Impact India Foundation

CHI Process Document

May 2012

TATA

TATA CONSULTANCY SERVICES

The word “Disability” and “Activity Limitations” are synonymous and are INTERCHANGED throughout the document

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Preface

Here is my modest attempt to introduce a professional Document which will assist replication of a most extraordinary project.

Impact India Foundation's Community Health Initiative in eight underprivileged blocks of Thane District in Maharashtra covering a population of about two million tribals, was the brainchild of our late Chairman, Mr A.H. Tobaccowala. It commenced in 2005 as a sustainable, replicable model in partnership with the Government, NGOs, the private sector and with ownership of the community. The aim was a dramatic reduction in disabilities to be achieved through preventive and curative measures, by using available delivery systems and existing infrastructure.

One of the objectives was to develop systems, methodologies and monitoring arrangements for easy replication in India and other developing countries. This Process Document includes the conceptual framework of the Community Health Initiative, its Process methodology, Operation procedures, and Achievements. It provides guidelines for Health authorities worldwide to establish similar projects in their areas. What this Document establishes, is not in the sense of scientific accuracy, but that the community can Make Things Happen. Credibility, of course, can survive in getting acceptability of the community, and that is what Impact India Foundation can showcase through this Document.

To Tata Consultancy Services and especially to Behram Sethna, Mehernosh Bulsara and their team we owe a debt of gratitude not only for preparing this Document but, in the process, for broadening our understanding of the need for professional inputs in order to assist replication. No words can express our sense of gratitude to the numerous persons involved who went out of their way to support this project.

Finally, we salute our staff for their qualities of perception, enthusiasm and endurance which allowed us to prove our mission– with a reduction of disability of 72% in the area. Now that their work has been documented, we hope they will also share our sense of satisfaction at having attempted an unprecedented project which has shown concrete results and which can be replicated all over rural India and in other developing countries for the explicit benefit of the disabled poor. To them, we say, God Bless You!

Mrs Zelma Lazarus
1st May 2012 Chief Executive Officer

Nhava House, 65 Maharshi Karve Road, Marine Lines, Mumbai 400 002, India. Web : www.impactindia.org
Tel: (91-22) 6633 9605 / 6 / 7 Fax: (91-22) 2201 0594 E-Mail: info@impactindia.org

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Abbreviations

ADIP	Assistance to disabled person scheme
AL	Activity Limitation
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BDO	Block Development Officer
BMI	Body Mass Index
CDPO	Child Development Project Officer
CEO	Chief Executive Officer
CHI	Community Health Initiative
DHO	District Health Officer
DOT	Direct Observation Treatment
FRU	First Referral Unit
Hb	Haemoglobin
ICDS	IntegrateedChild Development Scheme
IEC	Information Education Communication
IIF	Impact India Foundation
IMR	Infant Mortality Rate
ITDP	Integrated Tribal Development Programme
KPI	Key Project Indicators
LLE	Lifeline Express
LM	Lactating Mothers
MCH	Mother and Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
MoU	Memorandum of Understanding
MPW	Multi Purpose Worker
NRHM	National Rural Health Mission
NGO	Non-Government Organisation
PHC	Primary Health Centre
PNC	Post Natal Care
PPP	Public Private Partnership
PRI	Panchayati Raj Insttution
PW	Pregnant Women
SC	Sub-Centre
SHG	Self-Help Group
SRU	Second Referral Unit
SSA	Sarva Shiksha Abhiyan
SUN	Scaling Up Nutrition
TRU	Third Referral Unit
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Education Fund
WHO	World Health Organisation

1 Introduction

1.1 Purpose

The purpose of this document is to present a detailed insight into the process involved for modeling and executing the Community Health Initiative (CHI) programme within the boundaries of the NRHM defined by the Government of India. The intent of this document is to showcase, to the Government of India, sustainability of existing programmes and replication in different locations across India and abroad. The Process Document will outline how to decrease process variations for adaptation to various geographical modalities. This document is for use as a Reference Community Health model by various State Governments across India. The idea is for the Government to collaborate with various key players like Impact India Foundation and leverage its expertise as a Consultant/Facilitator.

1.2 Audience

The audience of this document is the State Government Head of the Health Department, across India and other developing countries. It would also serve as a Reference Document with guidance from Impact India Foundation (IIF), for a Government Task Force which would be responsible for facilitating and collaborating activities with the Government.

1.3 Background

Impact India was established by the UNDP, UNICEF and WHO following a United Nations General Assembly Resolution. It was launched in 1983 by the Government of India with a National Plan of Action (New Delhi Declaration), as a partner in National Health Programmes. It acts as a catalyst to bring together the NGOs, the private sector, professional persons and the community in support of the Government's National Rural Health Mission.

A Coordination Committee under the chairmanship of the Union Secretary of Health and Family Welfare with State representatives, was constituted by the Government of India to ensure that the objectives of Impact India and the National Plan of Action be achieved.

Based on its mandate, Impact India Foundation (IIF) focused on the prevention and cure of disability. Its 1985 "Polio Free Madras" campaign was recognized by the U.N as a major international achievement. IIF played a major role in developing systems and procedures for Polio Immunisation in Bombay (now Mumbai) city. However, it is IIF's Lifeline Express (LLE), the world's first hospital on a train, which resulted in international recognition. The Government of India has released a National Postage Stamp honoring the LLE. The LLE has since 1991 treated about 700,000 persons restoring mobility, hearing, vision, and correction of facial deformities with dental and neurological treatment, all free of cost. This has been made possible with the donated services of about 150,000 medical personnel from India and abroad. Hundreds of thousand volunteers from all over the world have so far worked for the LLE on its 132 projects, in 93 Districts of 17 States across rural India (as of January 2012).

IIF's aims are achieved through the use of available delivery systems, existing infrastructures, application of available appropriate technology and at an acceptable level of cost effectiveness.

IIF's Project Rationale

Activity Limitation (AL) may be physical, cognitive, mental, sensory, emotional, and developmental or some combination of these. It is an umbrella term covering impairments and participation restrictions.

Thus AL is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which the person lives.

Millions of people in India are disabled and 50% of these disabilities could have been prevented. While some AL causing diseases – smallpox and now polio - have been eliminated, most disabilities continue to remain widespread despite the earnest efforts of international agencies, Governments and NGOs. Some disabilities, such as cataract and clefts, cannot be prevented with currently available knowledge, most of the others can be prevented at a fairly low cost.

The Government Charter for IIF outlines a dual mandate:

1. To initiate, augment and intensify action against those causes of massively prevalent disablement against which there exists a potential for prevention and control, which can be delivered through on-going health and development programmes.
2. To treat millions of people who are disabled by curable blindness, physical handicaps and facial deformities through measures for restoring sight, hearing, mobility and correction of cleft lips/palate, as well as taking any possible action to prevent and mitigate mental impairment

The following are IIF's Commitments:

- Early identification and treatment of curable Disabilities
- Baseline Surveys
- Micro-Planning
- System Development (IT)
- Financial Control
- Feedback / Timely Implementation
- Data Collection / Documentation
- Independent Monitoring and Evaluation
- Community Empowerment by adequate training the trainers
- Networking and Facilitation of stakeholder involvement

The following are IIF's Strength:

- Quality deliverables by professionals
- Strategically building credibility
- Constantly measuring performance - completely accountable
- With systems to build efficiencies
- Extensive volunteer programme reduces costs and builds ownership
- Involves community for sustainability

IIF believes that a District level project focused on Activity Limitation(AL) will dramatically reduce or reverse the number of disabilities bringing enormous benefits to the people of the selected areas, develop systems, methodologies and monitoring arrangements which will be replicable in other parts of India and other developing countries, and most important, by the clear contrast not only with the starting point of the programme but equally in comparison with adjoining areas, provide the type of dramatic contrast that will invite media attention and spur policymakers to take action.

IIF constantly endeavors to adhere to priorities outlined by Government Health Programmes e.g. NRHM

About Community Health Initiative (CHI)

A disability may be physical, cognitive, mental, sensory, emotional, and developmental or some combination of these. Disabilities are an umbrella term, covering impairments, activity limitations, and participation restrictions. Impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives. (World Health Organization)

IIF deals with those disabilities that improve quality of life by transforming liabilities into assets for patients and their families as well as community.

It is imperative to identify the socio economic background of the CHI target area which includes division of geography, demography, economic norms into distinct categories.

With its wealth of experience, IIF has undertaken a challenging project: the Community Health Initiative (CHI), covering 2 million in the backward tribal areas of Thane District in Maharashtra. It aims at strengthening the available delivery systems within the existing infrastructure in order to achieve its goals of reduction of disablement through prevention and cure, including restoration of movement, sight, hearing, correction of facial deformities, as well as preventive aspects such as Health Information, Education and Communication (IEC). The CHI is planned as a model for the Governments and NGOs to replicate in other parts of India.

Objectives of CHI are listed below:

- Reduction by one-half in the incidence of future disabilities through prevention
- Reversal by one half of existing disabilities by curative measures
- Develop systems, methodologies and monitoring arrangements that can be successfully replicated in India and developing countries
- Use the existing Government delivery systems and infrastructure for sustainability.
- Catalyse support of the NGOs, Private sector and the community.

There are two categories under the CHI programme. Curative which primarily deals with correction of disabilities and Preventive which deals with prevention of possible disability.

List of areas covered under Curative category:

- Visual Impairment
- Hearing Deficiency
- Cleft Lips and Palates
- Oral Health Hygiene and Dental Care
- Orthopedic (mainly polio)
- Dermatology

List of areas covered under Preventive category:

- Immunisation
- Malnutrition (Anemia) amongst adolescent girls and expectant mothers
- Information Education and Communication (areas listed below)
  - Health messages- Spacing of children
  - Avoidance of early marriage
  - Safe Institutional delivery
  - Importance of breast feeding
  - Immunisation, Importance of Vitamin A
  - Sanitation and personal hygiene
  - Development of kitchen garden for low cost nutrition
  - Role of iron folic acid
  - Antenatal and postnatal care
  - Availing of Govt. schemes
  - Importance of education
- Body Mass Index (BMI)
- Vaccine Preventable Diseases
- Kitchen Gardens for Nutrition
- Water Management

1.4 CHI Programme - Key Performance Indicators

The following are the key performance indicators for the Community Health Initiative (CHI) programme.

Community Health Initiative - Key Performance Indicators

No.	Indicator	Unit of Measurement	Indicator		
			Before CHI	Target (End of Program)	Current
A	**MATERNAL CHILD HEALTH and NUTRITION**				
1	Newborns below 2500 gm and 2000 gm	Percentage %			
1	Newborns below 2000 gm and 1500 gm	Percentage %			
2	Newborns with Neonatal Asphyxia	Percentage %			
3	Newborns breastfed within half an hour after birth.				
4	Infants on absolute breastfeed for six months				
5	Immunisation coverage among infants.%				
6	Children aged 9-59 months who had received Vitamin A supplementation (%)				
7	Girls aged < 5 years underweight (%)				
8	Adolescent girls underweight (BMI) (%)				
9	Adolescent girls with Anaemia (%)				
10	Adolescent girls immunized against Rubella %				
11	Under aged girl marriage %				
12	Adolescent fertility rate (Per 1000 girls 15-19 yrs.)				
13	Expectant mothers with Anaemia (%)				
14	Expectant mothers immunized against Tetanus (%)				
15	Institution deliveries (%)				
16	Referrals of high risk ANC (%)				
17	Births by caesarean section (%)				
18	Births attended by skilled health personnel (%)				
19	Antenatal care coverage (%), Four scheduled visits				
20	PNC care coverage (%) Two scheduled visits of ANM after delivery				
21	Beneficiaries of Janani Suraksha Yojana				

No.	Indicator	Unit of Measurement	Indicator		
			Before CHI	Target (End of Program)	Current
22	Children aged < 5 years with acute respiratory infection.				
23	Children aged < 5 years with diarrhea receiving oral rehydration therapy (%)				
24	Expectant mothers / families consuming Iodised salt (%)				
25	Consanguineous marriages (%)				
26	Infant Mortality Rate (IMR)				
27	Maternal Mortality Rate (MMR)				
B	**FAMILY PLANNING**				
1	Total fertility rate				
2	Under aged girls marriage (%)				
3	Need for family planning (%) - Acceptance of temporary sterilization. - Acceptance of permanent sterilization (NSV and BTL)				
C	**HYGIENE and SANITATION** (Communicable Diseases)				
1	Population using improved drinking water sources (%)				
2	Population using improved sanitation (%)(Soak pits and Toilets)				
D	**HEALTH WORKFORCE**				
1	Number of physicians and density (Per 10,000 population)				
2	Number of Nursing and midwifery personnel and density (Per 10,000 population)				

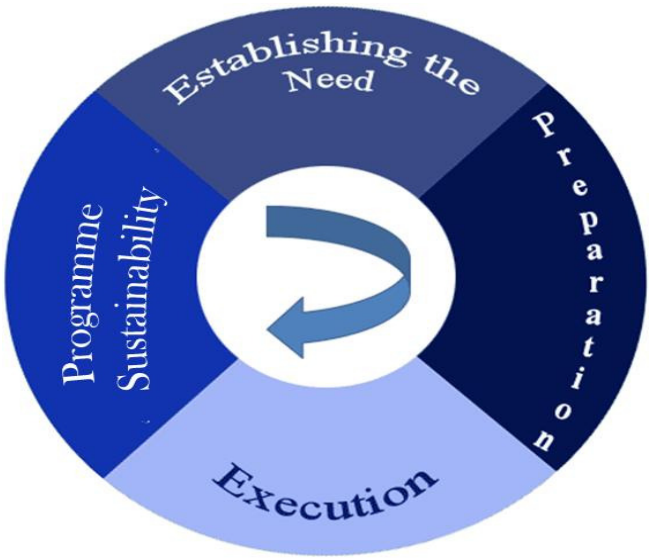
No.	Indicator	Unit of Measurement	Indicator		
			Before CHI	Target (End of Program)	Current
E	**CORRECTION OF DISABILITIES**				
1	Vision Number cataract surgery				
2	Hearing impairment corrected (Numbers) By Surgeries By Hearing Aids				
3	Clefts correction (Numbers) - Lip - Palate	Numbers			
4	Orthopedic disabilities corrected - By Surgery - By Aids and Appliances - By Physiotherapy	Numbers			

2 Process Methodology

This section will cover the various stages which need to be followed to facilitate identification and execution of Community Health Initiative (CHI).

There are 4 phases for CHI process stages:

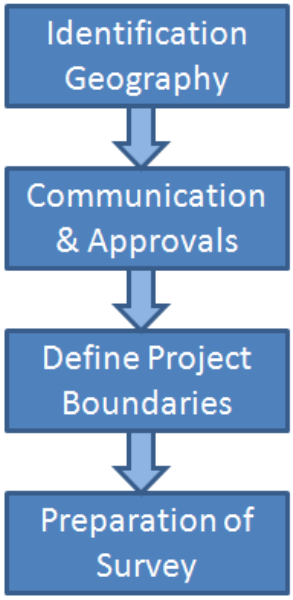
- **Establishing the Need:** Identifying geography and establishing credibility with stakeholders.
  - Identification of geography/stakeholders
  - Communication and Approval for commencement
  - Define Project boundaries
  - Preparation for Survey
- **Preparation:** Preparation of survey and other activities pertaining to CHI.
  - Pre-Survey Activities
  - Survey Collation
  - Survey Consolidation
  - Preparation of Project Plan
- **Execution:** Outlines activities for day to day management and execution of CHI.
  - Preventive programmes
  - Curative programmes
- **Programme Sustainability:** This phase outlines the activities for making the programme sustainable.



2.1 Establishing the Need (building credibility)

It is imperative that the State Government establish contact with the key personnel in the area (Healthcare staff, local bodies, partners, NGO & the Private sector) who influence the geography. IIF as a credible NGO can act as a catalyst to help facilitate Government connectivity with partner hospitals, NGO's and others working in that area. This would help in achieving result oriented activities and commitments from credible organizations towards the Community Health Initiative. It would also help establish Government to emerge as a credible and premium health body which has rapport with the masses. The intervention has to be need based.
Following stages are outlined below: -

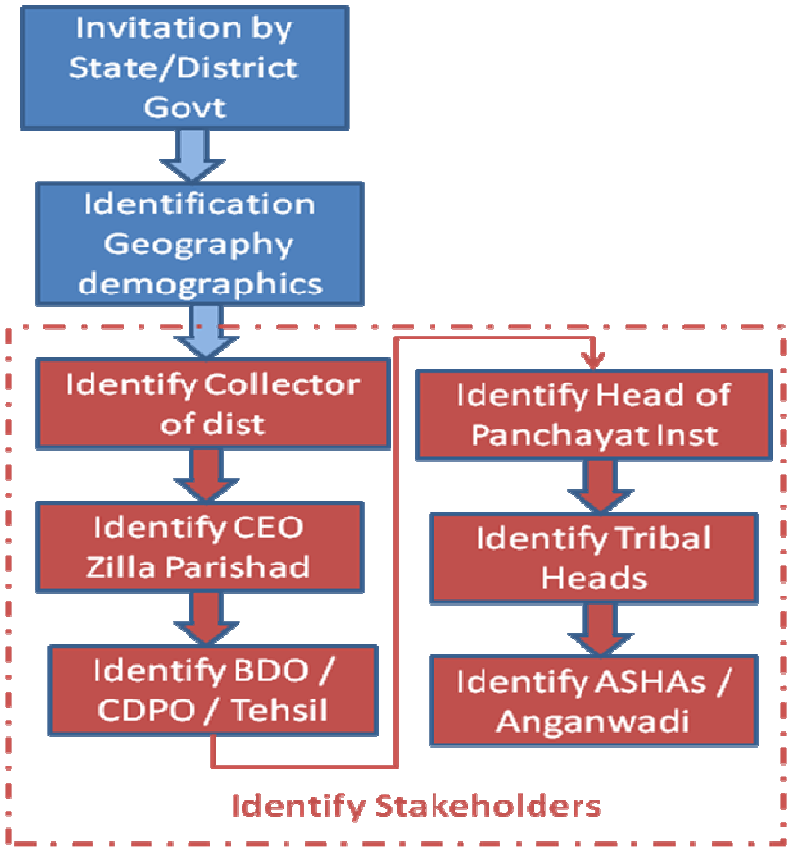
- Identification of geography/stakeholders
- Communication and Approval for commencement
- Define Project boundaries
- Preparation for Survey



The section below is an elaboration of the various stages and activities outlined above: -

Identify Geography & Stakeholders

- Invitation by State/District Government Authority
- Identify the geography (District) and demographics
- Identify stakeholders in the geography with hierarchies
  - Collector of District
  - CEO of Zilla Parishad
  - BDO (Block Development Officer)/ CDPO (Child Development Project Officer) / Tehsil
  - Identify Heads of Panchayati Raj Institutions
  - Tribal Leaders
  - ASHAs / Anganwadi / ANM (Auxiliary Nurse Midwife)

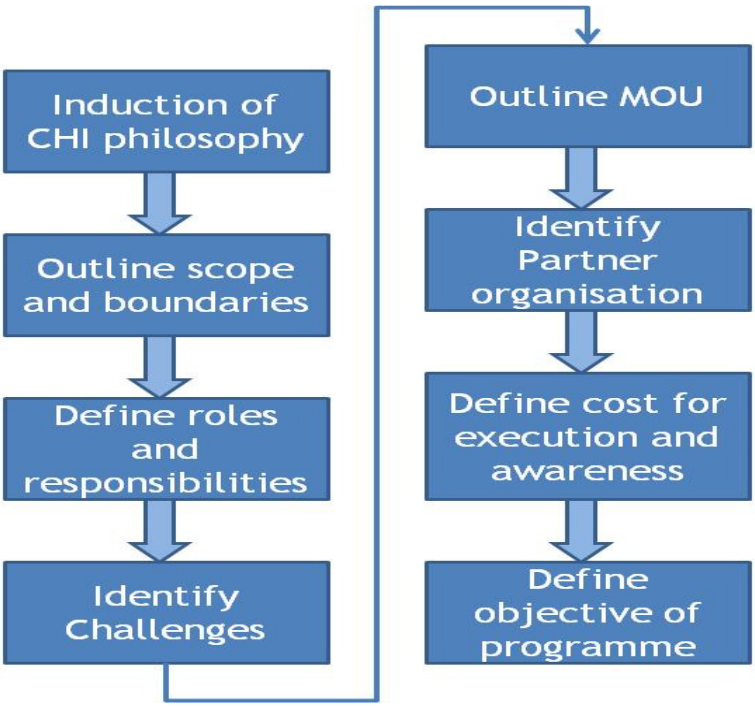


Communication and Approvals

- Create Community Task Force reporting directly to District Collector. The Task Force should have representation of the DHO, State Public Health Department, Private Sector Organizations, Health Practitioners and Professionals, the community and IIF's core staff.
- Orient the stakeholder on IIF-CHI interventions. Insight on IIF's activities and share success stories to stakeholders (Collector of District, CEO of Zilla Parishad, Community Leaders, Block Development Officer, Taluka Health Officer)
- Written consent with clear demarcation of project engagement (from Local, State and Central Government)
- Communication from Government to emphasize political will towards IIF engagement (to all health functionaries in project area).

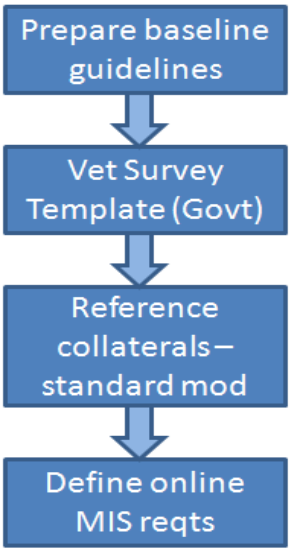
Define Project Boundaries

- Arrange orientation meetings with stakeholders in each District
  - Induction of IIF and CHI philosophy
  - Outline scope and boundaries of engagement
  - Define MOU
  - Define Roles and Responsibilities for IIF, partners and Govt staff
  - Identify challenges (with likely plan for intervention)
  - Collaborate by employing Public-Private partnership (PPP) by Government. Identify partner organizations in the geography (clinics, NGO's, hospitals etc ..)
  - Ballpark cost of implementation/maintenance based on previous CHI engagements
  - Budget to build awareness (TV, pamphlets, posters)
  - Planning long-term and short-term objectives of CHI (review periodically)
  -



Preparation of Survey

- Prepare baseline Survey guidelines (health parameters and programme reach)
- Vet baseline survey templates with IIF team, respective partners and Government bodies
- Standardized modules on preventive and curative interventions along with the audio-visual materials
- Outline requirements for web based Management Information System (MIS software) which will help in establishing the mission of the CHI programme at all times.



2.1 Preparation

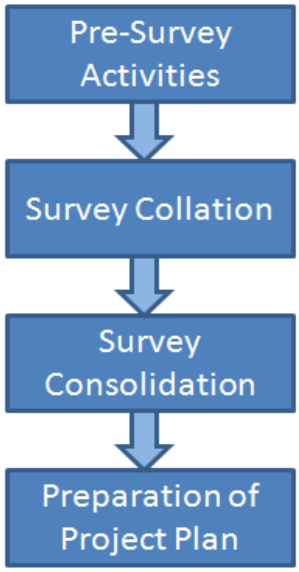
At the outset it is important to have a baseline survey, to identify the intervention areas and the scale of work required, within the boundaries defined by the project.

Language is always a key factor to establish the effective link with the masses. Particularly where the people might be from underdeveloped region and background, it would be advisable for some project team members to be conversant in communicating in the regional language.

Impact India Foundation's CHI engagement should be seen as an enabler, friend philosopher, advisor and guide. Government will be the owner of the CHI while IIF will act as a facilitator/consultant for the programme.

Following stages are outlined below: -

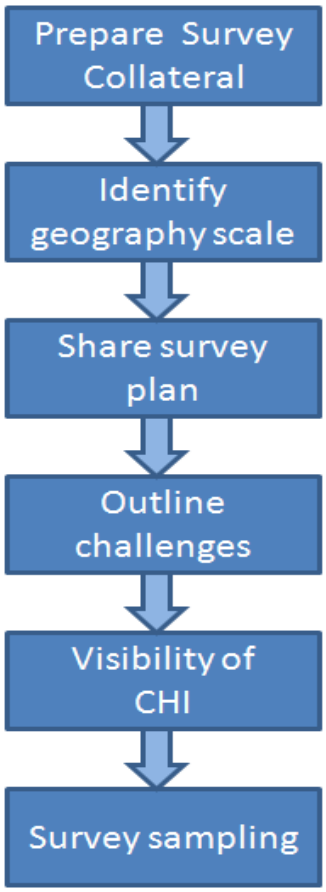
- Pre-Survey Activities (via workshop)
- Survey Collation
- Survey Consolidation
- Preparation of Project Plan



This section is an elaboration of the various stages and activities outlined above: -

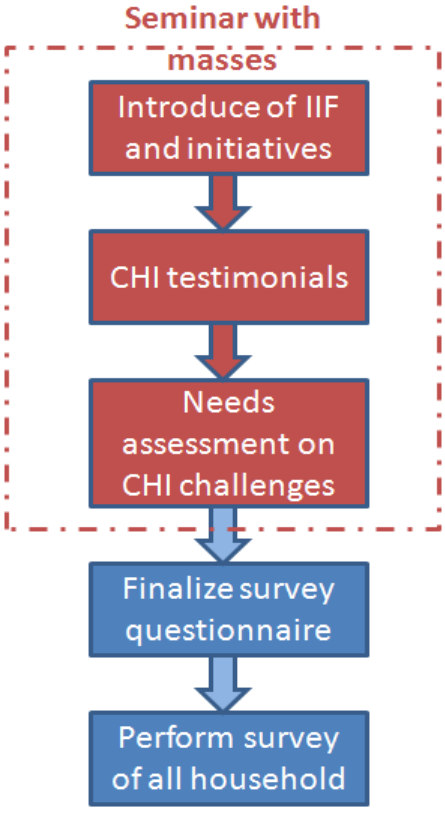
Pre-Survey Activities

- Prepare survey collaterals (questionnaires) in the regional language covering all programme objectives (vision, cleft, hearing, dermatology, malnutrition, social awareness etc.)
- Identify the scale of the geography with population (block, taluka, PHC)
- Outline and share plan to involve local Government bodies in project for survey
- Outline challenges for programme and mitigation plans (inaccessible areas, critical disabilities, language barrier, trust and credibility etc)
- Arrange appropriate visibility of CHI to establish goodwill in each block with local representatives' support (electronic and print media).
- Survey sampling, methodology, data collection norms need to be defined upfront (in line with research norms).



Survey Collation

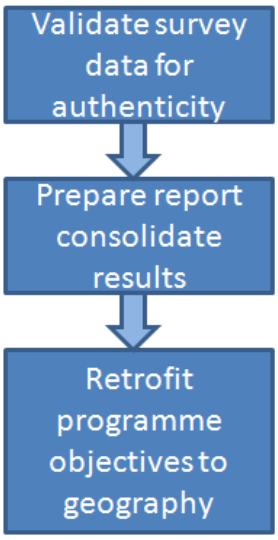
- Community Task Force to arrange seminar/informal meetings within each block to connect with masses
  - Introduction of Impact India Foundation and their initiatives
  - Testimonial of successful CHI implementation to showcase credibility in other areas (preferable to have some local body representation)
  - Needs assessment on the challenges faced by the community
- Finalization of survey questionnaires based on the seminars. Surveys approved by local Government body.
- Perform survey of all households in the area (with the help of anganwadi, ASHAS and local bodies)
- During collation of survey the defined techniques for Survey sampling, methodology, data collection norms need to be adhered.



(Refer Survey templates – Appendix 4.1)

Survey Consolidation

- Survey data needs to be validated to ascertain the authenticity of captured data
- Prepare a report which will consolidate the survey results and highlight the disabilities and challenge. Also prepare a disability profile to outline the challenges in each block.
- Retrofit programme objectives to the geography and highlight any out-of-scope areas. This should be in line with NRHM guidelines and Key Project Indicators (KPI) defined by the programme

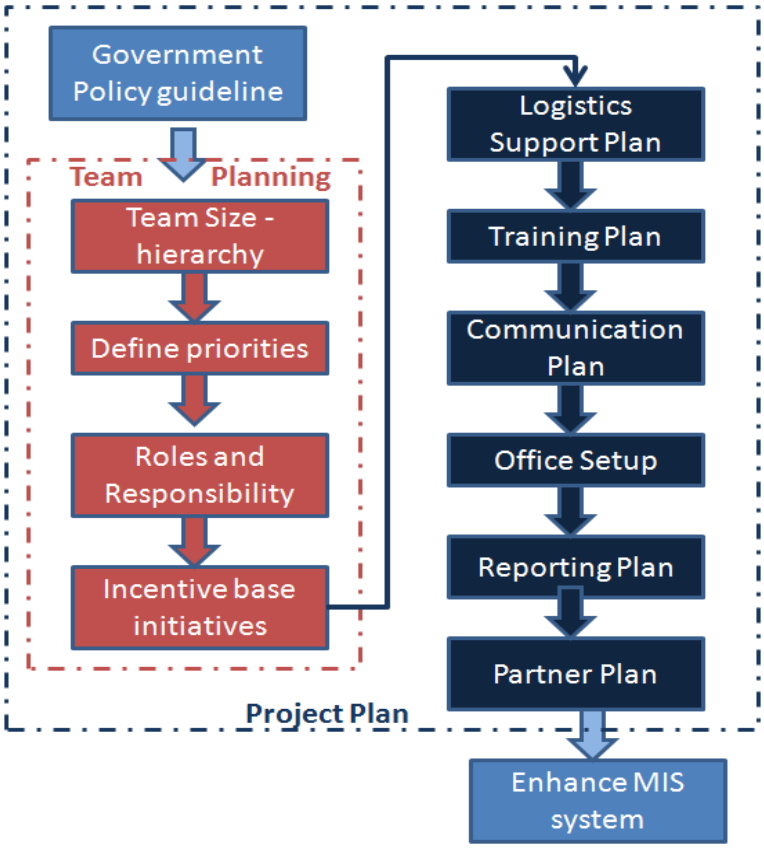


Preparation of Project Plan

- Government policy guideline with regard to the project period as well as the various activities to be undertaken/excluded within the mandate
- Outline high level plan for execution taking into account the tables below (2.2.1 and 2.2.2)
  - Outline duration
  - Outline Team Planning
    - Outline size of team with hierarchies (IIF, Govt) based on scale
    - Define priorities (disabilities and in accordance to NRHM goals)
    - Outline roles and responsibilities of the project team
    - Project Team (CHI staff) should be fluent in local language.
    - Prepare incentive based on outcomes and targets
    - Skilled team members to be made accountable in appropriate areas of expertise
  - Logistics Support Plan - vehicles (bikes, car, vans) for transportation and holding camps for patients
  - Training Plan - Training on identification of disabilities and Information, Education and Communication (IEC) modules by experts (through training of master trainers).
  - Outline Communications plan between IIF and Govt

Office setup for communication and collaboration
  - Office space in Govt quarters (also staff accommodation)
  - Phones to communicate (mobiles to key personnel in field)
  - Computers/ Laptops to capture ongoing progress in electronic form (with optimum internet connectivity based on usage)
  - Printers
  - Projector for demonstrations for masses as well as management meeting
- Reporting Plan
  - Outline progress reporting structure and frequency (daily, weekly, monthly, quarterly, half yearly, yearly)
  - Prepare templates for reporting
- Partner Plan
  - Listing of partner medical institutions in each area/block (for patient treatment)
  - Partner medical institutions and their specification
  - Key contacts and doctors in each medical institution
  - Monthly treatment which can be facilitated by institution
  - Report mechanism between IIF and medical institution to understand status of patient

- Enhance the web based MIS system to accommodate all relevant information for the targeted geography. Training of staff in MIS system.



Block Information		Geography Scale	Community Health		Project Team Size	Budget
No of Blocks	Size in sq kms	No of people	Curative	Preventive		

Table 2.2.1 for determining the team size and budget

Block Information		No of households surveyed	Community Health		Duration of Engagement	Target Percolation
No of Blocks	Size in sq kms		Curative	Preventative		

Table 2.2.2 for Target Percolation based on Survey results

2.2 Execution

It is imperative for the Government to set a strong background for the Community Health Initiative programme, which would help in sustaining the model and monitor a decline trend for disability in future.

Records have shown that by enabling and empowering people to setup local establishments (village level) for tracking critical health indicators of the community and advocating a pro-active outlook could help eradicate disability. Also by building awareness through educating school children would help in promoting healthy environment by preventive measures for future.

Based on the above there are four common activities outlined:-

- **Village level Programme: -** Under the National Rural Health Mission (NRHM) programme the Government has established a Village Health, Nutrition, Water and Sanitation Committee (Gram Arogya Samithi) in each village and is also providing untied funds for community use. IIF will take up a three day training programme of the committee members (the AWW, the ASHA, one Panchayat member and two youth volunteers – a girl and a boy) of these committees where they will be oriented on the health and nutrition needs of children (including an orientation on disability) and the need to ensure tracking of every pregnant woman and child below three years so that they receive all services as mandated. A tracking system will also be established in each village with the help of Anganwadi workers, ASHAS and village volunteers. This will also facilitate prevention and early detection of disabilities which could then be handled immediately at the family/community level or through referral services.
  The following will be the focus and will also be the monitoring indicators:
  - **Maternal Health-** Every pregnant woman receives necessary antenatal services and delivers in a health institution; receives payments from the Janani Surakska Yojana as applicable under the scheme.
  - **Immunization-** Every infant receives all primary doses of Immunisation before it completes its first year as well as the mandated five doses of Vitamin A solution between the 9th month and the 36th month.
  - **Growth and Development-** Every child is weighed every month and its growth monitored and supported to ensure that no child is malnourished. All minor illnesses are treated at the village level and serious cases referred to PHC/Health Facility.
  - **Disability detection & referral-** Early detection of any disabled children and necessary follow up counseling/services provided. Cases of disability in other age groups detected and referred to Government health institutions.
  - **IEC-** Carrying out IEC activities on child health and disability prevention.

  The training could be organized at the village level bringing two to three villages together. These could be three 3 hour sessions held in the afternoons and could be taken up by trained IIF staff. The training module could be evolved from existing modules that are already in use. The training and follow up activities will be taken up with the active involvement and support of the ICDS and Heath departments.
  (Refer to Appendix for details on NRHM)

- **School Children Programme:** - A five day life skills education camp will be organized in each Middle and High schools as well as Ashramshalas (Tribal residential schools). 40 children from classes V, VI and VII will be selected to attend this camp. Various activities that lead to the development of critical life skills, especially in living a healthy and purposeful life will be organized in these camps where children will become agents of change. The camps will also lead to the creation of Bal Panchayats in each school with various committees formed to take up school based and community centered activities. The camp will also include sessions on creating awareness on disability as well as sensitizing them on the need to include children with disabilities into the mainstream. These children will also undertake simple surveys in villages that would help them to understand and relate to their communities and environment more positively and to take up simple activities that could lead to the creation of better living conditions. They become leaders of change in their villages. These 40 children will share their learning with the rest of the children and mobilize them to participate in all activities that will be taken up by them.

  Special care will be taken to integrate this project within the Sarv Shiksha Abhiyan (SSA) banner and to link the activities with the Government's school health programme. Endeavour will also to be to introduce the Child Health Cards to track the health and follow-up should be strengthened for each child on a quarterly basis. Recently Rajiv Gandhi Jeevandayee Arogya Yojana—Arogya Patra has been launched to introduce Health card as a regular feature.

- **School Health Monitor Programme: -** This programme can also include a School Health Monitor Programme. The rationale is that the children in Ashramshalas and Government schools have full transparency by inculcating values for tracing disabilities early. For more details refer to Appendix section. As part of CHI, Impact has expanded on the Government of India's existing Vision 2020 Project for restoration of sight to the blind, to include hearing to the deaf, mobility to the orthopedically challenged and correction of Clefts.

- **Adolescent Programming: -** The CHI project already works with children in the Ashramshalas. The proposal is to run a 5 day life skills training for the adolescent students (Std. VIII and above) that would help them to understand the physical and psychological changes that they are going through and introduce them to the critical concepts of gender, sex and sexuality. Such an education programme has critical relevance in the prevention of early marriages leading to early pregnancies, child malnutrition, morbidity and mortality. This is also an important intervention against adolescent anaemia and stunting. The module also helps them to become responsible citizens in their communities. The training will also lead to these children taking up various activities within their schools and communities that would lead to healthier living and prevention of diseases and disability.

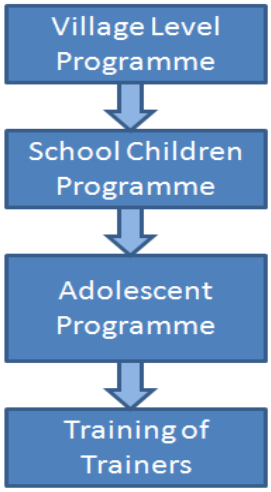
- **Training of Trainers (CHI staff, ASHAs, Anganwadi workers, volunteers): -** The success of a programme is mainly attributed to how well the team is aware of the programme objectives and is trained to perform its duties. This would display a sense of unified awareness, sensibility and accountability of the programme across the team.

Training at different levels needs to be imparted for conducive behavior of masses: -

- ✓ Generate Health Awareness in Community
- ✓ Outlining benefits of each CHI Initiative/programme
- ✓ Training of Trainers programmes for CHI staff, Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs), Accredited Social Health Activists (ASHAs) and volunteers to approach the following target groups:
  - Adolescent girls
  - Ante Natal Care (ANC) cases
  - Post Natal Care (PNC) cases
  - Community and children
- ✓ Using literature (Charts, pamphlets, Government schemes and entitlements and Information Education and Communication - IEC - on disability factors) and paintings on Sub Centre and School walls which are culturally appropriate.

Trainers need to have sufficient information to be convincing to the people. Periodic feedback needs to be obtained (probably every year) to evaluate change on 3 basic parameters: -

- Testing the community on Knowledge, Attitudes and Practices – KAP
- Check target penetration
- Check target mobilization (identifying target population)



It is proposed that all four components be initiated in the villages under a few Sub Centres adopted in each Block; this would provide a good understanding of the impact each component could make. Once these villages are completed the remaining villages under the same PHCs could be taken up. In the next phase, the remaining PHCs could be taken up.

It is imperative that adequate training for emergency medicine for rural communities is imparted. For more details refer to Appendix section 4.7. It is ideal to induct the newly recruited Anganwadi workers (AWW). AWWs provide services for immunization, health check-up, informal pre-school and nutrition education, supplementary nutrition and referral services.

Some of the supporting processes which would strengthen the Community Health Initiative are listed below: -

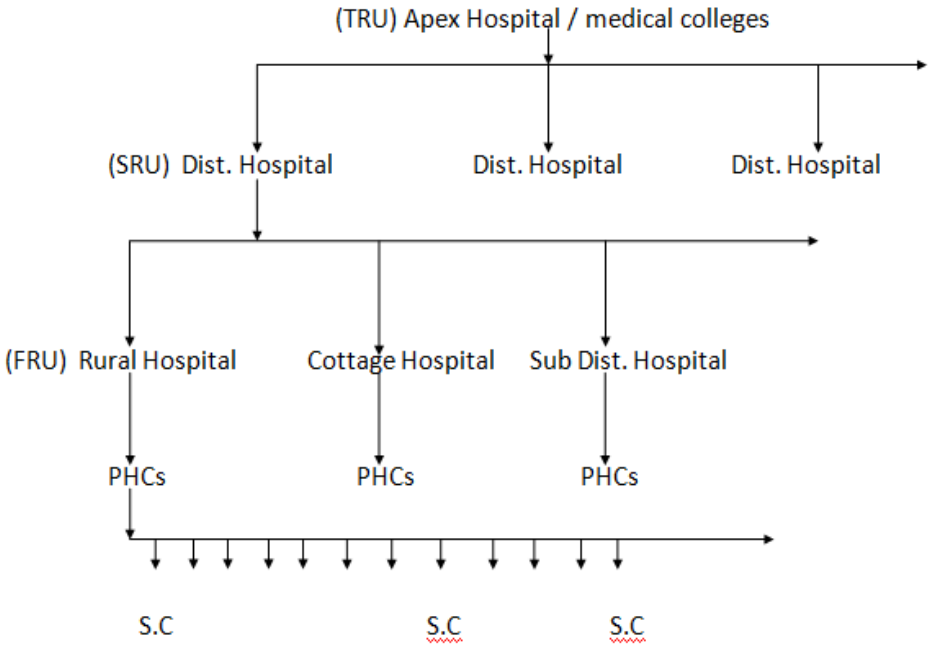
- ✓ **Government / Private Grants:** To ensure that the Community Health Initiative is sustainable, it is imperative to tap into Government Grants for regular funds for activities within the programme.

  In order to avail grants it is imperative to understand the Government Hierarchy and existing schemes provided by the Government. For more details on the Government hierarchy please refer to Appendix section.

Listed below are some of the Government / Private Grants: -

1. Nucleus Budget for health services for Tribals from the Integrated Tribal Development Project (ITDP)
2. Assistance for cultivation of household Kitchen Gardens from ITDP
3. Assistance to the disabled for Aids and Appliances from the Central Government's Assistance to Disabled Persons Scheme (ADIP) scheme.
4. Assistance from National Rural Health Mission (NRHM) from schemes such as 'Janani Suraksha Yojana', 'Matrutva Anudan Yojana' applicable to pregnant mothers.
5. Assistance to disabled through 'Sarva Shiksha Abhiyan'
6. Assistance from District Collector through 'Manav Vikas Yojana'.
7. Assistance from Integrated Child Development Scheme (ICDS) for 'Kishori Shakti Yojana',
8. Assistance from 'Rajmata Jeejau Kuposhan Mukti Gram Abhiyan'
9. Assistance from NGOs/voluntary organizations/corporates such as Syngenta, Adiwasi Uthaan, Rotary, Lions, HPCL, BPCL, HDFC, SBI, Tata Motors, Tata Consultancy Services, Britannia, Johnson and Johnson, Volkart Foundation, Mattel Children's Foundation, Temasek Holdings Ltd's Art Action programme etc.
10. Free treatment at Apex Hospitals and Specialised Hospitals (by collaboration) such as with The Smile Train, New York, for cleft surgeries.

- ✓ **Referral Services:** The main reason that health services do not penetrate is due to lack of accessibility of services. Health service is the right of every individual and the Health machinery should support this cause. The following are the means to improve health services: -
  - Identification of Primary Health Sub Centres which would be responsible for providing Health services to people in rural areas serving a population of five thousand.
  - One Auxiliary Nurse Midwife and one Male Health Worker are responsible for identification, counselling and timely referrals to a Primary Health Centre (PHC).
  - One PHC in a tribal area is responsible for a population of 30,000.
  - Simple cases are treated at PHC level whilst complicated ones are referred to Rural / Cottage / Sub District Hospital for treatment, being the First Referral Unit (FRU).
  - The Rural Hospital is expected to provide all necessary treatment including surgical interventions (by priority Pregnancy and Pediatric services). Difficult/complicated cases are referred to the District Hospital or Second Referral Unit (SRU) for complete treatment at Government cost, including surgeries. Only critical and chronic cases are to be referred to Medical colleges / Apex hospitals, being the Third Referral Unit (TRU) for possible treatment by Specialists. It is the duty of all Government Hospitals to provide follow up till treatment is over, including post operative care.



Referral Process – Defined

- ✓ **Water Harvesting;** Availability of water for general purposes – domestic use, farming and cattle use as well as drinking has a direct impact on health and disability. Clean drinking water acts as a preventive mechanism against spread of waterborne communicable diseases and thereby vastly reduce cost of providing healthcare to rural community. To alleviate the problem of water scarcity, the CHI with corporate donations and community participation accomplishes water harvesting interventions. The water management mechanism includes construction of dams, repairing of wells, cordoning springs, building trenches and installation of water purification system with innovative and technically proficient methods to raise the water table.

Preventive Programmes:

Below are some of the detailed preventive programme processes outlined to ensure seamless tracking of engagement: -

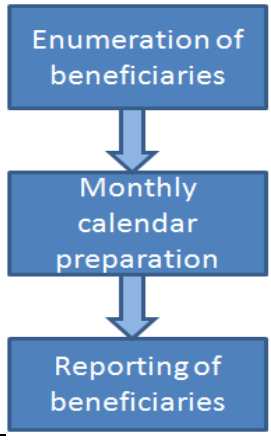
- Immunisation
- Hb Estimation **(Scaling Up Nutrition- SUN)**
- Ante Natal Care (ANC)
- Kitchen Gardens
- IEC

❖ Immunisation

Child Immunisation measures the percentage of children aged 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately Immunised against Diphtheria, Pertusis (or whooping cough), and Tetanus (DPT) after receiving three doses of vaccine.

Potential Challenges

- Community lacking in awareness of benefits.
- Poverty
- Geographical area (inaccessibility)
- Lack of availability of facility and services
- Natural causes (weather, epidemic)
- Migration (drop-outs)
- Work overload of Health staff and lack of supervision
- Lack of involvement / faith in Government initiatives



Process

I. Enumeration of beneficiaries.
   a. Essential baseline statistics – birth rate per 1000 population
   b. By birth register (There are on an average 125 births per year in a Sub Centre of 5000. Resulting in about 25 births per 1000)
   c. ANM/Volunteer to visit an average 5 – 10 households per day to check migration*

II. Monthly calendar preparation
   a. Identify the various centres where Immunisation will be conducted
   b. Map various beneficiaries of each centre (with dosage details)
   c. Communicate to beneficiary via Anganwadi Workers, ASHAs or volunteers, the date and venue of Immunisation

III. Reporting of beneficiaries
   a. Capture progress of Immunisation at each centre
   b. Monitoring of drop-outs
   c. Follow-up on drop-out cases (logistics, venue, migration)
   d. Re-planning to include drop-out cases

❖ **NUTRITION (Hb Estimation)**

Low level of Haemoglobin in the blood of an individual is considered as Anaemia. Anaemia is diagnosed by Haemoglobin (Hb %) estimation. Around 60% of rural population in India suffers from Anaemia. In general, Hb below 10 gm/100dl of blood is considered to be Anaemia. Micronutrient deficiencies such as in Iron, Folic Acid cause Anaemia. Green leafy vegetables are rich in micronutrients and help control the condition.

Potential Challenges

- Community lacking in awareness of adverse effects of Anaemia.
- Community is unaware of the fact that the vegetables are rich in micronutrients necessary for the growth of haemoglobin in blood.
- Poverty (cannot purchase green vegetables.)
- Water scarcity
- Geographic area not favorable to grow vegetables
- Lack of faith of community in Government initiatives for supplementation of Iron Folic Acid.
- Work overload of health staff and Lack of supervision
- Lack of personal hygiene (worm infestation)
- Community disinclined to make vegetables as a source of income for the family.

Process

For Adolescent Girls

I. Enumeration of beneficiaries.
   a. Baseline statistics of adolescent girls—10% of population
   b. Actual number of adolescent girls from register of Anganwadi
   c. Visit to schools, Ashramshalas and Kishori Mandals for enumeration.
   d. Registration of adolescent girls.
   e.

II. Awareness Programme through IEC and other media.
   a. Deworming
   b. Hb Estimation

III. Monthly preparation and execution
   a. Registration of girls having Hb below 10gm per 100dl of blood.
   b. Supplementation of Iron Folic Acid tablets through Directly Monitored Treatment method through girls to girls and ASHAs.

IV. Reporting and Tracking
   a. Sustenance through promotion of House Hold kitchen gardens.
   b. Re-Estimation of Hb (haemoglobin)
   c. Community awareness through satisfied beneficiaries
   d. Referral of resistant cases for experts' advice.

For Pregnant Women

I. Enumeration of beneficiaries.
   a. Baseline statistics from birthrate.
   b. Registration from ANC register with ANM, Anganwadi and Home visits of volunteers

II. Awareness Programme through IEC and other media
   a. Arrange health check up sessions
   b. Hb Estimation

III. Monthly preparation and execution
   a. Registration of ANC with Hb below 10gms per 100dl
   b. Supplementation of Iron folic acid from fourth month of pregnancy to delivery by DOT method through ANC group, ASHAs, adolescent girls at her home.

IV. Reporting and Tracking
   a. Sustenance through promotion of House Hold kitchen garden
   b. Re Estimation of haemoglobin after three months of supplementation of Iron folic acid
   c. Referral of resistant or severe Anaemia cases to experts

This Hb Estimation programme can be extended to include "Scaling Up Nutrition" (SUN) programme which was recently introduced in World Economic Forum. (Refer to appendix for more details)

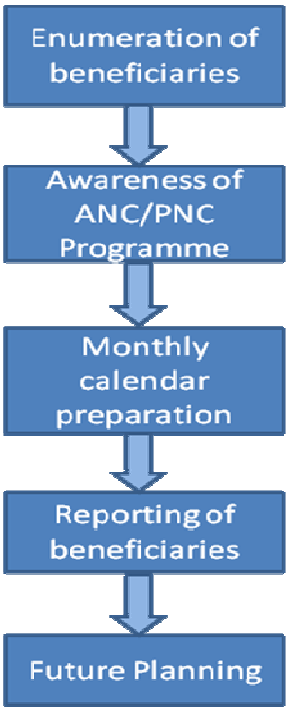
❖ Ante Natal Care (ANC)

Lack of antenatal care creates many problems during a woman's pregnancy period and delivery. Every pregnant woman does not have easy or ready access to the health system which results in high risk ANC cases. Anaemia in pregnant mothers is very prevalent in India and remains untreated. The under nutrition of pregnant women is neglected. Ignorance, misconceptions and harmful traditions cause a high rate of abortions, still births and premature deliveries. Failure of a sensitive approach and meticulous tracking of ANC cases in sub centre areas, by the health system is the main cause of a high Maternal Mortality Rate (MMR) and a high Infant Mortality Rate (IMR).

Potential Challenges

- High number of ANC cases with high birth rate.
- Failure of health system in tracking ANC cases.
- Severe Anaemia and under nutrition of ANC cases
- Poverty (The pregnant mother has to work throughout her pregnancy period for her daily subsistence)
- Ignorance, misconceptions regarding care during pregnancy
- Inaccessibility of many areas (lack of communication facilities)
- Lack of faith in the existing health system
- Work overload of health staff
- Vacant posts in Government health system.
- Incomplete infrastructure of health system

Process



Process

I. **For Adolescent Girls**

II. Enumeration of beneficiaries.
   a. Baseline statistic of ANC as per birth rate of the area.
   b. Enlisting of ANC from record of ANM, Anganwadi and through house-to-house visits of volunteers.

III. Awareness programme for Ante Natal Care (ANC) and Post Natal Care (PNC) cases

IV. Monthly calendar preparation
   a. Identify various centres where ANC checkup will be carried
   b. Map all ANC village/hamlet wise in the centre
   c. Tracking of ANC through Anganwadi Workers (AWWs), ASHAs, SHG, Mahila mandals and volunteers, on the date of ANC checkup and bring them at venue.

V. Reporting of beneficiaries
   a. Capture progress of ANC for weight, Hb, nutrition, Immunisation, and findings of abdominal examination
   b. Investigations for Hb and urine examination
   c. Recording high risk ANC and counseling
   d. Monitoring dropouts and follow up of dropout cases (logistics, venue, migration)
   e. Counseling for institutional deliveries and planning to track them from their home to institution for delivery.

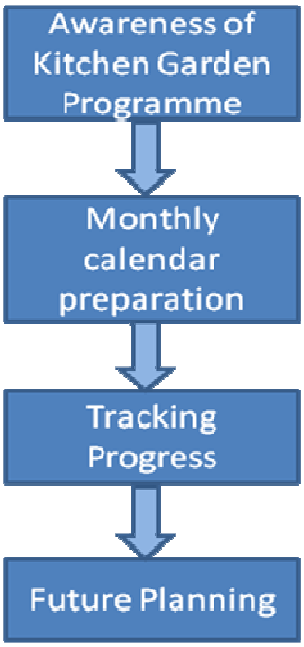
VI. Future Planning
   a. Planning to cover dropouts.
   b. Planning for directly monitored treatment to improve nutrition and hemoglobin percentage
   c. Counseling ANC cases for personal hygiene during pregnancy, delivery and postnatal period
   d. Counseling of ANC cases for newborn care and Breast feeding
   e. Counseling ANC cases for Family planning.

❖ **Kitchen Gardens**

In the eight tribal Blocks of the model CHI in Maharashtra, there is little irrigated land because of heavy rainfall which washes away the topsoil, and does not retain water naturally. The rain water flows away from the slopes of the hills of the area to the sea located on West of the CHI area. Only Paddy is cultivated during monsoon. No other crop is taken up during the remaining eight months of the year. The Tribals have to work hard on other jobs to sustain a living. Due to scarcity of water, vegetables are not cultivated. About 60% of girls and around 70% of pregnant women and other adults also suffer from Anemia. The promotion of household Kitchen Gardens is required towards sustainable efforts for the prevention of Anemia & other malnutrition ailments.

Potential Challenges

- Poverty
- Ignorance
- Water scarcity
- Lack of motivation
- Non availability of land
- Non availability of quality seeds
- Migration



Process

I. Awareness programme for acceptability of kitchen gardens by community

II. Monthly calendar preparation
   a. Select the area for cultivation of kitchen garden
   b. Record house holds
   c. Orientation of Anganwadi workers, ASHAs
   d. Create model Kitchen Gardens for demonstration

III. Tracking Progress
   a. Seeds/saplings distribution to households through AWWs/ASHAs
   b. Follow up of progress of kitchen gardens through AWWs/ASHAs
   c. To assess the yield and use of vegetables by households

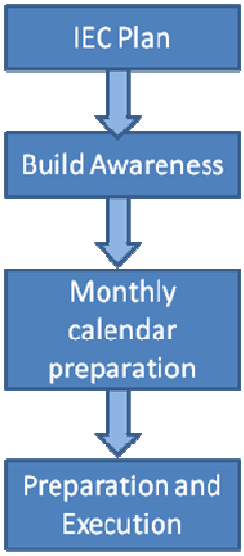
IV. Future Planning
   a. Scale up the programme through satisfied beneficiaries.
   b. Collaborate with NGOs related to Agriculture.
   c. To develop kitchen gardens on a large scale in Ashram schools and community homes.
   d. To involve the staff and students of Ashram schools in promotion of kitchen gardens at Ashram schools and for households using students as Garden Monitors and as agents of change.
   e. To motivate the community to avail of Government schemes for kitchen gardens

❖ Information, Education & Communication (IEC)

IEC is the back bone of any programme and more so for prevention of childhood disability.
The mistakes of the individual, the parents and the community at any point of an individual's lifecycle results in disability which may be inherited by future generations. Therefore, it is absolutely necessary to make everyone in the community aware of the causative risk factors for disability. IEC starts from awareness creation amongst children, adolescents, adults and the elderly as the habits, misconceptions and traditions of these sections form the cause for disability. Genetics, nutritive factors, disease, marriage system, family traditions and habits etc. are the causes for disabilities. Therefore, an intensive, sustained awareness-creation programme should be the priority activity of the disability prevention project and will contribute substantially to disability prevention.

Potential Challenges

- Large size of community
- Lack of access to different sections of the community (children, adolescents, married, unmarried and the elderly)
- Various different local dialects and languages
- Impact of traditions on community
- Inconvenient timing
- Illiteracy
- Poverty (the community remains engaged day and night for subsistence living and is not free)
- No quantitative clarity in results
- No direct and immediate benefit
- Geographical constraints
- Lack of trained and experienced personnel
- No system existing for continued, prolonged IEC activity
- Short project period
- Lack of ownership of the programme by the Government.
- Very few agencies / NGOs are interested in the programme
- Needs costly Audio-Visual aids for IEC
- Requires transportation facilities for the staff (Vehicles)



Process

I. Plan for Time and venue according to convenience of community

II. Build Awareness
   a. Creating awareness regarding disability prevention amongst illiterate people through street plays
   b. Arranging rallies on disability prevention
   c. Arranging exhibitions on disability prevention.
   d. Arranging seminars on disability prevention

III. Monthly calendar preparation
   a. Various Media
      i. Talks for Mahila Mandals
      ii. Talks for Bachat Gats (Self Help Group) meetings
      iii. Talks in schools (Ashram schools, Zilla Parishad Schools and private schools.)
      iv. Talks for youth club
      v. Talks for adolescent groups (Kishori Mandals)
      vi. Talks in Gram Sabhas
      vii. Talks for Village Health Committees
   b. Subjects Covered
      i. Personal hygiene
      ii. Anaemia
      iii. Nutrition
      iv. Immunisation
      v. Antenatal care
      vi. Postnatal care
      vii. Breastfeeding
      viii. Causative risk factors for disability (Prevention of disability)
      ix. Early detection and timely treatment of diseases /disabilities

c. Orientation on IEC for prevention of disability
    i. Project staff
    ii. ASHAs
    iii. Anganwadi workers
    iv. Health staff
    v. Group of adolescent girls
    vi. Teachers
    vii. Volunteers' force
    viii. NGOs working in health area.

IV. Preparation and Execution

a. Involvement of oriented personnel in IEC activities

b. Printing and distribution of literature in local language on Mother and Child Health (MCH), hygiene, sanitation and causative risk factors for disability through IEC sessions, fairs and festivals

c. Arranging film shows in schools, villages and hamlets on
    i. Malnutrition
    ii. Breastfeeding
    iii. Gender equality
    iv. Family planning
    v. IIF's Lifeline Express train
    vi. Sanitation
    vii. Government schemes
    viii. Planning for a better tomorrow

d. Slogan writing on prevention of disability at
    i. Schools
    ii. Villages
    iii. Primary Health Centres and sub centres.
    iv. S.T stands

e. Display of posters and boards and banners at
    i. Schools
    ii. Villages
    iii. PHC and Sub centres
    iv. S.T stands

f. Pictorial Paintings of health messages on disability prevention on earthen pots, saris and walls of the houses for illiterate, tribal people.

g. Folk Theatre and puppet shows

Curative Programmes:

Below are some of the detailed curative programme processes outlined to ensure screening and referrals for treatment of persons with disabilities: -

- Orthopedic
- Cleft (Lips and Palate)
- Hearing
- Vision (Cataract, squints, ptosis (dropping of eyelid))

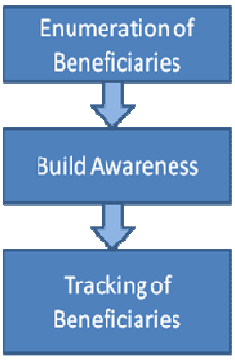
❖ **Orthopedic**

Physical impairment restricting movement.

Treatment of all orthopedic disabilities and deformities such as Post Polio Residual Paralysis, Club Foot, CTEV, Post Accidental Deformities, etc.

Potential Challenges

- Large size of community
- Lack of access to Government Health Communities
- Poverty
- Ignorance on disability



Process

I. Enumeration of beneficiaries
    a. Conduct exhaustive survey to identify Polio cases
II. Build Awareness
    a. Arrange workshop to educate people on Detection and Prevention of Polio
    b. Arrange Orthopedic screening camps (for patient motivation)
III. Tracking of beneficiaries
    a. Distribution of aids and appliances

❖ Cleft (Lips and Palate)

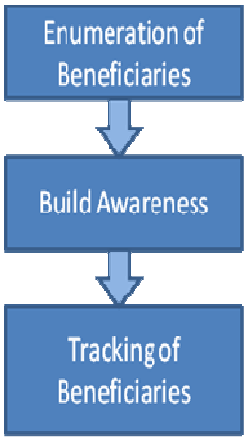
The cause of cleft lips is either genetic, deficiency of folic acid during pregnancy or the effect of drugs such as Thalidomide during pregnancy. It occurs during early development in the womb and the clefts are due to the non-fusion of the body's natural structures. Approximately 1 out of every 700 children is born with a cleft lip and / or cleft palate. The minimum age for surgery on cleft lips is 3 months and the earlier the operation is completed the better, as the scarring will be less noticeable as the child grows.

Cleft palates are to be operated on from one year, bone grafts usually take place from 8 to 11 years and any reconstructive surgery such as rhinoplasty will happen from the age of 16 years.

Many individuals with clefts often suffer with middle ear infections which can eventually lead to complete hearing loss and many have speech difficulties.

Potential Challenges

- Non Institutional deliveries. Ignorance, misconceptions regarding care during pregnancy
- Surrounding not hospitable for children
- Poverty
- Ignorance on disability
- Inaccessibility to existing health system



Process

I. Enumeration of beneficiaries
   a. Identification of plastic surgeons, facilities in geography
   b. Survey through ASHA, AWW and Health Staff
II. Build Awareness
   a. Arrange workshop to educate community about Cleft
   b. Build awareness about various institutions, Government schemes supporting cause
III. Treatment and Tracking
   a. Screening Camps to identify patient for surgery
   b. Perform Surgery (may be multiple in some cases – due to complexity)
   c. Patient support for post surgery Speech Therapy

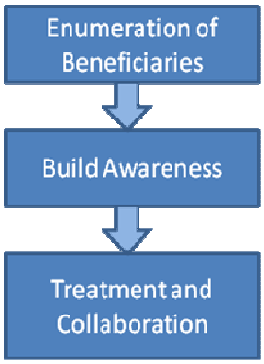
❖ Hearing

There are two main types of deafness, conductive hearing loss and sensorineural hearing loss.

A conductive hearing impairment results from dysfunction in the mechanisms that conduct sound waves through the outer ear, the ear-drum or the bones of the middle ear. Causes include ear-wax, ear infection, chronic perforation of the ear drum, fluid accumulation and intense noise levels.

Potential Challenges

- Poverty
- Ignorance on disability
- Inaccessibility to existing health system



Process

I. Enumeration of beneficiaries
   a. Survey through grass root level workers
   b. Screening camps with ENT surgeon and audiologist
II. Build Awareness
   a. Arrange workshop to educate community about Hearing
III. Treatment and Collaboration
   a. Surgeries for conductive hearing loss
   b. Provision of hearing aid to neutral hearing loss
   c. Fitment camps in collaboration with ADIP scheme for hearing aids

❖ Vision (Cataract)

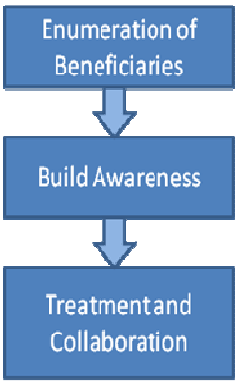
A cataract is the complete or partial opacity of the ocular lens.

Cataracts cause more vision problems globally than any other eye condition or disease. Causes of cataracts include ageing (most common between 50 and 60), diabetes, a trauma and excessive use of steroids.

Other vision related problems treated are squint, ptosis and refraction error.

Potential Challenges

- Inaccessibility to existing health system
- Community lacking in awareness of disability
- Poverty



Process

I. Enumeration of beneficiaries
   a. Village to Village screening camps
   b. Collaboration with Eye Hospitals
II. Build Awareness
   a. Arrange workshop to educate community about Vision related disabilities
III. Treatment and Tracking
   a. Arrange logistics
      i. Collect patient and send to Eye Hospital
      ii. Arrange stay if multiple surgeries are required
   b. Perform surgeries (if required)
   c. Follow-up of each patient treated
   d. Correction through spectacles provided through Government's nucleus budget

Action Plan

A high level plan for execution should be derived based on the baseline survey.
The success of the programme is highly dependent on the fact that the patients or individuals are willing to avail of services provided by the project. It would be advisable to have another seminar with the masses in each Block to convey the high-level plan to them and also introduce them to the core team in each area.

The following steps need to be followed: -

- Arrange seminar/informal meetings with masses in each Block (for visibility)
  - Share high level objectives of the programme
  - Share priorities of the programme (disabilities)
  - Proposed timeline of the programme
  - Key contact points in the programme
  -
- Setting quarterly targets for each Block (based on baseline survey)

- Detailed planning activities for efficient execution
  - Maintain Risk and Issue registers for each Block (with mitigation plan and actions) (This may be computerized)
  - Have a chart of partner medical institutions (with specializations) with key contacts.
  - Outline schedule for diagnostic van visits in each area/Block
  - Chalk out plan to track new disabilities and mechanism to report and track cases
  -
- Based on the target in each Block arrange through Government inventory (spectacles and hearing aid, medicines etc) and/or arrange assistance from medical institutions. First year target should be a bit low (about 25%) due to establishing confidence with masses.

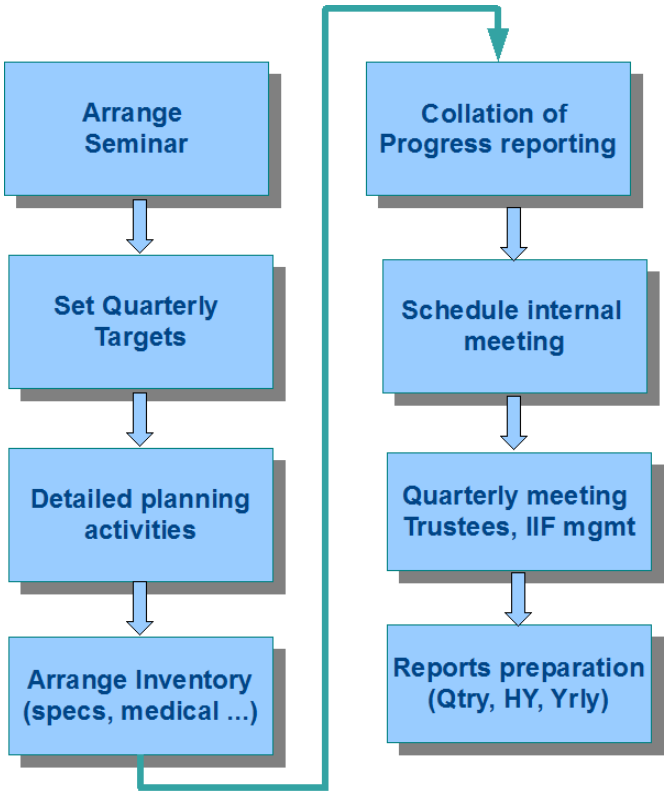
- Collation of progress and reporting
  - Each Area Manager to collate progress from field staff on a daily, weekly basis based on standard templates
  - Functional data should be entered in web-based MIS system on a monthly basis by each Area Manager
  - Area manager responsible for extrapolation of reports from the web-based MIS system and preparation of status report
  - Document key success factors and processes for providing the context of each factor (Report Template Appendix 4.2)

- Schedule internal meetings to review progress (frequency once a month)
  - Monitor progress in each area/Block
  - Highlight challenges and discuss mitigation plans
  - New Ideas and methodologies
  - Monitoring and optimizing QoS (Quality of Service)
  - Suggestion for Process enhancement
  - Review metrics and statistics of targets v/s actual
  - Identify potential improvements looking for efficiency and automation

- Programme Director Quarterly meetings with Project management.
  - Presentation showcasing progress of CHI
  - Targets achieved and plans to address the balance
  - Review short-term and long-term objectives of CHI
  - Feedback from management
  - Set target for the next quarter based on the progress and geographical modalities

- Continuous feedback cycle from Government bodies and the masses to evaluate progress of CHI in social term

- Preparation and generation of quarterly/half yearly and yearly reports to give overall view of the CHI engagement. These would be addressed to management and partners of the project. Reports should be descriptive, analytical and in line with the objectives. Numbers should be substantiated by placing within a context.



2.3 Programme Sustainability (in IIF's CHI project)

Impact India Foundation (IIF) acts as a catalyst to bring together business houses, NGOs, the Government and the community to implement health programmes of national priority. The Community Health Initiative (CHI,) covering a population of nearly two million in eight Tribal Blocks of Thane District, comprises partnerships with private sector, supported by Government health machinery, and medical professionals.

The CHI uses available delivery systems and existing infrastructure, for sustainability, in support of the Government's National Rural Health Mission's goal to establish a fully functional, community owned, integrated, health-delivery system.

No project can be successful unless the local community, including Self Help Groups, Panchayats as well as Teachers and Students, is fully involved.

To enable the sustenance of the project Impact is undertaking the following:

1. Formation of a Task Force headed by the District Collector/ Chief Executive Officer, Zilla Parishad, with representatives from the State Government (Public Health Department). In the case of the CHI in Thane District, Dr Sanjiv Kamble Deputy Director, Health Services, Thane, who is in charge of three Districts – Thane, Raigad & Ratnagiri – has been appointed as Liaison Officer for the CHI.

   The Task Force includes representative of local and interested private sector companies, health practitioners and professionals and the community.

   The Task force will hold periodic reviews to monitor the health delivery system against vital health indicators such as Infant Mortality Rate, Maternal Mortality Rate, Children suffering from severe to moderate malnutrition, Anaemia prevalence in adolescent girls etc.

   With the ownership resting with District head and also inclusion of all Government programmes under one umbrella, the CHI will become a State Government project, and as such Government funds could be fully utilized for sustenance of the project, leading to its institutionalization.

   This coordinated and convergent approach facilitates project replication in other districts within and outside Maharashtra.

2. Training of Trainers. Building the capacity of Government Health workers such as Auxiliary Nurse Midwives, Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs) by training them on the activities undertaken by IIF, such as Anaemia reduction in adolescent girls, Health education or Information, Education & Communication to mobilize the community to access Government services for timely immunisation of infants and pregnant mothers, registration at Primary Health Sub Centres and Centres for institutional births under skilled medical care and tracking of infants to lower the Infant and Maternal Mortality Rates. Literature on Health prevention is prepared and communicated in local languages through Pamphlets, Posters, Banners and Slogans. Songs and Film Shows are also used. CHI staff supervises the performance of its Government Trainees.

3. Training community volunteers to actively form and participate in the Arogya Samitis of Gram Sabhas (Village councils). Just as seats are reserved, under the Panchayati Raj system, for women Sarpanchs to head Gram Sabhas, but few women take up the responsibility because they lack training and empowerment, similarly, Gram Arogya Samitis are mandated by the Government but are rarely operational because they lack knowledge and the skills to fulfill the responsibilities. Government has authorized IIF to train and empower rural volunteers to function effectively as Arogya Samitis.

4. Using school students as Change agents. IIF serves to develop health awareness in children and rural communities on timely detection and treatment of disabilities. Students are asked to vote for their Health Monitor who is given a badge and a notebook and is responsible for early identification of any symptoms or signs of illness amongst her classmates. Health problems such as watering of eyes, ear discharge, skin rash, fever, stomach ache, head lice etc. are reported to the Teacher who motivates parents to obtain treatment from the nearest Primary Health Centre. Not only has this practice increased abilities to detect illness, but has also contributed substantially to cleaner and healthier rural children.

The following factors contribute towards CHI sustainability: -

- Health processes and systems are in place to track beneficiaries
- Community is empowered to avail of existing Government Services
- Existing Government Infrastructure and delivery services are as prescribed by NRHM

Thus CHI project tackles all three attributes of sustainability viz. project design & implementation, factors within organization setting & in broader community environment.

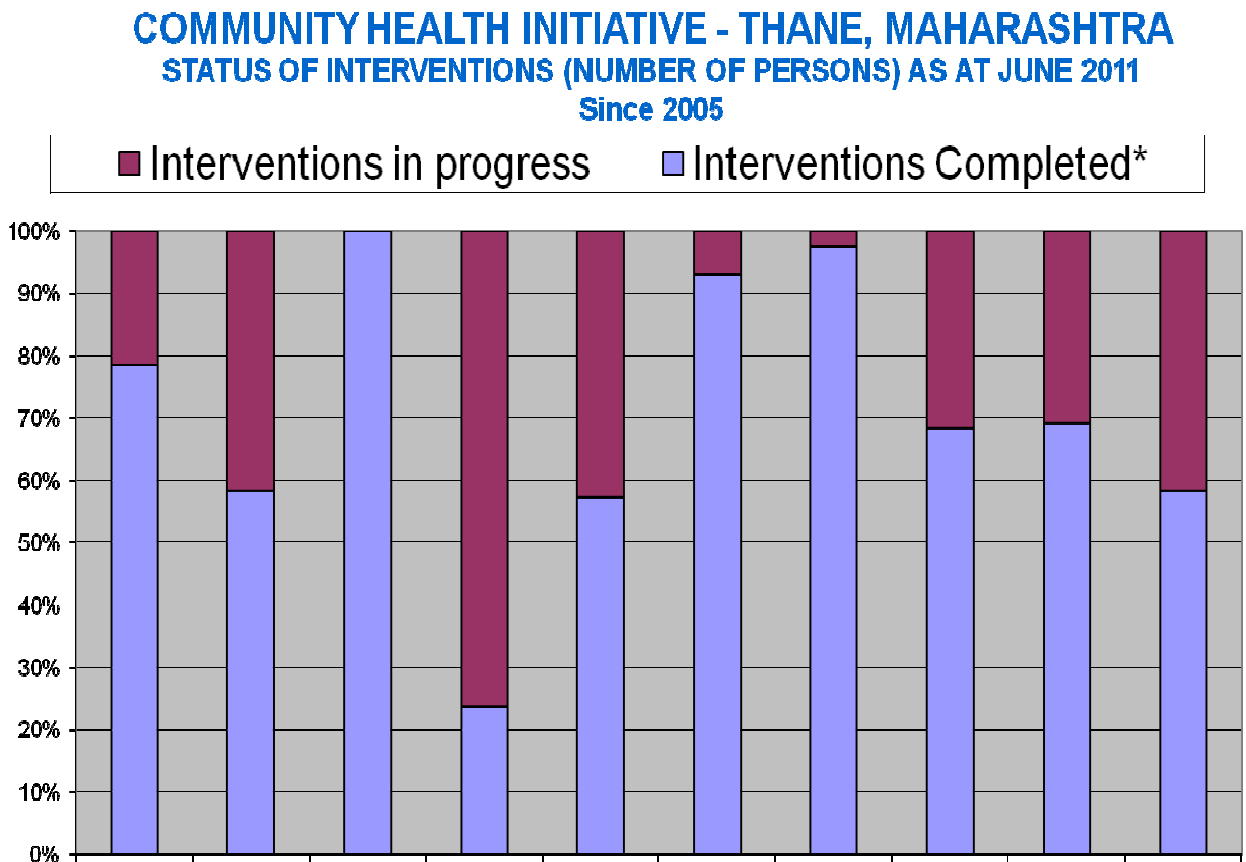
The Task Force will continue to engage NGOs, corporate bodies and other stakeholders from within the community to ensure the project's sustainability.

The CHI project involves Government and other agencies from inception with the Task Force being in place for implementation and monitoring.

Achievements of CHI in Thane, Maharashtra-

In 2005, the IIF introduced its ambitious CHI project in backward tribal areas of Thane district. At present it is well functioning in eight blocks of Thane namely Palghar, Talasari, Jawhar, Mokhada, Wada, Dahanu, Vikramgad and Shahapur covering a population of 2 millions. Various preventive and curative interventions described in this process document are meticulously executed in this project area. These robust CHI activities are yielding promising results which are seen as follows-

Process Indicators-



	Vision	Hearing	Clefts	Orthopaedic	Dental	Immunization	ANC	Hb Est.	Kitchen Gard.	IEC
Interventions in progress	11131	4083	0	1525	9847	4100	240	3671	10148	164043
Interventions Completed*	40609	5707	373	475	13162	53972	9332	7950	22725	230282

*Number of people successfully covered by the Curative and Preventive programmes.

Output Indicators

Indicators	Before	After	Improvement
Data Integrity	75%	95%	20%
Targets mobilization (identifying target population)	50%	80%	30%
Target Setting and Measuring of achievements	40%	80%	40%
Target Penetration	50%	90%	40%
Optimum utilization of resources	50%	85%	35%
Systematization of Programmes (with priorities)	40%	80%	40%
Enhanced accountability	75%	95%	20%
Enhanced Visibility	40%	90%	50%
Enhanced Traceability	50%	90%	40%

The qualitative benefits of the project are: -

- Ability to quantify activities from Social Return on Investment (SROI) perspective – by accurate articulation of Inputs, Tangible Outputs, Measurable Outcomes, Socio/Economic Impact
- Visibility across Community Health Initiative (CHI) programme (across geography) with ability to view detailed statistics for Curative and Preventive
- Accuracy in reporting of programme to Donors, Management and other stakeholders
- Measurement of "Disability Reduction" in that geography.
- Disability Trend analysis across regions within geography and identification of similarities
- Tracking of Key Performance Indicators (KPI) for ensuring programme is sustainable and replicable

Mr. Gopinath Menon, (former Unicef) of the Centre for Development & Leadership, was commissioned by Impact to conduct an evaluation of the CHI, reproduced below are selected excerpts of his findings-

"Considerable progress has been made towards achieving the goal of reversal of existing disabilities. Cases for corrective interventions are identified through the mobile diagnostic clinics and special screening camps held periodically.... CHI has established excellent partnerships with a good number of private hospitals where corrective interventions are carried out free of cost. The project has also started tapping funds from different Government schemes... The health check up cards introduced in some Ashramshalas in 2008 was a good initiative. It was not just a health monitoring tool but was also a powerful educational tool that helped children and teachers to understand different aspects of health monitoring and promoting much needed life skills."

3 Future Plans

As a result of strong delivery excellence and track record in implementing CHI in rural India. Impact India Foundation aspires to replicate the Community Health Initiative (CHI) programme in other rural parts of India.

In addition Impact India Foundation also aspires to adapt the Community Health Initiative (CHI) designed for rural India to establish an **"URBAN"** model for replication throughout India.

4 Appendix

This section contains all specific templates which would assist in the process methodology for Community Health Initiative.

4.1 Survey Templates

Here is a sample survey template used for a hamlet. The survey would have detailed disabilities viz for Vision it should list cataract, squint, glaucoma etc.

Impact India – Community Health Initiative
Thane Health Survey – One for each Pada

Pada: _____ Village: _____ Subcentre: _____ PHC: _____ Block: _____

Date: _____ Name of person completing form: _____ Person's Occupation (Anganwadi/ASHA /other): _____

1. Number of people in the Pada. This can be found in register?

Age	*Males*	*Female*	*Total*
0-19			
19 and over (Adults)			

2. Number of children 0 – 6 with a disability in the Pada. Please find out from the disability register.

Name	Age	Sex	Vision Problem	Hearing Problem	Orthopedic Problem	Cleft Lip	Cleft Palate	Other, Please Name

3. Who else do you know in the Pada, aged 6 and over, has a disability like the ones in the flip chart. If you are unsure, please visit the household to find out.

Name	Age	Sex	Vision Problem	Hearing Problem	Orthopedic Problem	Cleft Lip	Cleft Palate	Other Please Name

4. Number of ANC Mothers. Please check from register 13.

Name	Age	Child Issue Number	Space/gap if second child or more	Is taking Iron Folic Acid Supplement? Yes or No?	Has had TT Vaccination? Yes or No?	Has had at least one ANC check-up at PHC? Yes or No?	Receiving Janani Suraksha Yojana? Yes or No?	Receiving Matrutva Anudaan Yojana? Yes or No?

5. How many children in the Pada aged 0 - 6? Please take the following information from register 5, the Immunisation register.

No. children currently below 2 years	No. children currently above 2 years	Total no. children

	Number of Children currently below 2 who have received the following immunisation doses	Total Number of Children currently above 2 who have received the following immunisation doses
Polio & BCG at birth		
DPT 1 and OPV 1		
DPT 2 and OPV 2		
DPT 2 and OPV 3		
Measles and Vitamin A		
Booster DPV and OPV and Vitamin A		
Hepatitis B 1		
Hepatitis B 2		
Hepatitis B 3		

6. Number of Children malnourished. Please take from register 1 and 2.

Malnutrition Level	Number of children aged 0-6
Normal	
Grade 1	
Grade 2	
Grade 3	
Grade 4	
Don't Know	

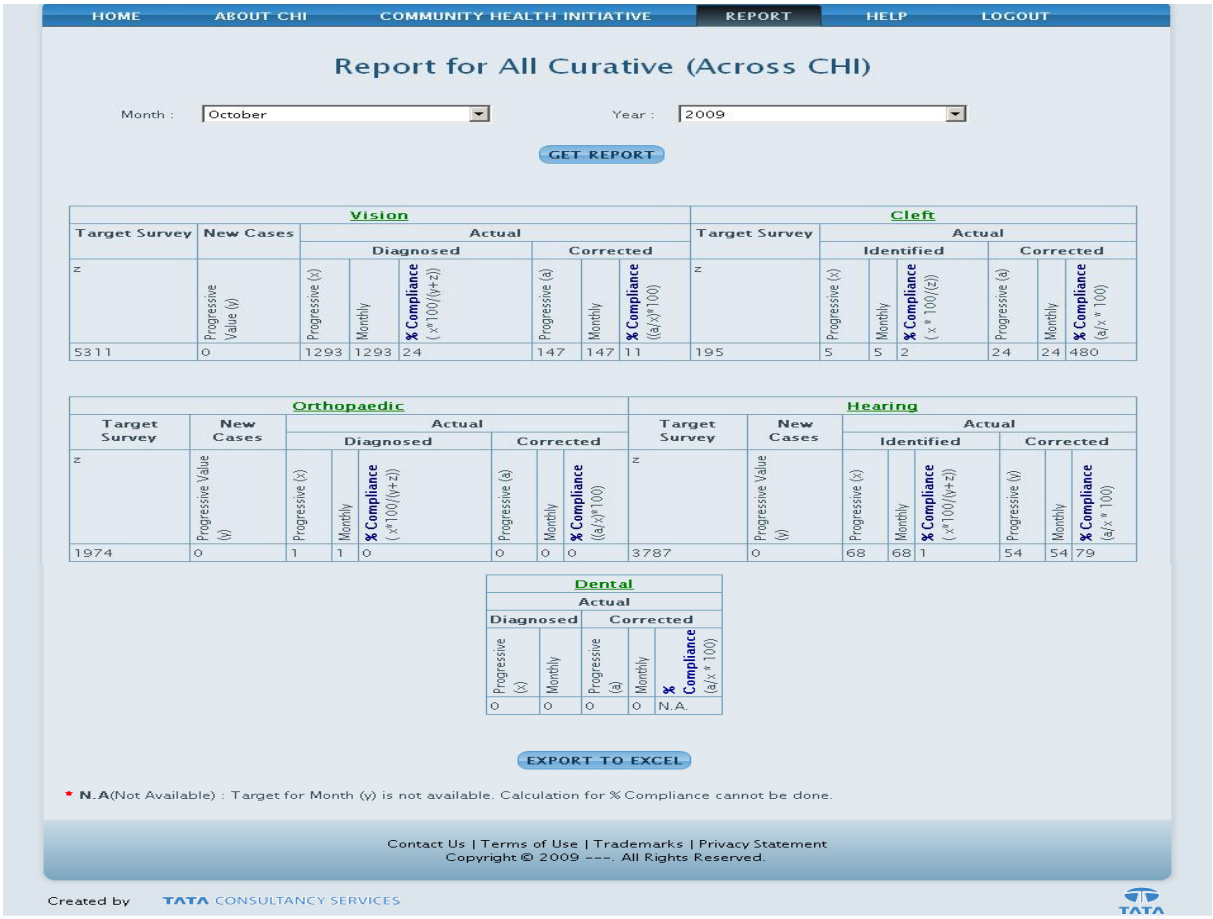
7. Number of "drop-out" Adolescent Females (age 11 – 19). Question unfinished. We need to find out if this can be answered and what information AWW record. Otherwise omit it.

Name	Age	Taking Iron Folic Acid Supplement	Taking de-worming supplement

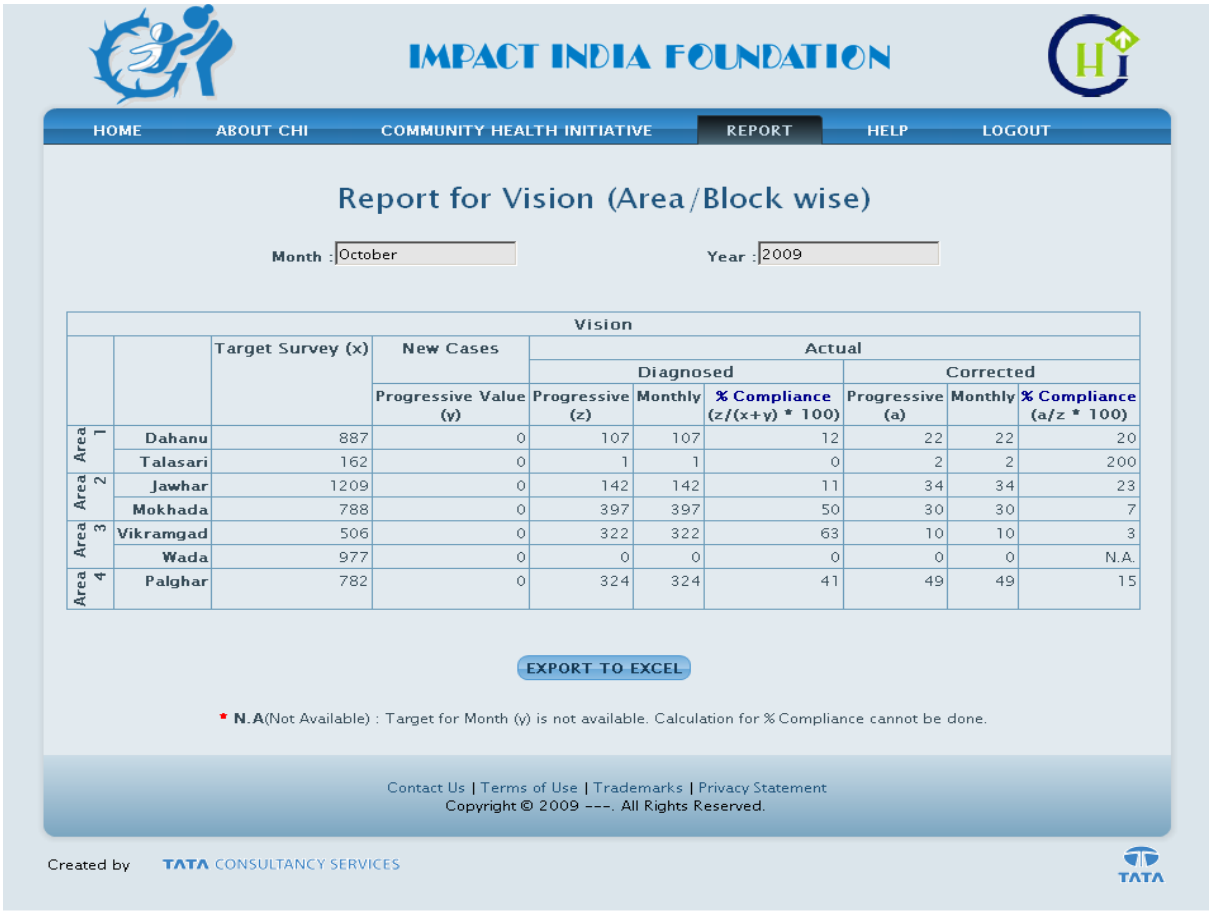
4.2 Report Templates

Following are some of the report templates which are derived from the MIS system. These reports are in addition to the daily, weekly and monthly reports shared within the programme.

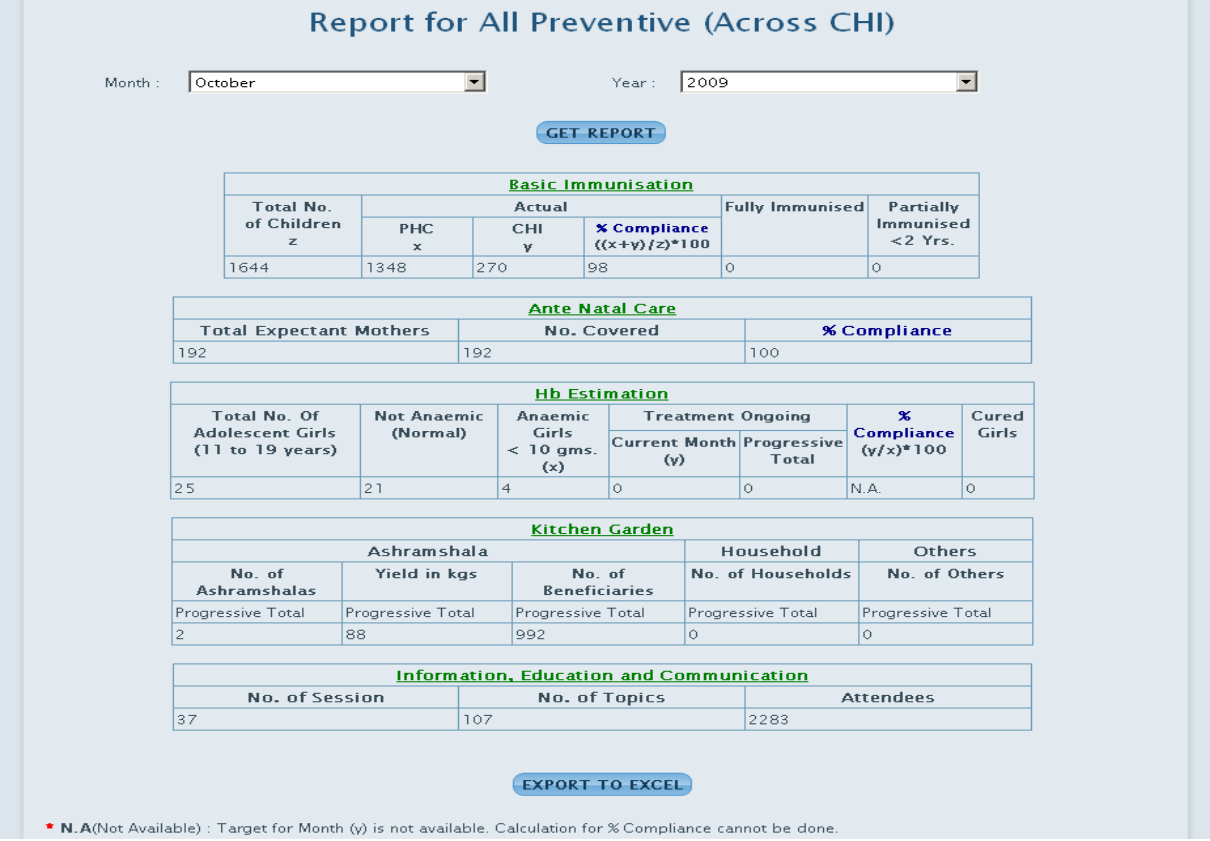
Monthly Progress Report Template



Curative Summary Report



Curative - Vision Consolidated Report



Report for All Preventive (Across CHI)

Month : October Year : 2009

GET REPORT

Basic Immunisation

Total No. of Children z	Actual			Fully Immunised	Partially Immunised <2 Yrs.
	PHC x	CHI y	% Compliance ((x+y)/z)*100		
1644	1348	270	98	0	0

Ante Natal Care

Total Expectant Mothers	No. Covered	% Compliance
192	192	100

Hb Estimation

Total No. Of Adolescent Girls (11 to 19 years)	Not Anaemic (Normal)	Anaemic Girls < 10 gms. (x)	Treatment Ongoing		% Compliance (y/x)*100	Cured Girls
			Current Month (y)	Progressive Total		
25	21	4	0	0	N.A.	0

Kitchen Garden

Ashramshala			Household	Others
No. of Ashramshalas	Yield in kgs	No. of Beneficiaries	No. of Households	No. of Others
Progressive Total	Progressive Total	Progressive Total	Progressive Total	Progressive Total
2	88	992	0	0

Information, Education and Communication

No. of Session	No. of Topics	Attendees
37	107	2283

EXPORT TO EXCEL

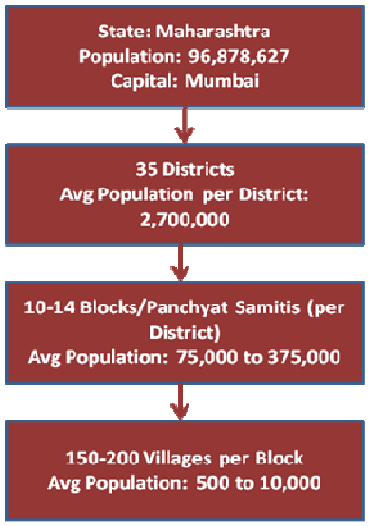
* N.A(Not Available) : Target for Month (y) is not available. Calculation for % Compliance cannot be done.

Preventive Summary report

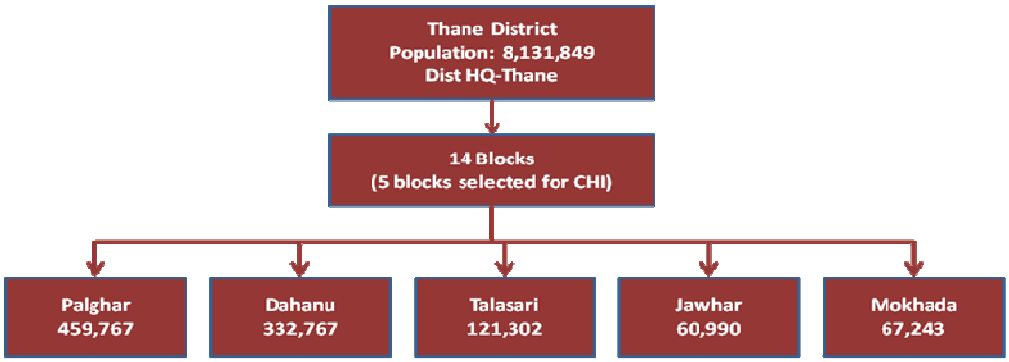
4.3 Government Hierarchy

Government is a key stakeholder and contributes heavily towards the success of Health Initiative. It is imperative to effectively understand the modalities of the geography and map to relevant official or department in the Health machinery.

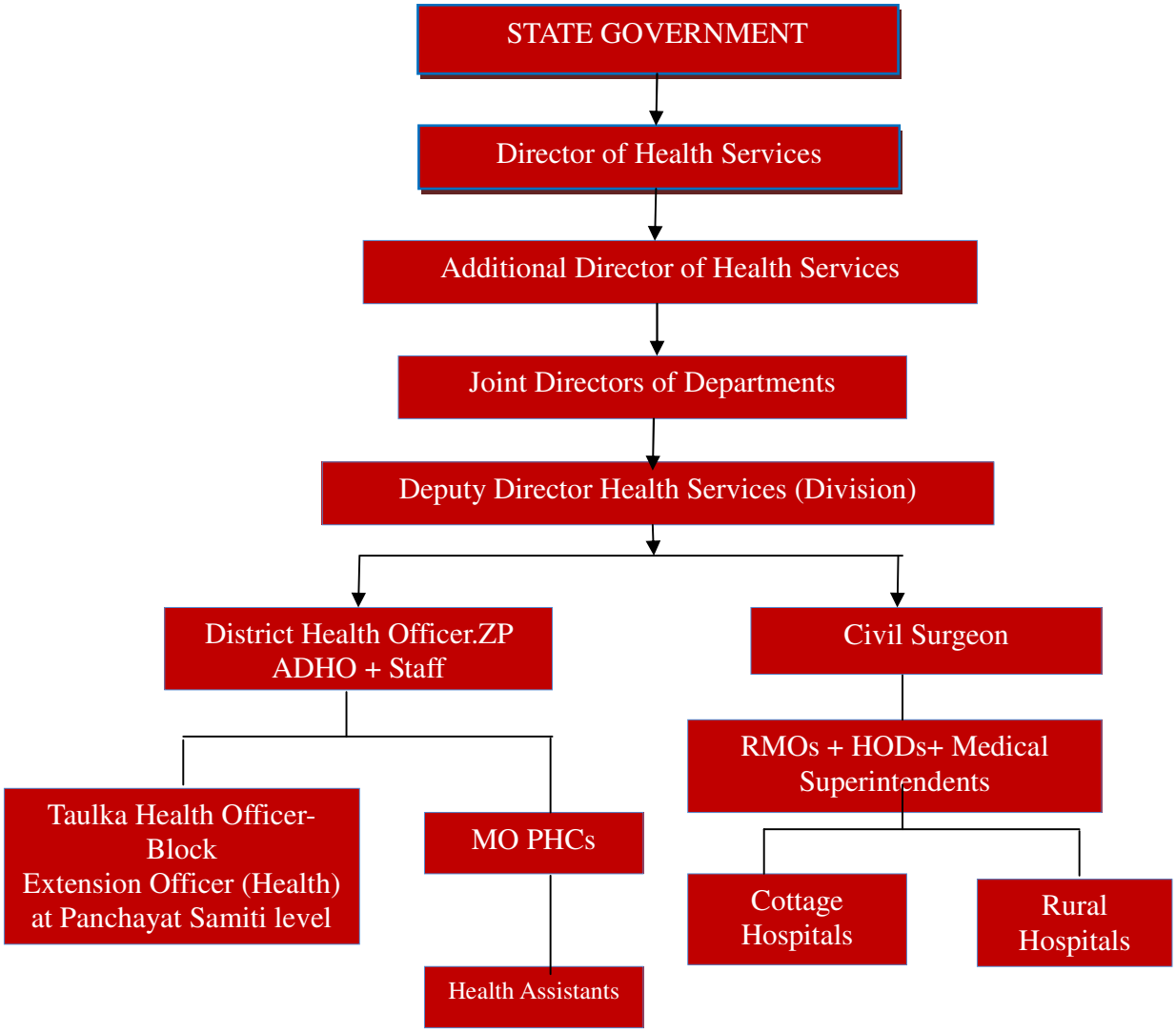
Impact India Foundation started with understanding the broad structure of Maharashtra state.



Impact undertook the following district with due consent from State and Central Governments..



Below is the structure of government official under department of Health



All development work under Central and State Government sponsored schemes are implemented by the Block Development Officer (BDO). These are Jawahar Gram Swarojgar Yojana, Indira Awas Yojana, Suwarnajayanti Gram Swarojgar Yojana (SGSY), Matrutwa Anudaan Yojana.

Some of the above schemes include health, education, agriculture, employment guarantee, construction and repair to roads, school building, minor irrigation works and distribution of seeds, insecticides and pesticides etc.

4.4 National Rural Health Mission (NRHM)

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, providing technical support and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.

It aims at effective integration of health concerns with determinants of health like sanitation and hygiene, nutrition, and safe drinking water through a District Plan for Health.

It seeks decentralization of programmes for District management of health.

It seeks to address the inter-State and inter-District disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.

It shall define time-bound goals and report publicly on their progress.

Goals of NRHM

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation and hygiene, Immunisation, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

Core Strategies

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in underserved areas.

The Community Health Initiative (CHI) would be inline WITH the NRHM guidelines to be able to blend and compliment/supplement National Health Goals and objectives.

4.5 Scaling Up Nutrition (SUN) programme

Nutrition was the main subject of discussions at the recent World Economic Forum in Davos, Switzerland. The SUN programme brings together a cooperative global effort to support nutrition advancement in developing countries.

Impact India's Community Health Initiative covers a population of nearly two million in eight Tribal Blocks of Thane District, Maharashtra, with Pregnant Women (PW) expected to be about 3.5% and Lactating Mothers (LW) with their children below three years, at about 3% of the total population. For the SUN programme IIF proposes to target 50% of the population who are mainly from Below the Poverty Line.

The SUN programme covers a 1000 day period (minus 9 to 24 months) which will see 13 direct nutrition interventions, under the following three strategies: -

1. Intensive Information, Education and Communication (health education) sessions for Behavior change.
    a. Promotion of breastfeeding
    b. Appropriate complementary feeding practices
    c. Proper hygiene, specifically hand washing

2. Micro nutrient and De worming campaigns.
    a. Periodic vitamin A supplements
    b. Therapeutic zinc supplements to manage diarrhea
    c. Multiple micronutrient powders
    d. De worming drugs
    e. Iron-folic acid supplements for pregnant women
    f. Iodized oil capsule if iodized salt in unavailable
    g. Iron fortification of staple foods
    h. Salt iodization

3. Complementary and therapeutic feeding
    a. Prevention or treatment of moderate malnutrition
    b. Community-based management of severe acute malnutrition

The programme will be conducted in partnership with the Government and will seek support from the corporate sector and other NGOs to fill in the gaps. It may be noted that

- 9 out of 10 deaths under 5 are amongst those infants who are not breastfed
- 1.2 million diarrhea and pneumonia cases are due to poor breastfeeding practices
- 3.5 million under-5 deaths are due to poor breastfeeding practices

The programme will cover:

1. Antenatal and delivery care or safe motherhood programs, taking care of Breastfeeding promotion and support, Iron-folic acid supplements and Iodized oil capsule where iodized salt is unavailable.
2. Child health days – for Vitamin A supplementation, De worming drugs for children 12-59 months of age and provide Micronutrient powders for children 6-23 months.
3. Primary health care system - Therapeutic zinc supplements for diarrhea management, Identification of severe acute malnutrition and Supervision of community-based management of acute malnutrition.
4. Market-based delivery - Salt iodization, Iron fortification of staple foods and fortified complementary foods for children 6-23 months.
5. Community nutrition programs - Breastfeeding promotion, Promotion of appropriate complementary feeding practices and Hand washing promotion

The programme offers cost-effective interventions to prevent and treat under nutrition, as the focused period is a window of opportunity where we get the highest returns from investments. The programme outcome will not only result in the reduction of Infant and Maternal Mortality but will also lead to improved cognitive and physical development in beneficiaries leading to higher earning capacities.

The ownership for the sustainability of the programme rests with the community and the Government.

4.6 School Health Monitor Programme

School Health Monitor Programme marked the initiation of the CHI with an activity which was undertaken by the Government of India under the Vision 2020 programme for the early identification and control of Blindness.

This was successfully tried out in Orissa by Impact India Foundation and has been extended to include other disabilities in Thane District, Maharashtra.

As part of CHI, Impact has expanded on the Government of India's existing Vision 2020 Project for restoration of sight to the blind, to include hearing to the deaf, mobility to the orthopedically challenged and correction of Cleft.

Objectives: -

- To develop a system for the early and timely detection and treatment of vision related problems (especially refractive errors), hearing related impairment, orthopedic disabilities and cleft amongst children
- To promote health-seeking behavior in rural communities
- To develop a system for the delivery of primary health care
- To develop sustained demand generation and to improve the utilization of existing health care services

Target was to reach 300,000 school children in the tribal belt of Thane district, Maharashtra within the area of CHI. The programme was conducted in rural schools where the children come from extremely backward tribal villages.

4.7 Emergency Medicine Training for Rural Communities

Different target group should be given different levels of training depending on their previous understanding and exposure in handling any emergencies. For instance, an Auxillary Nurse Midwife (ANM) conducts deliveries and is very close to medical practice in her day to day work. Hence ANMs are ideally suited to be trained to handle certain difficult methods while managing emergencies (for example, Cardiac Pulmonary Resuscitation – CPR, Rescue breathing etc).

It is ideal to induct the newly recruited Anganwadi workers (AWW). AWWs provide services for immunization, health check-up, informal pre-school and nutrition education, supplementary nutrition and referral services.

The following are the areas of training: -

1. **First Aid**: - It is the care administered by a person immediately after an accident or illness. Any aid that can be given at the moment is first aid.

   Objectives
   a. To save affected people's lives
   b. To reduce the impact of injuries or to prevent further, deterioration
   c. To relieve pain

   One does not need a special degree or qualification to administer first aid. Any individual can learn how to administer first aid. Only basic training, self confidence and a desire to help others is required.

2. **Bleeding Control: -** Following actions need to be taken to stop bleeding
   a. Locate points of bleeding; start with the most serious bleeding point
   b. Elevate the injured part to slow down the bleeding.
   c. With a thick cloth, (if absolutely necessary use hand), apply direct pressure just above the bleeding wound and hold pressure until the part stops bleeding. To stop bleeding apply pressure for 15 minutes to an hour.
   d. Apply ice to the surrounding area

   Note: - If a foreign object is found in a bleeding wound, DO NOT remove the object; removal could cause further injury.

3. **Shock Management**: - Shock results from insufficient blood supply to all cells in the body. Shock can be caused by uncontrolled bleeding, severe infection, dehydration, a large burn, heart failure and a severe allergic reaction. Sometimes shock can be fatal in the short – term and can lead to long-term vital organ damage.

   Common Symptoms

   a. Breathing: - fast or irregular
   b. Mental and emotional state: - confused, faint, depressed, fearful, drowsy
   c. Skin: cold, pale, tender and sticky wet
   d. Dehydration: feeling thirsty
   e. Pulse: fast but weak

   Treatment

   a. Make patient lie down with legs higher than the head
   b. Cover the body with a blanket or sheet to try to maintain body temperature
   c. Control any causes of bleeding
   d. If the patient is conscious and able to drink then try to give sips of water
   e. Arrange for professional help immediately
   f. Keep the patient calm
   g. Do not allow the patient to sleep. Talk to patient to prevent from going into coma

4. **Orthopedic Injuries/Fractures and Sprains: -** Fractures occur commonly due to car or train accidents and fall from heights. Improvised treatment of fractures can lead to serious injury of the blood vessels and nerves around a bone and can permanently disable an individual. Keep the bone in the fixed position to prevent further disability.

   Symptoms

   a. Pain
   b. Swelling
   c. Bruising
   d. Observe dip or mound near fractured spot
   e. Difficulty in movement
   f. Change in size or position of body parts
   g. Patient may have heard a crack or pop during injury

Other areas of training which need to be imparted: -

(i) Head and Neck injuries
(ii) Care of wounds
(iii) Burns
(iv) Heat Strokes
(v) Snake Bites
(vi) Diarrhea

4.8 PUBLIC PRIVATE PARTNERSHIP :-

Some major partners include:

(1) The Rotary Clubs of Mumbai, Stevenage Grange & Bournemouth North, U.K.

(i) Lifeline Express Mobile Clinic for diagnosing vision and hearing impairment benefitting 50,000 persons.

(ii) Cataract Surgeries – 416 in Palghar and neighbouring areas

(iii) Public Dam at Karoli village, Mokhada, serving a population of about 1000 in three adjoining villages. Recharge of ground water of table of two nearby wells thereby ensuring regular supply of water. The top portion of the dam wall serves as a road.

(iv) Solar lights for streets and households

(v) Spectacles, Aids & Appliances for the disabled

(vi) Drinking water purification units for six Ashramshalas (village residential schools – each with about 600 boys and girls) benefitting about 3,600 students.

(vii) Orthopaedic surgeries - 22 patients

(2) The Ammada Trust, Mumbai

Rain Water Harvesting structures in Jambulpada, Kadupada and Mohapada - remote villages in Parali Primary Health Centre area of Wada Block

(3) Cipla Ltd.
Donation of medicines

(4) Mattel Children's Foundation, USA

(i) Sponsorship of Lifeline Express Mobile Clinic (Diagnostic Van)

(ii) Sponsorship of Playground equipment in Daggadipada Ashramshala

(iii) Cultivation of Kitchen Gardens in Ashramshalas

(iv) Medical check–ups of Ashramshala children.

(5) Cosmos Ignite Innovations, Delhi

Donation of 40 Solar Lamps to Daggadipada Ashramshala benefitting around 600 students

(6) Art Action Holdings Ltd. – Temasek Group, Singapore
Supported Information Education & Communication sessions for the community using Warli Art (paintings, folk dance & music and street theatre) to convey social messages.

(7) Hindustan Petroleum Corporation Limited

Rain Water Harvesting structures:

(i) Dapati village in Jawhar Block benefitting around 300 people who will get drinking water even during the summer. In the long run availability of increased water will help preventing migration to cities.

(ii) Dolhara village in Mokhada Block benefitting 1660 mainly Below Poverty Line families. Recharge of wells through construction of sub surface walls and spring cordons.

(8) Johnson & Johnson

(i) Installed drinking water systems in eight schools:
Khutal Ashramshala in Palghar Block, Daggadipada in Vikramgad Block and Guhir Ashramshala in Wada Block, Balkanji Bari Grant-in-aid Ashram School-Dahanu, Taharpur Private High School-Shahapur, Grant-in-aid Ashramschool-Shahapur, Vadoli Private High School-Jawhar and Shigaon Grant-in-Aid Ashram School. These water purifying systems have benefitted around 4,800 students.

(ii) Construction of Toilet Blocks. Dagdipada Ashramshala for girls.

(iii) Construction of a shed at Khutal Ashramshala

(iv) Construction of a Wire-mesh Compound Wall at Kalamdevi Ashramshala, Dahanu

(9) Pfizer Ltd.

Mobilisation of the community in two Sub Centres to access the services of Parali Primary Health Centre located in Wada.

(10) HDFC Ltd

Rainwater Harvesting Project at Mendhvan Village in Palghar Taluka, benefitting a population of 750, mainly Tribals.

(11) Ion Foundation

Water Treatment Plant at Pali Ashramshala in Wada Block benefitting about 600 students for drinking and bathing.

(12) Britannia Industries Ltd. through Britannia Nutrition Foundation

For the supply of iron-fortified Tiger biscuits for reduction of Anaemia in primary school children of two Ashramshalas.

And many more……..