Summer Placement
In
Child in Need Institute (CINI)
(April 8 to June 5th, 2015)

A Report

By

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MBA Hospital and Health Management

2014 – 2016

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IIHMR UNIVERSITY

CERTIFICATE

This is to certify that Miss **Priya Chaturvedi,** a student of MBA Hospital and Health Management, **IIHMR University**, Jaipur, batch 2014-16 has successfully completed her summer training for the period from **April 8th to June 5th, 2015** under **Child In Need Institute, Kolkata** under my guidance. During this period she has completed a study titled, "**Understanding a Civil Society Organization's Role in partnership with the Government to Fight Malnutrition in First 1,000 days of a Child in Ward 58, Kolkata and Diamond Harbour II Block, South 24 Parganas in West Bengal"** as a part of partial fulfillment of the course requirements, recommended for MBA Hospital and Health Management with **specialization in Health Management**. All the data related to the study is primary data. Her approach towards the study has been sincere, scientific and analytical.

I wish her all the best for future endeavors.

Col. (Dr.) Ashok Kaushik (Retd.)

Dean (Academic & Student Affairs)

Dr. S.D. Gupta

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help the mother
help the child...

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Completion Certificate

Certified that Ms. Priya Chaturvedi, MBA Hospital and Health Management First Year student from IIHMR University, Jaipur, Rajasthan was placed in Child in Need Institute (CINI) during 8th April to 5th June 2015 for the purpose of two months summer training.

During the course of the internship she was engaged in understanding and learning through programme interventions of CINI. She has undertaken unit / division wise 'Observational Learning' and a study to "Understand a Civil Society Organization's Role in partnership with the Government to Fight Malnutrition in First 1,000 days of a Child in Ward 58 in Kolkata and Diamond Harbour II Block, South 24 Parganas in West Bengal". She has undertaken home visits, conducted community and stakeholder's meetings for the purpose of developing this concept note.

She has shown keen interest in understanding the activities of the organisation and also interacted with senior officials for the purpose of summer training. She is very hard working and made necessary field visits for the purpose of learning.

We wish her all the best.

05/06/2015

CHILD IN NEED INSTITUTE Daulatpur Pailan 24-Pgs.(S) CINI

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CINI, Community facilitators, who work very hard in the communities, helped me to understand the actual field level operations. I am very thankful to them.

I express my sincere gratitude to **Dr. Aditi Roychowdhury**, my **mentor at CINI** and **Dr. S.D Gupta**, my **mentor at The IIHMR University** for their support, cooperation, and motivation provided to me during the training for constant inspiration, presence and blessings.

I am grateful to **Dr. Samir Chaudhuri,** worthy **founder of CINI** for providing me an opportunity to undergo summer training at **Child In Need Institute**. I am thankful to **Mr. Manoj Sircar**, Internship coordinator & Planning and Monitoring Officer at CINI.

Lastly, I would like to thank the almighty and my parents for their moral support and my friends with whom I shared my day-to-day experience and received lots of suggestions that improved my quality of work.

Table of Contents

Acronyms/Abbreviations

ANM- Auxiliary Nurse cum Midwife

ASHA- Accredited Social Health Activist

AWW- Anganwadi Worker

BCC - Behaviour Change Communication

BMOH- Block Medical Officer of Health

CINI- Child In Need Institute

CF- Community Facilitators

ICDS- Integrated Child Development Services Scheme

JSSK- Janani O Shishu Surakshshya Karyakram

MAM - Moderate Acute Malnutrition

MIS - Management Information System

MUAC- Mid- Upper Arm Circumference

NCCS-Nutritional Counselling and Child Care Session

NRC-Nutrition Rehabilitation Centre

PRI- Panchayati Raj Institution

RI- Routine Immunization

SAM- Severe Acute Malnutrition SC Sub Center

SHG- Self Help Group

SHC - Slum Health Committee

VHSNC -Village Health Sanitation & Nutrition Committee

VHND- Village Health & Nutrition Day

Observational Learning

Section – 1: Introduction: Brief Description of the Organization Profile and Specific Objectives

Brief Description of Child in Need Institute (CINI)

Child In Need Institute (CINI) is a registered national level voluntary organization working with deprived community since 1974. CINI has received twice the National Award for Child Welfare – 1985 and 2004 – for its contributions to child welfare. It is guided by its mission of sustainable development in the domains of health, nutrition, education and protection for children, adolescents and women in need. The organization Developed a convergence model known as "Child and Woman Friendly Community" (CWFC) to reach vulnerable children and women access Nutrition, Health, Education and Protection services from govt. functionaries. In this last 40 years of journey, CINI has grown over the years and made significant contributions in the sector of Health, Nutrition, Education & Protection of which many have been recognized at the National & State level:

Health & Nutrition

- CINI has experience on maternal & child health & nutrition issue through Life-cycle based approach since last four decades.
- 40 years of experience in rehabilitating severe and moderately malnourished children both in a hospital setting as well as in the community.
- CINI initiated the Nutrition Rehabilitation Centre (NRC) to treat severely malnourished children at its main campus in Daulatpur in 1974. This evidence based model has now been scaled up in NRHM programme at the national level.
- Child Health & Development Division of CINI has qualified and trained nutritionists and public health specialists.
- Developed and tested out Nutrimix (a cereal/pulse mix) to treat and prevent malnutrition in 1974.
- CINI started training AWW, Supervisors of ICDS since the late 70s including support in monitoring the ICDS training centre

- CINI has been identified as State Nodal Agency for ASHA training as well as HIV/AIDS.
- Trained local self help groups, PRI functionaries to work closely with ICDS and NRHM to reduce child malnutrition, improve timely access to health care, thereby reducing child morbidity and mortality.

Education & Protection

- During 2003, CINI introduced the Child Tracking system in the schools of Kolkata in collaboration with Sarva Shiksha Abhiyan, Kolkata.
- The Jharkhand Education Project Council (JEPC) engaged CINI in the state for the purpose of addressing the children in difficult circumstances in Ranchi & Gumla.
- CINI initiated a school centric motivational centre commonly known as 'Utpreran Kendra' in Ranchi & Gumla districts of Jharkhand. The same model has been implemented in the government schools of West Bengal through the Child Friendly School approach.
- CINI has developed an accelerated learning package for the out-*of*-school children and children lagging behind their age appropriate academic competency. This package has been effectively applied across West Bengal for both urban and rural children. Paschim Banga Sarva Shiksha Mission has also acclaimed the package and involved CINI as Resource Team member of the State Level Special Training Curriculum Development Committee.
- CINI is now one of the state level resource agencies for developing Social Science curriculum of 'Special Training' component in spirit of Right to Education.
- CINI's model of drop-in centre has been adopted under Integrated Child Protection Scheme of GoI
- CINI is running National Programme - Childline (1098) in five district of West Bengal, It is one of the pioneer organisations to initiate CHILDLINE programme in Kolkata
- CINI runs two Open Shelters, financially supported by GoWB, WCD department in Kolkata & Darjeeling

- CINI's community based model of safety net through formation Village Level Child Protection Committee (VLCPC) under ICPS programme has been endorsed by District Magistrate in the district of Murshidabad

CINI's Divisions

CINI started its work with nutrition which broadened to the area of Health, Education and Protection being managed by thematic divisions. CINI has the following thematic division/resource centre in place:

- **Division of Women and Child Health Development** being headed by Dr. Aditi Roychowdhury, PhD Nutrition
- **HIV/AIDS division** headed by Dr. Rumeli Das, MBBS, DMCW, Trained in reproductive health research from London School of tropical medicine and hygiene.
- **Adolescent Resource Centre** headed by Dr. Indrani Bhattacharya, Ph.D
- **Training Unit** headed by Ms Mitun Bose, Masters in Social Work
- **Education Resource Centre** coordinated by Manoj Sircar, Masters in Social Work
- **Child Protection Resource Centre** coordinated by Nairita Banerjee, Masters in Social Work

The above mentioned personnel have wide range of experiences in their respective field. These divisions/resource centres are supported by well qualified, experienced professionals in the field of health, nutrition and social science.

Awards & Recognition: Over the years, CINI has been officially recognized, both in India and abroad, as a leading authority on mother and child nutrition and healthcare. Some of the major accolades CINI is proud to have received are:

- 2013 Certificate of accreditation for adherence to the desirable norms prescribed for good governance of voluntary organizations from 2013-2018, by Credibility Alliance.
- 2011 WHO award for excellence in Primary Health Care at India Healthcare Award 2011 by ICICI LOMBARD & CNBC TV18
- 2008 Annual Rotary India Award for most significant contribution in reducing child mortality by Rotary Club

- 2004 The National Award in the field of Child Welfare (CINI is the only NGO to have won this award twice)
- 1985 The National Award in the field of Child Welfare

Specific Objectives for observational learning were as below

a) Literature Study of CINI: History, Strategies, Annual Report, Website

b) Interaction with various divisional and Unit heads of CINI to understand operational priorities and visit to CINI Under five Clinic, Daycare-Nutrition Rehabilitation Center and CINI Training Unit.

c) Understanding the organization Behaviour and Work Culture at CINI

Section – 2: Mode of data collection

The data was collected through observational study and key Informant Interview of concerned officials of different department of CINI. The questionnaire used during interview was open ended and unstructured.

Section– 3 : General findings on learning: Department-wise observations.

Critical factors affecting the functioning of Department

Human Resources Management:

Interviewed **HR Officer, Sayantani Bagchi**. She explained about policies such as child protection policy, gender policy, Work place policy on HIV related issue, Sexual harassment of women at workplace. Apart from these, there are thematic departmental policies such as HR policy, finance policy, purchase policy, Branding policy. In manpower planning CINI has employees such as contractual, assignment, volunteer, and regular staff. In all, as on March 2015, CINI human resource strength is 1951. The employee breakup is - contractual - 227, assignment- 784, volunteer (paid)- 924 and regular -16employees.

There is a staff requisition format. CINI is Project bounded. Project name, post, sanctioned staff, recruitment needed, vacancy and actual staff needed is tracked. Advertisement is given in devnet, newspaper. If a project is going on and in last few months someone leaves then no

one from outside would come for such a short time and so internal candidates are selected as required for the vacant post through interview process same as it is done for external candidates. They may be interchanged with states as well as within different belts of same state. If walk-in interview is there then there is no need for shortlisting and call letter. For shortlisting, a CV profile with scoring pattern is made for screening so that when a candidate is not selected he or she may know the reason. Then staff requisition format is filled and call letter is sent. For team members, only walk-in interview is done but f or higher post like supervisor etc. shortlisting and call letter is sent. Candidates are sent the venue, date and time and all other details like post, project, unit and other details and so and so board member will be taking the interview. Atleast 3 members in interview board is required, who fill the scoresheet. Final decision is taken jointly and all 3 scoresheets together form the final scoresheet. For joining, either through walk-in or through shotlisting and interview permission needs to be taken from Head Office Admin if it is not a HO candidate. Without Job Description no one gets an offer letter. Capacity building and training also done within the units. While joining they are given a CD so that they can know about CINI. On job training and internal training also done like project wise training , if any one needs soft skills training like in spss, documentation, excel. Performance appraisal sheet is present with details of employee with JD . Both employee and reviewer gives the rating and it is signed by both. If increment is given then, the employee sign is required to know if he is satisfied with the increment given to him/her. For resignation, contractual employees have to give notice before 1 month, and assignment employee if is for 1 year assignment then 15 days before notice should be given. If contractual employee don't gives the notice on time then salary is deducted depending on the delay he/she does. Resignation sheet needs to filled with name, last working day, notice period, post, project etc. Then handover form is filled and account settlement form is filled and important documents are taken away. A feedback form is being filled by the person so the if he has any suggestions, grievances etc. While leaving if the person wants to say something or any grievance, he/she can freely talk to Admin or if he is at very high post then directly talk to Dr. Samir Chaudhuri. The designation of are decided according to the donor of the project. Every post defined under a level of category based on experience, salary, qualification. Employee benefits include PF, Gratuity, leave. For 1 year contract employees casual leave and sick leave, for 2-3 years contract earned leave is also

given. CINI has its own PF and gratuity governing body but it follows government interest rate.

Purchase/ Procurement Committee:

Interviewed **Pradeep kumar Dey, senior program officer, Administration, and member of purchase committee** regarding purchasing process. 1st all suppliers are enlisted. Advertisement is given in March every year. Then, 10-15 days time is taken to fill form by vendors from all units of CINI. The form costs Rs 20-25 and contains firm name, agency, vendor name, pan card details, trade license, credentials, bank account and if they have worked with CINI before or not. The forms are submitted. Data entry operator enters the data according to different categories of vendors. Based on it, they are screened that if necessary details available or not. Those who lack any of the documents and details are disqualified. After that, vendors are informed that within a particular time they will get to know if they are selected or not through phone or via email. Then, the project head is asked to fill the requisition slip and enlisted persons. Quotations are invited and then Bid analysis is done. Project head and procurement committee together decide to fulfill the required criteria. The vendor which charges the lowest amount is called and invited for work. If someone wants to buy a laptop then purchase committee refers to IT cell because they know better. IT department talk with the project head and then requisition send to purchase committee. Quality of both material and services are maintained.

Financial Management:

Interviewed **Sushanta Saha, Assistant director, Finance** about financial management of CINI. Since CINI is an NGO, its most finance depends on grand donation. The training unit of CINI is also an income source. On an average 75-80 projects are run by CINI. The staff salary is recovered from project. Its planned in such a way that each staff's salary can be recovered from the project so that organization liabilities are less. A project has administrative overhead. Overhead is not directly related to the project but without which a project cannot be run like accounting charges etc. Staff salary is recovered from it. Sometimes it may be generated from corpus fund generate which is almost similar like capital in a private firm. One of the earnings is interest which is gained from bank investment

of corpus fund. CINI gets donation from foreign source as well as local Indian source. Ministry of Home affairs has a registration certificate. Separate books of account is maintained and at the end of the year return file is to be sent. This is in regulation with MOHA, for internal security reasons. The purpose of sending money is seen by MOHA. 1st of all for a project, budget is prepared in which salary, admin cost and all expenses are taken . It is then approved by the funding agency. It is signed. At the end a program report need to be sent to the agency and utilization certificate is generated in which details of expenditure made is shown.

Health Management information System:

Interviewed **Sushanta Chatterjee, Assistant Director IT regarding HMIS of programs based on First 1,000 days approach .** Mainly through HMIS of 1000 days, the following data are recorded :i) entry of baseline household survey ,ii) entry of health and nutrition related data of mother and child, iii) analysis of health and nutrition related data for supporting decisions, iv) for appropriate interventions, tracking of every mother and child dyad on real-time basis for making interventions promptly in the time of need. This is an interactive system to provide effective intervention in the 1st 1000days of life of children. Firstly, login to the cini1000days.org. An android phone with the software installed in it is provided to CFs. The mother is identified through voice data and send to server. The mobile is inbuilt with android app with GIS feature, and CINI's own software related to 1000 days project. At the end of the day, real time data is synced with web and saved in the server. A specific data entry manager operates the web based software app. It is accessed by him and voice file can be heard. Then, necessary data is entered by him and then different alarm and alert report generated. Then through GIS report location and address of mother is known. Alert means if the condition is serious like if someone missed 4 ANC or weight loss occurring. Alarm is for warning like if only one ANC missed. Alarm and alert reaches directly to mobile of community facilitators, so that necessary actions can be taken. All the necessary details of mother and child are recorded such as identification, pregnancy, ANC,delivery, PNC, initial feeding, child health and nutrition and hygiene, child growth and immunization.

Fund raising Unit Management & Branding Management:

Interviewed **Shreyasi Ghosh, Officer, Communication and Branding.** Funds are raised through three sources: Individual. Schools, Corporates and sometimes through events and campaigns. Individuals are categorized into LIG, MIG, HIG i.e low income group, middle income group and high income group. Different strategy used for different category of people. If the person comes through someone's reference, then the task becomes easier as he already knows about CINI and it is very difficult to make a new person understand about CINI. Funds are also collected from schools. The fund raising unit members meet the Principle of the school and asks for a date so that they can give a date for on EPHN. They ask children to collect fund from their parents, relatives and friends and not from strangers. The money is collected and a small gift is given as a token of appreciation. Corporates have their CSR bill so they donate in areas where interventions are going on according their will. Educate a child and Adopt a mother are the sponsorship programs. Its very difficult to raise funds because people wont get anything in return. International Unit of CINI, like CINI-Italy, UK , Australia try to raise fund but not that much is gained. Some funds are also raised from government as some are government run project. But then, they also get the fund project wise and not as fund raising unit.

Regarding branding, Ms Ghosh explained that CINI has many divisions and it was known through different units such as CINI Bondhon, CINI Asha, People started recognizing different units as the main brand but later it was realized that the brand CINI is to be focused on. That's why later the branding strategy was changed and specific names were changed into generic names such as CINI Urban unit, CINI HIV/Aids division etc. Logo was also changed. Instead of using many colours just yellow and maroon colour logo was used. Thus new branding strategy is thus formed and once it gets approved by governing body, it will become the branding guideline of CINI.

Healthcare Delivery Services:

Interviewed **Dr. Samresh Bhattacharya, Consultant Medical,** regarding health care delivery system. CINI provides preventive, promotive and curative care through OPD and Thursday clinic. On other days CINI provides promotive and curative care but on Thursdays, curative, promotive and preventive care are given. Care givers are counseled about feeding habits to keep their child healthy. Immunization is also done on Thursdays. Mainly the 8 common diseases for which preventive care is given are:- measeles, tuberculosis, polio myletius, diphtheria, whooping cough, tetanus, influenzae bacteria & hepatitis B. The pentavalent vaccine includes DPT, H. Influenzae, and Hepatitis. CINI provides services to children under 5 years. Malnutrition is bad and it is of 2 ways: Over and Under. Under nutrition is more concerned because of the following reasons: i) growth of child will falter, ii) cognitive development , effect on brain iii) immunity also compromised and they fall sick frequently. CINI has strong linkage with governmet. Vaccines for immunization is provided by government. In return, CINI provides the data of number of child immunized at CINI clinic. CINI also helps in surveillance, of two diseases, i) acute flaccid paralysis for polio and ii) measles. CINI sends the details about child like its address and mobile number also. Then government track the child and does the necessary investigations like tests and treatment. CINI also gives training to ICDS worker, supervisor. CINI keeps the vaccine of government required for pulse polio immunization. Staff of CINI also go to field for immunization program. ASHA trainers training is also conducted at CINI. CINI works at field level and provides information to community about institutional delivery, weighing of child, ANC, PNC and promote the services implemented by government.

Behaviour Change Communication Management: CINI has great resources for Behaviour Change Communication focusing on maternal and child health and nutrition. Observed various IEC material prepared by CINI. They prepare their own BCC material and sometimes for other organizations also when they demand. Behaviour change communication is one of the major strategy, which is part of CINI,s field level implementation programs.

Section- 4: Conclusive learning, limitations and suggestions for improvement

Most important learning from the internship was the - 1st ever exposure to a healthcare organization and to a civil society organization. Understood the overall functioning of CINI

as a NGO. Roles and responsibilities of various functionaries and departments and how these departments perform their functions to help in management of program operations.

It was also realized by the end of the internship that time management with focus on field work and documentation are equally important.

Time was a major constraint and limiting factor. The vastness and huge operations by organizations like CINI, need lot more time to completely understand its functioning.

CINI is doing great in the health and nutrition services and has lots of field idea. Since it has years of experience of field level, a course specially for field learning for students who are really interested in public health would add more value to CINI"s good work.

What is 1000 Days?

The 1,000 days between a woman's pregnancy and her child's 2nd birthday, are most critical and crucial period of the child's life, which includes 270 days of pregnancy and 730 days - 0-2 years - of the child.

Why focus on 1000 days?

According to "Lancet", the 9 months of pregnancy and the first two years of life provide the base for a child's mental and physical development in later life. The reasons being, that up to 80 per cent of brain growth take place during this critical period of the human life cycle. Malnutrition and disease during this period can play havoc and may lead to impairment of physical and mental growth.

Project Report

Understanding a Civil Society Organization's Role in partnership with the Government to Fight Malnutrition in First 1,000 days of a Child in Ward 58, Kolkata and Diamond Harbour II Block, South 24 Parganas in West Bengal

Section 1-: Introduction: Rationale, Research Question and specific objectives

Child malnutrition is a major developmental challenge with long lasting consequences. Malnutrition in first 1,000 days of the child i.e. the period from pregnancy upto a child's 2 years after birth, may lead to poor fetus brain development, poor physical and mental growth, and poor learning capacity of children. This in turn may lead to high morbidity, stunting and

poor survival. Poor childhood nutritional status may surface as later onset diabetes, hypertension and obesity in adulthood. Child malnutrition levels are dismally high in India as well as in West Bengal. Nearly 40% of the children under 3 years of age are underweight and 45% stunted in the country. India, with one of the highest population of young people, faces very high rates of infant mortality and maternal mortality i.e IMR: 50/1000 live births in India and 31/1000 live births in West Bengal (SRS 2007-09) and MMR: 212/100000 live births in India and 145/100000 live births in West Bengal (SRS 2007-09).

Nutrition security is broadly defined as physical, economic and social access to and utilisation of an appropriate, balanced diet, safe drinking water, environmental hygiene, and primary health for all. Thus, this period is a unique **'window of opportunity'** to ensure future nutrition security and prevent under nutrition and break the intergenerational cycle of malnutrition in India, where critical interventions can prevent the onset of child malnutrition. Once this is gone, the window of opportunity closes for life. Addressing the first 1,000 days is an approach to fight malnutrition right from the beginning of life in the womb (pregnancy) till the first two years of the child's life. This can lay the foundation for future generations.

The 1,000 days plan focuses on ten Essential Outcomes

1. Early initiation of breastfeeding within one hour of birth
2. Exclusive breastfeeding during the first six months of life
3. Timely introduction of complementary foods at six months
4. Age-appropriate, energy and nutrient-dense complementary foods for children 6-24 months of age with continued breastfeeding
5. Safe handling of complementary foods and hygienic complementary feeding practices ;
6. Full immunization and bi-annual vitamin A supplementation with de-worming;
7. Frequent feeding and breastfeeding during and after illness, including oral rehydration therapy and zinc supplementation for children with diarrhea;
8. Timely and quality therapeutic feeding and care for children with severe acute malnutrition;
9. Improved food and nutrient intake for adolescent girls, particularly to prevent anemia; and
10. Improved food and nutrient intake for adult women, particularly during pregnancy and lactation, along with proper health care (ANC and PNC checkups).

The health and survival of mothers and their newborns is linked intrinsically. Many of the interventions that save maternal lives also benefit their infants collaterally. Both mothers and

infants are vulnerable in initial days and weeks after birth – this is a critical time for life-saving interventions. In the past two decades there has been an awakening to the need of strengthening the mother & child care at the primary level by inclusion of various government programs under the Ministries of Women and Child Development (ICDS), Health & Family Welfare (Health, NRHM) and Rural Development (P&RD). Unfortunately, these efforts have not resulted in the expected decline in the maternal, neonatal and infant mortality after an initial fall.

ICDS is one of the India's largest and oldest national programs committed to the welfare of pregnant/ lactating women and children under six years to address child malnutrition and pre-school education. The system though needs to be revitalized from being a mere 'food dole programme' to achieving its cherished goal of being a child development programme. The age group of 0 to 2 years has been a challenge for the ICDS and programme monitoring records often show higher malnutrition levels for the under three age group in comparison to children in the 3-6 age group. 1,000 days approach would focus specifically on improving the coverage of the five components of ICDS - supplementary nutrition to Children (0 to 6 years old) and Pregnant and lactating women followed by regular growth monitoring, immunization, counseling and finally referral service. Better coverage for these five components would indirectly also ensure higher coverage for the sixth component i.e. pre-school education.

The need for Convergence

The success of addressing the first 1,000 days, along with intensive monitoring of the micro-plan will depend on improving inter-departmental convergence, integration and collaboration at all levels, from state to panchayat, of departments of Women and Child development and social welfare, Health and Panchayat and Rural Development department (P&RD), where each player has a vital role in ensuring expected outcome against each and every mother and child. This approach requires day to day follow up and tracking of each pregnant lady and her child in a constant manner on health and nutrition outcome for first 1,000 days. It is therefore expected that service providers especially at the District, Block and Village level would support fulfillment of objectives of the existing schemes and services. The state has well-established local self governance (PRIs and Urban Local Bodies) that could be

effectively harnessed to address issues related to women and child health and nutrition. Therefore, the 1,000 days outcomes would lead to a sustainable nutrition security in the communities.

CINI's mission is "Sustainable development in health, nutrition, education and protection of child, adolescent and woman in need." CINI has been working on this approach in villages and slum areas in WB, involving adolescent, women members of local self help groups and elected representatives and the service providers such as AWW, ANM and PRI members for almost a decade. This project addressing first 1,000 days approach in West Bengal is an effort to take forward the process of convergence for improved maternal and child health and nutrition, strengthening governance and convergence, nutrition security, and community ownership/engagement to ensure a continuum of nutrition care.

Thus the research question was to understand a Civil Society Organization's Role in partnership with the Government to Fight Malnutrition in First 1,000 days of a Child in Ward 58, Kolkata and Diamond Harbour II Block, South 24 Parganas in West Bengal. **The specific objectives were:**

1. To understand the Government Health System under NHM through direct interaction with the service providers and observation of the services provided and
2. To Understand Civil Society's Role (CINI's role) through the project on Fighting Malnutrition in First 1,000 days of a Child in Ward 58, Kolkata and Diamond Harbour II Block, South 24 Parganas in West Bengal

Section -2: Mode of data collection

Primary data was collected through survey using different techniques of data collection – both quantitative and qualitative methodology.

- Key informant interviews with Government officials at District, Block as well as Urban health Setup
- Semi structured interview with mothers of children less than 2 years of age and pregnant women
- Individual interviews with community facilitators of CINI under this project.
- Observations

Section - 3: Data compilation, analysis and Interpretation

The data collected was analyzed in the form of tables which is as follows:

Table:1 Socio- Economic Status

INDICATORS	NUMBERS	PERCENTAGE
1.No of women interviewed	20	100%
2.CASTE:		
General	13	65
OBC	3	15
SC	4	20
3.BPL		
Yes	9	45
No	11	55
4. **Type of family**		
Nuclear	10	10
Joint	10	50
5. Total members in family		
< 3	0	0
3 to 5	10	50
more than 5	10	50
6. Age of women interviewed		
less than 18 years	2	10
above 18 years	18	90
7. Educational level of mother		
Primay (upto 5)	5	25
Secondary and above	11	55
Illiterate	4	20

Table 1 provides information pertaining to socio-economic characteristics of 20 female from both rural and urban areas interviewed during the field visit. Out of 20 women, 13 were from General category and only 9 were under BPL category. Half of the women had joint family and they had more than 5 members in their family. Surprisingly, out of 20 women, 2 women

were married before completing 18 years. Regarding education, it was found that 11 women were educated till secondary level.

Table:2 Health Seeking Behaviour

Indicators	Numbers	Percentage
No of Women Interviewed	20	
8. Did anybody child fall sick at home in last 15 days		
Yes	9	45
No	11	55
Symptoms:		
fever	8	88.9
diarrhoea	1	11.1
acute respiratory infection	1	11.1
common cold and cough	3	33.3
9. Treatment taken		
private	3	33.3
government	4	44.4
Quack	2	22.2
10. Reason for not seeking treatment from government facility		
cant take child so far and child gets cured at once when seen by private child doctor	1	20
homoeopathy medicine suits the child	1	20
going to government hospital is time consuming,and there is long queue and	3	60

crowd		

Table 2 shows data related to health seeking behaviour of the women interviewed regarding their child. Out of 9 children fallen sick, 3 were taken to private and 2 were taken to quacks and only 4 were taken to government facility. The reason was asked to mothers for not taking the child to government facility. Out of 5 mothers, 3 mothers said that going to government hospital is time consuming and there is long queue and crowd.

Table:3 Ante-natal Care

Indicators	Numbers	Percentage
11. Number of Pregnant Women Interviewed	6	
12. Gravid		
Prime	2	33.3
2nd gravid	2	33.3
3rd gravid	2	33.3
13. Registration for ANC at Government facility		
Yes	6	100
No	0	0
14. Weeks of gestation on the date of registration		
<12 weeks	5	83.3
>12-24 weeks	1	16.7
25-36 weeks	0	0
15. Total Number of ANC visits		
1 time	0	0
2 times	1	16.7
3 times	4	66.7
4 times	1	16.7
16. Record of ANC examination		
Abdominal Examination	6	100
Urine sample	6	100
edema checked	2	33.3
B.P taken	6	100
Weight	6	100

Blood Test	4	66.7
TT 1st dose	0	0
TT 2nd Dose	6	100
TT Booster	0	0
Iron folic Acid received	6	100
17. **where will you get your delivery**		0
at home	1	16.7
at institution	5	83.3
18. Reason for home delivery		
go to their hometown (desh) for delivery and husband will decide where to deiver	1	16.7
19. Reason for institutional delivery		
facility and proper care	3	60
get birth certificate, proper checkup, medicine and report	1	20
avoidance of risk and at home no one can do anything	1	20
20. Who motivated for Institutional delivery		
self	1	20
family member	4	80
ASHA	0	0
AWW	0	0
Health Staff	0	0

Table 3 shows the data pertaining to the antenatal care utilized by the pregnant women. All the 6 pregnant women interviewed had registered for their ANC in the government facility. From the data it was observed that all the other checkups except edema and blood test were done for all the 6 women. When asked about place of expected delivery, one women said that she would go to her hometown for delivery and her husband will decide where to deliver- at home or at institution. Out of 5 women who wished to deliver at hospital explained that availability of proper facility and care was the main reason for their decision.

Table:4 Delivery and Post-Natal Care

Indicators	Numbers	Percentage
21. No of women delivered in last 1 year	12	

22. place of delivery		
Home	4	33.3
government facility	7	58.3
private	1	8.3
23. Type of delivery		
Normal	10	83.3
Caesarian section	2	16.7
24. transport facility to reach institute		
Public transport	7	87.5
ambulance	1	12.5
25. Who accompanied you		0
Husband	1	12.5
Relative	7	87.5
ASHA	0	0
ANM	0	0
26. Did You receive any money from government for institutional delivery		
yes	0	0
No	8	100
27. Discharge from hospital		
same day	1	12.5
after 24 hours	2	25
after 48 hours	5	62.5
28. was PNC checkup done at home after delivery		
Yes	1	12.5
No	7	87.5
29. If yes, how many?		
one	0	0
two	0	0
three	1	100
four	0	0
30. Who conducted PNC		
ANM	1	100
LHV	0	0
doctor	0	0
31. if yes, then you were asked the following		
fever	1	100

excessive bleeding	1	100
foul smell discharge	1	100
breast engorgement	1	100

Table 4 shows data pertaining to delivery and PNC. Surprisingly, it was observed that out of 12 pregnant women 4 women had home delivery and 1 women delivered in private hospital. Shockingly, it was noticed that only 1 out of 8 women used ambulance as a means of transport for reaching the facility for delivery. Most of them were accompanied by family members and relatives. Shockingly, none among 8 women got money for institutional delivery because they either didn't have BPL card or they were unaware of this kind of services. It was found that out of 8 women, 3 were discharged from the facility before completing 48 hours. It was also a surprise to see that there was hardly any PNC checkup.

New- Born Care

Indicators	Numbers	Percentage
32. was the baby weighed at birth		
yes	8	66.7
no	4	33.3
33. if yes, then birth weight		
>2000gms		
2000-2500 gms	2	25
<2500gms	6	75
34. When was the baby given bath		
within 1 hour	0	0
same day	0	0
2-3 day	3	25
after 3rd day	9	75
35. when was breastfeeding initiated after birth		
within 1 hour	6	50
same day	3	25
2-3 day	2	16.7
after 3rd day		0
no breastfeeding	1	8.3
reason: mother could lactate the child only for 4 days, there after no milk so couldn't		

Table 5 shows the data related to new born care. From the data, it was clear that those 4 women who had home delivery, their children were not weighed at birth. 9 babies were given bath after 3rd day. Breastfeeding practice was also noted. Only 6 out of 12 babies were breastfed within an hour of delivery. One of the mothers said that she could not lactate her child for more than 4 days because after that there was lack of milk production. It was a surprise to see that 4 out of 12 babies were given pre-lacteal and 4 children were partially immunized because of home delivery.

Section- 4: Recommendations and conclusion

Overall, Child in Need Institute (CINI), a Civil Society Organization, had a very important role to Fight Malnutrition in First 1,000 days of a Child in Ward 58, Kolkata and Diamond Harbour II Block, South 24 Parganas in West Bengal. CINI facilitated the uptake of services by the community with regard to health and nutrition government programs and at the same time supported government to improve the quality and reach of the services to families unreached.

During field visit it was seen that community facilitators are reaching to the mother and child of the community and counseling them regarding health and nutrition. Meetings of pregnant mothers and lactating mothers are also arranged but due to lack of human resources it was difficult for a CF to manage the meetings properly. So, if human resources could be increased a bit then it would be more smooth to implement the programs at field level.

Further, though CINI plays an important role, it is very important to make sure that CSOs don't duplicate the services already covered by the government. Also CSOs should be the supporting pillar and not be replace the actual government services providers.

References

http://www.cini-india.org/

http://www.cini-india.org/content/annual-report

Annual report on Fighting Malnutrition in West Bengal 2013-2014

CINI Stratergy paper series 2010- 2015 ; Health and Nutrition

CINI Strategy paper series 2010- 2015; Child and women friendly communities

Pamphlets and various IEC material published by CINI

Annexure

The annexure includes all the activities performed and persons met during the 2 months of summer training at CINI in a daily report format. It includes all the learnings of the training.

Summer Training at CINI – Day wise Report

9 Weeks (8th April- 5th June)

Week-1

8th April

On the 1st day of summer training, we met **Mr. Manoj Sircar, Planning and Monitoring Officer** at CINI. He gave us some literature (CINI's Strategy papers, CINI's Annual Report) to read. Then we met our mentor **Dr. Aditi Roychowdhury, Divisional Head of Woman and Child Health Development.** She asked us about our objectives and told us to prepare a work plan for 2 months with objectives divided into sub-objectives. Then I met **Dr.Samresh Bhattacharya** at CINI Clinic area. In the afternoon, we had a meeting with **Mr. Swapan bikash Saha** and his team. He discussed about research project he is working on and asked us to make a work plan. I visited the campus area of CINI. I learnt that Cini mainly works for poor & deprived mothers and children. Its main focus areas are Health & Nutrition, Education and Protection.

9th April

Observed the **Thursday Under-5 clinic,** under the guidance of **Miss. Aditi Singha, Nutritionist.** In eastern India, one and only clinic that serves for under-5 children at nominal rate. At Institutional level, CINI under -5 clinic is conducted from Monday to Friday. On other days, Rs 50 is charged but on Thursday very minimum amount of Rs 20 is charged, and immunization is done so there is a whole lot of gathering of mothers and children. CINI

Clinic provides mainly 5 services-**1. Registration and and growth monitoring, 2. Health Checkup by Doctors, 3. Nutrition counselling of mothers, 4. Immunization of children, 5. Medicines provided.** Name, age, address and other details of child and parent is registered. Growth Monitoring Chart used for monitoring age wise growth of children. **MUAC Tape (Mid- Upper Arm Circumference)** is used to measure malnutrition status of child. Muac measures the protein deficiency of child. If it comes under **red** area then child is **SAM (Severely Acute Malnourished),** if in **yellow** region then **MAM (Moderately Acute Malnourished)** and in **green** area then **Normal.** If the child is SAM, and his/her weight is 70% less than normal then it is referred to **NRC(Nutrition Rehabilitation Centre)** at CINI campus which is the **Day Care Centre** and it operates from 10 am to 4 pm. Here, SAM child and its mother is given **NUTRIMIX** and nutritious khichdi and egg to eat and counselled by Nurse and Health worker to change the feeding behavior of child. The child is weighed after every 5 Days to see if there is improvement in the malnutrition status of the child and if there is 15% weight gain then the child is no more required to be treated at NRC. Mothers are counselled by nutritionist with the help of **National Flag as BCC material.** The orange, white and green colour denotes three different types of nutritious food and Ashok Chakra denotes oil with which food is to be cooked. The blue part which holds the flag denotes water which helps in digestion and is very important for our body. All the data of a child is entered in computer and a registration no of child is generated which is used next time if the child visits the clinic again. Met **Mr Pradeep Dey, Senior programme manager** at CINI Clinic. He said that he has been in research department since 13 years. He is associated with training unit and is the master trainer.

10th April

Preparation of objectives and sub-objectives for Summer Training At Home

Week-2

13th April

Objectives discussed with mentor. Reading about NHM and government run Programs and Healthcare delivery system of India.

14th April

Visited **CINI Chetana Resource Centre**, also known as **CINI training unit**. There I visited the library and observed the available resources and met **Mr. Sujoy Roy**, **Programme Manager**. He is associated with **WHITE RIBBON ALLIANCE** in West Bengal. Interacted with him about WRA. White Ribbon Alliance is about safe motherhood. 11th April is considered as safe motherhood day. Then we met **Mr. Malay Das**, and interacted with him and got to know about CINI's history and why and how it was founded. He said about Dr. Samir Choudhury, founder of CINI. In 1974 when Dr. Choudhury came to West Bengal for doing research on malnourished children.. A housuehold survey of 1500 houses was done. Dr. Choudhury found that malnourishment is not a disease but a social issue and so it needs much effort. The work for fighting malnutrition started in 1974 only with the help of community leaders at Thakurpukur Behala and other nearby areas. CINI got registration as an NGO under WB Society Registration Act 1961 in 1975- 76. In 2013 Dr. Samir Choudhury got the Shresth Bengali Award. In 1985 and 2004, CINI won National award for Child Welfare. All the trainings in CINI started in 1989. CRC was registered separately but now it is under CINI Main. Formally, In 2003 October Resource Centre was formed. CRC prepares training material according to need. Government of Jharkhand adopted the format of nutrition flag. CINI has different units- CINI Bondhon- HIV/AIDS unit- Dr. Rumeli Das is the divisional head, CINI Yuva- Indrani Bhattacharya, CINI Asha/ Urban unit- Monidipa Ghosh, CINI fund raising- Kakoli Dey. CINI works in West Bengal, Jharkhand and Chattisgarh. CRC has great resources for training of ASHAs, AWW, and AW H. It has great resources for Behaviour Change Communication. Observed various IEC material prepared by CINI. They prepare their own BCC material and sometimes for other organizations also when they demand. I also observed AWW and AWH training. Got to know about their work. Met **Mrs. Mitu , Assistant Director of CINI training unit.**

15th April

Studied government document on National Health Mission at CINI.

16th April

Visited the Under-5 Clinic. I was given the task for data entry in computer for mothers and children who had come to clinic and registered their details. Interacted with Mr. Pradeep Dey. We discussed about case study. Observed the Day Care centre (NRC) of CINI. Discussed with mentor my objectives and finally the topic was decided.

17th April

Preparation of work plan for summer training period and got it checked by mentor.

Week-3

20th April

Studied about Urban Health Structure. During afternoon, we had a meeting with Miss Aditi Singha and her project team. I met the community facilitators- Soma, Jayashree, Chaitali, Sandip. Learnt about CINI's project- Indoor air quality and its effect on pregnant women. Aditi Mam told about the project. The project is done in collaboration with TERI- The Energy Resource Institute. TERI provides stoves to 250 pregnant women and they need to cook food on the stoves. They will then be compared by 250 pregnant women without stove. Then comparison of volume of Carbon Monoxide in blood of women among both the case and control will be done to show the harmful effect of indoor bad air quality on pregnancy outcomes During 2nd and 3rd trimester USG of pregnant women would be done to see the effect on child. They have made a contract with Amtala Hospital and Bishnupur Diagnostic centre or the checkups. It is being implemented on 250 pregnant mothers in Bishnupur area I and II. TERI provides gas for households which will be used by mothers for cooking. CF will be monitoring the pregnant women during 9 months.. Then we made the planning for rural field visit with community facilitators. Interacted with CFs and got to know about their work at field level and how panchayat help them in the project. Panchayat helps in giving support to health workers so that they can interact and work with the community. Without Panchayat's support its difficult for health workers to work in field. If any problem occurs then panchayat helps, like it gives the household data , convince the villagers and motivate

them. On the other hand, CFs submits an updated report of their work to panchayat once in a month or a week. Through CF Soma, I learnt about the rural heath structure in West Bengal.

Health Infrastructure in rural Setup

District Hospital

↓

Sub- Divisional Hospital

↓

BPHC- Block Primary Health Centre (BMOH- Block Medical Health Officer of Health)

↓

PHC- Primary Health Centre (Medical Officer)

↓

Sub Centre (1st ANM+ 2nd ANM+ ASHA)

Administrative level

District (Sabhadhipati)

↓

Subdivision (SDO)

↓

Block (BDO) Sabhapati

↓

G.P (E.A/ Secretary) Pradhan

↓

GUS → VHSNC (Sadasya)

AWW works under ICDS. ASHA, AWW and ANM all works for children from 0-6 months. ASHA works at village level. She motivates mother for registering her pregnancy, immunization and institutional delivery. She weighs the child from birth till 42 days. There

after every 6 months weight is measured. 1st Wednesday is the immunization Day. Every Wednesday ASHA reports at the subcentre BMOH

↓

Health Supervisor

↓

1st ANM

↓

2nd ANM

↓

ASHA

VHND camp is organized in integration with ICDS worker and ASHA. It takes place 4 times per month at 4 different places. Immunization is done on this day. VHSNC meeting takes place every 3rd Saturday at Subcentre in which ICDS supervisor and health workers participates. Another meeting known as 4th Saturday meeting takes place at Gram Panchayat every month. It includes ICDS Workers, Health Worker, and G.P level person.

21st April

Visited Panchayat of Dakhin Gauripur and Chandi. I was accompanied by Miss Aditi Singha and CF Chaitali and Jayashree. Interacted with **executive assistant of Dakhin Gauripur- Mr. Vikas Chandra Shaw and Pradhan of Chandi Panchayat- Mr. Tarak Mondal**. Executive assistant said that there are 14 sansad and sansad wise ASHA is selected. ASHA should be of 30 years age and minimum madhyamik pass. She may be married, unmarried or divorcee. She has to appear in an exam that takes place in SD office. When I asked about Rogi Kalyan Samiti, he said that it is operated at block level and it includes 11 pradhan of that area, BMOH,MLA and Sabhapati. He said about 4th Saturday meeting which takes place at Gram panchayat and includes all the Swasthya Karmi. Discussion on problems occurring in different area takes place in the meeting. A report of the meeting is sent through mail to block and district on 5th day of next month. AYUSH doctors are also included in the meeting

to check the attendance of patients treated or attended by health workers. A cash book is maintained and when ANM wants to purchase any material the voucher is signed by pradhan. Chandi Gram Pradhan discussed about Panchayat's work. He discussed about Rural hospital. He said that Sansad wise ASHA and ANM are selected. They track pregnant women who are identified by ICDS workers. VHC includes mukhiya, ASHA, ICDS Chief. Taking different schools 2nd and 4th Saturday meeting is organized. Sansad wise whatever problem related to women and child health issues and other problems occurring in different field is discussed in the meeting. A General meeting of sarpanch and mukhiyas occurs every month. Under chandi panchayat there are 19 mukhiya. Out of that 1 sarpanch is elected. Problems which are discussed in 2nd and 4th Saturday meeting are finally discussed in General Meeting with mukhiyas of different booth. Issues like no institutional delivery reported by ASHA and other health issues are discussed. People who are BPL given certificate so that they get health services like in hospital bed and free drugs. ICDS worker and ASHA visit all the villages under their area and prepare a list of all the people under BPL Taluka. There are 4 cards under BPL Taluka- Red, Green, APL,BPL. Out of 100 if 33, then he/she declared BPL and registered under BPL Taluka and gets Rs 30,000 medical service free. The tax collection of Chandi Gram Panchayat is good. So, panchayat gives Rs 2000- Rs 4000 to Cancer patients and poor patients. Panchayat also gives Nutrimix to malnourished children who are under BPL. In 2015 Annual meeting, it was decided to give Rs 400 to person who is poorest under chandi GP. The Pradhan also said that in 2013- 14 under MGNREGA Scheme 30- 40 lakhs of rupees would come from central Government so, a good effort was made for improvement of conditions in villages but in 2015 not even 1 lakh rupees have been received so there is being a lot of delay in work.

22nd April

Community Facilitator Soma and I visited **Sub-centre Chandandaha, Block- Bishnupur II, South 24 Paraganas, Moukhali G.P**. **Bangur Hospital and Bidyasagar Hospital** are the hospital for referral. During the visit I interacted with CF and asked about her role in the project Indoor Air Quality and its Effect on Pregnant Women. She said that she has to do field visit 5 days a week. She get the names and details of pregnant mothers from ASHA at sub-centre. CFs have to arrange place for blood test, organize mother's meeting to share their

problems. They have to take the women for USG, collect COD blood from hospital to Jadavpur Hospital. At Sub-cente, I met **1st ANM**, **Tapati Shaw.** The sub-centre at Chandandaha covers 2 villages- 1 full (Chandandaha)and 1 half (Moukhali). PHC is at Moukhali and BPHC is at Samali. District hospital is at Bangur. The subcentre covers a population of 7700 population. She said that mothers are taught about Copper-T, counseling is also done. Doctor visits whenever he wishes to and not every month. Officially the timing of service from 9 am to 4 pm but they have to stay until mother and child is there. When doctor gives the information that he will be visiting the subcentre then ANM and ASHA inform the public. There is no Lady Health Visitor. ASHA takes pregnant women for institutional delivery. During summers, they visit field in the morning. There is no labour room and no instrument for delivery at sub-centre so, mother is referred to rural hospital. The transport facility is only Van rickshaw. There is no 24*7 electricity available. Slide collection and other tests are done at subcentre. National health Programs such as pulse polio programme and filaria programme are done but since 2 years filaria is not done. Since it was a Wednesday, I got an advantage of meeting all the ASHAs as they report every Wednesday at subcentre. The dress code of different officials are different.

Supervisor- Green saree,

1st ANM- Pink saree,

2nd ANM- Yellow saree,

ASHA- Purple saree.

I interacted with almost all the ASHAs at subcentre Chandandaha. The duty of ASHA is to inform the mothers about date, details, list and place of immunization and Tetanus dose 1&2. They give health talks to mothers and they also have to keep a record of all the work they do. If the pregnant lady goes through labour pain then she calls up ASHA and ASHA takes her to BPHC Samali. ASHA faces a lot of problems. They are harassed by senior officials when they want to get the voucher signed/ stamped. The Doctors also harass ASHA by not signing the document because they don't want to let her go so soon. The duty of ASHA is just to admit the mother but sometimes she has to stay until the lady delivers and it

becomes risky for ASHAs as they have to return their home at odd times. If the patient is reffered to district hospital from BPHC then the referred hospital doesn't provide vehicle for transport while returning. The vehicle from subcentre is taking the women to referral but while returning from referral hospital specially **Bidyasagar** Hospital is not providing vehicle during returning journey. ASHA also said that they get their incentives very late. I also talked with 2nd ANM. From her I got to know that 2nd ANM is posted on contractual basis. Total population of 7700 is divided into two half between both the ANMs. Under 1st ANM there are 2 ASHAs and remaining are vacant and under 2nd ANM 3 ASHAs. The difference between ANM and ASHA is that ANM mainly has office work and ASHA do mostly field work. ANM is most of the time at Subcentre but ASHA visits Subcentre only on Wednesdays for which she gets Rs 200 and report to ANM about any birth, death, eligible couple in the community. Data is entered by ANM and reported to BPHC. Further ASHA don't have any duty hours. Later on, I asked about **ASHAs Training.** They said that they are trained on the topics such as:

- Mother's Registration
- Pregnancy Care
- Newborn care which includes:
    - Proper technique of breast feeding
    - How to hold a child
    - Protecting a child within cloth
    - See if the child has fever
    - Weighing a child
    - Six methods of washing Hands

A training book/module is given to ASHA. They were given a kit just once, which included ORS, IFA tablet for pregnant women, Paracetamol, gauge bandage ,cotton, and medicines for children. A meeting of Anganwadi and ASHA is held in a month. Adolescent meeting also takes place and ASHA counsel them. ASHA also has to visit home for PNC till 42 days since mother has delivered the child.They counsel the mothers about breastfeeding. If the child is delivered in hospital then the visit starts after 7 days at a gap of 7 days i.e 14, 21,28,35,42th day. If the child is low weight at birth then more and more visits required. They counsel

mothers to give only mother's milk till 6 months and nothing else. After 6 months the child needs to be registered under Anganwadi centre. ASHA s don't get holidays. If a ASHA delivers a child then she gets maternal leave of just 1 and half months. They go from door to door by walking. The monthly salary which is given through state government is just Rs 1500 and the incentive given on the amount of work done by ASHA from Central government. For motivating a mother for institutional delivery, ASHA gets Rs 300. Likewise, for other works different incentives are there. ANC visit is done 4 times i.e 1st on 12th week, 2nd on 16-24 weeks, 3rd on 28-34 weeks, and 4th on 36-40th week. In the 1st 3 visits, mother herself goes to doctor but during 4th visit ASHA visits the home of pregnant lady. I also got to know about the Selection Process of ASHA.Advertisement on vacancy of ASHA, She should be 30-40 years old and minimum Madhyamik pass, may be divorced or married and a resident of that village only. Oral exam is taken and then the list of selected candidates come out.

Met **Antara----------** after field visit, She discussed with me about the Project named **"Fighting Malnutrition through 1000 days".** It is a project of those 1000 days from pregnancy of mother till the child becomes 2 years old. CINI is implementing the project and the funds are given by international donor Lavazza to Save the Children. Save the children is giving financial support to CINI for implementing the project. The project is being implemented in 2 areas- Urban and Rural. In Urban, Ward no 58, because it is the largest slum under Kolkata borough VII. In Rural, Diamond Harbour Block II of South 24 Paraganas. Urban area under Kolkata Municipal Corporation. Many Lanes constitute Para, Many paras constitute ward, many wards constitute borough. In ward 58, 40 slum lanes which constitutes approx. 1,00,000 population. The population of Ward 58 is most vulnerable because of Migratory population, minority group, low economic status, most unhyegenic, and prevalence of malnutrition. In case of rural area, district includes block, block includes 8 gram panchayat and Gp constitutes villages. 1 Block constitutes 1 ICDS head called CDPO. Under CDPO many supervisors and under supervisors many AWW and with each AWW there is a AWH. In Urban field only 1 ICDS centre for 10,000 population. ICDS focuses on Pregnant and Lactating mothers and children upto 6 years. The project has three units:

Diamond Harbour Unit- A Project Coordinator and a field associate, 35 Community facilitators

Head Office- A Project Manager and a MIS officer

Urban Unit- A Project Coordinate and a field associate, 30 community facilitators.

An accountant manages all the finances.

Activity- capacity building up of project staff, baseline survey and mobilization of caregiver, community and service provider.

23rd April

Absent- Not well

24th April

Visited ICDS office of Bishnupur II and BPHC Samali with CF Soma and Aditi Singha. But unfortunately, at both the places no official were present with whom I could interact. Interacted with Kalyani Deb,_____ . After interacting with her, I got to know that inspite of so many government schemes women do not want to go for institutional delivery because of their old beliefs. I also updated my work.

Week- 4

27th April

Modified my objectives and studied the strategy paper of CINI. The new objectives include observational learning at CINI and Project learning. The strategy of CINI mainly includes comprehensive community based interventions. CINI acts as a facilitator between communities, service providers and local government bodies. CINI works through CFWC approach. (Child and Women Friendly community).

28th April

Identified the department which I need to know for observational and management learning. Prepared open ended questionnaire for observational learning- Department wise/ Division wise

29th April

Worked from Home. Studied the project Report of Fighting malnutrition in West Bengal.

30th April

Strike in West Bengal. So, worked at home. Preparation of Questionnaire.

1st May

Finally prepared qualitative as well as quantitative questionnaire for project and shown to mentor. Got to know about persons whom I need to interview to fulfill my observational learning and took appointment from the concerned persons for their interview.

Week-5

4th May

Interviewed **HR Officer, Sayantani Bagchi**. She said about policies such as child protection policy, gender policy, Work place policy on HIV related issue, Sexual harassment of women at workplace. Apart from these, Thematic different departmental policies such as as HR policy, finance policy, purchase policy, Branding policy. In manpower planning CINI has employees such as contractual, assignment ,volunteer ,and regular only 16 staff. Altogethor employees as on march 2013 is 1951. The employee breakup is - among 1951 employees, contractual -227, assignment- 784, volunteer (paid)- 924 and regular -16employees. There is a staff requisition format. CINI is Project bounded. Project name, post, sanctioned staff, recruitment needed, vacancy and actual staff needed is tracked. Advertisement is given in devnet , newspaper. If a project is going on and in last few months someone leaves then no one from outside would come for such a short time and so internal candidates are selected as

an when required for the vacant post through interview process same as it is done for external candidates. They may be interchanged with states as well as within different belts of same state. If walk-in interview is there then no need off shortlisting and call letter .For shortlisting, a CV profile with scoring pattern is made for screening so that when a candidate is not selected he or she may know the reason. Then staff requisition format is filled and call letter is sent. For team members, only walk-in interview is done but f or higher post like supervisor etc.. shortlisting and call letter is sent. Candidates are sent the venue, date and time and all other details like post, project, unit and other details and so and so board member will be taking the interview. 3 members in interview board. All of them given scoresheet. Final decision is taken jointly and all 3 scoresheets together form the final scoresheet. For joining, either through walk-in or through shotlisting and interview permission needs to be taken from Head Office Admin if it is not a HO candidate. Without Job Description no one gets an offer letter. Capacity building and training also done within the units. While joining they are given a CD so that they can know about CINI. On job training and internal training also done like project wise training , if any one needs soft skills training like in spss, documentation, excel. Performance appraisal sheet is present with details of employee with JD . Both employee and reviewer gives the rating and it is signed by both. If increment is given then, the employee sign is required to know if he is satisfied with the increment given to him/her. For resignation, contractual employees have to give notice before 1 month, and assignment employee if is for 1 year assignment then 15 days before notice should be given. If contractual employee don't gives the notice on time then salary is deducted depending on the delay he/she does. Resignation sheet needs to filled with name, last working day, notice period, post, project etc. Then handover form is filled and account settlement form is filled and important documents are taken away. A feedback form is being filled by the person so the if he has any suggestions, grievances etc. While leaving if the person wants to say something or any grievance,he/she can freely talk to Admin or if he is at very high post then directly talk to Dr. Samir Chaudhury.. The designation of post are decided according to the donor of the project. Every post defined under a level of category based on experience, salary, qualification. Employee benefits include PF, Gratuity, leave. For 1 year contract employees casual leave and sick leave, for 2-3 years contract earned leave is also given. CINI has its own PF and gratuity governing body but it follows government interest rate.

Interviewed **CINI Clinic Staff, Mahabbat Ali Ghazi, Senior Project Associate**. I talkedith him regarding CINI clinic. He is the supervisor of CINI clinic. His ,ain work is maintaining the medicine stock at the clinic, immunization with government, sending report to NRHM government, collecting age wise data of patients coming to clinic. I saw the list of medicines required at the clinic and recording and maintaining of medicine stock. When medicines are about to end sister tells and then the requisition slip is filled and send to purchase committee. The record is maintained daily about the no of pieces/ bottles of medicines dispatched to patient. Every month expiry date of medicines are checked so that those medicines which are near to expiry date are finished earlier than others to prevent wastage. The clinic is held from Monday to Friday from 10 am to 1 pm. On Monday, Tuesday, Wednesday and Friday for new Registration card Rs 75 is taken and for old card Rs 70. On Thursday, minimum amount of Rs 25 for new and Rs 20 for old. So, on Thursdays, more poor people come to take the benefit. On Thursday specially, Vacination/ Immunization is done. The child Immunization is as follows: At birth or within 20 days - BCG, Hepatitis 0 ,

After 1.5 month, 2.5 month, 3.5 month- Pentavalent (DPT, Hepatitis, Polio),

At 9 month- measeles, At 1.5 yr, 5yrs- Booster of Pentavalent

Vitamin A is given from 9 month age till 5 years at an interval of every 6 months.

The medicine for immunization is taken by CINI from government and they have to send a report of immunization every month to the government for the requisition of vaccines. MR Bangur hospital is the district hospital. The requisition of vaccines is to be done at District hospital with a letter and a report of immunization. Since CINI is a NGO, it has to show a proof. The record of OPD of clinic is maintained age wise. The data is utilized for donor agency to show the no of patients covered in the clinic. A 3 month data or yearly data is sent to the donors who donate every 3 months or once in a year. The Clinic Human resources includes many people**. Dr. Aditi Roychowdhury, divisional chief of DWCHD** manages all the manpower planning**, Dr. Samresh Bhattacharya**, **Consultant Medical** mainly links the clinic with government. **Mahabbat Ali Ghazi, Supervisor of Clinic** manages the clinic. There is 1 Nurse, 1 Health Worker, and 1 person for Registration.. But on Thursdays, more human resources are required: 1 person for coupon, 2 person for Registration, 1 person for Weighing child, 3 person for medicine, 1 person for Nebulai (gas for Respiratory problem),

2 nurse – 1 for NRC and 1 for vaccination, and 1 person for growth monitoring – **Aditi Singha** and others .

Malnourished children identified by doctors are sent to day care centre of CINI where they are taken care of and given proper food. A child needs to visit NRC minimum 10-15 days but generally it doesn't happen because people come from faraway places and they can't afford to come daily. They come just for 1-2 days. Patients who come from Bishnupur I and II are not charged for day care but those from far places need to pay Rs 20. Since CINI has collaboration with ICDS centre of these 2 blocks, so those children who are severely malnourished, are referred to NRC. CINI had a meeting with the BDO of that area that since the area is undeveloped and so malnourished children would be referred to NRC with a slip to show the proof that they are being sent by ICDS of the area. It is seen that the Day care centre is not so successful because mothers don't want to stay and they want to leave as soon as possible as they live far away. Earlier there was an emergency ward as which is not there now because of lack of funds or any other reasons.10-15 days mothers and children used to stay as inpatient. They used to get food and all other facilities free. NRC was also very much well flourished and mothers who could not breastfeed her child due to lack of milk production, their treatment was done and then left. because the main reason behind malnutrition is improper breastfeeding. But now government has taken some initiatives so NRC at CINI has become less functional. It now provides food for malnourished children. During registration, if the mother doesn't know the date of birth then problem occurs. She is asked about the season of birth or any occasion or festival occurred if near birth. But now there are many facilities by government and it has become mandatory for having birth certificate and its registration. NUTRIMIX is a type of nutritious food for the malnourished child. When Dr. Chaudhuri started working for malnourished children then at that time wheat and cereal mixed with milk used to be given free to poor malnourished children. Later, 50paise was charged for 500 gm. It was seen that Nutrimix when consumed by children, there is a lot of improvement in health status of child. Thus, originated the concept NUTRIMIX. Earlier, Nutrimix was not so popular but now almost all of over West Bengal it is distributed through ICDS. Nutrimix is a part of CINI but now it is separated under CINN-COMM. Now, NUTRIMIX costs Rs 40 per 500gram. Earlier when there was no government

initiatives, CINI originated, and its main work was field visit and to identify pregnant mothers within 12 weeks. They used to counsel mothers, arrange meetings for pregnant mother, counsel them to take care during pregnancy, give training to TBA because of home delivery. There used to be Mahila Samiti. Later, their husbands also included and thus male involvement was done. Male and female adolescent groups were formed. Later family planning and gap between two child also taught. Nukkar Natak and Awareness camp were also conducted to create awareness among people. Now CINI has moved away a bit from field because government has taken initiatives and now ASHA, AWW and ANM is there to provide services. CINI originated with health but now it has started with other areas such as protection and education. Total expenditure for CINI clinic for a year is approximately 30-35 lacs. Earlier there were many human resources for CINI clinic, but now it has been reduced and funds too. CINI has come a long way through its noble and hard work.

Interviewed CINI NRC Staff, Nurse ,**Phulmoni Soran** and health worker, **Lakhi Majumdar** . Doctors at clinic refer the child at NRC if age wise weight is not appropriate and the child comes in yellow or red area of growth monitoring chart or MUAC. If there is faulty feeding and the child health status falls on the border of and yellow then also child is referred to Day Care Centre. Mothers are counselled on child feeding habits. According to the rule, if any patient from blocks other than Bishnupur I and II, comes then Rs 20 is charged. Both mother and child given Egg, Nutrimix, and Khichudi made with Chola daal, Masur daal, kumro,potato and tomato. The reason behind giving food to mother is that when she will eat the food, she will understand the way it is prepared and also the taste of the food and it is expected that she would prepare the food in this way at home. The timings for Day care is from 10 am to 4 pm but for mother's convenience they are released at 2 pm only. Mothers are counselled about food that needs to be given to the children of different age group for their proper growth. A child needs to be given food to eat at morning 6 am, then at 9 am, at 12 noon and at 4pm according to the age of the child so that the weight of the child increases. Many children have respiratory problem. Mothers are counselled on food items given during this time. A child whose age is 7-11 months need to be given ½ egg and ½ banana and after 1 year, 1 egg and 1 banana. Mothers are asked to give soft food to children and everyday food should include 1 green,1 yellow and 1 white for increasing the weight of child. Both the

sister and health worker said that there is whole lot of improvement in the health status of children in comparison to earlier days.

5th May

Visit to Diamond Harbour Field Office with **Urmi Sengupta Chowdhury, Monitoring and Documentation Officer of the project** and **Antara Dhar Gupta, program manager of the project.** Observed the refresher training of community facilitators. They were trained on various topics related to adolescents, mothers and children. The topics were: MTP, Menstruation Hygiene, Kanyashree Yogna, AIDS/HIV symptoms, RTI, STI, Contraception methods, ANC and PNC, Identifying malnourished child, Gender Discrimination, Population Control, Sex Determination, PCPNDT Act, Anaemia, Child Marriage, Illegal abortion, Pregnancy process. Each CF was given a topic to speak about. They would speak about it in the same way as they will communicate with the community. Some new CFs who were not so good in communication were instructed by Urmi mam to change their way of speaking. CF needs to be friendly with adolescent and before they start counseling with mothers or adolescent they need to introduce themselves. Some of the problems with new CF was : communication problem because of lack of confidence and their expressions were not good. They were taught about way of preparing nutritious food, when to give salt, hand wash before eating etc. Some CFs who are working since a long time discussed their problems which they face at field level. Some of the problems were: Few Mothers don't want CF to counsel their daughters about reproduction process, Some mothers ask about irregular periods among girls then what should they do and some mothers don't give iron and folic acid tablet to girls during periods because they think that it will increase the blood flow. Urmi mam and Antara mam gave their valuable suggestions to deal with these kind of problems. Met **Debopriya Bose, Block Co-ordinator** and **Sumitra Seth Majumdar, Field Associate.** They introduced me to CFs and we made the rural field visit plan.

Interviewed **Sahana Ghosh, CFC Co-ordinator. CWFC** is basically an institutional approach and all projects in CIINI works this approach. It has mainly 3 components: Panchayat, Service Providers like ASHA, ANM,AWW and Community. CWFC mainly brings all the 3 in a common platform and talk on main issues and in consensus with all the

most preferred issue is discussed. Through CWFC, all the issues of EPHN, Education, Protection, Health and Nutrition are addressed. The community is made to know about the available services and whom to meet and seek help. Service providers also come to know that if their supply of medicine, vaccines is not coming or stopped then where to go . The Panchayat also come to know about the problem of community and service providers. In this way all the 3 can link together. It is then reached upto block level. At present CWFC has changed into only CFC, Child friendly community because main aim of CINI is to take care of a child's health nutrition protection and education. At present CFC work going on Mallickpur G.P and scaling up of the program has also started. There are mainly 7 building blocks of CFC approach as:

Sensitizing (panchayat community and service providers are made aware about EPHN issues)

Collectivization (community group, Self Help groups are formed w and they help themlesves through their own ownership. Children group, VHSNC group, Nutrition group etc are formed)

Collective Analysis (Discussion and analysis of existing issues of EPHN is done)

Prioritizing (priority is given to most predominant issue)

Planning (a plan to solve the issue is decided)

Implementation(A time period is set for implementation of all the activities that need to be done)

Monitoring (Whether all the activities are actually implemented or not is monitored)

6th May

Day 1 of my rural field visit. I was accompanied by **Benojir Khatun, lead CF of Diamond Harbour block II.** She monitors and give support to other CFs of 4 G.P. 1st of all, I visited

ICDS centre no 197 of Nainan Village, GP- kolatolahat. Met CF of that field**, Mitali Majhi**. She works for 6 ICDS centre which constitutes 2 villages

Got to know about NCCS program. NCCS- Nutrition Childcare and Counselling Sessions. First of all, weight of child above 6 months till 2 years of age is done and seen in growth chart. If the child falls under SAM or MAM then mother is advised to attend this program. It is a 12 days program. Preagnant and lactating mothers also attend NCCS. On day 1, weight of the child is measured through hanging weight machine and it is recorded. CFs discusses about a different topic related to health and nutrition on each day of NCCS and khichudi and egg is given for child on each day. Each day mothers need to draw a mascot which would represent her child. On each day one more part of the body is added to the existing structure. On day 1, face is drawn, then each day a part of body like left eye, right eye, nose, mouth, left ear, right ear, body, right hand, left hand, right leg, left leg. Mothers are made understood that if they absent for a single day during those 12 days session, then a part of the body of mascot will not be formed and it is related to her child body formation. Since no mother would want her child to be physically challenged, they attend the program on all 12 days. On the last day of NCCS, again the child is weighed and if it is found that the weight of the child has increased then hands of the mascot is drawn in upward direction. Mothers are advised to follow the same feeding habit for child at home also. They are follow up by CF. After 18 days the child is again weighed and if the weight is found to be increased then the legs of the mascot drawn is directed upwards. It signifies that the child is happy to have gain weight. In this ICDS centre 5 children were found to be malnourished and others were normal. The growth chart is different for girls and boys. It is seen sometimes that a child may fall in normal category (green) in MUAC but SAM (red) in growth chart and vice versa. On the other hand some child fall in red portion in both MUAC and growth chart which means the condition of child is severe and it needs extra care. A bowl and a spoon was given as a gift to children above 6 months of age sponsored from Save the Children. The reason behind it was that since the child has crossed 6 months of age and now it will be given complimentary food apart from breast milk. That complimentary food (khichudi,egg) will be served in that bowl. Those children who didn't come to the centre were given the gift through home visit and they were told the reason behind it. Everyday the mothers who attend the NCCS program will sign

the attendance sheet and on the last day also she will sign under the mascot drawn by her. Mothers were asked to wash their hands with soap and water using the six methods of washing hands. Then, freshly prepared khichudi was given for spot feeding of their child. MUAC measurement was also done. Pregnant women were also there. While attending the Program they will also learn about child care and it will help them preparing for motherhood. Some mothers come for attraction of gift but most of the mothers were keenly interested in knowing about the program. Those who don't require NCCS , they also come and stand on the gate to learn what is going on. Mothers are counselled on spot feeding. If they take food at home it will be distributed among other members of the family that's why spot feeding is done so that the particular amount of food required by child is fed and it will help in increase in weight of child. Since it takes minimum 10-12 days to increase 200-400gram weight of child , that is why NCCS is a 12 day program.

A girl child, **Monica**, 1 yr 3 months age, **falls under SAM in both MUAC and Growth Chart**. CF said that they tried hard enough to improve the condition of child but anyhow unable to do so. One of the main reason behind this is that Monica's mother suffers from Thalassemia. She even could not conceive. After 5-6 years of marriage, she got pregnant and Monica was born. During pregnancy also, there were lots and lots of complications. Monica has some digestive problem also. Whenever monica consumes nutrimix she vomits and loose motion occurs. She even cant eat egg because eating egg yolk creates gas in her body. Since her birth, monica is malnourished and never been healthy. Agewise, she is normal in everything, except weight. Her weight measured was 6 kg 400 gm. She falls in the red portion of growth chart. According to GMP if a 15 month child has weight less than 7 kg 400gm will fall in red zone and if weight less than 8 kg 300 gm will fall in yellow zone.

Met ICDS worker i.e **Anganwadi worker**, **Rina Halder** and **AWH Pakhija BiBi Sheikh.** AWW and AWH both helps in the conduction of NCCS program. AWH prepared the Khichudi. While talking to them I got to know about their work. The AWW visits field for immunization and finds pregnant women and counsel her. BCG vaccine is given from every ICDS centre because it needs to be given within 21 days of birth of a child. Its not necessary that mothers have to come to ICDS centre in their area only. If they miss out somehow, then

they can visit other centre also where immunization camp is going on. During interaction with pregnant mothers I came to know that they are going for ANC properly.

After NCCS program, I visited Home of SAM, MAM and normal child with CF Benojir and Mitali. SAM children were given a first aid kit and explained how and when to use the kit. The kit includes bandage, bandaid, cotton, soframycin, Dettol and mercurocrom. SAM children were given NUTRIMIX by home visit. Both the CF were counseling mother of a SAM child's mother. The mother was advised to give complimentary food which includ to the child apart from breast milk.

Visited the sub-centre of Nainan. Since it was a Wednesday, all ASHAs were present at sub-centre to report their work. Had a personal interaction with 1st ANM, Ranjita Dutta.

7th May

Visited **ICDS centre no 16 of Highland Village, G.P- Kolatolahat, Daimond Harbour block II with CF- Benojir Khatun.** Observed the VHND camp (Village Health and Nutrition Day) and VHSNC Meeting at outreach. Persons involved in the VHND Camp were CF Monija, ASHA, 1st and 2nd ANM, AWW and other social workers. Blood pressure of pregnant women was measured. CF Monija was counseling pregnant mothers regarding ANC, PNC, importance of eating Folic acid tablets, JSSK benefits, motivating for institutional delivery using MCP card.Weight of child was measured on with the help of weighing machine. Children were given Immunization by 1st ANM and 2nd ANM was maintaining the record of Immunization. CF was counseling lactating mother about child healthcare practices and telling about growth monitoring through growth chart. Counselling about breastfeeding till 6 months. Mother was advised to drink more and more water and fresh vegetables so that breast milk quantity increases. Mothers were counselled about the proper breastfeeding practices. MUAC was measured. Weight of pregnant mother was measured. A mother was not at all ready for her son's hepatitis vaccination because she was fearing that the child would feel pain and cry. CF ,AWW and all other health workers tried their best to make her understand about the importance of hepatitis vaccination. Finally, after

much effort she was convinced and she got her child immunized. AWW and CF said that its very difficult for them to make the community understand about the importance of vaccination. They don't want to come. Health workers have to pull women and child from their home to attend the VHND camp. They have to visit door to door and request them to come atleast 4-5 times. A pregnant mother with oedema had come. She had lots of swelling and was adviced to take proper care by ANM and CF. The ICDS centre had very limited space and it is very difficult to manage during rainy season as all the water comes in. The infrastructure is not proper.

VHSNC meeting was held just after the camp. In VHSNC meeting two decisions were taken. One, to visit home of those pregnant women whose weight is not increasing and they will be counselled on their feeding habit. Second, those mothers will be counselled who are not ready to immunize their children. They would be made understood about importance of immunization. Those pregnant mothers who are at high risk would be visited at their home and advised to take rest and keep their feet upon pillow. Visiting home and observing their breastfeeding practices because most of the child becomes malnourished due to faulty breastfeeding practices.

Problems faced are: When NUTRIMIX given to SAM child, mothers of normal child feels that why they are not given NUTRIMIX. CF asks them to pay RS 40 if they want to have it but then they ask why are others given free of cost and why they charging from us. Due to lack of knowledge among women it becomes difficult for health workers to make them understand.

8th May

Visited another **ICDS centre, Nainan Villag with lead CF- Benojir Khatun andCf – Mitali Majhi**, Observed the Pre- School Education programme. Observed that for the preparation of Khichudi, vegetables were washed and then cut by AWH. Children were taught by AWW. Then, attended **Pregnant and lactating mother's meeting.** ASHA also present and mothers gathering. They were educated about JSY , JSSK and its benefits and ANC.

Visited **ICDS centre, Highland Park, Cf- Monija di.** Observed Adolescent girl's meeting. There were a good number of adolescent present. They were being educated about cause behind RTI, and its symptoms and methods to prevent it. Discussion on cleanliness and hygiene of female reproductive organ were done. If any problem occurs then adolescent girls were advised to visit Arnesha clinic.

Visited **ICDS centre, Parshurampore.** This ICDS centre was far better than other centres I visited. It was a cemented building and had toilet. Adolescent mothers were gathered and they were taught about Anaemia in adolescent girls. Its symptoms, cause and cure were discussed with mothers. They were advised to prepare vegetables that are rich in iron. Mothers were advised to give adolescent girls iron (folic acid) tablets and seek doctor's help if any problem occurs regarding menstruation irregularity.

Visited a **School at Bhadurai, with Cf- benojir.** Observed the school program on health education by CINI. CF Benojir taught school girls from class 6 to 12 about Anaemia and Menstruation. They were shown the diagram of female reproductive tract and main reason of maenstruation was discussed. They were also taught about maintaining menstrual hygiene.

Week-6

11th May

Visited **Village Kamarpole, Lashkar Para.** Interviewed 10 mothers regarding ANC, PNC, GMP and other related issues. It was found that there is no ASHA in that village. Out of 10 mothers , 3-4 were found to have done home delivery. Due to home delivery many children didn't got Hepatitis B 0 dose. Mothers here are very little educated and lack awareness. Early marriage leading to early motherhood was observed. Mothers don't know their age. They even don't know their husband's education and age.

12th May

Visited **ICDS centre, Kamarpole Dighipara. CF- Sahara Bibi .** Observed meeting on malnourishment. CF demonstrated about proper feeding habit through flag. She taught

mothers about three different kinds of food items that needs to be included in daily feeding habit for proper growth of child. MUAC of child was measured. Mothers don't understand about SAM, MAM terms but they understand it in terms of Red, green, yellow area of growth chart. They know that if their child falls in green then it means normal weight of child and red and yellow means not in good condition. Mothers were told to cook those food item that contains iron. Wash vegetables before cutting because vitamins are lost if cut and then washed. Use iodized salt because its good for mental growth. Right time to put salt in food. And how to identify if salt is iodized. Its through sign of sun on salt packet and putting lemon juice changes the colour violet. When mothers were asked about GMP, if the know or not, some said that their child has not been weighed yet and some don't come regularly. Those who get the information about GMP sould only attend the program.

Interacted with **ASHA, Dipannita Baidya** and discussed about her work. Now ASHA has been given a book to follow. She has to visit home for PNC checkups till 42 days from birth of child on 3rd, 7th, 14th ,28th,42th day. Those who deliver normally they start PNC checkup from 3rd day but those who deliver through caesarian, their checkup starts from 14th day. Equipment carried by ASHA are digital thermometer, digital watch, IMNCI chart (Integrated Management of Childhood Illness). In Imnci 6 form its written that if child falls ill within 42 days then what needs to be done . Child if serious then taken to FRU (first referral unit) where 24*7 services are available.. If vehicle available then the child is taken to hospital by vehicle. A form for mothers also is filled by ASHA if any problems occurring with mother. Before and after delivery, mothers are counselled by ASHA. They are told about feeding practices of child. Only breast feeding to be done and no water no juice should be given to child. Advice is given to not to throw away colostrum and not to give pre-lacteals. They are also told to give complimentary food after 6 months. ASHA possess a medicine named Cortymoxol which needs to be given as 1 tablet at 12 hours of difference to child from 29- 59 days if the child weighs 3-4 kg. 2 tablets to be given twice if the child of age 2 months- 1 year weighs 4-18 kg. But the problem is that the medicine cannot be given until and unless the child is weighed. So, mothers are advised to weigh their child. Weight measuring is a problem because lack of human resouces. So, a particular day should be fixed for weighing.

Interviewed **AWW, Monica Mondol.** She said that weight of the child of age group 0-5 months cannot be measured because the body is not well developed and hanging them in the weighing machine becomes risky. So weight of child of age 6 month- 5 year is done. If she finds any SAM,MAM child then it is reported to the office. NUTRIMIX is given and counseling of mothers done. They are advised for spot feeding at ICDS centre. She said that mothers negligence plays a big role in malnourishment. Spot feeding is a big problem because mothers say child is sleeping and other excuse. The rule is that those mother and child would receive food from ICDS who will do spot feeding but normally it doesn't happen. Mothers take away food saying child is at home but in actual he/she is not at home, may be at grandparents place. She suggested that if CINI, ASHA, AWW come together and work then it would be better implemented. The work is not properly defined. ICDS says it is the work of Health and health says it is the work of nutrition department. Senior level officials not giving proper direction at field level officials.

Observed **Health and Nutrition Camp conducted by CINI at Sarisha sub-centre no 18.** It is organized once in a month. Doctor is provided from CINI and medicines also sponsored by CINI. All malnourished children who are not cured by feeding practices and needs medication come and get treated at the camp. At many places doctor of BPHC also comes. Many CFs and supervisor Sumitra Mam were present. They organize the camp and manage everything including providing medicines to mothers and child from medical store.

Interviewed **1st ANM-Aparna Koel, 2nd ANM- Meena Khatun and Supervisor Kalyani Rai at Sarisha Sub-centre.** Population covered is 9000-9500. Under Sarisha G.P, there are 3 subcentre, Sarisha , Nausa, Tamir. Supervisor has to visit all the 3 sub-centre. If any camp of health is held then record is maintained in register. A mother if found to be pregnant then she is registered and her Hb test, Urine test, Albumin test is done. ASHA counsel mother for checkup. Immunization is done at camp. On 2nd Wednesday , camp is held. On 1st 2nd 3rd Thursdays, outreach camp for mother and child is held. ANM does Immunization, ANC,PNC. She has to send message through mobile to office. Since according to rule a subcentre covers 5000 population but actually it goes upto 9000, 10,000, or sometimes 12000 population. So to manage the work apart from 1st ANM , 2nd ANM was posted to help her in managing the work. Since both ANM used to be busy in office so ASHA was posted at field

level for per 1000 population. DH II block has huge population. ANM has to do a lot of paper work.

Visited **BPHC, Sarisha**. Interacted with **Medical Officer- Dr. Apurva Mridha.** He gave a full idea of government health structure. A district is divided into many blocks. Daimond Harbour block II is the headquarter . BMOH is the head. Under BPHC there are 2 PHC- Bhadura and Paschim Bhawanipur. PHC may be bedded or non-bedded. If bed present then maximum 10 beds. Normally, a BPHC constitutes 10-20 beds but if there are 30 beds then it is said to be upgraded BPHC. Under BPHC Sarisha there are 22 sub- centre. BPHC mainly follows 2 aspects of health: **Curative and Preventive.** Curative includes services at indoor level as a hospital with 30 beds at BPHC. For each sub-centre there is an incharge. Under incharge is 1st and 2nd ANM. 1 anganwadi worker is present in each village and 1 ASHA per village. Under BMOH there are 4 MO. In upgraded BPHC/rural hospital, 6 MO present. BPHC/ CHC/ rural hospital are almost same. In BPHC Sarisha, 2 Pharmacist, 8-10 sisters, 6 Group D assistants and 6 sweeper posted. , BPHC at Sarisha had 14 bedded female ward, pathology room, CSSD, Doctors chamber, USG X-Ray, male ward, labour room, sterilization, O.T, recovery room and cold chain for vaccines of polio, TT. In preventive care, maximum services provided at field level from sub-centre. Diseases like leprosy, TB, Kala-azar, polio, malaria programs are run. Apart from this, malnourishment treatment, routine immunization, AFP survelliance is done.

13th May

Visited Nainan village and **Observed Self Help Group Meeting** of Panchanantala, Sansad no-7. SHG group is formed by panchayat. Under 1 PRI, 1 SHG group present. The area covered by PRI is the area of work of SHG also. 1 SHG includes 10 members. SHG group includes all ladies because basically all health works related to mother and child and so it will be comfortable to collect data from them. The ladies selected for SHG should be educated. They have to visit the health centre once in a month. They are also a part of VHND camp and VHSNC meeting, 2nd Saturday meeting and also participate during weighing of children at Anganwadi centre and Adolescent meeting. Basically, the work of SHG is almost similar to other health workers. All the reports by SHG,AWW,ANM, ASHA are matched to find if

there are any difference or not. SHG uses a social map. Using bindis of different colour houses are identified. If Red bindi- SAM child, Yellow- MAM, Green- normal child, pink/orange- pregnant lady. The social map is updated every month. Saw a map of Nainan village with health centre. There are 2 health centre in Nainan. SHG have also been given weighing machine for measuring the weight of children. When home delivery happens then SHG only measures weight and gives the data to CINI, ASHA, AWW. 2 members of SHG and CF visits home and advises pregnant mother about proper care during pregnancy. They also inform panchayat about non- availability of toilets through survey. The main 5-6 works of SHG are: Immunization of mother and child, taking care of pregnant mother, prevention of diarrhea, malaria, arrangement of purified water and cleanliness of ponds and drainage, clean toilets. SHG group of Nainan complained that during SHG meeting mothers don't want to come because of no attraction of gift which they get when they attend CINI's meeting. The SHG group salary for each member is Rs 50 per month. Overall rs 500 per month but SHG of Nainan has not got salary since 2 years and they are asked by panchayat to work selflessly.

ASHA said that she has to serve and cover all details from birth to death. She advise and councel for family planning and leprosy and dots, fever immunization given. Details of per house/family is taken by her. Fixed Salary per month is Rs 1500 apart from incentives.

Visited subcentre Nainan. Interviewed **BPHN, Sangeeta Gayen.** She does monitoring and supervision at block level and reports to district hospital. The hierarchy of nurse is as follows: ANM→Supervisor→PHN (public health nurse)→BPHN (block public health nurse)

Interviewed **ANM, Ranjita Dutta, Nainan subcentre.** Main work of ANM is field supervision. Nainan subcentre covers 3 village.: Nainan, Gazipur, Ramnagar. The ANM counsels eligible couple so that they don't have children very soon after marriage. Young 15 year girls also given health talk. ANM needs to work with full mental involvement. When vaccine injection is given ,the patient or caregiver is told about its purpose. Anyone who comes for immunization, be she is literate or illiterate she is informed about the purpose of injection. Sometimes camp organized in community hall for outreach level.

Visited **PHC, Gondia Raghunathpur, and SC as SC was attached with PHC.** Met **ASHA**s. They face problem regarding incentives. Since the area is full of educated people, there are not many children, so no vaccination and health talks. Some ASHA get RS 500 and some get RS 5000. This is creating disparity and unequality among them. An ASHA working for VHND at centre on Wednesdays get no money but another ASHA doing the same VHND on Thursdays at outreach gets Rs 200. Both doing same work but not getting equal incentive. This leads to decrease in motivation among ASHAs. Met **Dr.Aparna Baidya, at PHC.** In the PHC, 1 nurse, 1 doctor, 1 GDA present. Examination room, dressing room, medicine room present.

Saw a glimpse of **District Hospital, Daimond Harbour Block II.**

14th May

Discussed field work with mentor at CINI, Pailan office.

Interviewed **Mr. Arup Das, Senior Programme Officer.** Got the basic knowledge of CINI's strategy. CINI is implementing its program through units and divisions across state following CWFC approach. In West Bengal PRI is very active and functional in comparison to other states. For this reason, Health, Nutrition, Education and Protection programs service supervised by PRI. PRI covers 20000-25000 population. G.P is the lowest Administrative unit. All government run programs implemented at G.P/PRI level, so they supervise and manage all the implementation program. Health programs are implemented by Division of Family and Child Welfare (DFCW) and not by G.P but they supervise and monitor it. It generates community demand and at the same time strengthening the linkage between service providers and community so that the services reaches to vulnerable community. PRI helps in community mobilization and help them to get access to service available with service provider. The main responsibility of PRI are: empowering the people and making the community place their demand, strengthening the linkage and overseeing that service are available and accessible, monitoring. CINI acts as a facilitator. Services are available but not timely available and accessible. Eg- Immunization not properly supplied. CINI fills the gaps. Health and ICDS are there. CINI establishes linkage between service provider so that beneficiary gets maximum benefit. Earlier CINI was more into services and now the strategy

changed and now CINI's role in efficient functioning of panchayat. Like PRI in rural area, in urban area CINI co-ordinates with Ward Counsellor. Its difficult to work in Urban area because in urban area mainly Migrant population and no bonding. But in rural area stable population and moreover 70% villages, so more focus in rural area. CINI is giving people, a basket of choices and making them aware.

Interviewed **Dr. Samresh Bhattacharya, Consultant Medical,** regarding health care delivery system. CINI provides preventive, promotive and curative care through OPD and Thursday clinic. On other days CINI provides promotive and curative care but on Thursdays, curative, promotive and preventive care are given. Care givers are councelled about feeding habits to keep their child healthy. Immunization is also done on Thursdays. Mainly the 8 common diseases for which preventive care is given are:- measeles,tuberculosis, polio myletius, diphtheria, whooping cough ,tetanus , influenzae bacteria & hepatitis B. The pentavalent vaccine includes DPT, H. Influenzae, and Hepatitis. CINI provides services to children under 5 years. Malnutrition is bad and it is of 2 ways: Over and Under. Under nutrition is more concerned because of the following reasons: i) growth of child will falter,ii) cognitive development , effect on brain iii) immunity also compromised and they fall sick frequently. CINI has strong linkage with governmet. Vaccines for immunization is provided by government. In return, CINI provides the data of number of child immunized at CINI clinic. CINI also helps in survellience, of two diseases, i) acute flaccid paralysis for polio and ii) measeles. CINI sends the details about child like its address and mobile number also. Then government track the child and does the necessary investigations like tests and treatment. CINI also gives training to ICDS worker, supervisor. CINI keeps the vaccine of government required for pulse polio immunization. Staff of CINI also go to field for immunization program.ASHA trainers training is also conducted at CINI. CINI works at field level and provides information to community about institutional delivery, weighing of child, ANC, PNC and promote the services implemented by government.

Interviewed **Sushanta Chatterjee, Assistant Director IT regarding HMIS of 1000 days project.** Mainly through HMIS of 1000 days ,the following data are recorded :i) entry of baseline household survey ,ii) entry of health and nutrition related data of mother and child, iii) analysis of health and nutrition related data for supporting decisions, iv) for appropriate

interventions, tracking of every mother and child dyad on real-time basis for making interventions promptly in the time of need. This is an interactive system to provide effective intervention in the 1st 1000days of life of children. Firstly, login to the cini1000days.org. An android phone with the software installed in it is provided to CFs. The mother is identified through voice data and send to server. The mobile is inbuilt with android app with GIS feature, and CINI's own software related to 1000 days project. At the end of the day, real time data is synced with web and saved in the server. A specific data entry manager operates the web based software app. It is accessed by him and voice file can be heard. Then, necessary data is entered by him and then different alarm and alert report generated. Then through GIS report location and address of mother is known. Alert means if the condition is serious like if someone missed 4 ANC or weight loss occurring. Alarm is for warning like if only one ANC missed. Alarm and alert reaches directly to mobile of community facilitators, so that necessary actions can be taken. All the necessary details of mother and child are recorded such as identification, pregnancy, ANC,delivery, PNC, initial feeding, child health and nutrition and hygiene, child growth and immunization.

Interviewed **Sushanta Saha, Assistant director, Finance** about financial management of CINI. Since CINI is an NGO, its most finance depends on grand donation. The training unit of CINI is also an income source. On an average 75-80 projects are run by CINI. The staff salary is recovered from project. Its planned in such a way that each staff's salary can be recovered from the project so that organization liabilities are less. A project has administrative overhead. Overhead is not directly related to the project but without which a project cannot be run like accounting charges etc. Staff salary is recovered from it. Sometimes it may be generated from corpus fund generate which is almost similar like capital in a private firm. One of the earnings is interest which is gained from bank investment of corpus fund. CINI gets donation from foreign source as well as local Indian source. Ministry of Home affairs has a registration certificate. Separate books of account is maintained and at the end of the year return file is to be sent. This is in regulation with MOHA, for internal security reasons. The purpose of sending money is seen by MOHA. 1st of all for a project, budget is prepared in which salary, admin cost and all expenses are taken . It is then approved by the funding agency. It is signed. At the end a program report need to

be sent to the agency and utilization certificate is generated in which details of expenditure made is shown.

15th May

Interviewed **Pradeep kumar Dey, senior program officer, Administration, and member of purchase committee** regarding purchasing process. 1st of all of suppliers is done. Advertisement is given in march every year. Then, 10-15 days time is taken to fill form by vendors from all units of CINI. The form costs Rs 20-25 and contains firm name, agency, vendor name, pan card details, trade license, credentials, bank account and if they have worked with CINI before or not. The forms are submitted. Data entry operator enters the data according to different categories of vendors. Based on it, they are screened that if necessary details available or not. Those who lack any of the documents and details are disqualified. After that, vendors are informed that within a particular time they will get to know if they are selected or not through phone or via email. Then, the project head is asked to fill the requisition slip and enlisted persons. Quotations are invited and then Bid analysis is done. Project head and procurement committee together decide to fulfill the required criteria. The vendor which charges the lowest amount is called and invited for work. If someone wants to buy a laptop then purchase committee refers to IT cell because they know better. IT department talk with the project head and then requisition send to purchase committee. Quality of both material and services are maintained.

Visited **Uttar kamarpole, Hait Para.** Observed **the Nutrition demonstration camp.** CFs were teaching the mothers to prepare Daliya Khichudi with green vegetables. They were also taught why to wash vegetables before cutting them into slices. The main purpose behind nutrition camp is that mothers are taught the proper way of preparing food so that the nutrition of the food is not lost while cooking and also to make them understand that they can keep their children healthy by providing them nutritious food, and the ingredients of which are easily available near their locality and also cheap in cost. At last, the mother who prepared the khichudi demonstrated again the whole method of its preparation. The reason of putting salt into the food at the end was also demonstrated. The iodized salt loses its nutrient

value if it is cooked more. After the preparation of khichudi it was distributed among all the mothers and children who had come.

Interacted with **AWW, Sampa Hait**. The condition of AWC was very bad as there was very little space. ICDS worker explained that government asks them to find 3 satah area place in the village and government will construct a centre there. She said that the ICDS centre where she is currently working is on rent. The rent paid is Rs 200 per month. She also said that many ICDS centre have no shed and are operated openly without any concrete infrastructure. For repairing the centre AWW has to spend Rs 3000-4000 from her own pocket and government compensates it by giving only Rs 500. She explained that stock supply of raw food is sometimes not available which hinders the program of supplementary food to pregnant and lactating mothers and their children. Since its mandatory to provide the complementary food to children for at least 21 days in a month from ICDS centre for proper growth of malnourished child, but sometimes the supply of stock is not available then the program gets disrupted. If a child won't get proper food then how will his condition improve.

Week -7

18th May

Visit to **CINI Urban Unit.** Met **Namrata Mallick, Block Co-ordinator.** She told me about urban structure. Many slum lanes constitute a ward. Many wards constitute a borough. Under Kolkata Municipal Corporation (KMC) total 15 boroughs. Administrative level includes CMOH, then Borough Health Executive, Ward Medical Officer, and then Honorary Health worker who covers 3000 population.

Visited **Dhobiatalab Slum lane with Namrata Mallick.** Observed the NCCS program. The program concept was same as rural but the difference was that since there are only few ICDS centre in urban area and so the Khichudi and eggs for NCCS program were arranged by CINI . The main drawback was lack of space to sit and conduct NCCS. Either they are conducted in clubs or on the street. Clubs are far away and mothers don't want to go so it is conducted at their homes A local vendor has been arranged who brings Khichudi and all the CFs take the Khichudi to their field for NCCS. The condition of urban slums are very

deteriorating and unhygienic. On the very first day I could feel the difference between urban and rural condition. In urban field there are very few ICDS centre, so CINI is providing supplementary food to pregnant and lactating mothers and SAM, MAM children. But other people who don't get the food feel that CFs are doing partiality with them. They feel that CFs are taking away their part but in real its not so. Even adolescent girls think so. Its very difficult to work in urban field as mothers here don't co-operate and don't want to understand. One of the main problem is also that mothers in urban field don't have time as almost all of them are working to earn their livelihood.

Visited CF Savita's field and talked with her about urban field and community hall of that area where also NCCS program is conducted. Talked to a mother of SAM child who has improved and now falls into SAM category.

Mohammad Sonu is 1 year and 8 month old. Begum Jahanara Bibi, 25 years old, mother of sonu said that at birth sonu was 2.5 kgs but was not so healthy. Sonu's mother said that sonu was breastfeed only for 3 months. After that milk production stopped so she couldn't breast feed the child. She consulted the doctors but nothing happened. She even took mother's Horlicks for milk production but it had no effect on her. Lastly, she started feeding lactogen to the child. It had a negative effect on child and loose motion started. He was taken to ID hospital, where diarrhoea is treated. From there doctors referred him to Sishu Hospital. Sonu was admitted there for 16 days. After tests and other checkups, doctors said that Sonu has some problem in his liver and so he has problem in digestion. Doctors suggested Sonu's mother to feed him with Zerolax milk till 1 year because it is light. After 6 months of age, Sonu's mother started giving him complimentary food such as rice, pulses, potato and khichudi. Doctors recommended not to give oily food items to Sonu till 3 years of age. When sonu was 5 months old his weight was just 4.5 kg. CINI's community facilitators weighed sonu every month and counclled Sonu's mother for changing the feeding habit and she also regularly attended NCCS program. Sonu was a SAM child and used to fall in red portion of growth chart but now through NCCS program and proper care he has become MAM and so falls in yellow portion of the chart. Earlier his weight was 6 to 6.5 kg but now he is improving and the weight has increased and reached upto 8 kg.

19th May

Visited slum with CF Jyotsna. Visted homes. She did the MUAC and weight measurement of the children during home visit. I visited a home for questionnaire fill up. During NCCS program I talked to a pregnant women and filled the questionnaire. Thereafter, proper field visit plan was made at the meeting of CFs and block co-ordinator and field associate.

20th May

Visited Bilaspuria slum at Christopher Road with CF Chandana, because covers migrants from bilaspur. Interviewed 2 mothers. Visited the Routine Imunization centre , Zone III 59, Christopher Road, WB health department. Interacted with Health Assistant Mr. Sanjeev Dutta. There is a Chief Health Officer (CHO) at Kolkata Meteropolitan Development Authority. There are 4 zones under KMDA. At each zone there is a Zonal office. And there is a Health Inspector at each zone. There is a Health centre under each zone which has a Health Assistant, Health Inspector and Group D Assistant. Interacted with CF. She explained her work. She works on malnutrition for pregnant mother, lactating mother ,0-2 years children.

21st May

Visited **Dhapa Dispensery** and urban slum **Rajarghat Natunpara**. and observed **nutrition demonstration camp**. At Dhapa dispensary I met **Pharmacist, Abhijit barik**. He described the urban health structure. Under Municipal Corporation there are borough, under borough there are many wards. One of the ward is ward no 58. Under ward 58 there are 2 dispensary: Dhapa dispensary, Gobra dispensary and a ward health unit 58. In a dispensary there is a medical officer, pharmacist, lab technician and other para medical staff. Ward health centre provides prevention care on malaria, dengue, immunization. In dispensary treatment on RNTCP-Revised National TB Control Program, leprosy, ARV- Anti Rabies Vaccine, Physical treatment on common diseases, blood test, malaria, Hb, sugar are also done.

Interviewed 2 mothers.

Pallavi Mondol, 1year 6 months old, daughter of Kakoli Mondol was a SAM child. When the mother was asked about health history of the child she said that the child was breastfeed only for 3 months because milk production stopped after that. Without consulting anyone she

started feeding the child with milk and cheura, rice, cerelac, lactogen for 1 month. The condition of child deteriorated and from normal and it became MAM and then gradually SAM. CFs of CINI identified that the child is falling under SAM category. They motivated the mother to participate in NCCS program held by CINI. She attended the program but there was no improvement then also. Then under the advice of CF the child was referred to NRC, Shishu Hospital, Phoolbagan. Checkup was done and the child was admitted for 21 days. Both mother and child were admitted free of cost. There the child was given Khichudi twice a day and in the morning a banana and milk. A sandesh with cashew was also given everyday. At night also after every 2 hours, the mother is asked to feed the child. Like this, for 21 days the child was treated and then discharged. At the time of entry to NRC the child weighed 6 kg and when he was weighed after 21 days his weight became 8 kg. The mother started taking proper care of child and slowly the child became normal.

22nd May

Visited **Durgapur** village under ward no 58. Observed nutrition demonstration camp and interviewed 2 mothers.

Week-8

25th May

Visited **ICDS centre 04/22 , Tangra Yuvk Sangha, 12 no GT Road**. Met AWW, CINI facilitators, **field Associate- Shraboni Das**. Observed mother's meeting. Interviewed 2 mothers. Talked to **CF Nira Thakur**, about the project. She explained that from 1st March, 2011 Human resource planning for the project was done . Approx 90,000 population under Ward 58. There are 30 CFs , each covering 3000 population. CFs were given training. From 1st April, 2011 the project came into effect. In the 1st year Baseline survey was done. CFs visited from door to door enlisting the name and details of mother, child, husband and other family details. Since there are very less ICDS centre in Urban field they need to find out some influential persons who can help in implementing the project. So, the club members were identified and informed about the project. Change Agents were identified. Slum Health Committees which includes some teachers, party members and other influential persons were

formed. SHC monitors CFs work and inform them if any area is not covered by them or mother's meeting not held. In 2nd year, NCCS program was started and linking with NRC was also done. In 3rd year, adolescent girls and their parents also included in the program. She also explained about the HMIs system. There is a cohort register where 164 details of a mother and child is recorded. All the details are updated every month. In 2013, mobile with android app and with particular software was introduced. CFs ask the details of mother and child and then record it in the mobile. They have to enter details everyday. It is then saved and sent to the server. If no net connection is there then it is saved in the SD card. Automatic Alarm and alert are sent to the mobiles of CFs regarding any important events missed by child or mother so that proper action can be taken.

I asked about the problems faced by community facilitators. CFs explained that when they visit a child's home then sometimes the child is sleeping and sometimes mothers are busy having no time to talk. CFs are then asked to come later. Adolescent also say that they don't have time on weekdays and they are free after 5pm which is not suitable time for CFs. Sometimes people even ask for ID proof of CFs. For new registration, CFs have to make the family understand everything related to the project.

26th May

Visited Hatgachia with CF Dipannita and Rajarhat Natunpara with CF Ragini. Observed Adolescent mothers meeting. CFs talked with mothers and explained about the topic of menstrual hyigene which they will discuss with their daughters in adolescent meeting. CFs seek permission from the mothers and also if they don't have any problem. Almost all of the mothers were convinced and willingly ready. They appreciated the work done by CINI and want their girls to have knowledge. Mothers also asked if they had any queries and CFs clarified them. They cooperate with CINI CFs.

27th May

Interviewed **Shreyasi Ghosh, Officer, Communication and Branding.** Funds are raised through three sources: Individual. Schools, Corporates and sometimes through events and campaigns. Individuals are categorized into LIG, MIG, HIG i.e low income group, middle

income group and high income group. Different strategy used for different category of people. If the person comes through someone's reference, then the task becomes easier as he already knows about CINI and it is very difficult to make a new person understand about CINI. Funds are also collected from schools. The fund raising unit members meet the Principle of the school and asks for a date so that they can give a date for on EPHN. They ask children to collect fund from their parents, relatives and friends and not from strangers. The money is collected and a small gift is given as a token of appreciation. Corporates have their CSR bill so they donate in areas where interventions are going on according their will. Educate a child and Adopt a mother are the sponsorship programs. Its very difficult to raise funds because people wont get anything in return. International Unit of CINI, like CINI-Italy, UK , Australia try to raise fund but not that much is gained. Some funds are also raised from government as some are government run project. But then, they also get the fund project wise and not as fund raising unit.

Regarding branding, Ms Ghosh explained that CINI has many divisions and it was known through different units such as CINI Bondhon, CINI Asha, People started recognizing different units as the main brand but later it was realized that the brand CINI is to be focused on. That's why later the branding strategy was changed and specific names were changed into generic names such as CINI Urban unit, CINI HIV/Aids division etc. Logo was also changed. Instead of using many colours just yellow and maroon colour logo was used. Thus new branding strategy is thus formed and once it gets approved by governing body, it will become the branding guideline of CINI.

Discussed with mentor about project report.

28th May

It was World Menstrual Hygiene Day. Observed Adolescent girls meeting with CF Salma and Puja at a peer leader's home and at Vivekananda Club. Girls were shown the diagram of female Reproductive tract and explained about menstruation process and maintaining hygiene during this period.

29th May

Documentation of work done in last 2 months.

1st to 5th June

Daily work notes updated. Data entry, Data analysis and compilation. Discussion with mentor regarding final report work. Final Report Submitted. Received Certificate.