried out at a time convenient to mothers.

Whatever food and the amount the PD children are eating that is only was used for the PD meals. In the ADP Jaipur setting, staple foods consumed by PD children were a pulse, vegetable and rice or wheat chapatti. These hence formulated the PD foods on which menus were developed. In each hearth cycle, 8-12 children are enrolled. Priority is given to severely undernourished and those with siblings. Cycles are continued till all malnourished children are covered. Each CDC starts the first cycle of hearth simultaneously. But within each CDC, a staggering approach is used to implement hearth cycle. In this, the first volunteer starts a hearth in her area. The second volunteer starts her hearth after 3 days and first volunteer helps her in starting the hearth as she as already spend 3 days in during so and is hence aware of the teething problems. It takes about a month to complete two hearth cycles for each volunteer and cover all malnourished children within her allocated area. During the hearth, the food, cooking oil and utensils for cooking are arranged by the participant mothers only. Occasionally ADPs may donate 1-2 utensils, spices or some oil at the start of a hearth in extremely poor and needy areas. However, this practice is strictly discouraged. Each mother is informed to get her own quarter plate/katori and a spoon to feed the child. Active feeding styles and important child care messages are shared with the participant mothers. When the children come, they are asked to wash their hands with soap and wipe their hands with a towel. Mother is asked to cut the child’s nails too for which a nail cutter is provided. In ADP Jaipur program, even some malnourished children from rich families are included in hearth as the program objective is to rehabilitate all children. PD mothers and their PD child/ren are also included so that the PD mother can demonstrate through cooking to the mothers of malnourished.

On the 1st day of Hearth, all participating children are weighed, de-wormed, immunized, and provide needed micronutrients (if needed). After 12 days an exit weight is also taken. The child should gain atleast 400 grams to be considered to have graduated from the hearth. If
only 200 grams weight gain is seen then referral is suggested. If the child is extremely poor the ADP takes responsibility to support the hospitalization costs. Follow-up counselling visits at home through volunteers for 10 days on daily basis. Herein, mothers are negotiated to continue the behaviours promoted, continue to access these and other preventive health services including growth monitoring. She assesses the danger signs indicative of referral and suggests the same. Those children who remain malnourished after one hearth cycle are enrolled for another cycle. Each child is eligible to attend two cycles. The weight of these children is monitored until two years of age.

In ADP Jaipur, PD/HEARTH activities started in November, 2008. By the year end, 10 sessions have been 4 CDCs have completed 10 sessions, covering 125 children. Of these, 35 gained at least 400 grams and 65 gained 200-400 grams. A few lessons that emerged are – mothers on daily wage labour and go in the morning and come in evening do not have the time to attend PD/HEARTH sessions. To ensure no caste/class problems within each hearth, sessions can be held in each locality. No form of food contribution should be given by an organization in the hearth and it should be solely managed through community contributions. PD/hearths should take place preferably in poor and needy communities and where community accepts the need for it.

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Calcutta Kids

Calcutta Kids Trust is a non-government organization committed to improving nutrition and health of the poorest children and expecting mothers in the underserved slums in and around Kolkata India, by increasing their access to health and nutrition services, providing them health information, and encouraging positive health-changing behaviours.

The Maternal and Young Child health initiative (MYCHI) is one of its programs for reducing maternal and child undernutrition. This is a three-year pilot program started in late 2005 for improving health knowledge and increasing access to healthcare for young pregnant women and their children ages 0-3 living in Fakirbagan slum of Howrah, India. This program reaches out to 20,000 population and is funded by Calcutta Kids International, USA. The MYCHI is briefly described below:

**Target group:** Pregnant women, mothers of children under the age of 3 and their children.

**Delivery channels** are Community Health Workers (CHWs)—some are from the very slums in which they serve and some come from adjacent communities to which they serve. Calcutta Kids currently employs 4 such CHW. Some of these workers are mothers who were practicing positive behaviours despite resource constraints and had visibly well nourished children. CHWs are paid an honorarium of 2,000/- per month. Each CHW is in charge of a distinct area of the slum and carries a caseload of 25-30 target families.

**Training/Capacity Building of CHWs:** Intensive in-house training for all CHW’s was carried out in groups through outside experts as well as one-on-one tuition with project coordinator. Topics range from behavioural change communication strategies to development project management to monitoring and evaluation.

**Strategies:**

**Home visits by community health workers:** Identification and registration of pregnant women in the program is done by the CHW on monthly basis. Each CHW conducts home counselling visits to pregnant women on bimonthly basis. Post-delivery these mothers are met bimonthly in the first month postpartum and then on monthly basis upto six months postpartum. Counselling is provided on recommended behaviours, as applicable to them (prenatal, birth preparedness, intranatal, postnatal, infant feeding and birth spacing), their progress is monitored using a monitoring format and they are informed about immunization scheduling. All mothers of children 7-35 months are also informed about immunization scheduling and motivated to access these outreach services. These home visits are important in monitoring a woman’s health but they also serve as a confidential means for women to talk with a caring CHW about personal problems. These visits also provide the assurance to a pregnant woman that a caring CHW is watching out for them and is genuinely concerned about their health and the health of the developing life within them.

**Weekly Health Clinics and medical case management:** The weekly health camp is a mobile outpatient clinic which is set up every Tuesday in donated space provided by the Welfare Society of Fakir Bagan. Between the hours of 8:30 and 11 A.M. each Tuesday, the Welfare Society, a small clubhouse in the center of the slum, is turned into a clinic charged with the task of bringing health services to the people. For a nominal fee of only 5 rupees (approximately US$0.12), pregnant women and children under the age of three (with a caretaker) go through a triage/registration process where CHWs pull out a card with that person's medical history, or create a new one. The patient then receives a medical consultation from a highly respected and deeply committed private medical practitioner. Following the consultation, the patient takes his/her card to the pharmacy where the prescribed medicine is provided. The patient then meets with a Calcutta Kids staff member who provides counselling to the patient on e.g. how to take the medicine, danger signs to watch for, and the importance of finishing the prescribed medicine. Apart from aid on medical problems, pregnancy weight gain monitoring, pre and postnatal checkups, IFA distribution also takes place in these clinics. The drugs and vaccines for this clinic are purchased at a nominal fee from a non-government organization – community development medicinal unit.

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The latter purchase these drugs and vaccines from a pharmaceutical of repute and is also the West Bengal government distributor for vaccines and drugs.

During the following days, each patient receives a follow-up home visit by a CHW to ensure that the patient is recovering well. These home visits are carried out within 3 days of their checkup. In each case, the doctor and the CHW talks with the family about the illness which occurred, the recovery process, the importance of finishing the medicine prescribed even if the patient is feeling better, and ways in which to avoid such illness in the future. If the patient is not recovering, follow-up treatment is carried out. In the clinic, pregnant women are also provided prenatal check-ups and iron folate tablets.

**Immunization sessions:** Calcutta kids hold child immunization sessions on monthly basis in their office, which is adjacent to their served slums. Vaccines and some drugs are provided by the municipality and sessions are held by their own RMP. The CHW mobilizes and escorts the target beneficiaries to this place.

**Growth Monitoring Promotion:** Children attend a growth monitoring promotion camp once a month for 36 months. Here they are weighed and their weights are recorded on growth charts by CHWs. If a child is found to be growth faltering, his or her parents are given extra counseling on health-promoting behaviours by CHWs and those mothers who have well nourished children and those mothers how have experienced the positive benefits of counselling.

**Community Meetings:** Monthly community meetings are an integral part of MYCHI. These meetings not only provide a safe space for female residents to discuss and share health issues with female health professionals, but, equally important, provide a forum for social interaction and empowerment among women of this slum. Each community meeting focuses on a specific health issue and its management. Health information is disseminated through discussions, puppet shows, films, quizzes and demonstrations.

**Food demonstration/hearth sessions:**

In addition to community meetings, food demonstration sessions are also held wherein each CHW invites mothers of children 6-24 months to participate in these sessions. These sessions may be held monthly or once in two months, as per convenience of the mothers. In these sessions each participating mother is asked to get some raw food ingredient. It is an adapted version of hearth, wherein all mothers and not only mothers of malnourished children participate. Emphasis is laid on teaching complementary feeding through mutual learning and demonstration.

**Provision of sprinklers:** This program was implemented for four months with micronutrient initiative (MI). MI provided the sprinkler sachet (Anukha). Anuka is a single-service multiple micronutrient powder that is to be added to the food consumed by children 6-24 months of age. A pack of 16 sachets were priced at Rs. 15/-. She was given 4 sachets each week and was asked to add the sprinkler sachet every alternate day. She was asked to follow this regime for 4 months. This program is not being implemented as of now, as its implementation depends on provision of these sachets by MI. As far as acceptability is concerned, since these communities were being mobilized through other activities as well and visits by CHWs, they did not hesitate and complied well with this intervention.

**Formation of a local people committee:** A committee of active and interested young men within the slum was formed to act as a liaison between the people of the slum and Calcutta Kids. They participate in situation analysis, reaching out underserved areas, counselling their male counterparts, mapping of the slum and coordinate all slum level initiatives under the program.

**Referral linkage:** The women served by Calcutta Kids receive a 75% subsidized facility-
based delivery and tubal ligation in a private medical clinic contracted by Calcutta Kids for this very purpose. TB management for postnatal mothers is also done.

**Monitoring:** Calcutta Kids uses an MIS which tracks the progress of each mother and patient with whom they work. CHW's enter information into the computer every day before leaving the office. The project coordinator uses the MIS to look, in real time, at problems being faced and quickly acts to rectify those problems. The Managing Director, project coordinator, one RMP and one MBBS doctor are managing the program.

This area was unserved by the ICDS program when Calcutta Kids entered this slum but an Anganwadi has been allocated to this area since mid-2007. On the surface, positive change is apparent in the health seeking behaviour of families who are utilizing responsibly the medical services available to them. Community participation and acceptance of the program is also visible. During the past year, just under 80% of the infants born in Fakir Bagan have had birth weights of at least 2.5 kilograms. And the average birth weight has increased from a disgraceful 1.8 kilograms at our baseline in late 2005 to 2.8 kilograms in August 2007. A three year evaluation is set to take place in January 2009.

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