Helping Mothers and Children

Society for Nutrition, Education & Health Action: Nourishing India

Nishita Murarka and Anuraag Singh Dalal
Photography/Charlotte Anderson
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A walk by a caring pediatrician through one of the world's largest slums inspired the founding of a Mumbai NGO that became a model for how to help poor mothers and families learn about nutrition and protect the health of their children.

Malnutrition is the underlying cause for nearly a third of all child deaths — about 2.6 million a year — across the world. For India and other emerging nations whose economic security greatly depends on having a young and robust workforce, the loss in human capital is disastrous. Countries lose between 2 percent and 3 percent of their annual gross domestic products due to nutritional deficiencies, experts say.

India's malnutrition numbers make for particularly somber reading. In spite of a 50-percent increase in its GDP since 1990, India continues to contend with a grim reality — one out of every three malnourished children in the world is Indian, with the percentage of underweight children twice the world average. Just in Mumbai, the country's

A young mother sits by her child's cradle during SNEHA home visit.

financial capital, approximately 70 children succumb each day to malnutrition.

In 1999, the situation was worse, in Mumbai and in the country. Dr. Armida Fernandez, then the dean at a prominent Mumbai government hospital, was aware of how deep the problem ran, as she had confronted the issue time and again within the hospital, even as India grew more prosperous and increased its food security.

One day, Dr. Fernandez stepped out of Lokmanya Tilak Hospital in Mumbai's Sion district and took a walk along the narrow winding streets of Dharavi, one of the largest slums in the world. What she saw, along with her 25 years of experience as a pediatrician and medical researcher, led to the birth of the Society for Nutrition, Education and Health Action, or SNEHA, meaning "affection" in Hindi.

"I started out with the vision of saving newborn lives because I saw so many children dying in Sion Hospital," she recalled. "I said to myself that we have to stop this violence being faced by children and women. We had to work with the poor communities."

Beginning then and continuing on to today, SNEHA works at the community level to empower people to become catalysts of change by collaborating with existing public health systems and health-care providers to create sustainable improvements in urban health.

FATE AND SEED MONEY

In 1972, Dr. Armida Fernandez began working as a pediatrician at Lokmanya Tilak Municipal General Hospital, commonly known as Sion Hospital, which largely catered to Dharavi and surrounding areas of Mumbai's Sion district. The situation at the hospital was dire; about 74 percent of newborns admitted with various maladies were succumbing to their illnesses. This shocking death rate made Dr. Fernandez want to take action; however, the enormity of the task soon made itself apparent. Because of the crippling budgetary and resource constraints that most government hospitals face, she found that she could not institute the sweeping changes the situation required. What followed instead was a remarkable exercise in patience and creativity, backed by a personal commitment above the call of duty.

Armed with ingenuity and determination, and aided by other medical staff, Dr. Fernandez set about making incremental changes that would help reduce infant mortality. She banned containers of baby milk formula to reduce the chance of bacterial infection in the neonatal intensive care unit (NICU). Instead, she stressed the importance of breastfeeding and approved procuring milk for babies from different mothers if need be — a contentious move at the time, but one that sowed the seeds for India's first milk bank. To encourage better hygiene, she shifted the locations of wash basins in the hospital to more accessible areas, focusing on the vulnerable wards where patients needed greater care. She started allowing mothers entry into the neonatal intensive care unit (NICU) to nurse and nurture babies, ensuring that the stimuli received by the babies were not limited to generally routine check-ups by hospital staff.

Her biggest innovation was pioneering a frugal and ingenious way to replace the hospital's infected incubators, which she found were the greatest cause of newborn deaths, with a system of strategically placed lamps to mimic incubator temperatures. Replacing the incubators with new equipment was not an option available to the hospital. Realizing that Mumbai's humidity was perfect for newborn babies, Dr. Fernandez devised an elaborate network of lamps and blankets in a sterilized room to simulate the warmth generated by an incubator. She tested different lamp wattages at various distances until she achieved the required temperature. She ran tests to determine how temperature could be modulated by changing the orientation of the lamps. She later wrote journal articles to report her findings for other public health institutions facing similar issues.

Her efforts began to produce results. The mortality rate for pre-term babies at Sion Hospital fell steadily from 74 percent to 12 percent over a

period of 15 years. The success pried loose some resources for the hospital, enabling it to build what was, at the time, only the second specialized neonatology wing in India. At conferences, she spoke of India's need for a gentler, more compassionate approach to neonatal medicine.

Despite improvements inside the hospital, Dr. Fernandez knew that children often died soon after they left the safety of the hospital, or later developed various irreversible cognitive disabilities. Her disillusionment with this reality caused her to ponder whether saving a premature child for a mother ill-equipped to deal with its needs was cruel for families already financially and emotionally stretched. She questioned the humanity of her work.

The issues Dr. Fernandez struggled with stemmed in part from the liberalization of India's economy, intended to create a vibrant, self-sufficient country. In 1991, P. V. Narasimha Rao, the then-prime minister, and his government ended *license raj*, an elaborate system of government regulation and licensing, and opened India's market to the world. The decision put India on a fast track toward industrialization, away from an agrarian-based economy. Consolidation of landholdings and the mechanization of farming, along with suddenly booming metropolises and small towns, led to large-scale migration from villages to cities.

The inability of urban civic infrastructure to cope with migration resulted in the ghettoization of migrant communities in sprawling slums across India's major cities. Makeshift houses with tenuous legal status created a vacuum that rendered government institutions unable to provide slum dwellers any sort of acceptable standards of health care, sanitation, or access to public utilities.

According to the last census in 2011, almost 28 percent of India's population resides in slums. That amounts to 65 million people, comparable to the entire population of France. In the city of Mumbai alone, it is estimated that 21 million inhabitants, or approximately 60 percent of the city's population,

A mother tends to malnourished child.

resides in slums covering a mere 6 percent of the city's area. None of these shanty towns is more infamous than Dharavi.

Occupying more than 500 acres of prime real estate in the heart of the peninsular Mumbai, Dharavi has long been portrayed both by Bollywood and Hollywood as Mumbai's seedy underbelly. Its origins date to the late 19th century, when it became the home of displaced *Koli* fishermen. The *Kolis* were joined by *kumbhars* or potters from Gujarat, tanners from South India, and thousands from northern India drawn to Dharavi's booming recycling business. What they created was a diverse urban micro-community, with a population of approximately one million and a shadow economy valued at more than US$500 million.

Today, its tanneries and earthenware kilns, and its recycling plants, which involve the handling of hazardous heavy metals, operate with little regard for health or environmental concern. Cramped quarters and the lack of basic sanitation facilities (one bathroom per 1,400 residents), also makes Dharavi an incubator of disease and epidemics. From the 1896 plague, which wiped out half its population, to the 1986 cholera epidemic, a litany of other diseases, including typhoid, cholera, leprosy, amoebiasis, and polio, has swept through Dharavi over the years.

Since most Dharavi residents do not own the land they live on, and most of the slum itself illegally occupies public land, many parts of Dharavi are not officially recognised by the government. Therefore, they do not receive the same level of public health service and utilities as other areas. With few major hospitals and even fewer municipal health outposts and dispensaries, in relation to its large population, basic health-care remains out of reach for the average Dharavi resident, who earns less than US$2 a day.

The realities of Dharavi led Dr. Fernandez to conclude that if she were ever to make a difference, she could not do it from Sion Hospital alone. Arming Dharavi's residents with the knowledge to help themselves was the only way to ensure that they did not end up in the hospital time and again, straining an already failing public health system. It took more than simple inspiration to make it happen, however, and it began with what SNEHA's founder called the "simple fate" that led to its seed funding.

At a wedding at Mumbai's upscale Willingdon Gymkhana, Dr. Fernandez was speaking with some of the guests about the problems facing women and newborns in Dharavi, and the need to take health care and education into the slum. One guest, Neville Soans, a businessman who already knew Dr. Fernandez, spontaneously offered to donate the proceeds of the sale of his holiday property to Dr. Fernandez to help begin the mission. "There are many different types of businessmen in this world, but Neville Soans was a man who went out of his way to do things for people, no matter who it was," she said in an interview for this case study. "If you ask 100 people about Neville, all 100 will have stories to share about his generosity."

While Dr. Fernandez thought little of Soans' offer at the time, she promised to get in touch soon. However, the following day he suffered a fatal heart attack, leaving behind a widow and their five children. Dr. Fernandez naturally assumed that was the end of that, but to her surprise Soans' widow, Patricia Soans, arrived on her doorstep three months later, the proceeds from the sale of a holiday property in hand. Mrs. Soans had overheard her husband's offer, and wanted to make good on it. "When Patricia first came to me with the money, I refused to take it — because here was a widow in her 40's with five children to look after, while I on the other hand just had an idea, that of working in the slums, but I had no knowledge of how to do it. However, Patricia refused to take no for an answer."

In a little while, Patricia Soans would go with Dr. Fernandez to a government office to begin the necessary paperwork for founding a non-governmental organization (NGO) in India.

FOR THE PEOPLE

The world Dr. Fernandez was leaving was different from the one she was entering. "In the

beginning, all I knew is that we had to work in the slums, with people from the poorer sections of society, but, I had no idea how to do this social work," she said. "I was a doctor and a professor, and the world I came from was very different, so I knew I had to learn a lot about running an NGO." To help get SNEHA going, Dr. Fernandez looked to hire people based on what her instincts told her. "I hired people based on the commitment and passion I saw without looking at their certificates or diplomas or conducting reference checks, because I didn't know any better." She found and hired people who have been with SNEHA since the beginning, including a colleague from Sion Hospital, Dr. Shanti Pantvaidya, known to most as simply Dr. Shanti, who is now SNEHA's executive director.

Four other SNEHA staff members who have been with it since the beginning currently serve in director-level positions and were vital to its growth. Neena Shah More, for example, current director of the SNEHA Centers and Malnutrition Program, and the only team member back then with a social work background, was the first to tell Dr. Fernandez how SNEHA workers had to relate with Dharavi's people. They had to sit on the ground when talking with community members and speak with them in their local language — to be like them and become one of them. "I respected and trusted my team, and this is something everyone must learn," Dr. Fernandez said.

SNEHA remains firmly rooted in Dharavi, but it also grew to serve residents of other slums. As of 2015, it had reached out to more than 4,500 pregnant women through home visits, and through its networks it assisted more than 21,000 women with potential birth complications. It had monitored the growth of nearly 24,000 children under three years of age in Dharavi, and it provided health and life skills education to more than 10,000 children and adolescents. SNEHA had also intervened in more than 5,000 incidents of violence against women and children.

A core component of SNEHA's connection with the community is the deployment into the field of its own cadre of trained women workers and volunteers selected from within the community. The SNEHA *sakhis* or *sanginis*, meaning friends or partners, work in the slums, or *bastis*, and coordinate with community members to identify women and children who require assistance. They conduct group meetings and local events to engage other family members.

Using women from the community as its field-level workers provides sustainability for SNEHA's programs, because it ensures local people are vested and become agents of change themselves. The approach fosters a strong personal connection between the SNEHA *sakhis* and the households in the communities where they operate.

Najma, a 25-year-old mother of three children, whose two-year-old daughter was suffering from severe malnourishment, said she and others feel a natural affinity for the *sakhis*. "I have learned lots of things about tackling malnutrition, such

Pregnant women are counseled at home by SNEHA volunteers.

as boiling water before drinking, and cooking healthier meals," she added. "I have also taught my neighbors some of the things I have learned. It is because of SNEHA that our daughter has been saved as she has gained weight and is no longer malnourished. We are forever grateful to SNEHA."

As word of SNEHA spread, field-level workers began to be approached by women in the community with a multitude of problems. "I once had a mother crying to me because her husband wasn't ready to take her child to the hospital even though she was ill," a SNEHA volunteer recalled. "I had to step in and convince him that his child required medical attention in the hospital. It was in the best interest of the child, and I was happy I was able to influence her parents to take the right decision."

Over time, SNEHA leaders developed an integrated service strategy aimed at helping women across stages in the life cycle. "The more we did work in the community, the more we learned. It was only through our programs that we understood how to work in the community and have realized that an integrated approach is really what is needed," said Dr. Fernandez of SNEHA's current program strategy, which can be classified under four parts: maternal and newborn health, child health and nutrition, prevention of violence against women and children, and sexual and reproductive health.

GOVERNMENT PARTNERS

The public health-care sector that Dr. Fernandez came from — "worlds apart," in her words, from the vision she saw at SNEHA's founding — became a core part of SNEHA's work. Early on, its leaders came to see the necessity and value of working in collaboration with the government, rather than trying to set up parallel approaches. Only the government, with its unequalled resources, infrastructure, and systems, has the means to affect large-scale change. Dr. Fernandez and Dr. Shanti, veterans of the public hospital system, were well aware of how difficult it can be for NGOs to navigate India's bureaucracies and overcome resistance to change, but they believed it was strategically important for SNEHA's growth and impact to commit to the work it was doing with government.

They were soon given the opportunity to test this commitment with the launch of the City Initiative for Newborn Health (CINH), its first formally funded major project. The CINH program was formed in collaboration with the Municipal Corporation of Greater Mumbai (MCGM), the public authority that governs the Mumbai metropolis and its neighboring suburban areas.

One of the characteristics of Mumbai's public health system was the stratification of hospital health services, where each layer was set up to provide a certain type of care. The problem, however, was that these institutions operated nearly independent of each other, with little coordination, which led to inequitable and ad hoc distribution of patients, and even worse, patients being made to go to one hospital to another with little logic or concern.

SNEHA responded to these issues with the CINH program to reduce maternal and neonatal mortality in eight Mumbai wards (administrative sub units), assisting about 283,000 people by formalizing coordination between levels of hospitals and clinics, a mammoth task. Any solution to the problem would require creating an atmosphere of cooperation among administrators and clinicians, despite there being no natural incentive for them to do so. Dr. Fernandez and Dr. Shanti fully expected that it would take much effort to achieve coordination through formal links, and they saw their roles as those of facilitator and moderator. At the first meeting of all those involved, they began by praising government officials for their accomplishments. They acknowledged the difficulties government workers faced in their jobs, the constraints they faced, and their desire to make a positive difference in their communities.

This simple act of appreciation, coupled with SNEHA's understanding of shortcomings in the system, demonstrated to governmental officials that SNEHA was a cooperative rather than critical partner and that it was interested in solutions rather than finger-pointing. "Having worked in the

public sector, we understood the system's strengths and weaknesses very well," Dr. Shanti said. "We knew that if we could work through their strengths to address their weaknesses, we could add value or cement gaps. As facilitators of the CINH meetings, we ensured that all the officials present in the room found a voice, irrespective of their level. We used a totally participatory process which made everyone feel good and important."

The approach worked, and it paved the way for the country's largest urban health initiative for maternal and newborn health, the CINH program. The acceptance that SNEHA had gained allowed it to advocate for change and win government support to reform the delivery of health care. It worked with stakeholders to set down standardized clinical protocols and minimum benchmarks for every level of health care. Lines of communication were established between government hospitals, and norms were set for the transfer of patient cases between health providers, along with a system to track patient progress across institutions.

Today, most of SNEHA's programs involve some level of contact with local government agencies, either through delivery of services or advocacy. As of 2015, SNEHA had directly trained more than 3,000 public health-care providers for improved medical care; 2,900 government outreach workers for effective maternal and neonatal care; and 4,500 police officers, cadets, and 2,100 public hospital staff for dealing with cases of violence and abuse.

DATA-DRIVEN SERVICE

Dr. Shanti said the CINH program illustrated the value of quantitative data in helping achieve program success. "Government doctors were used to getting only qualitative feedback, which meant that if a doctor serviced 300 patients in the month, it was statistically likely that at least a few patients were dissatisfied, and hence doctors ignored this [type of] feedback," she added. "On the contrary, if you told the doctor that a bed's capacity was 600 deliveries and only 300 were conducted, this was a far better means of judging performance."

As SNEHA grew into a major social-service organization, data collection for monitoring and evaluation became an essential component of its day-to-day operations. As a researcher and author, in addition to pediatrician and teacher of young doctors at Sion Hospital, Dr. Fernandez understood the value of putting data collection and analysis at the core of SNEHA's program designs and operations.

In 2003, SNEHA got an opportunity to build up its research capabilities when ICICI Bank, one of its funders, brokered a partnership with University College London (UCL) to assist SNEHA with its research and evaluation studies. David Osrin, a professor at the Institute of Global Health at UCL, moved to Mumbai to work with SNEHA. "I was very impressed with SNEHA when I first started working in the early 2000s," he said. "I felt it is a very ambitious NGO, and unlike some other organizations with which some of my colleagues collaborate, it existed in itself and was very boldly driven. The charisma of its leader, second-in-line management comprising resilient and articulate women who are the directors, and a 'can-do' attitude have to be the strongest things about this NGO. SNEHA has proven to be a very good partner for UCL."

Over the years, Professor Osrin has come to serve as SNEHA's in-house expert on integrating research with best practices in its programs. In 2011, just before SNEHA undertook a large three-year randomized control trial under the stewardship of UCL, it began collecting data electronically, which led to more data in less time. Soon, for example, SNEHA was collecting data in the field, with its *sakhis*, who used mobile phones and data-collection software to collect information from individual beneficiaries to assess program impact and tailor delivery.

In 2013, SNEHA used data from the field to support a decision to shut down its daycare centers in Dharavi that were being used to service malnourished children. Each daycare center was equipped to serve 20 severely malnourished children through intensive care and additional nutrient supplements

for tackling malnutrition. However, on monitoring the output of each daycare center, SNEHA found that most of the children attending the center were not severely malnourished, that attendance was poor, and that malnutrition-reduction targets were not being met. The SNEHA program and management team soon realized that the cost of running the centers did not justify reaching a small handful of malnourished children, and then made the decision to close down the centers. Instead, SNEHA began to focus its efforts and resources on undertaking greater community-based management techniques for malnutrition, such as conducting home visits and community-awareness events.

SNEHA's data collection and analysis are also used to provide government rationales for action. For example, when SNEHA analyzed government data to tailor its CINH program, it found that the number of available patient beds at one hospital was far less than the number of patients treated, while the situation was reversed at another location. This led to an analysis of staffing capacities for hospitals in which gaps in the system were identified and addressed. In 2012, SNEHA also hired a full-time research director and began strengthening its efforts to use research for greater advocacy efforts with the government and to share it through publications and at international forums.

INSTITUTIONAL CHANGE

By 2010, SNEHA had come a long way from the day Dr. Fernandez went with the widow of Neville Soans to a government office and began processing the paperwork required to register SNEHA as a NGO — the day when, as Dr. Fernandez puts it, all SNEHA had was "an idea and some money." It had evolved from a small group of doctors and social workers to an organization with more than 100 employees and a budget of more than US$400,000. Its nearly 50,000 beneficiaries were served by health workers, psychologists, and anthropologists in addition to doctors and social workers. In a reflection of the independence with which they operated, it had created program teams called "islands of excellence." It also had a knowledge base it was ready to leverage

In the wake of such growth, Dr. Fernandez recognized the importance of developing a stronger management team to coordinate staff and programs. Dr. Fernandez, a doctor by training and a social worker at heart, doubted she was the one to provide stronger management and that her skills in that area might become a strategic weakness for her organization.

She decided to beef up the institutional management team by appointing Dr. Wasundhara Joshi, a lecturer, researcher, and member of SNEHA's board, as chief executive officer. For a short period, it appeared Dr. Fernandez had managed to navigate her way out of a tricky situation. But Dr. Joshi, looking to resume her research career, stepped down, leaving SNEHA back where it had started. Around the same time, a personal tragedy in Dr. Fernandez' life left her further unable to provide SNEHA with strong leadership. The attrition and vacuum at the highest level generated an air of negativity that filtered down SNEHA's hierarchy, with program directors feeling unsure of the organization and their own futures.

SNEHA had reached a watershed moment. Without the critical guidance and direction needed to manage its many moving parts, SNEHA's ability to deliver effective programs seemed at risk and any future growth seemed like a stretch. A large foundation based in the United Kingdom, Maitri Trust, which had been supporting SNEHA for some time, put pressure on Dr. Fernandez and its board by making its next grant provisional on the recruitment of a full-time CEO. "There was no question about the excellent work SNEHA was doing, but the presence of a strong CEO to manage the institution at that juncture was wholly in SNEHA's best interest and critical for ensuring its continued success," said Jo Davis, CEO of Maitri Trust. "As SNEHA's partners, we wanted to see it grow and succeed."

Dr. Fernandez, who had so successfully hired almost all of SNEHA's core staff after simple

five-minute conversations, now hired professional head hunters and interviewed more than 18 candidates without finding someone suitable. While the search unfolded, a former banker looking for a fresh challenge in her career began volunteering at SNEHA. She took time out to learn about the programs to create and deliver pitch presentations to funders and other stakeholders. It was during one of these that Dr. Fernandez realized that SNEHA might have found its new CEO — Vanessa D'Souza, formerly a director at Citibank. D'Souza thought she did not know enough about the social sector and declined the offer; however, Dr. Fernandez gradually persuaded her that she was indeed the perfect fit for SNEHA. With that, SNEHA got its first full-time CEO who did not have any medical or public health background.

D'Souza understood that for her to live up to the expectations that rested on her appointment, she would have to gain the confidence and trust of her employees. She attended department-level meetings to learn about core operations and discovered that some staff members were overly cautious about sharing information that might be considered negative, even if it would help the organization. She sought to change this culture by creating a process to ensure information-sharing and feedback. She also began reorganizing SNEHA's internal structure to try to ensure a common sense of vision and mission. She developed a second line of programmatic leadership with assistant director appointments. These enabled the program directors to focus on program development and strategy rather than day-to-day operations.

D'Souza viewed SNEHA's board of directors as a strategic tool worth putting to work. The board contained expertise and experience that she drew upon to strengthen SNEHA's internal processes. She formed subcommittees for departments such as finance and human resources so that board members with relevant knowledge could begin to help in ways they had not before.

For example, SNEHA's troubles raising funds for its domestic violence campaign puzzled board

A community volunteer leaves SNEHA office to conduct her rounds.

SNEHA conducts monthly weight checks for children to detect signs of malnutrition.

member Luis Miranda, a banker and entrepreneur. "I wondered how it was possible that we [SNEHA] were having difficulties raising money for a 'Violence Against Women' program with the national mood being what it was," Miranda recalled. In India at that time, there were large demonstrations protesting government apathy in the aftermath of a brutal act of sexual violence against a woman in New Delhi. "I took their proposal, cut out all technicalities and made a simple one-page document with all the positive outcomes which could be affected," Miranda said. "By noon we had the funding we needed." Miranda said SNEHA's approaches were sometimes too ponderous for laymen outside the social-service world. "The lesson was to keep the message simple."

From the day she started volunteering, D'Souza understood SNEHA's culture and how it was critical to the work it did and that it might be necessary to let go of employees who seemed out of step with that culture. She implemented her reforms with the support of Dr. Fernandez and other board members. "The trustees have been very supportive by giving me a free hand, and at the same time helping me out when I have reached out for assistance," she said. "I don't get interference on the small issues, so we can devote time to really discuss the bigger strategic issues."

D'Souza sees SNEHA's future in ways different from social-sector leaders focused on continuous expansion. She believes it is more important for SNEHA to continue developing program models that have proven effective, rather than growing its programs exponentially, and perhaps spreading itself too thin. The rationale is that it might be more valuable for Indian society for SNEHA to create and fine-tune programs that can be replicated by either the government or other nonprofits, rather than become a larger organization. In an ideal world, if SNEHA's programs were successfully replicated, its field-level services would no longer be needed.

LESSONS AND CHALLENGES

From 1999 to 2015, SNEHA evolved from a five-member team working on an ad hoc basis and driven by the simple desire to help the poor, to a 360-person institution with focused and integrated programs to nurture the physical and emotional health of its clients. The development of community-rooted programs with demonstrable impact was a key reason for its success. The approach was simple and two-pronged: spread information about healthy habits and provide the resources to develop them.

A second reason for SNEHA's success was the decision to collaborate with government to utilize and coordinate public health systems and maximize resources. The government experience of its leaders enabled it to establish government relationships that might have been more difficult for organizations too prone to accept ideas about how government red tape can stand in the way of progress. The bottom line is not red tape, but what is possible. Through its City Initiative for Newborn Health (CINH) program, SNEHA worked successfully with government to improve the level of care in Mumbai's hospitals.

SNEHA's adoption of a data-driven approach for monitoring and evaluating impact was not new in the maturing social sector, but it does illustrate how it helped use information from its community-rooted programs to adapt and improve service delivery and program outcomes. "We never collect data to merely admire the problem," said Dr. Shanti, speaking of SNEHA's decision to shut down its daycare centers when it appeared statistically that they were no longer an efficient use of its resources and decided instead to focus its efforts on greater community outreach.

The decision by one of SNEHA's funders to tie further funding to improvement of SNEHA's management is a lesson of a different sort — organizations, in order to meet donor expectations, have to listen to what donors have to say. In SNEHA's case, it led to a new management that brought new ideas and enabled it to strengthen and focus its programs, partly by using the expertise of its board members.

The commitment and passion of a founder such as Dr. Fernandez — who had the same qualities she looked for in others as SNEHA was getting off the ground — is often at the root of an organization's success. The necessity of creating a succession plan as organizations grow is also common to successful organizations, and it proved important when Vanessa D'Souza took over the leadership job at SNEHA and Dr. Fernandez moved to the board of directors. Changes in leadership bring in new vantage points, such as the one SNEHA is now considering: positioning itself as more of a capacity builder for other nonprofits and government, in order to spread the expertise and knowledge that its original leaders began developing in 1999.

To make this shift, to make its expertise and knowledge as important if not more so than its program delivery, SNEHA will have to continue developing its models through even more emphasis on research and data analysis. It also will have to strengthen program teams with the capabilities to train other partner nonprofit organizations working in different communities in different contexts.

Children's shoes pile up outside a room where children are weighed each month.

To grow its influence beyond the state of Maharashtra, SNEHA will need to share its findings and experiences in popular and academic media so that it can affect social-sector advocacy at the national level. One step toward this came in 2015, when SNEHA began piloting its first hands-on partnership with a community-based organization looking to address the issue of domestic violence in the Indian state of Jharkhand.

As with most change, SNEHA will have to make a case that change is necessary. Dr. Fernandez sums up that challenge through the lens of her personal experience: "I have become wiser after working in this [social] sector for so long. I realize that you can't look at those you want to help in isolation. Our approach needs to be wider, consolidating on what we do well and working with people on things that they do better. We need to keep learning, keep documenting what we see, look back, reflect and then look forward."

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QUANTITATIVE INDICATORS

Financial

Planned budget or income versus actual expenditure for the fiscal year (2014-15)*	Income: INR135.32 million (US$2.15 million) Expenditure: INR121.29 million (US$1.93 million)
Income composition by source: individuals, corporations, events, trusts, other (please specify) (2014-15)	Institutions: 87% (includes foreign foundations, research organisations, NGO's, multilateral agencies) Corporations: 12% Individuals: 1%
Income composition: domestic versus international	Domestic: 44% International: 56%

Personnel

Staff retention rate	82.55% staff retained (Dec. 2014-Nov. 2015)
Turnover rate	17.45% staff left (Dec. 2014-Nov 2015)
What is the board composition?	Medical and Health Sector: 4 Private/ Corporate Sector: 4 Social Worker: 1
How many meetings does the board hold per year?	4
How many staff members are there?	388 (as of Nov. 30, 2015)
How many staff members have attended some non-profit or management training course?	5

Quantitative Indicators Continued

Organizational

Do you publish an annual report?	Yes
How many sites/locations do you currently operate in?	9 municipalities, including 6 in Mumbai and 3 in neighboring municipalities.
Do you measure results?	Yes. Project results measured include: • Proportion of infants under 6 months who are exclusively breastfed • Proportion of infants who start receiving complementary food at 6 months • Proportion of infants who continue to be breastfed up to 15 months • Proportion of under-6 children consuming meals at appropriate frequency • Proportion of under-6 children consuming meals with minimum nutritional diversity • Proportion of children born in the last 2 years who availed of ICDS services (services provided by the national child development scheme) • Proportion of home deliveries for births in previous year • Proportion of engaged youth/adolescents demonstrating sound knowledge of general, sexual, and reproductive health • Proportion of engaged youth/adolescents demonstrating improved attitude towards gender equality • Contraceptive prevalence rate • Number of change agents identifying and encouraging reporting of violence against women and children
What types of outreach?	Printed materials, community-based events, community campaigns, door-to-door visits, community group meetings
Do you regularly meet with government representatives?	Yes
If yes, on a scale of 1-3 how close is the relationship with government? 1 = not close; 2 = somewhat close; 3 = very close	Closeness of relationship = 3

* Exchange rate, INR63 = US$1