Ashish Gram Rachna Trust (AGRT)

Institute of Health Management, Pachod, (IHMP)

Annual Report

2013 - 2014

IHMP

Ashish Gram Rachna Trust (AGRT)/
Institute of Health Management, Pachod, (IHMP)

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About Ashish Gram Rachna Trust, Pachod

Ashish Gram Rachna Trust, Institute of Health Management, Pachod (AGRT/IHMP) undertakes programmes with the aim of innovating concepts, strategies and methodologies for implementing health and development programmes in rural areas and urban slums. AGRT/IHMP has been working in the underdeveloped Marathwada region of Maharashtra for the past 35 years. During this period, it has implemented innovations in the field of community health, Behavior Change Communication (BCC), water and sanitation, child development and nutrition, empowerment of adolescent girls and women. These innovations have provided policy options at the state and national levels. AGRT/IHMP's innovations are disseminated to the NGO sector through training programmes and to the government sector through policy analysis, research and advocacy.

Mission and Goal

AGRT/IHMP strives for the health and development of communities through implementation of innovations, training, research and policy advocacy. The Institute aims at the holistic development of the individual, family and community and is deeply committed to the development of marginalised groups. Within the broad mandate of reaching the most disadvantaged groups, it is committed to the health and development of women, adolescent girls and children. AGRT/IHMP's basic commitment has been to reduce gender inequities intrinsic in Indian society.

The Institute implements its programmes by mobilising communities toward self-reliance and sustainability. Organising and mobilizing children and adolescents to achieve a sustainable, inter-generational change is a part of this mandate, which has been operationalised as health and development programmes for children, implemented through them.

AGRT/IHMP is an integral part of the larger NGO sector. AGRT/IHMP has provided training to several thousand NGOs. It aims to strengthen this sector through training, resource material and linkages with other NGOs. Over the years, AGRT/IHMP has successfully collaborated with NGOs having expertise in development of training curricula, non-formal education, drinking water supply, agricultural development, vocational training, etc.

Relationship between AGRT and IHMP

Ashish Gram Rachna Trust (AGRT) is a Public Trust, registered under the Bombay Public Trust Act, 1950. In order to implement its programmes of health and development in rural areas and urban slums, AGRT has established the Institute of Health Management, Pachod (IHMP). All programmes and activities of AGRT are implemented through this executive body.

AGRT/IHMP headquarters are located in Pachod, District Aurangabad. Facilities consist of two conference halls, hostel for 32 trainees, mess, residential facilities for external faculty, computer laboratory, library, documentation centre with photocopying facilities & audio - visual library. The Pune centre constitutes the AGRT/IHMP's urban branch.

Organizational Profile:	
Legal Status	Registered Trust
Registration No.	E-249 (Aurangabad)
Income Tax Registration No. (Under Section 12A)	No. Nsk/Tech/12A (a)/79-80-81/4854
Income Tax Exemption (Under Section 80G)	ABD/CIT/TECH/80G/AGRT//144/38/2008-2009
FCRA Registration No.	083750005
Permanent Account No.	AAATA 3276G
Registered Office Address	Ashish Gram Rachna Trust Institute of Health Management, Pachod P.O. Pachod – 431 121 Tal. Paithan, Dist. Aurangabad, Maharashtra
Head Office Address	Ashish Gram Rachna Trust Institute of Health Management, Pachod P.O. Pachod – 431 121 Tal. Paithan, Dist. Aurangabad Maharashtra
Auditors	M/s R. S. Lotke & Co. Chartered Accountants 17 Shaktinagar, Aurangabad Maharashtra
Bankers	Bank of Maharashtra, Pachod Branch P.O. Pachod – 431 121 Tal. Paithan Dist. Aurangabad

Key programmes implemented by AGRT/IHMP
(Starting with most recent)

1 Integrated project for adolescent health and development
2 Innovations in NRHM with a focus on MCH
3 Reproductive and child health – in rural and urban slums settings
4 Mainstreaming HIV AIDS into RCH
5 Capacity building of NGOs working in urban slum setting
6 Capacity building of NGOs working in rural setting
7 Research in community health with a focus on maternal and neonatal health
8 Scaling up maternal and neonatal health with a focus on married adolescent girls
9 Maternal and neonatal health with a focus on married adolescent girls
10 Life Skills education for unmarried adolescent girls

11 Relief and disaster management following Latur earthquake in 11 villages
12 Complete reconstruction of one village following Latur earthquake
13 Behaviour change communication
14 Child centered development through Bal Panchayats
15 Safe drinking water and sanitation – Beed and Aurangabad District
16 Prevention of Malnutrition in children below 5 years
17 Maternal and neonatal health care through Traditional Birth Attendants

Training Institute

The training Institute was established in 1986. The Institute offers training to other NGOs in the following areas:

- Community needs assessment / Community diagnosis, high risk assessment
- Basic epidemiology for field managers and coordinators
- Basic biostatistics for field managers and coordinators
- Participatory planning and management of health and development programmes
- Decentralized micro-planning
- District level management of health services
- Effective supervision of health and development programmes
- Community based management information systems
- Behaviour change communication
- Reproductive and sexual health
- Health and development of adolescent girls

Projects implemented during the period 1st April 2013 to 31st March 2014

1. **Integrated Project for the Reproductive /Sexual Health and Development of Unmarried Adolescent Girls, Married Adolescent Girls and their Spouses**

2. **Primary Health Care in a Rural Setting**

3. **Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city**

4. **Project for Strengthening a Primary Urban Health Centre of Pune Municipal Corporation (PMC) with special emphasis on Non Communicable Diseases**

5. **Research Studies Undertaken by AGRT/IHMP**

1. Integrated project for reproductive /sexual health and development of unmarried adolescent girls, married adolescent girls and spouses

Introduction:

Institute of Health Management, Pachod, Ashish Gram Rachna Trust initiated an "Integrated Project for the Reproductive and Sexual Health and Development of Unmarried Adolescent Girls, Married Adolescent Girls and their Spouses", in the villages under Adul Primary Health Center (new project area) from January 2013. This project was a continuation of a previous project and was initiated through a no cost extension from the balance of the previous grant.

Modified social mapping of the villages, numbering of households, census and listing of the three target populations was initiated in January 2013. During the same period the staff undertook vigorous community mobilization. Meetings were held with members of Gram Panchayats, village heath and sanitation committees, parents of unmarried adolescent girls, husbands and in-laws if married adolescent girls and parents of young men. It took about six-months to complete these preparatory exercises. The report for the period January to March 2013 was submitted last year (Refer Annual report -2012-2013).

The integrated project has three components:

Part 1: Empowerment of unmarried adolescent girls through life skills education
Part 2: Attitudinal change in unmarried and young married men, thereby demonstrating a measurable change in the prevalence of sexual and domestic violence and gender inequitable behaviors
Part 3: Protection of young married women from the adverse consequences of early marriage and sexual and domestic violence.

Broad Objective
To develop, test and demonstrate an integrated model for a synergistic impact on empowering adolescent girls, to prevent discrimination against them, and to protect them from the adverse consequences of early motherhood, and sexual and domestic violence.

The annual activity report has three parts and describes various activities undertaken for the three components.

Part 1: Empowerment of unmarried adolescent girls through Life Skills Education

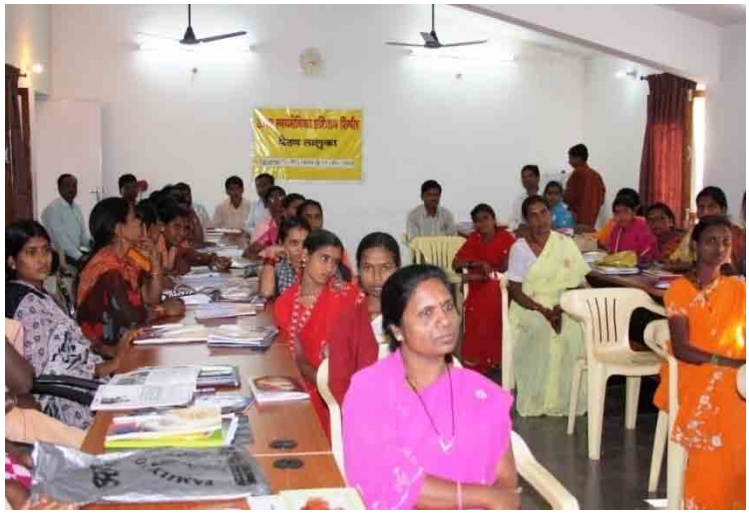
Activities undertaken during April 2013 to March 2014:

No. of villages covered = 17

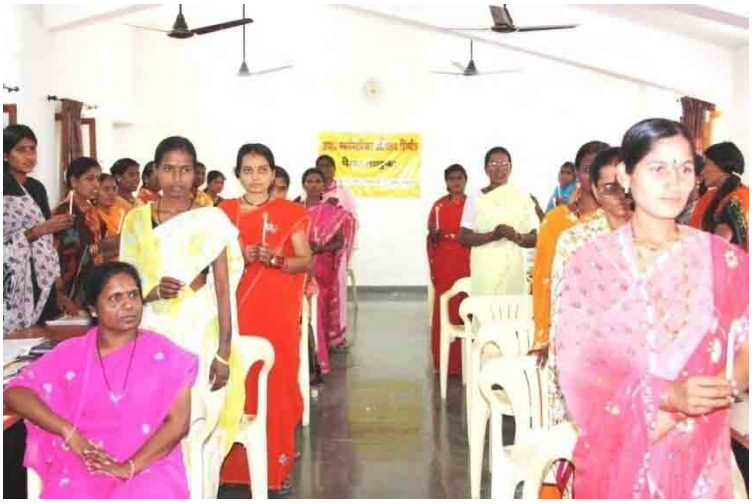
No. of ASHAs = 24

Capacity building: Three trainings were organized for ASHAs during the reporting period.

1. **Surveillance and BCC:**



2. Life Skills Education:



A total of 797 adolescent girls were enrolled for the first batch of ‘Life Skills’ education.

Meetings with the Parents:
In each ASHA's village/area of work, separate community level meetings were conducted for both fathers and mothers before starting the Life Skills education classes. On an average 14-15 parents attended each meeting. Pamphlets describing the course content were distributed in these meetings.

The purpose of the meetings was to explain to the parents about the contents of the course, its importance for their girls and to request them to enroll and send their daughters regularly for the Life Skills course.

Meetings with Mothers:
A total of 47 meetings with mothers of adolescent girls were organized in the month of March 2014 to inform and get permission from mothers to send their daughters for a 3-day residential workshop on "Know Your Body and Reproductive Health".

Supervision of LSE Classes:
Two Kishori Mandals were established in each ASHA area. Field coordinators visited each Kishori Mandal twice a month. During the field visits the coordinators observed sessions facilitated by the ASHA and gave their feedback. On an average 15 adolescent girls attended life skills education in each Kishori Mandal. They resolved issues related to the place and electricity for the classes. During the second supervision visit, they facilitated activities of the Kishori Mandal. Every month the coordinators visited the parents of adolescent girls to motivate them to send their daughters regularly for the classes.

Kishori Mandal 1: Average no. of girls present per session = 16

Kishori Mandal 2: Average no. of girls present per session = 15

Supervision of Kishori Mandal Activities:
It was planned with the Kishori Mandals that they would undertake activity to create awareness about importance of education. A script was written by the girls that was shared with all the Kishori Mandals. In the month of October 2013, each Kishori Mandal performed a street play in their village. Girls took out a rally in the village prior to the street play. The main message disseminated through the street play was importance of education especially for girls. In all the villages, girls got a very positive response from their parents and other stake holders.

Kishori Mandals with the help of ASHAs arranged for a visit to the police station, post office and bank. Girls had to contribute towards their bus fare to come to Pachod, since the police station is at Pachod. Kishori Mandal from one of the villages used money they had received as a prize when they performed the street play for coming to Pachod.

Training of Peer Leaders:
A three-day training of Peer Leaders was organized during the period October and November 2013. A total of 83 peer leaders and 23 ASHAs attended the training. Resource persons from 'Sahaj', Vadodara facilitated the training. Focus of the training was on how Kishori Mandals can function as a group, what is leadership, qualities of a peer leader, what they can do for other adolescent girls in their village, etc. Many participatory exercises were used and films were shown. After the training, peer leaders have started keeping reports of the sessions facilitated by ASHAs and activities of the Kishori Mandal.

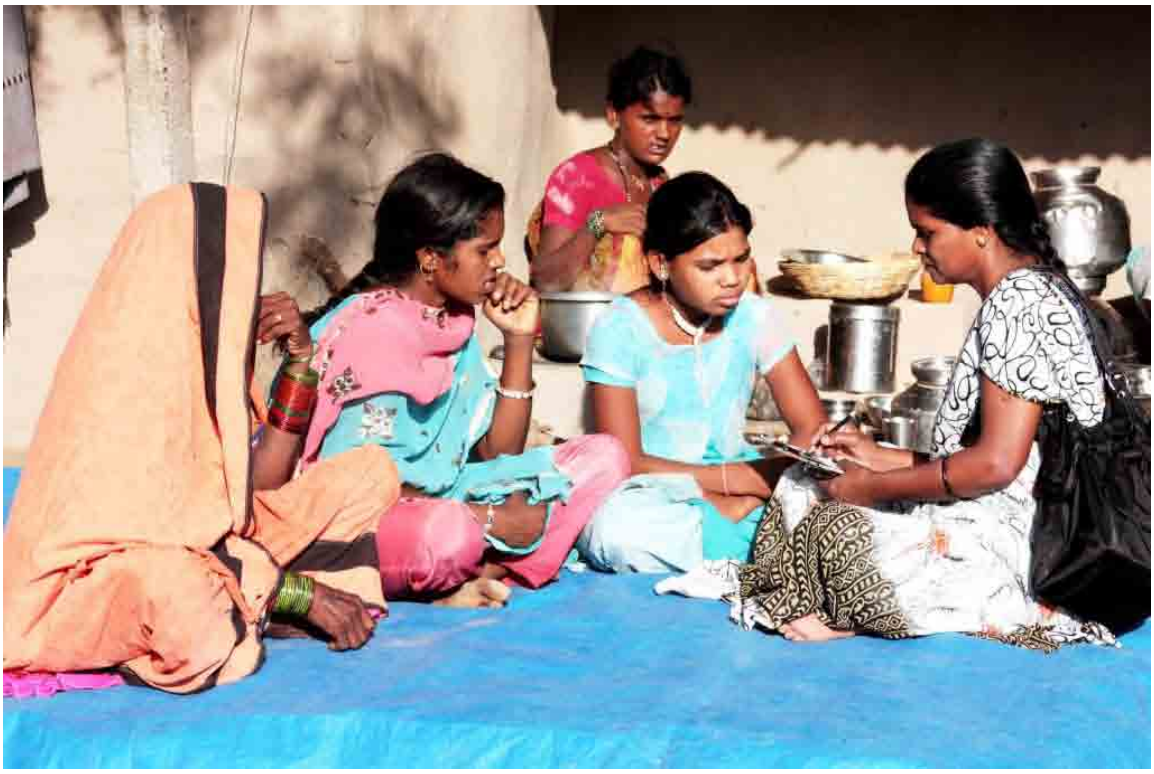
Kitchen Garden:
It was proposed that one of the activities undertaken by Kishori Mandals will be to develop kitchen gardens using waste water and to undertake nutrition education, recipe demonstration, etc. to prevent nutritional anemia in girls. It was envisaged that through a girl an entire family can be involved into developing a kitchen garden. It was also assumed that increased availability of vegetables will result in increased consumption of vegetables by the entire family.

Kitchen garden training was organized with the assistance of resource persons from AFARM, Pune in four different locations in the month of November 2013. A total of 81 adolescent girls and 21 ASHAs participated in the training. These girls and ASHAs were given a packet with the seeds of 12 different vegetables.

Research:

Baseline information was collected in the villages of intervention PHC (Adul PHC) and control PHC (Sukhapuri PHC). Information was collected from 321 adolescent girls in the intervention area and 330 adolescent girls from the control area. A semi - structured questionnaire was used for collecting information on cognitive and practical skills. At the same time, information was also collected using the scale developed by the IHMP for measuring self-esteem and self-efficacy. Analysis of the baseline data and first draft of the baseline report is complete.

In the month of December 2013, a consultant, child psychologist was invited, who conducted interviews of girls with low score and their families to study factors contributing to low self-esteem and self-efficacy. The consultant also will be helping IHMP to develop a manual for girls with low self-esteem and self-efficacy.



After the enrollment of adolescent girls for the Life Skills education, pre-test for the sessions covered in the first three months was conducted for 793 adolescent girls. Information on self-esteem and self-efficacy was also collected from these girls using scale developed by the IHMP.

A post-test was conducted for 764 girls after completing first three-month's sessions and at the same time pre-test for the next three-month's session was conducted. Analysis of pre and post-test data is yet to be completed.

Part 2: Attitudinal change in unmarried and young married men thereby demonstrating a measurable change in the prevalence of domestic violence and gender inequitable behaviors.

Activities undertaken during April 2013 to March 2014:

Development of Tool to Measure General and Sexual Self-esteem and Self-efficacy in Youth:

Pre-testing of the tool to measure general and sexual self-esteem and self-efficacy was done with 9 youths from the older project villages at Pachod. They were asked to give feedback through a specially designed instrument. We also needed to find out the local lexicon for designing the questionnaire and how much time it takes to complete the questionnaire. After necessary modifications of the questionnaire, the instrument was once again pre-tested with 20 youth. Based on the feed-back received the final tool is being finalized.

Planning for the Youth Component:

In September 2013, one day meeting of the senior staff was organized to finalize the interventions and strategy for the youth component. It was decided to put in place six interventions.

1. BCC Group Meeting: Organize monthly BCC group meetings at the village level.

2. Pocket Diary: Prepare a pocket diary on Reproductive and Sexual Health problems and doubts of the youth. After the BCC group meetings, distribute diaries to the youth.

3. Ballot Box: A ballot box is kept at the time of BCC group meeting. Youth are asked to write their questions or doubts on paper and then put these in the ballot box. These questions are answered in the next meeting after consulting a consultant.

4. Newsletter: A newsletter will be prepared and distributed in the villages. It will have answers to frequently asked questions.

5. Individual Counseling: If any youth after the BCC group meeting approaches the facilitators for any sensitive issue, he is given individual counseling.

6. Counseling for the Family: In certain cases parents and other family members will have to be counseled with the youth. In these cases, household of the youth are visited for counseling after the BCC group meeting.

Preparation of the sessions for BCC group meetings: Sessions on the following 11 topics for the BCC group meetings have been prepared. Each session describes steps of conducting the session in a participatory manner.

List of topics:

1. What is the appropriate age at marriage and first conception and why?
2. Domestic violence
3. De-addiction
4. Premarital sex - counseling on myths and misconceptions.
5. How does conception take place?
6. HIV/AIDS
7. Male reproductive system
8. RTIs and STIs
9. Gender discrimination
10. Anemia – What is anemia? Cause, treatment and prevention
11. What is family planning and different methods of family planning

First draft of the diary for the youth has been prepared.

Meetings have been held in each village to motivate youth to volunteer for peer led education of sex and sexuality. The selection of peer volunteers in going on.

Part 3: Protection of young married women from the adverse consequences of early marriage

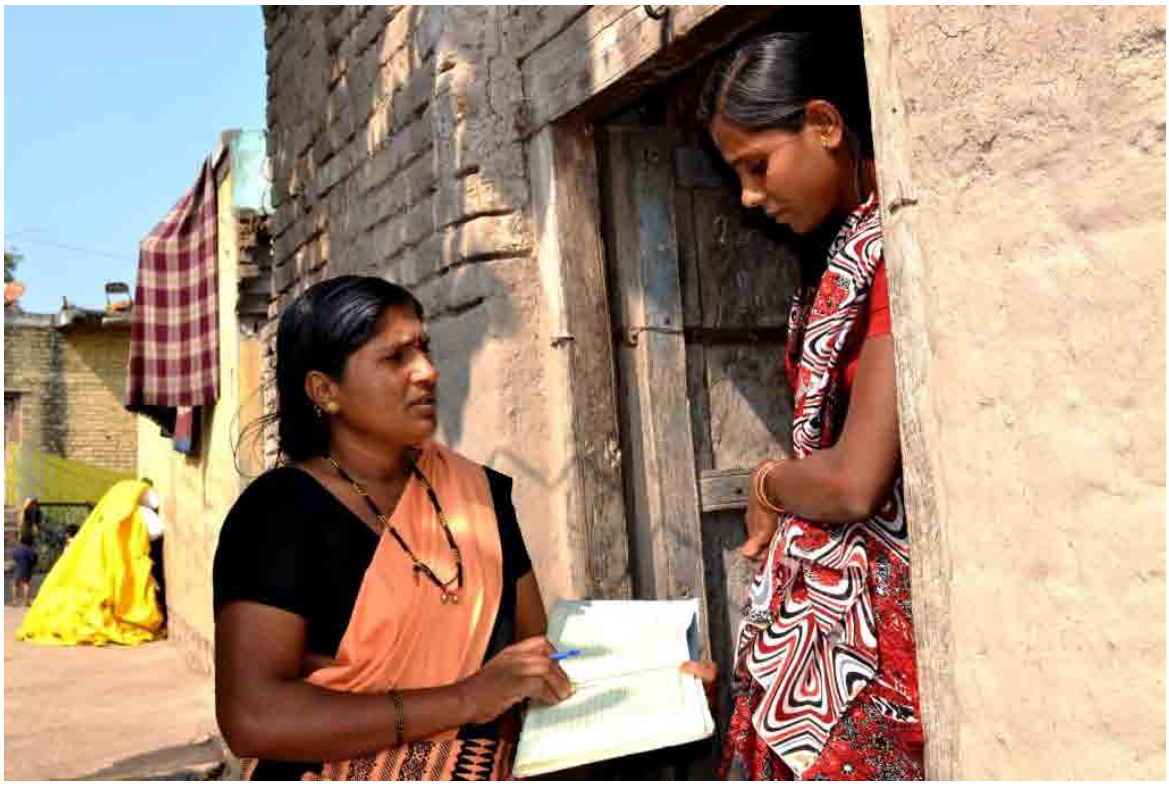
Activities undertaken during April 2013 to March 2014:

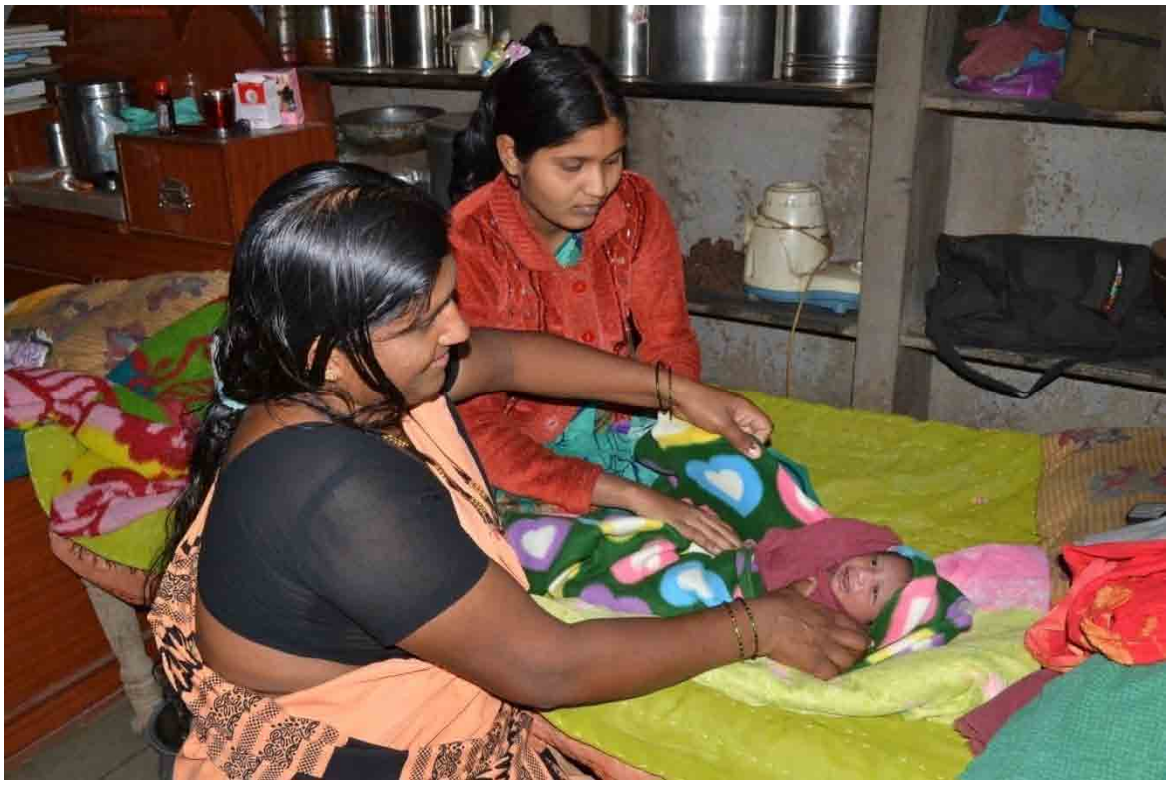
Community Based Monitoring:

During the reporting period, on an average 14 Village Health Nutrition Water Supply & Sanitation Committee (VHSC) meetings were conducted every month and on an average 66 members (60.0%) attended the meetings at the village level. Out of these 25 were male and 41 were female members. Every month, committee reviewed health needs assessed by ASHA & services provided by the ANM. After which only committee certified work done by the ASHA.

Surveillance Coverage:

Surveillance data indicates that, during the reporting period on an average of 87.6 percent of MAGs were visited during the surveillance visit every month by ASHA.





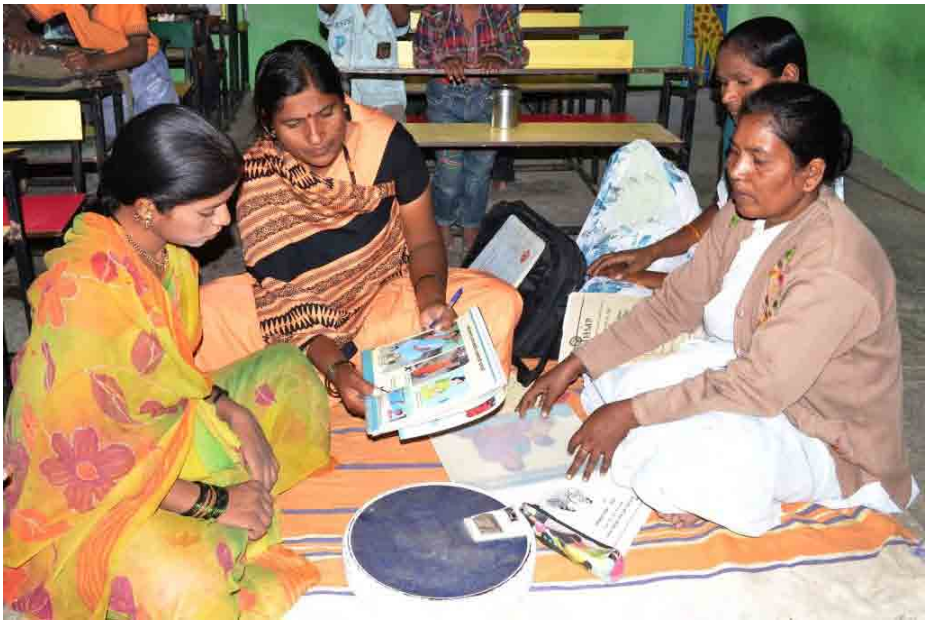
BCC Group Meetings with Married Adolescent Girls:

Three project ANMs conducted BCC group meetings with Married Adolescent Girls every month at the village level. The topics of BCC group meetings were decided and finalized in consultation with the community women. The project area was divided into 43 smaller geographical units. There was a fixed schedule for covering 43 units once a month for BCC group meetings.

Table 3: BCC Group Meetings with Married Adolescent Girls:

Month	Group meetings			Attendance in the meetings		
	Expected	Held	%	Expected	Attended	%
June 2013	43	36	84	540	229	42.4
July 2013	43	43	100	645	270	41.9
Aug. 2013	43	43	100	645	231	35.8
Sept. 2013	43	42	98	630	304	48.3
Oct. 2013	43	43	100	645	330	51.2
Nov. 2013	43	43	100	645	304	47.1
Dec. 2013	43	43	100	645	343	53.2
Jan. 2014	43	43	100	645	332	51.5
February 2014	43	43	100	645	332	51.5
March 2014	43	43	100	645	345	53.9
Average	**43**	**42**	**98**	**633**	**302**	**47.7**

Table 3 indicates that during the reporting period on an average 42 meetings were conducted every month. On an average 48 percent of the expected number of Married Adolescent Girls attended BCC group meeting at the village level every month.



Following subjects were discussed in the BCC group meetings:

- Consequences of early marriage and first conception
- Temporary family planning methods
- Antenatal care and services
- Danger signs in pregnancy and importance of HIV testing in pregnancy

- Birth preparedness, complications at the time of delivery and importance of hospital delivery
- Postnatal care
- Neonatal care
- Care of low birth weight baby and immunization
- Miscarriage and post miscarriage care

Table 4: Reported miscarriage rate among MAGs:

Month	No. of MAGs visited	No. of MAGs with pregnancy outcome	No. of MAGs who had miscarriages	Rate per 100 pregnancies
April 2013	386	06	0	00.0
May 2013	406	15	2	13.3
June 2013	431	10	2	20.0
July 2013	442	25	3	12.0
August 2013	363	22	3	13.6
September 2013	442	16	1	06.3
October 2013	455	15	1	06.7
November 2013	447	11	1	09.1
December 2013	441	20	0	00.0
January 2014	449	14	1	07.1
February 2014	398	10	1	10.0
March 2014	345	21	1	04.8
Total	**-**	**185**	**16**	**08.6**

Table 4 indicates that a total of 16 women reported miscarriage as the outcome of pregnancy i.e. miscarriage rate of 8.6.

Table 5: Reported post miscarriage complications

Month	No. of MAGs visited	No. of MAGs who had a miscarriage	No. of MAGs reported post miscarriage complications*	% of MAGs with post miscarriage complications*
April 2013	386	0	0	0.0
May 2013	406	2	0	0.0
June 2013	431	2	0	0.0
July 2013	442	3	0	0.0
August 2013	363	3	0	0.0
September 2013	442	1	0	0.0
October 2013	455	1	0	0.0
November 2013	447	1	0	0.0
December 2013	441	0	0	0.0
January 2014	449	1	0	0.0
February 2014	398	1	0	0.0
March 2014	345	1	0	0.0
Total	**-**	**16**	**0**	0.0

Table 5 indicates that there was not a single woman with post miscarriage complications. This indicates a sharp decline of post miscarriage complications from 68 percent at baseline to 0 percent.

Table 6: Reported Use of Temporary Family Planning Methods

Month	No. of MAGs visited	Currently non pregnant MAGs	MAGs using any FP method	% MAGs using any FP method
April 2013	386	285	39	13.7
May 2013	406	316	48	15.2
June 2013	431	328	51	15.5
July 2013	442	353	59	16.7
August 2013	363	290	55	19.0
September 2013	442	342	55	16.1
October 2013	455	351	65	18.5
November 2013	447	347	59	17.0
December 2013	441	324	68	21.0
January 2014	449	326	67	20.6
February 2014	398	256	59	23.0
March 2014	345	256	56	21.9
Average	**417**	**315**	**57**	**18.1**

Table 6 indicates that on an average there were 315 non pregnant MAGs every month. Out of these, on an average 57 couples used any one temporary family planning method. Prevalence of current use of any temporary family planning method was 18.1 percent. During the reporting period, four spouses of MAGs underwent vasectomy operation.

Table 7: Reported use of family planning methods by types:

Month	Currently non pregnant MAGs	MAGs using any FP methods	Number of MAGs currently using following type of Family Planning methods					
			Condom	%	Pills	%	Cu T	%
April 2013	285	39	27	09.4	10	3.5	02	0.2
May 2013	316	48	32	10.1	13	4.1	03	0.9
June 2013	328	51	33	10.1	14	4.3	04	1.2
July 2013	353	59	36	10.2	17	5.2	06	1.7
August 2013	290	55	36	12.4	15	4.7	04	1.4
September 2013	342	55	32	09.4	16	3.1	07	2.0
October 2013	351	65	44	12.5	11	2.0	10	2.8
November 2013	347	59	45	13.0	07	4.3	07	2.0
December 2013	324	68	44	13.6	14	6.1	10	3.1
January 2014	326	67	39	12.0	20	5.6	08	2.5
February 2014	256	59	35	13.7	15	4.3	09	2.5
March 2014	256	56	35	13.7	11	4.3	10	3.9
Average	**315**	**57**	**37**	**11.7**	**14**	**4.4**	**07**	**2.2**

Table 7 indicates that during the reporting period 11.7 percent spouses of MAGs used condoms, 4.4 percent MAGs used oral pills & 2.2 percent MAGs were using Copper T.

Table 8: Reported proportion of new born weighed at birth

Month	Number of MAGs visited	MAGS delivered live births*		No. of neonates weighed at birth	% neonates weighed at birth
		Maheri	Sasari		
April 2013	386	04	02	02	100
May 2013	406	08	05	05	100
June 2013	431	06	02	02	100
July 2013	442	16	06	06	100
August 2013	363	14	05	05	100
September 2013	442	13	02	02	100
October 2013	455	09	05	05	100
November 2013	447	06	04	04	100
December 2013	441	16	04	04	100
January 2014	449	11	3	03	100
February 2014	398	06	04	04	100
March 2014	345	17	05 (1 Twins)	5	100
Total	**-**	**126**	**47**	**47**	**100**

*MAGs delivered from area of 24 ASHAs in 17 villages

Table 8 indicates that 126 women delivered at their Natal homes and 47 delivered at in law's place. 100 percent new born babies delivered at in law's place were weighed at birth.

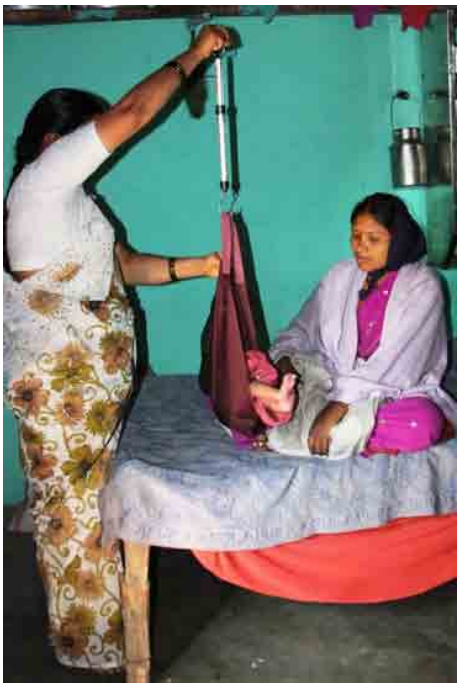


Table 9: Reported proportion of low birth weight babies

Month	No. of MAGs visited	No. of newborns weighed at birth	No. of newborns were LBW	Percent LBW newborns to MAGs
April 2013	386	02	00	00.0
May 2013	406	05	00	00.0
June 2013	431	02	00	00.0
July 2013	442	06	01	16.7
August 2013	363	05	02	40.0
September 2013	442	02	00	00.0
October 2013	455	05	00	00.0
November 2013	447	03	01	33.3
December 2013	441	04	00	00.0
January 2014	449	04	00	00.0
February 2014	398	04	01	25.0
March 2014	345	05	01	20.0
Total	**-**	**47**	**06**	**12.8**

Table 9 indicates that during the reporting period among the neonates that were weighed at birth, 12.8 percent were born with low birth weight.

Table 10: Detection of Reproductive Tract Infections:

Month	No. of MAGs visited	No. of MAGs with symptoms of RTIs	Percent MAGs with symptoms of RTIs
April 2013	392	23	06.0
May 2013	413	23	05.7
June 2013	438	30	07.0
July 2013	449	25	05.7
August 2013	369	21	05.8
September 2013	450	22	05.0
October 2013	463	16	03.5
November 2013	455	15	03.4
December 2013	448	12	02.7
January 2014	449	07	01.6
February 2014	398	14	03.5
March 2014	357	09	02.2
Average	**423**	**18**	**04.3**

Table 10 indicates that on an average 18 MAGs (4.3%) reported any one symptom of RTIs during surveillance every month.

Table 11: Reported treatment seeking for RTIs

Month	Number of MAGs visited	Number of MAGs with symptoms of RTIs	Number of MAGs sought treatment on RTIs	Percent MAGs sought treatment for RTIs
April 2013	392	23	15	65.2
May 2013	413	23	16	69.6
June 2013	438	30	25	83.3
July 2013	449	25	22	88.0
August 2013	369	21	19	90.5
September 2013	450	22	16	72.7
October 2013	463	16	13	81.3
November 2013	455	15	12	80.0
December 2013	448	12	09	75.0
January 2014	449	07	06	85.7
February 2014	398	14	06	42.9
March 2014	357	09	05	55.6
Average	**423**	**18**	**14**	**77.8**

Table 11 indicates that on an average 18 MAGs reported any one symptom of RTIs, out of these on an average 14 MAGs sought treatment for RTIs every month.

Table 12: Reported prevalence of post natal complications

Month	No. of MAGs visited	No. of post natal MAGs*	No. of MAGs reported post natal complications	% MAGs with post natal complications
April 2013	386	--	--	--
May 2013	406	--	--	--
June 2013	431	02	00	00.0
July 2013	442	05	00	00.0
August 2013	363	02	00	00.0
September 2013	442	06	01	16.0
October 2013	455	05	00	00.0
November 2013	447	02	00	00.0
December 2013	441	05	01	20.0
January 2014	449	06	01	16.7
February 2014	398	02	00	00.0
March 2014	345	02	00	00.0
Total	-	**37**	**3**	**08.1**

Table 12 indicates that 3 MAGs reported post natal complications out of a total of 37 post natal MAGs.

Table 13: Reported treatment seeking for post natal complications:

Month	No. of MAGs visited	No. of MAGs reported post natal complications	No. of MAGs sought treatment for post natal complications	% MAGs treated for post natal complications
April 2013	386	--	--	--
May 2013	406	--	--	--
June 2013	431	00	00	00.0
July 2013	442	00	00	00.0
August 2013	363	00	00	00.0
September 2013	442	01	00	00.0
October 2013	455	00	00	00.0
November 2013	447	00	00	00.0
December 2013	441	01	00	00.0
January 2014	449	01	00	00.0
February 2014	398	00	00	00.0
March 2014	345	00	00	00.0
Total	-	**03**	**00**	**00.0**

Table 13 indicates that none of the 3 mothers sought treatment for post natal complications.

Maternal Health Care:

ANMs from IHMP started conducting antenatal clinics in 30 villages of Adul PHC from April 2013. Antenatal clinic is conducted on the same day as the Village Health and Nutrition day. This section of the report is for the services provided by the ANMs. In addition to these MCH clinics, monthly RTI / STI clinics are also conducted for young women.

Table 14: New registration during April 2013 to March 2014:

Sr. No.	Month	MAGs		
		<12	>12	Total
1	April 2013	02	20	22
2	May 2013	20	63	83
3	June 2013	13	40	53
4	July 2013	09	26	35
5	Aug. 2013	07	04	11
6	Sept. 2013	29	14	43
7	Oct. 2013	23	13	36
8	Nov. 2013	11	11	22
9	Dec. 2013	25	20	45
10	Jan. 2014	25	11	36
11	Feb. 2014	15	07	22
12	March 2014	20	11	31
	Total	199	240	439

Table 14 indicates that during the reporting period, a total of 439 new pregnant women were registered, out of which 199 (45.3%) were registered <12 weeks of pregnancy and 240 (54.7%) were registered >12 weeks of pregnancy.

Table 15: Antenatal clinic:

Month	Expected clinic	Actual clinic	%	Expected no. of ANC to be examined	Actual no. of ANC examined	%
April 13	08	08	100.0	22	22	100.0
May 13	44	39	88.6	138	126	91.3
June 13	49	49	100.0	200	157	78.1
July 13	52	42	80.8	233	175	75.1
Aug 13	55	51	92.7	216	141	65.3
Sept 13	48	45	93.8	210	153	72.9
Oct 13	41	38	92.7	234	129	55.1
Nov 13	44	36	81.8	189	115	60.8
Dec 13	45	43	95.6	260	166	63.8
Jan.14	45	43	95.6	285	178	62.5
Feb.14	38	38	100.0	222	161	72.5
March 14	36	36	100.0	214	115	53.7
Average	**42**	**39**	**92.9**	**202**	**137**	**67.8**

Table 15 indicates that on average 39 antenatal clinics were conducted every month and 137 (67.8%) pregnant women were examined every month.

Table 16: Deliveries and Postnatal visits

Beneficiaries	Deliveries*			Abortions	PNC visit			
	Total	Maheri (natal home)	Sasari (In-laws home)		I st	IInd	III rd	Total
MAG	244	196	48	16	14	06	28	48

*Deliveries from 30 villages

Table 16 indicates that during the reporting period 244 women delivered and 16 abortions were recorded. Out of 48 women who delivered at in law's place, 14 mothers received one post natal visit, 06 mothers received two post natal visits, and 28 mothers received three or more post natal visits.

Table 17: Maternal health care services taken - April 2013 to March 2014

Beneficiaries	Total deliveries	Antenatal check up				T.T. injection			Place of delivery		Who conducted delivery		
		0	1	2	3+	0	1	2 and Boost	Hospital	Home	TD	Hospital	Other
MAG	244	01	0	84	159	01	05	238	237	07	00	237	07

Table 17 indicates that during the reporting period out of 244 women that delivered, 159 (65.2%) women were examined three or more times during pregnancy and 238 (97.5%) women received two T.T. injections or booster dose. Out of 244 women that delivered, 237 (97.1%) were delivered in a hospital.

Table 18: Outcome of delivery - April 2013 to March 2014

Beneficiaries	Total deliveries	Outcome of Delivery*		Weight*	
		Live birth	Still birth	Normal	Low birth
MAG	244	243	04	221	20

***Twins – 3** ***Weight not available - 2**

Table 18 indicates that there were 243 live births and 4 still births. Out of 241 new born babies weighed, 20 (8.3%) were low birth weight babies.

Three case studies given below demonstrate the role of VHNWSC in resolving problems at the community level, importance of identifying high risk pregnant women and early detection of RTIs through the monthly surveillance system.

Case Study: 1

Name of the village: Abdulapurwadi
Problem: Suitable place not available to conduct Life Skills education classes

Abdulapurwadi, village is under Adul PHC and has a total population of 500. There is one Anganwadi worker and one ASHA in the village. Since there was no suitable place available for conducting Life Skills classes, adolescent girls were not attending the classes regularly. Classes were discontinued for some time in September 2013.

This problem was discussed with the Village Health and Sanitation Committee members and parents of adolescent girls in September 2013. They were explained the objectives of the program, content of Life Skills education and skills that will be imparted to adolescent girls, which will be useful for them in future. Finally, everyone agreed about a suitable place for the class and ensured that there was electric supply. Since September 2013, regular classes are being conducted at that place and girls without any inhibitions are attending the classes.

Case Study: 2

Name of the village: Kadethan (Bk.)

Kavita Bappasaheb Jadhav is a resident of village Kadethan (Bk). She got married when she was 15 years old and she became pregnant for the first time when she was 16 years old. She has studied up to 9th Standard and she works in her agricultural fields.

A nurse from the IHMP identified her as high risk during antenatal check-up. High risk factors identified were - her weight was only 35 Kg. during pregnancy and she was short – less than 145 centimeters.

The IHMP nurse followed her up regularly during pregnancy and counseled her regarding care to be taken during pregnancy and at the time of delivery. The nurse found out that her mother-in-law and husband were planning to have her delivered at home. The nurse visited Kavita's home and explained to the mother-in-law and husband the complications that Kavita and her newborn could experience if she delivered at home. After several rounds of counseling her husband and mother-in-law agreed to take her to the hospital for delivery.

In the ninth month of pregnancy, Kavita started getting labour pains. She was taken to the PHC in Adul. The doctor examined her and realized that her labour pains were not strong and labour was not progressing well. So the doctor decided to refer her to Medical College, Aurangabad. She had a Caesarean section and her baby weighed only 1.5 Kg. She went to her natal home after discharge from the hospital. Nurse visited her, when she came back to her village after 4 months, both mother and baby are doing well and now baby boy weighs 5.5 Kg.

Case Study: 3

Name of the village: Adul Tanda

Arati Sandip Rathod is a resident of Adul Tanda village. She is 17 years old, studied up to 5th standard and is a housewife. She was pregnant for the second time. In the fourth month of pregnancy, she started having white discharge. She discussed her symptoms with the visiting nurse from IHMP when she went for antenatal check-up. The nurse advised her to come to the RTI clinic conducted at the village level by a lady doctor from IHMP.

After about one week she came for a check-up to RTI clinic and took treatment. The doctor advised her to come for follow up visits. She did come for follow up visits even after completion of the treatment. The doctor examined her and found that she was completely cured. She took the stipulated, standard antenatal care and delivered in the Government hospital. Both mother and baby are doing well.

2. Primary Health Care in a Rural Setting

Introduction: The Institute of Health Management, Pachod (IHMP) implements Primary Health Care (PHC) project in 30 villages of Adul PHC. Maternal health care is provided to women in the reproductive age group. RTI/ STI services are provided by the IHMP to both women and men through a mobile clinic.

Activities undertaken during 1st April 2013 to 31st March 2014:

1. **Maternal Health Care:** Every month 36 Village Health & Nutrition Day (VHND) were organized in Adul PHC by the sub-center ANM. On the same day, ANM from IHMP also visited the village and complemented health services provided by the government ANM. Pregnant women were examined from head to toe and screened for the risk factors. Pregnant women identified with the risk factors were either referred to PHC or to a visiting doctor from IHMP.

   A total of 758 pregnant women were registered during the year. Out of which 615 (81%) were registered before 12 weeks of pregnancy and remaining 19 percent was registered after 12 weeks of pregnancy. A total of 486 women delivered during the year. Out of which 482 were live births and 4 were still births. Ten pregnant women reported abortion. Out of the total women delivered, 470 (96.7%) were hospital deliveries (444 delivered in the PHC & 26 delivered in the private hospitals) and 16 (3.3%) were home deliveries. Out of 482 newborns weighed at birth, 64 newborns weighed less than 2.5 kg., which is indicating prevalence of low birth weight as 13.3 percent.

2. **RTI/ STI Services:** Every month, a lady doctor and nurse from the IHMP visited each village and examined women referred by ASHAs who were identified during surveillance visit with the symptoms of RTIs.

   During the year, 27 cases of RTI/STI, 42 cases of gynecological problems and one case of infertility in women above 19 years of age were examined and given treatment. A total of 299 other cases and 129 pregnant women referred by the ANMs were also examined by the IHMP doctor. Pregnant women requiring referral services were referred to the tertiary level care centers.

Lessons Learnt: It is possible to achieve universal coverage if VHNDs are conducted on a regular basis and quality of coverage also can be improved.

3. Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city

April 2013 to March 2014

1. Summary

The project **'Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city'** successfully demonstrated the six innovations developed by IHMP. In the urban context the public health system is complex and fragmented. It is difficult for the urban poor, living in slums, to navigate the health system to access adequate and quality health care in the public sector without any assistance. The key intervention to address this barrier is empowering civil society for generating demand for services and ensuring access to primary, secondary or tertiary levels of care depending upon the need of the individual. The key front line worker is a community link worker equivalent to the ASHA in rural areas. She assesses health needs and morbidity on a monthly basis providing an epidemiologically robust system for public health practice. Based on the needs assessment she generates demand and empowers the community through interpersonal communication, and links her clients with the appropriate health facility. What is required is sustained capacity building and hand holding of slum health and development committee members.

So far IHMP has concentrated on primary health care with a focus on Reproductive and Child Health. While working in slums to demonstrate a scalable model, IHMP realised that there is also a high prevalence of non communicable diseases - diabetes and hypertension among the urban slum poor of Maharashtra. The public health sector does not have any system in place to deal with this developing epidemic. Both these non communicable diseases require monitoring on a biweekly, or at least a weekly basis. The cost of merely monitoring blood pressure and blood glucose would be exorbitant for slum dwellers. Hence, neither do people living in slums get these illnesses monitored on a regular basis, nor can they afford regular treatment. IHMP is testing appropriate technology and community based outreach strategies for developing an affordable system that can be replicated at the level of the Municipal Corporation. The pilot programme implemented by IHMP has the potential to develop a well defined "Outreach" strategy for screening of slum communities for diabetes and hypertension and linking individuals with positive findings to Government health facilities; thereby demonstrating an urban model for the prevention and control of Non Communicable diseases.

2. Introduction, Goal and Outcomes

Institute of Health Management Pachod is working in the slums of Pune city. Oxfam approved a grant for three years to demonstrate 6 IHMP innovations in a formal Primary Urban Health Centre (PUHC) established by the Pune Municipal Corporation and advocate for their adoption in National Urban Health Mission (NUHM).

Goal - To build evidence of the efficacy of 6 innovations developed by IHMP by demonstrating the innovations through a Pune Municipal Corporation's Primary Urban Health Centre (PUHC) and advocating their replication in the urban public health sector.

The specific objectives of the urban health program are:

- **Specific objective 1:** Build evidence regarding the efficacy of key innovations, such as monthly surveillance, micro-planning, outreach, need specific BCC and community based monitoring to improve access and utilization of primary health services by the urban poor living in slums.

- **Specific objective 2:** Demonstrate the efficacy of Obstetric and Gynecological services through a (per clinic) out-sourcing strategy at the primary level to ensure timely referral for emergency obstetric care (EMOC) and treatment of RTIs and STIs.

- **Specific objective 3:**Empowering Civil Society for generating demand for services and ensuring accountability of health providers and facilities

- **Specific objective 4:** Capacity building of CHWs/ ANMs for effective implementation of 6 IHMP innovations.

- **Specific objective 5:** Develop linkages for providing secondary and tertiary level health care services in collaboration with the tertiary level health care institutions.

Expected outcomes of a model PUHC are:

At the community level - there will be a change in the health status of the community

- Increase in utilization of maternal and neonatal care services by the community
- Increase in treatment seeking for reproductive health problems
- Increase in contraceptive use and reduction in the total fertility rate
- Increase in the coverage of children with complete primary immunization
- Early detection and treatment for childhood illness
- Early detection and treatment for communicable diseases – malaria and TB
- Early detection and treatment for non-communicable diseases – diabetes and hypertension

At provider level - community and facility based health workers (PUHC) will be able to demonstrate the capacity / skills to implement the key innovations introduced by IHMP. The key innovations that will be introduced in the public health sector are:

- Monthly surveillance of health needs
- Micro-planning and monitoring of health needs by Community Health Workers (CHWs)
- Outreach services to create effective linkage of health needs with primary, secondary and tertiary levels of health care.
- Early detection and treatment of women in need of EMOC and Gynaecological services through a per clinic, contractual strategy
- Need and situation specific BCC combined with a social norms approach.
- 'Slum Health and Development Committees' empowered to demand health rights and monitor identification of health needs and services provided at all levels.

At Policy level: IHMP will demonstrate an understanding of the innovations at a policy level and will advocate their large scale replication at a State and National level.

3. Changes in context

The implementation of NUHM was initiated in the month of March 2014. IHMP is collaborating with Pune Municipal Corporation to roll out this programme in the urban slums of Pune city.

In March 2014, AGRT IHMP won the National DASRA award for the project "Intervention to delay age at first conception and avert the adverse consequences of early motherhood among Married Adolescent Girls". Dasra has communicated to IHMP that it is committed to mobilizing CSR funds over the next 3 years for mainstreaming this project in the National RCH programme in the urban slums of Pune city.

4. Progress with implementation of the Project* (both quantitative and qualitative)

Specific objective 1: Build evidence regarding the efficacy of key innovations, such as monthly surveillance, micro-planning, outreach, need specific BCC and community based monitoring to improve access and utilization of primary health services by the urban poor living in slums.

Surveillance and Monitoring System:

Protocols for the surveillance and monitoring system for urban slum areas were designed and printed. In order to develop practical skills for filling surveillance registers, IHMP staff provided on the job training to the CHWs. Monthly needs assessment through surveillance was carried out by the CHWs. The surveillance system covers the following broad areas:

- Maternal health
- Neonatal health
- Reproductive health – Reproductive tract infections
- Family planning
- Child immunization
- Child health – Diarrhoea, fever, and ARI

Last year IHMP added to this list the risk factors related to hypertension and diabetes. It is envisaged that a replicable model for surveillance and outreach will be tested and demonstrated for replication of the National programme for the control of non communicable diseases.

Needs specific behaviour change communication:

During monthly household visits CHWs identify the information needs of each individual. Based on the behavioural diagnosis they provide information and counselling specific to the needs of the individual and family. This need specific BCC approach has brought about a measurable change in health related behaviours. During the reporting period, 14,327 household visits were undertaken by CHWs during which they provided need specific BCC. (Refer Table 1)

Table 1: Needs specific BCC provided by the CHW at household level

Sr.	Topic	Number of clients received needs specific IPC & counselling from CHWs at household level			
		Apr to Jun 2013	Jul to Sep 2013	Oct to Dec 2013	Jan to Mar 2014
1.	Maternal care	321	437	575	436
2.	Treatment for symptoms of maternal morbidity	51	59	78	39
3.	Use of family planning methods	1966	3304	2274	2674
4.	Treatment for reproductive tract infections	138	192	230	265
5.	Child immunization & management of child morbidity	346	330	291	321
	Total	2822	4322	3448	3735

Behaviour change communication through a social norms approach:

Behaviour Change Communication (BCC) is also being implemented through a social norms approach. Group BCC sessions were conducted to influence social norms like age at first conception, birth interval, early registration for antenatal services, utilization of minimum standard antenatal care, utilization of minimum standard postnatal care, screening for non-communicable diseases, etc.

A total of 196 group BCC sessions for women aged 15-44 years and 18 group BCC sessions for all slum dwellers were conducted at the slum level, by the project staff. The group BCC sessions for reproductive and child health were conducted by the project ANMs and the group BCC sessions to increase awareness & generate demand for screening of NCDs were conducted by the project senior social workers.

They conducted these meetings using participatory methods through effective use of audio-visual material. A total of 2669 women from the 18 project slums attended the meetings. Group BCC to generate demand for screening of NCDs and PMCs “Shahari Garib Yojana” (Health Assurance Scheme for the Poor) was carried out in 3 slums and a total of 373 individuals attended the group BCC sessions. (Refer Table 2).

Table 2: Group BCC sessions conducted at slum during April 2013 to March 2014

Sr.	Period	Group BCC sessions conducted	Participants attended	Topics discussed during group BCC sessions
1.	April to June 2013	61	739 women 15-45 yr of age	• Abortion & post abortion complications • Postnatal care • Use of family planning methods
2.	July to September 2013	51	769 women 15-45 yr of age	• Reproductive tract infections Sexually transmitted infections
		08	231 individuals of age 30 & above	• Screening for NCDs – hypertension & diabetes • PMCs "Shahari Garib Yojana" (Health Assurance Scheme for the Poor).
3.	October to December 2013	63	901 women 15-45 yr of age	• Female reproductive system • Menstrual cycle • Antenatal care
4.	January to March 2014	21	260 women 15-45 yr of age	• Minimum standard postnatal care
		10	142 individuals of age 15 & above	• Screening for NCDs – hypertension & diabetes
	Total	214	3042	

Outreach clinics conducted by project ANM: The CHWs prepare a micro-planner every month which provides details of the health needs of women and children along with details of the services they require. Based on the micro-planner, the CHWs actively link their clients to Vasti level clinics conducted by ANMs. A total of 150 clinics were planned and organized during the reporting period in the project area. Primary level care services for maternal health, child health and family planning were provided at the clinics, 1565 antenatal examinations were conducted by ANMs, and counselling on use of family planning methods was given to 254 eligible couples during the reporting period. The ANM cross-checked whether all the clients listed in the micro-planner had availed services or not.

Specific objective 2: Demonstrate the efficacy of Obstetric and Gynecological services through a (per clinic) out-sourcing strategy at the primary level to ensure timely referral for emergency obstetric care (EMOC) and treatment of RTIs and STIs.

Clinics for emergency obstetric and gynecological services were conducted at the Galande Patil dispensary. Treatment was provided to 521 patients by IHMP's consulting gynecologist once a week at the PUHC. In the reporting period, 39 obstetrics /gynecology clinics were planned and conducted by the PUHC and IHMP project staff.

Specialized clinics at the PUHC have resulted in a substantial increase in referral and utilization of services by women with maternal and reproductive morbidities.

Policy Implications:
Cost effective specialist care in obstetrics and gynecology can be made accessible to the poorest living in slums by providing these services at the PUHC level through Gynecologists from the private sector appointed and paid on a per clinic basis.

Specific objective 3: Empowering Civil Society for generating demand for services and ensuring accountability of health providers and facilities

Capacity building of Slum Health and Development Committee (SHDC): 12 Slum Health and Development Committees (SHDCs) have been established. During the reporting period, two orientation meetings for SHDC members were planned and conducted.

Orientation of SHDC members about PMCs "Shahari Garib Yojana": During the reporting period, a one day orientation program about the Pune Municipal Corporation "Shahari Garib Yojana" (Health Assurance Scheme for the Poor) was conducted for SHDC members. The PMC health officer – in charge of "Shahari Garib Yojana" was invited for the training program as a resource person. Participatory methods were adopted for the training. The experience of implementing the Pune Municipal Corporation "Shahari Garib Yojana" by IHMP in Khulewadi slum was discussed in length with the SHDC members and it was used as a case study to demonstrate the implementation plan. SHDC members discussed and cleared their doubts regarding the "Shahari Garib Yojana", with the PMC health officer. They understood how the barriers in accessing this scheme can be overcome. They understood how to solve the problems in enrollment and utilization of the scheme. (Refer Table 4)

Training of SHDC members to facilitate a right's based approach in urban health: One day refresher training was carried out for the SHDC members in December 2013. Field demonstrations were used to provide cognitive and practical skills during the training. (Refer Table 4)

Two exposure visits were arranged for SHDC members. The first visit was organized at the tertiary care centre, i.e. Sasson Hospital to observe functioning of all departments, procedures for OPD and IPD, documentation, management of emergency cases, use of referral slips, and ensure its processing etc.

Second field demonstration was held at SHDC of Panchasheel Nagar from IHMP's old project area. During the visit discussion with old SHDC members was organized.

The older SHDC members shared their experience where their efforts resulted in solving several problems that the entire community was facing. The old SHDC members also shared the constraints faced by them when they started as SHDC members and how gradually, over a period of time, they were able to overcome the challenges and were successful in their efforts with the community and the various departments of the PMC. The interaction with the older SHDC members proved to be an effective motivation for the SHDC members from Yerwada area.

Table 4: Training programs organized for SHDC members during April 13 to March 14

Sr. No	Training subject	Month	SHDC members attended	Topics covered
1.	Pune Municipal Corporation "Shahari Garib Yojana" (Health Assurance Scheme for the Poor)	Nov 2013	29	• What is "Shahari Garib Yojana" • How it helps in reducing out of pocket expenditure for health care • Eligibility, documentation required, procedures for enrollment • Benefits that will accrue if the poor enroll under the PMC "Shahari Garib Yojana" • Implementation of the scheme at the community level – processes • FAQs and answers
2.	Right's based approach in urban health	Dec 2013	28	• Roles and responsibilities of SHDC members • Community based monitoring, of CHWs, ANMs and PUHC • Referral system – linking clients from primary to secondary & tertiary centres • Services available at Sasson hospital, how to utilize the services available at Sasoon hospital • To increase awareness of 'SOFOSH' NGO/Sasoon Mitra Mandal at Sasoon hospital (Tertiary care centre). Sasoon Mitra Mandal provides services to underserved patients and their family

Mass meetings (Jahir Sabha) conducted at the slum level:

Mass meetings at the slum level were planned and organized. The objective of these mass meetings (Jahir Sabha) was to orient community people on CHWs work and the activities undertaken by the SHDCs for their slum. Importance of involving community people actively to generate demand for need based services and their utilization was discussed during these

meetings in length with the community. Participatory methods were used to disseminate the information during these meetings. Out of the 12 meetings that were planned, 9 were actually conducted and a total of 350 individuals participated in theses meeting. It is observed that, community recognizes the CHWs and SHDCs work, and as a result, substantial number of people approached the CHW for primary care services, which also helps to strengthen referral services.

Following decisions were taken by some of the SHDCs:

In Siddharth Nagar, SHDC members plan to discuss and take necessary actions by involving community members on the issues related to the houses which were destroyed during road widening work.
SHDC members of Chandrama vasti plan to approach PMC officials to obtain subsidies for individual latrines
SHDC of Rajiv Gandhi Nagar took a decision to visit PMC office to solve issues related to drainage system, water and environmental sanitation.

Slum Health and Development Committees **(SHDCs):** During the reporting period, 13 Slum Health and Development Committees were functioning in the 18 slums. SHDC meetings were planned once in a month for each slum area. Out of the 143 SHDC meetings that were planned 95 were actually conducted in the last one year. A total of 540 SHDC members were present at the monthly SHDC meetings.

Table 5: SHDC meetings conducted during the period - April 2013 to March 2014

Sr. No.	Period	SHDC meetings planned	SHDC meetings conducted	Attendance at SHDC meetings	Topics discussed during meetings
1.	April to June 13	32	24	114	Review of CHWs work, outreach clinics conducted by ANM
2.	July to Sept 13	33	18	94	CHWs performance, Gynaecological services at PUHC, work initiated by the PMC in their respective slum on water supply, sanitation, garbage disposal
3.	Oct to Dec 13	32	27	151	CHWs performance, MPR, Discussion on how to increase demand for PMCs “Shahari Garib Yojana”.
4.	Jan to March 14	32	22	130	CHWs performance, MPR, services provided by the project ANM and services delivered at the PUHC, Utilization of PMCs “Shahari Garib Yojana”, screening of diabetes and hypertension.
	Total	129	91	489	

SHDC members monitored the work of CHWs and ANMs. They visited households to cross check and certify the needs assessed by the CHWs. SHDC members reviewed the work-plans prepared by CHWs to ensure completeness and accuracy and the MPR prepared by ANMs to ensure that those who required services actually received them. SHDC members motivated the community to utilize services offered at the PUHC.

Policy Implications: The Pune Municipal Corporation has budgeted a considerable amount of funds for this scheme. The funds are underutilized as slum communities are unaware of this scheme and even those who have heard about it do not know how to get enrolled. Civil society can play a crucial role in securing this entitlement for the poorest.

Specific objective 4: Capacity building of CHWs/ ANMs for effective implementation of 6 IHMP innovations.

Capacity building of Community Health Workers (CHWs): **Capacity building of the CHWs is an important component of the project. The goal is to build capacity of CHWs for effective programme implementation by providing them with technical, management and BCC (Behaviour Change Communication) skills. Following training programmes were organized for CHWs during reporting period.**

Table 6: Training programs conducted for CHWs during April 2013 to March 2014

Sr. No.	Training subject	Month	Duration – days	No. of CHWs attended	Knowledge & skills provided
1.	Processes and functioning of secondary and tertiary care hospital	May 2013	01	09	Cognitive skills - Functioning of all departments, Process of registering patient for OPD and IPD cases, Document required for registration, for enrolment under various Govt. schemes, Management of emergency cases, referral management Practical skills: How to fill up the registration form, where to submit the filled up forms, registration fee
2.	Orientation on PMCs "Shahari Garib Yojana"	Aug 2013	01	06	Cognitive skills – What is health insurance, PMCs health assistance scheme - eligibility, documentation required, procedures for enrolment Practical skills: Implementation of the scheme at the community level
3.	Induction training for newly appointed CHWs	Oct & Dec 2013	07 days	04	Cognitive skills – maternal health, neonatal health, child health, reproductive health, family planning. Practical skills on implementation of 6 IHMP innovations

In-service training: During the reporting period, 12 in-service training sessions were conducted. CHWs and project staff participated in these training sessions. Project inputs, outputs and coverage were reviewed and participatory planning was done during the meetings. Cognitive and practical skills were provided to the CHWs.

On the job training by Supervisors during field visits: Five CHW areas were allotted to each supervisor. Monthly two supervisory visits were planned for each CHW area. Using supervisory check lists, supervisors assessed skills of the CHWs, and provided practical skills to strengthen the processes – i.e. surveillance for needs assessment, needs specific BCC, referral system, linking clients to providers, preparation of micro-plans and MPRs. A total of 336 Supervisory visits were planned during the reporting period out of which 237 (70 percent) visits were conducted.

Specific objective 5: Develop linkages for providing secondary and tertiary level health care services in collaboration with the tertiary level health care institutions.

Meetings with PUHC: During the reporting period several meetings with Medical officer PUHC were organized. Participatory planning of the gynaecologist clinic at PUHC, review of outreach activities, upgrading the services at the PUHC, MIS for referral tracking was discussed during the meeting.

Meetings with PMC officials: Several meetings with PMC officials were conducted during the reporting period. Impact of outreach on health service utilization for MNH & RH, Facilities for providing OB gynaecologist clinic at PUHC, NUHM implementation, Implementation of PMCs health insurance scheme in the 18 project slums, and rolling out of NUHM in the city of Pune etc. were topics that were discussed during the meetings. Following key decisions were taken by the PMC officials:

- PMC Asst. MOH agreed to arrange lab technician once a week at PUHC.
- PMC officials provided required AV material i.e. copies of brochure of the scheme; application forms, etc. and they were actively involved in the implementation of the scheme
- PMC clarified roles and responsibilities of community link worker in provision of outreach services
- PMC assistant MOH agreed to discuss with PMC ward officer to solve the water problem faced by the PUHC staff

i) <u>Outcome / Key Result</u>

- Progress against planned activities/outputs (both quantitative & qualitative information)

Table 1: Surveillance Coverage.

Period	Reporting for Number of CHW areas	Number of registered eligible couples	Number of eligible couples visited	Percent ECs visited
April to June 13	09	8681	7760	89.3
July to Sept 13	10	9481	7144	75.3
Oct to Dec 13	10	9058	7367	81.3
Jan to March 14	13	10445	9635	92.2

The average percentage of ECs who had been covered by monthly surveillance was 84.5%.

Table 2: Reported Symptoms of Reproductive Tract Infections.

Month	Reporting for Number of CHW areas	Number of ECs visited	Number of ECs with symptoms of RTIs	Percent ECs with symptoms of RTIs
April to June 13	09	7760	138	01.8
July to Sept 13	10	7144	192	02.7
Oct to Dec 13	10	7367	230	03.1
Jan to March 14	13	9635	265	02.7

The proportion of ECs detected with RTI symptoms was 2.6%.

Table 3: Reported treatment seeking for Reproductive Tract Infections.

Month	Reporting for Number of CHW areas	Number of ECs with symptoms of RTIs	Number of ECs sought treatment on RTIs	Percent ECs sought treatment on RTIs
April to June 13	09	138	77	55.8
July to Sept 13	10	192	94	48.9
Oct to Dec 13	10	230	138	60.0
Jan to March 14	13	265	167	63.1

The average proportion of women with RTIs who had sought treatment was 57.8 percent.

Table 4: Coverage of Antenatal Care.

Month	Reporting for Number of CHW areas	Number of Antenatal examinations planned	Number of antennal examinations carried out	Percent received antenatal care
April to June 13	09	382	321	84.0
July to Sept 13	10	544	437	80.3
Oct to Dec 13	10	575	469	81.5
Jan to March 14	13	436	346	79.4
Total		**1937**	**1573**	**81.2**

The proportion of pregnant mothers who received antenatal care was 81.2%.

Table 5: Reported Symptoms of Antenatal Complications.

Month	Reporting for Number of CHW areas	Number of Currently pregnant mothers	Number of pregnant mothers with antennal complications	Percent pregnant mothers with antenatal complications
April to June 13	09	382	51	13.3
July to Sept 13	10	544	59	10.8
Oct to Dec 13	10	575	78	13.5
Jan to March 14	13	436	39	08.9

The proportion of pregnant mothers reporting any one antenatal complication was 11.6%.

Table 6: Reported Treatment Seeking for Antenatal Complications.

Month	Reporting for Number of CHW areas	Number of pregnant mothers with antennal complications	No. pregnant mothers sought treatment for antennal complications	% pregnant mothers sought treatment for antenatal complications
April to June 13	09	51	40	78.4
July to Sept 13	10	59	55	93.2
Oct to Dec 13	10	78	66	84.6
Jan to March 14	13	39	36	92.3

The average proportion of pregnant mothers with symptoms of antenatal complications who sought treatment was 86.8 percent. Substantial increase in utilization of treatment for antenatal complications is observed in the second, third & fourth quarter as compared to first quarter.

Table 7: Institutional Deliveries.

Month	Reporting for Number of CHW areas	Total deliveries	Institutional deliveries	Percent institutional deliveries
April to June 13	09	27	27	100.0
July to Sept 13	10	70	65	92.8
Oct to Dec 13	10	52	52	100.0
Jan to March 14	13	54	53	98.2

Almost all i.e. 98 percent mothers were delivered in a hospital.

Table 8: Coverage with Postnatal Care.

Month	Reporting for Number of CHW areas	No. of postnatal mothers identified	Home based post natal care by CHW	Post natal visits by ANM	Post natal mothers with post natal complications
April to June 13	09	29	29	29	00
July to Sept 13	10	72	69	60	01
Oct to Dec 13	10	60	54	43	02
Jan to March 14	13	54	54	48	01
Total		**215**	**206**	**180**	**4**

215 postnatal mothers were identified, CHWs provided home based post natal care to 206 mothers and 180 mothers were examined after delivery by the ANM, at home, within 42 days.

Table 9: Reported Use of Family Planning Methods.

Month	Reporting for Number of CHW areas	Non sterilized ECs	ECs using any temporary FP method	Percent ECs using any temporary FP method
April to June 13	09	2335	369	15.8
July to Sept 13	10	3888	584	15.0
Oct to Dec 13	10	2847	573	20.1
Jan to March 14	13	3546	872	24.5

The average proportion of non-sterilized ECs using any form of temporary contraception was 18.9 percent. An increase in the use of temporary contraceptives among non-sterilized Eligible Couples (ECs) was observed in the fourth quarter as compared to the previous quarters (24.5% Vs 20.1% Vs 15.0%).

Table 10: Reported Prevalence of Diarrhoea among Children Under Three Years of Age

Month	Reporting for Number of CHW areas	No. of children under 3, visited by CHW	No. of children under 3 with symptoms of diarrhoea	Prevalence of diarrhoea among children under 3
April to June 13	09	1853	88	04.7
July to Sept 13	10	1448	76	05.2
Oct to Dec 13	10	1641	64	03.9
Jan to March 14	13	2170	71	03.3

The average reported prevalence of diarrhoea among children under three years of age was 4.2 percent. 299 children that were suffering from diarrhoeal episodes were referred and treated.

Table 11: Reported Prevalence of ARI among Children Under Three Years of Age

Quarter	Reporting for Number of CHW areas	Number of children under 3 years visited by the CHW	No. of children under 3, with symptoms of ARI	Prevalence of ARI among children under three
April to June 13	12	1853	155	08.4
July to Sept 13	12	1448	210	14.5
Oct to Dec 13	09	1641	204	12.4
Jan to March 14	08	2170	197	09.1

The average reported prevalence of ARI among children under three years of age was 10.7 percent. 766 children that were suffering from ARI episodes were referred and treated.

5. Beneficiary information

	Women		Men	
	Beneficiary Number	**%**	**Beneficiary Number**	**%**
Dalit	3791	44.0	4107	44.0
Tribal	560	06.5	607	06.5
Muslims	732	08.5	739	08.5
Others[1]	3532	41.0	3826	41.0
Total	8616		9334	

Footnote: In the urban slum context these figures are in a constant flux.

6. Lessons learned

1. There is evidence that the six components of the proposed strategy, for health of the urban poor, have the potential for universal coverage with RCH services. However the 6 interventions need to be separately evaluated to understand pathways that bring about change.

2. CHWs are crucial for assessing health needs, generating demand and providing needs specific IPC on a monthly basis. They are effective in modifying health seeking and utilisation behaviours, strengthening outreach and primary level care, linking clients with various levels of health care facilities and ensuring accountability of health providers to civil society though the Slum Health and Development Committees.

3. The innovations, systems, tools and protocols designed for RCH are being shared with the NGO and public sector. There is substantive evidence that these innovations can increase utilization and coverage in a short period of time.

4. When serious morbidities are taken care of, women living in slums tend to utilize preventive and promotive services more effectively. Morbidity surveillance combined with specialized clinics on a contract basis is effective in reaching slum communities.

5. Providing obstetric and gynecological services through a (per clinic) out-sourcing strategy at the primary level is a cost effective strategy for ensuring timely referral of obstetric emergencies and treatment of RTIs and STIs.

6. Strengthening outreach service that is capable of timely assessment of health needs and linking individuals and families to the appropriate level of care is the most effective way of ensuring universal coverage with RCH services. This is an effective way of addressing the 3 delays that occur in responding to health emergencies.

7. The key to introducing innovations for universal health coverage is continuous training and hand holding of frontline workers. Their capacity building needs to continue till they are able to demonstrate skills for implementing innovations.

8. Mere capacity building of frontline workers and slum health and development committees is not complete unless they are oriented to the complexities of secondary and tertiary levels of care and provided with skills on how to navigate the system. In this process ensuring a positive response from health providers is equally important.

9. In addition to community based monitoring, SHDCs can play an important role in enabling the poorest to avail of their entitlements like PMC health insurance scheme.

10. The Pune Municipal Corporation has a considerable amount of funds for “Shahari Garib Yojana”. The funds are underutilized as slum communities are unaware of this scheme and even those who have heard about it do not know how to get enrolled. Civil society can play a crucial role in securing this entitlement of the poorest.

11. Low awareness and knowledge of the PMCs “Shahari Garib Yojana” scheme are found to be key barriers in the enrolment and utilization of PMC’s “Shahari Garib Yojana”. The most vulnerable and marginalized households in the community have not even heard of the assured health entitlement.

12. Slum Health and Development Committees can be empowered so that they can enable the poorest to benefit from PMCs Shahari Garib Yojana” entitlement. If implemented on a large scale this initiative could save many vulnerable households from catastrophic health expenditure.

13. The prevalence of hypertension and diabetes was much higher than expected. Data indicate that several undiagnosed individuals continue with their lives despite obvious hypertension and diabetes validating reports of increasing vulnerability among the urban poor.

14. Counseling material to modify life styles among slum communities is going to be a unique contribution of this experience.

Challenges:

The greatest challenge has been the attrition of community health workers. The socio economic condition of slum dwellers and the job opportunities available to them have changed. As a result very few agree to work as CHWs on a long term basis.

During this project period, IHMP undertook the challenge of serving migrant communities, particularly those working at construction sites. Providing this population, particularly, women and children with regular services continues to be a challenge. Collaborating with the employers and providing services at the workplace appears to be the most effective way of covering this population.

7. Monitoring and Evaluation

IHMP has a well established surveillance and monitoring system, including a MIS. Quantitative data presented to Oxfam on a quarterly basis is an outcome of this evolved MIS. In addition to the routine monitoring of the project, IHMP has endeavoured to evaluate some of the key innovations such as monthly surveillance of health needs, interpersonal communication specific to the needs of the individuals and households. The emphasis on process evaluation is to enable us to share these processes with other NGOs and the Government.

8. Financial Progress

Over 90 percent of the approved budget was utilised. The under expenditure was primarily because of attrition of CHWs, SHDC members and one staff. This led to a request for reallocation of resources. Once the reallocation was approved there was no variance of over 10 percent for any line item.

9. Accountability

Accountability to civil society through Slum Health and Development Committees (SHDCs) is a specific objective of this project. Every month CHWs report the needs assessed in the community and ANMs report the needs addressed / services provided through outreach and at the PUHC. This comparison undertaken by Slum Health and Development Committees forms the basis for community based monitoring by SHDCs. In addition to monitoring health providers, results of monthly progress as well as the findings of various studies have been discussed in detail with the community through Jahir Sabha's.

10. Feedback

Feedback is sought through community level meetings and on a routine basis

11. Conclusion / General Comments

The project successfully demonstrated the six innovations developed by IHMP. The project provided empirical evidence that these innovations increase the utilisation of health services at the outreach level and at PUHCs and reduce out of pocket expenditure substantially for the urban poor living in slums. Provision of specialist care at PUHCs increases treatment utilisation for moderate to severe morbidity thereby further reducing costs of critical care. It also makes secondary and tertiary level health care more accessible for the urban slum poor.

The NGO sector should advocate the recruitment of CHWs in urban slums similar to the ASHA scheme under NRHM. CHWs are crucial for assessing health needs, generating demand and providing need specific IPC on a monthly basis. They are effective in modifying health seeking and utilisation behaviours, strengthening outreach and primary level care, linking clients with various levels of health care facilities and ensuring accountability of health providers to civil society though the Slum Health and Development Committees.

Early detection of morbidity, providing specialist care at the primary level through consultants, on a weekly basis, is an efficacious intervention for EMOC and gynaecological care for women.

There are insurance schemes and entitlements for the urban poor that are not accessed because people are either unaware of them or they do not have the knowledge how to access these entitlements.

Slum Health and Development committees (SHDCs) are not merely effective at undertaking community based monitoring; they monitor and lobby for other essential amenities and services as well. IHMP has linked them to the PMC to articulate their demands. Several case studies indicate that the committees have been very effective in securing water, drainage, electricity, solid waste management and other PMC services.

Contrary to the prevailing perceptions, the prevalence of hypertension and diabetes is high among socio economically marginalized slum households / individuals. There is need for protocols for surveillance of high risk factors for diabetes and hypertension and relevant preventive protocols and culturally appropriate BCC material that can be put in the public domain.

4. Project for Strengthening a Primary Urban Health Centre of Pune Municipal Corporation (PMC) with special emphasis on Non Communicable Diseases

Special clinic for migrant population: A special clinic for a large migrant population was organized in three slums in Kharadi area. Since community health workers are not appointed in these slums, primary level health care is being provided by project ANMs. Children below the age of five years and women in the reproductive age group were examined at the clinic. A total of 98 children less than five years of age were examined, 76 were immunized, and counselling on family planning was given to eligible couples. Condoms were distributed to 167 eligible couples. The special clinic was organized by the PUHC in coordination with Panchshil Group of builders and Institute of Health Management Pachod, Pune centre.

Policy Implications: Whereas, the National Urban Health Mission (NUHM) policy has prescribed "Outreach" as one of the key strategies for urban health care there has been progress on this only since March 2014. IHMP has contributed in terms of providing an operational definition and designing necessary processes, systems and protocols. This is a key contribution of IHMP and these innovations are in the public domain after collecting sufficient evidence of their efficacy.

Community based screening for diabetes and hypertension: Screening camps for diagnosis of diabetes and hypertension were planned and conducted in two slums. Behaviour Change Communication (BCC) activities were implemented to create awareness and generate demand for the camps. House visits were organized to list out individuals age 15 and above, and to motivate them for screening of diabetes and hypertension.

Golwilkar Metropolis Health Services, Pune a WHO certified laboratory was appointed for testing blood glucose levels. IHMP doctors and ANMs took blood pressure readings during the camp. Height and weight observations were taken by the IHMP staff.

Slum Health & Development Committee (SHDC) and Community Based Organisations (CBOs) i.e. Youth Mandals and Mahila Mandals were actively involved in the implementation of these camps. SHDCs along with other key stakeholders of the community made logistic arrangements – i.e. hall, water, tables and chairs required for the camp. Also the SHDC was actively involved in mobilizing individuals for the camp.

Table 1: Screening camps conducted for diabetes and hypertension during April 2013 to March 2014

Sr.	Name of the slum	House holds	Individuals contacted	Number of individual participated	Individuals detected with diabetes	Individuals detected with hypertension
1.	Dalit slum	365	525	239	51	60
2.	Yamuna Nagar	355	1296	531	24	70

Screening camps conducted at Dalit slum:

This slum is established exclusively by and for the Dalit community. A total of 365 households were contacted, 525 individuals age 30 and more were listed out, and of them 481 individuals indicated a willingness to participate in the camps. This information was effectively used for planning and implementation of the camp. Around 120 individuals were invited for each camp. A second round of home visits were organized one day before the camp for mobilizing people, during these visits an IHMP social worker explained fasting procedures to the potential individual. (Refer Table 1)

A total of 239 individuals of age 30 & above were attended the camps. Of theses 239 individuals, 10.6% were found to be thin, 48% found to be overweight; 25 percent individuals were diagnosed with hypertension and 33 percent individuals diagnosed with diabetes (Refer Table 1).

Care and support for individuals with Diabetes and Hypertension in Dalit slum:

A total of 60 individuals were detected with sever hypertension and 51 individuals were detected with diabetes. During the reporting period, a total of 36 patients (out of 60) with hypertension and 42 diabetic patients (out of 51) were followed up regularly by the CHW & project staff. During the follow up visits, special counseling on treatment and monitoring of dietary & other life style behaviours was provided by the project staff. During the initial follow up visits, the project staff pre-tested the content for needs specific BCC, and MIS. The initial draft of the protocols for needs specific BCC and MIS for hypertension and diabetes have been designed and are being field tested. A total of 49 patients were actively linked to the secondary and tertiary care facilities for treatment of diabetes and hypertension. 38 patients are taking regular treatment for management of hypertension and 29 patients are taking regular treatment for management of diabetes.

Screening camps conducted at Yamuna Nagar slum:

A total of 355 households were contacted, 1296 individuals age 15 & more were listed out, and of them 927 individuals indicated a willingness to participate in the camps. This information was effectively used for planning and implementation of the camp. A second round of home visits were organized one day before the camp for mobilizing people, during these visits an IHMP social worker explained fasting procedures to the potential individual (Refer Table 3).

A total of 531 individuals age 15 & above attended the screening camps. Out of 531 individuals that were tested, 13 percent were diagnosed with hypertension.
Of the 531 individuals aged 15 years and above, 5.1 percent were found to be pre-diabetic (Plasma glucose fasting – 100 to 125 mg/dl); 4.3 percent individuals were diagnosed with diabetes (Plasma glucose fasting – >=126 mg/dl) (Refer Table 1).

Of the 531 individuals, 4 percent individuals had high levels of total cholesterol (total cholesterol >240 mg/dl), 16.1 percent were found to be having borderline value for total cholesterol (200-240 mg/dl).

A detailed protocol for need specific IPC and counseling is being prepared for disseminating the findings of the test results. 531 home visits will be made in the first & second week of April 2014 to provide need based IPC and counseling. Individuals diagnosed with diabetes and hypertension will be actively linked to government secondary and tertiary care hospitals for care and support.

Policy Implications:

1. There is a high prevalence of diabetes and hypertension among the urban slum poor of Maharashtra.
2. Contrary to the prevailing perceptions, the prevalence of hypertension and diabetes is higher among socio economically marginalized households / individuals.
3. The public health sector does not have any system in place to deal with this developing epidemic.
4. Both these non communicable diseases require monitoring on a biweekly, or at least a weekly basis. The cost of merely monitoring blood pressure and blood glucose would cost slum dwellers more than what they can afford. Hence, neither do people living in slums get these illnesses monitored on a regular basis, nor can they afford regular treatment.
5. IHMP is testing technology and community based outreach strategies for developing an affordable system that can be replicated at the level of the Municipal Corporation. This includes providing BP apparatuses and Glucometers and skills development among CHWs to use this technology and provide monitoring services for a small fee.
6. IHMP is developing protocols for surveillance of high risk factors and hopes to design relevant preventive protocols and BCC material that can be put in the public domain.

Campaign to increase awareness and generate demand of PMCs "Shahari Garib Yojana" – a right based approach through Slum Health and Development Committees (SHDC):

In the reporting period, SHDC members conducted campaigns and cluster meetings to increase the awareness about the scheme among marginalized households and generate demand for PMC's "Shahari Garib Yojana" in their slums. A total of 10 cluster meetings were planned and carried out during the reporting period. A total of 215 individuals from marginalized households attended the meetings where the following topics were discussed - What is "Shahari Garib Yojana"; how it helps in reducing out of pocket expenditure for health care; eligibility, documentation required, procedures for enrollment; benefits that will accrue to the poor who are eligible to enroll; implementation of the scheme at the community level – processes; FAQs and answers.

After the cluster meetings, SHDC members listed out the potential households i.e. marginalized households and gave them guidance on how to complete the documents and enrollment procedures for the scheme. As a result of this initiative by SHDCs, during this quarter, a total of 126 households started the enrollment procedures, and 13 families received enrollment cards under PMCs "Shahari Garib Yojana".

5. Research Studies Undertaken by IHMP AGRT

In addition to the routine monitoring undertaken by IHMP, three research studies were carried out during the reporting period.

Study 1: Intervention research to increase awareness and utilization of PMC health insurance scheme in Khulewadi Slum

An intervention research on utilization of health entitlement scheme implemented by Pune Municipal Corporation was carried out in the Khulewadi slum in the reporting period. A pre-post study design was adopted for the research.

A structured interview schedule, observation tools were designed and pre-tested. At the pre-test, a total of 96 households were selected randomly and interviewed from the Khulewadi slum. Data on knowledge regarding health insurance scheme, RSBY scheme, and PMC health entitlement scheme was collected. The study included assessment of utilization of the PMC health entitlement scheme for the slum poor, barriers in utilization of this entitlement, etc. were asked to all the respondents. The survey was carried out by an external researcher.

Only 6.3% respondents were aware of PMC health entitlement scheme for the slum poor, nobody reported enrolment under the scheme at the pre-test. Lack of awareness about the scheme, poor knowledge regarding documentation required for the scheme, lack of knowledge regarding procedures of enrolment under the scheme and lack of knowledge of benefits of the scheme are the key barriers found in utilization of PMC health entitlement for the urban poor.

The findings of baseline KAP study were used to design interventions. Group BCC sessions at the community level, needs specific IPC to the eligible households, and enrolment camps for the scheme were initiated sequentially in Khulewadi slum.

After two months, the impact of the intervention was assessed by conducting a post-test. A total of 96 households were selected and interviewed at the post-test. The results of the evaluation showed significant increase in the knowledge and attitudes among the respondents regarding the PMC health entitlement for the urban poor. At the post-test compared to pre-test the change in knowledge was highly significant (68.8% Vs 6.3%).

Also, the researcher observed substantial proportion of respondents indicated an intention to utilize the scheme at post-test compared to pre-test (37.3% Vs 4.2%). There was a significant increase in initiating procedures for enrolment under the scheme at post-test (21.9%) households.

Findings and experiences learned from this pilot intervention research project will be used to scale up the interventions to increase the utilization of PMC scheme in the rest of the 17 slums.

Study 2: Intervention research to study factors associated with hypertension and diabetes, and barriers in utilization of screening services for diabetes and hypertension

The objectives of the research are:

- To study utilization of diagnostic (screening) services for diabetes and hypertension among individuals age 30 & more in the slums of Pune city
- To study barriers in utilization of diagnostic (screening) services for diabetes and hypertension
- To study efficacy of Glucometer for measurement of blood glucose and efficacy of digital BP apparatus for measurement of blood pressure

The study was conducted in a Dalit Slum in Pune city. A baseline KAP survey was conducted to study the levels of awareness regarding symptoms and complications of diabetes and hypertension, awareness regarding facilities available for screening, utilisation of screening services for diabetes and hypertension, and care and support utilized by patients of diagnosed with diabetes and hypertension.

A structured interview schedule was designed and pre-tested. Data collection was carried out by an external researcher. A total of 94 individuals age 30 years and above were interviewed from the Dalit slum. Around half the respondents reported symptoms of diabetes. A lower proportion of respondents (35%) reported history of screening for diabetes and 3 out of 4 respondents reported screening for hypertension. 12 known diagnosed cases of diabetes and 38 known cases of hypertension were found, and half of them were under treatment. Low awareness regarding diabetes and hypertension, accessibility, availability and affordability are found to be key barriers in utilizing screening services for diabetes and hypertension.

Group BCC, IPC interventions were implemented in the Dalit slum to create awareness, and to generate demand for screening of diabetes and hypertension. After community mobilization and demand generation activities, four screening camps were planned and organized at the community level with the help of SHDC and other CBOs.

Fasting and post prandial samples of blood were taken to measure levels of blood glucose from all individuals and measured using Laboratory method and Glucometer. Readings of blood pressure were taken separately using sphygmomanometer and digital BP apparatus. A total of 239 individuals (78 males, and 161 females) age 30 and above participated in the camps. Written consent was taken by Golwilkar laboratory from all the individuals for taking their blood to measure blood glucose levels. Detailed history and information on risk factors was collected from all individuals during camp.

Data was analysed using STATA. High level of agreement was observed in the diagnoses of diabetes using Lab method and Glucometer readings (observed agreement 93.4% and Kappa – 0.85). Glucometer method showed high sensitivity (0.86) & specificity (0.86) compared to standard Lab method for diagnosis of diabetes. High level of agreement was observed in

diagnoses of hypertension using digital BP apparatus and sphygmomanometer (observed agreement 84.5% and Kappa – 0.65). Measurement of blood pressure using Digital BP apparatus showed high sensitivity (0.98) & specificity (0.80) compared to readings taken using standard mercury sphygmomanometer (used as gold standard) for diagnosis of hypertension. The study demonstrated efficacy of glucometer and digital BP apparatus in diagnoses of diabetes and hypertension. By providing comparatively low training and financial inputs, this technology can be used for screening of diabetes and hypertension at community level through paramedical staff.

Limitations:

The laboratory findings for blood glucose as well as the glucometer readings were based on blood drawn from a main vein. In the next round it is proposed to use venous blood for the laboratory tests and capillary blood for testing with the glucometer, to validate the process for community level screening.

Study 3: Community based research to detect prevalence of diabetes and hypertension among urban poor population in the slums of Pune city

Research to study the prevalence of diabetes and hypertension and risk factors associated with the NCDs among urban poor population residing in the slums was carried out in the reporting period. The objectives of the research are:

- To study the prevalence of diabetes and hypertension among urban poor population in the age group 15-65 living in the slums of Pune city
- To study the risk factors associated with the prevalence of diabetes and hypertension
- To study levels of knowledge and awareness regarding the symptoms of diabetes and hypertension
- To formulate an outreach strategy for prevention, care and support for NCDs
- To pre-test, design and develop protocols, systems and communication materials for the control of NCDs in urban slums

The study was conducted in Yamuna Nagar Slum in Pune city. A quantitative study was conducted to find out IDR score, risk factors, levels of awareness regarding symptoms and complications of diabetes and hypertension, awareness regarding facilities available for screening, utilisation of screening services for diabetes and hypertension, and care and support utilized by patients diagnosed with diabetes and hypertension.

A structured interview schedule was designed and pre-tested. Data collection was carried out by the project staff. They were given five days of intensive training which included class room plus field training.

The data collection was carried out during 11 Feb to 12 March 2014. Census of all household was carried out to list out individuals in the age group 15 years and above. A total of 1296 individuals age 15 & above were listed from 355 households. A total of 927 individuals age 15 & above were interviewed from the Yamuna Nagar slum.

A data entry program in EPIdata was designed and pre-tested for data entry. In the reporting period, out of 927 filled questionnaires for individuals aged 15 and above, data entry for all 927 cases is complete.

In this round the fasting blood sugar levels were computed using venous blood for the laboratory tests and capillary blood for testing with the glucometer. Level of agreement between diagnoses of diabetes using a glucometer and a WHO certified laboratory. At the end, kind of error that occurs in the diagnosis of diabetes using glucometer Vs standard laboratory method will be studied to validate the process for community level screening.

Key Organizational Initiatives

Provide health and related services with a focus on the poorest and most marginalized

Organize and mobilize communities toward self-reliance and sustainability

Modeling and demonstration of innovative health and development programs

Dissemination of innovations in the Government and NGO sectors

Process evaluation and applied research

Development of replicable systems and strategies

Conduct training for Government and NGO functionaries

Policy analysis, research and advocacy

NGO networking - training and resource centre

Governance

Organization Structure

Board of Trustees

▼

Managing Trustee

▼

Director / Addl. Director

▼

Management Committee

▼

Coordination Committee (All programme coordinators)

▼

Individual Programme Committees

▼

Field Supervisors and Field Workers

▼

Community Health Worker

▼

Village / Slum Health & Development Committees

Board of Trustees

Sr. No.	Name	Age	Gender	Occupation	Position in the Board
1	Dr. C. A. K. Yesudian	64	Male	Dean, School of Health Systems, Studies, TISS, Mumbai	Chairperson
2	Ms. Manisha Khale	60	Female	Additional Director, IHMP	Managing Trustee
3	Prof. (Mrs.) Kalindi Mazumdar	82	Female	Retd. Prof. Nirmala Niketan, Mumbai	Trustee
4	Mr. David Gandhi	51	Male	Development Consultant, Pune	Trustee
5	Dr. A. Dyalchand	66	Male	Director, IHMP	Trustee

AGRT /IHMP Board of Trustees are not related by blood or marriage. There are two office bearers among the Board of Trustees – The Chairperson and Managing Trustee. The term of each office bearer is 2 years.

Board of Trustees Meetings

The Board of Trustees meetings were held during the period 2013-2014 as follows:

Sr. No.	Date
1	23/06/2013
2	12/10/2013
3	18/01/2014
4	22/02/2014

Apart from the regular review of projects, finances and other business, the Board of Trustees reviewed and approved the audited statement of accounts including the balance sheet for the period 1st April 2013 to 31st March 2014 on 20th December 2014.

The budget for the period 1st April 2014 to 31st March 2015 was reviewed and approved on 22nd February 2014.

Transparency Disclosures

- No remuneration, sitting fees or any other compensation is paid to any Board of Trustees
- The Director and Additional Director who are also trustees are paid salaries.
- Travel reimbursements were made to Board of Trustees attending Board meetings
- Total costs of travels incurred by Board of Trustees during the year amounted to Rs. 13,457/-

Legal Compliances

Ashish Gram Rachna Trust, Pachod complies with statutory requirements of Income tax Act. 1961, BPT Act 1950 and Foreign Contribution Regulation Act. 1976.

All donor requirements were duly complied with.

Ashish Gram Rachna Trust, Pachod followed a rigorous audit process. The statutory auditor was appointed during the Board of Trustees meeting held on 16th February 2013.

Audited statements of accounts and balance sheet for the financial year 1st April 2013 to 31st March 2014 were accepted and approved in the Board of Trustees meeting held on 20th December 2014.

Salary Distribution by Gender as on March 31, 2013			
Monthly Salary of Staff Members (in Rs.)	**Men**	**Women**	**Total**
≤5,000	09	00	09
5,001 – 10,000	07	14	21
10,001 – 25,000	04	03	07
25,001 – 50,000	02	01	03
≥50,001	01	00	01
Total	**23**	**18**	**41**

Brief bio-data of professional staff and consultants at AGRT/IHMP

AGRT/IHMP has a comprehensive team of qualified and dedicated professionals and consultants coming from diverse backgrounds like medicine, public health, development, social work and accounts. The team members possess skills for implementing innovations, undertaking applied research and as faculty for training. Most of the professional staff has been working at the Institute for periods ranging from 10 to 35 years.

Sr No	Name	Designation	Experience	Education	Specialization
1	Dr. A. Dyalchand	Director	AGRT/IHMP 37 years	MBBS MD CMC Vellore MPH, Johns Hopkins, Baltimore, US	Health Management Epidemiology HIV AIDS
2	Ms. M. Khale	Additional Director	AGRT/IHMP 35 years	M.Sc. Biochemistry, M.Sc. RCH London School of Hygiene & Tropical Medicine, UK.	PHC / RCH HIV AIDS
3	Mr. K. Abraham	Financial Management / Cost analysis	AGRT/IHMP 28 years	B.Com, DBA, DHA, CCO	Financial Mgmt. and Admin.
4	Dr. N. Kapadia-Kundu	Consultant	AGRT/IHMP 25 years	MPH, PhD JHU, Baltimore, US	Behavioral Sciences
5	Mr. S. M. Shinde	Coordinator, Integrated ARSH	AGRT/IHMP 26 years	MSW	Rural drinking water supply & sanitation
6	Mr. H. B. Pawar	Coordinator, Child health	AGRT/IHMP 24 years	MSW	Child nutrition & development
7	Mr. S. L. Mohite	Coordinator, PHC and RCH	AGRT/IHMP 22 years	MSW	PHC and RCH
8	Mr. J. J. Rupekar	Integrated Counselor	AGRT/IHMP 22 years	MSW / HIV Counseling	Integrated counseling
9	Mr. G. R. Kulkarni	Research Coordinator, Biostatistician	AGRT/IHMP 15 years	M.Sc. Statistics; Training in Epidemiology at Johns Hopkins.	Biostatistics / research
10	Ms. Kalpana Sanas	In-charge Desk Top Publishing (DTP)	AGRT/IHMP 15 years	DTP & website designing	Designing and production of BCC material
11	Ms. Rohini Sanap	Coordinator, urban health	AGRT/IHMP 15 years	MSW; Training in ARSH	Health services in urban slums
12	Ms. Rupa Takale	Field coordinator Life skills Education	AGRT/IHMP 13 years	MSW; Training in ARSH	Life skills Education for Adolescent girls
13	Ms. Pushpa Kharat	Integrated Counselor	AGRT/IHMP 10 years	MSW/ HIV Counseling	Integrated counseling
14	Dr. K. Bharucha	Consultant	Retd. Prof. Ob. Gynae. BJMC, Pune	MBBS, MD	Ob. Gynae. RTI / STI / HIV AIDS
15	Prof. T. Kanitkar	Consultant	Retd. Prof. IIPS, Mumbai	MPS	Demography

Finance

Responsibility Statement by the Management

AGRT/ IHMP confirms:

1. The Annual Accounts have been prepared on the basis of the accounting policies adopted by the organization with compliance to Accounting Standards wherever necessary.

2. Sufficient care has been taken for the maintenance of accounts as per the applicable legal statutes of India.

3. The Statutory Auditors have performed their task in an independent manner and the management letter submitted by the Statutory Auditors has been considered by the management.

4. During day to day operations of the organization, ethical accountability, value of money and environmental concerns has been given highest priority.

No part of the income during the previous year has been applied and used directly for the benefit of:

a. The author or founder of the organization
b. Any person who has made a substantial contribution to the organization
c. Any relative of the Board of Trustees
d. Any concerns in which the above mentioned category of persons have substantial interest. (As required under Sec. 13(3) of Income Tax Act, 1961)

None of the Board of Trustees has been given any honorarium and none of them occupies a place of profit in the organization.

Financial Statements

Audit Report

M/S R.S. LOTKE & CO.
CHARTERED ACCOUNTANTS

17, Janki, Shakti Nagar,
CBS Road, Aurangabad.
Phone No. 0240-2337152

AUDIT REPORT

Date : 26/09/2014.

To,
The Trustees
Ashish Gram Rachana Trust,
Pachod, Dist.Aurangabad.
P.T.R. No. E-249, Aurangabad.

: FOR THE YEAR ENDING 31ST MARCH, 2014 :

We have completed the Audit of the accounts of your Trust. We enclose herewith the consolidated Balance Sheet as on 31st March 2014, consolidated Income & Expenditure Account for the year ended upon that date duly certified by us subject to the report under rule 19 of the B.P.T. Rules 1951 and to our remarks as under :

1) **ACCOUNTS :**

Accounts for various projects, activities as required by various donor agencies have been maintained separately separate accounts as required under the provisions of the Foreign Contributions (Regulations) Act, 1976 have been maintained properly.

All the accounts relating to various projects, activities (Foreign and Indian) have been finally consolidated and presented in the consolidated form of Balance Sheet and Income and Expenditure Account as required under the provisions of the Bombay Public Trust Act, 1950 and Rules 1951.

2) **GRANTS :**

It is explained to us by the Managing Trustee of the Trust that the donor agencies give grants for various projects as per the Budgets approved by them, these projects take a period of any years from one to three / four / five years for their completion. Hence the Grants are allocated over a period of completion. This is also as per the Accounting standards. AS 9 and AS 12 prescribed by the Institute of Chartered Accountants of India.

The Grants used for projects are taken as income of the year and the remaining portion of the Grant is treated as Advance grants and shown in the Balance Sheet. This portion is again transferred to Income and Expenditure A/c with the progress of the project.

The details of Grants received, transferred to Income and Expenditure A/c and treated as Advance Grants are enclosed to the Statements of Accounts.

We have obtained all the information and explanations, which to the best of our knowledge and belief were necessary for carry out our audit duties.

Accounts have been maintained neat and as required by law.

For and on behalf of
M/s R.S.LOTKE & CO.
Chartered Accountants.

Chartered Accountant
Proprietor.

Balance Sheet

R.S.LOTKE & CO.
Chartered Accountants
17, Shaktinagar, Aurangabad
Phone : 0240-2337152

ASHISH GRAM RACHANA TRUST, PACHOD, DIST.AURANGABAD.

BALANCE SHEET AS ON 31ST MARCH 2014

FUNDS AND LIABILITIES	RS.	RS.	PROPERTIES AND ASSETS	RS.	RS.
Trust Fund or Corpus :			Immovable Properties : (At cost)		
Balance as per last balance sheet		69852433.21	As per details No.6		9209769.00
Other Earmarked Funds		Nil	Investment : (At cost) : As per details No.9		
(Created under the provisions of the Trust Deed or scheme out of the income)			F.D.'s with Bank		50152548.00
Depreciation Fund			Furniture and Fixtures :(At cost) :		
Sinking Fund			As per details No.5		3455142.00
Reserve Fund			Copy rights of Books : As per details No.8		42000.00
Any other Fund :			Loans - (Secured / Unsecured / Good / Doubtful)		Nil
Loans - (Secured / Unsecured)		Nil	Loans Scholarships		
From the Trustees			Other Loans		
From others			Advances -		Nil
Liabilities -			To trustees		
For expenses	Nil		To employees		
For advances - Grant	779000.00		To contractors		
For rent and other deposits	Nil		To Lawyers		
For sundry credit balances	Nil	779000.00	To others		
			Income Outstandinn :		
			Rent	Nil	
			Interest	Nil	
			Other Income : T.D.S.etc. As per details No.10	11525.00	11525.00
1) Income Outstanding :					
2) Accounts were maintained on cash basis.			Cash and bank balance -		
The above Balance sheet to the best of my / our belief contains a true account of the Funds and Liabilities and of the properties and Assets of the trust			As per details No.3		5239632.45
			Income and Expenditure A/c		
			Balance as per last balance sheet	1481066.92	
			Add : Deficit for the year	1039749.84	2520816.76
	TOTAL RS.	70631433.21		TOTAL RS.	70631433.21

As per our report of even date
For and on behalf of
R.S.LOTKE & CO.
Chartered Accountants.

Dated at Aurangabad
25.9.2014

Trustees
Managing Trustee
Ashish Gram Rachna Trust
Pachod Aurangabad Dist.

Chartered Accountant.
Proprietor

Income & Expenditure

R.S.LOTKE & CO.
Chartered Accountants
17, Shaktinagar, Aurangabad.
Phone : 0240-2337152

ASHISH GRAM RACHANA TRUST, PACHOD, DIST. AURANGABAD.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDING 31ST MARCH 2014 Regd.No. E-249, Aurangabd

EXPENDITURE	RS.	RS.	INCOME	RS.	RS.
To Expenses in respect of Properties		Nil	By Rent Accrued / Realised		Nil
Rates, taxes, and cesses			Buildings		
Repairs and maintainance			Lands		
Salaries					
Insurance			By Interest - Accrued / Realised		
Depreciation by way of provision or adjustment			On loans	Nil	
Other expenses			On securities : F.D's. (As per details No.2)	4593712.00	
To Establishment expense :		Nil	On Bank account	369915.00	4963627.00
To Remuneration to trustees -		Nil			
To Remuneration to the head of the math including his household expenditure if any -		Nil	By Dividends		Nil
To Legal expenses		Nil	By Donations in cash or kinds :		Nil
To Audit fees : As per details No.7 13		73036.00			
To Contribution and fees		Nil	By Grants :		
To Amounts written off -		Nil	Previous Adv. Grant Trd.form B/s	4038724.00	
a) Bad debts			Add : Received during the year	2000000.00	6038724.00
b) Loan scholarships					
c) Irrecoverable rents			By Income from other Sources :		
d) Other items			Travel Refund 0833 A/c (As per details 19)	31860.00	
To Miscellaneous expenses :		Nil	As per details No.11	286501.00	318361.00
To Depreciation : As per details No.7		691727.00			
To Amounts transferred to reserve or to specific funds		Nil	By Transfers from Reserves		Nil
To Expenditure on objects of the trust :					
As per details No.12			By Being the excess of expenditure over income carried over to balance sheet		1039749.84
Medical Relief	8982264.84				
Secular Education	2529084.00				
Other Objects	84340.00	11595098.04			
	Total Rs.	12360461.84		Total Rs.	12360461.84

As per our report of even date
For and on behalf of
R.S.LOTKE & CO.
Chartered Accountants,

Dated at Aurangabad
25.9.2014

Managing Trustee
Ashish Gram Rachna Trust
Pachod, Aurangabad Dist.

Chartered Accountant.
Proprietor

Consolidation of Accounts

M/S R. S. LOTKE & CO.
CHARTERED ACCOUNTANTS
17, SHAKTINAGAR, AURANGABAD
PHONE:0240 2337152

ASHISH GRAM RACHNA TRUST, PACHOD

CONSOLIDATION OF ACCOUNTS AND DETAILS FOR THE YEAR ENDING 31ST MARCH 2014

1. GRANTS (ORDINARY) FOREIGN	ADVANCE GRANT AS ON 31-3-14	GRANT TRANSFERED TO INCOME & EXP.(2013-14)	ADVANCE GRANT BALANCE DURING (2013-14)	TOTAL GRANT RECEIVED DURING THE YEAR	NON-RECU-RRING GRANT RECEIVED DURING THE YEAR	GRANT RECU-RRING TRANSF. IN.& EXP. A/C DURING THE YR.	RECURING ADVANCE GRANT RECEIVED	TOTAL ADVANCE GRANT AS ON 31-03-2014
	1	2	3	4	5	6	7	8
1) PROJECT RSHD OF UNMARRIED ADOLESCENT GIRLS - & SPOUSES -MACARTHUR A/C	4817724	4038724	779000					779000
2) SCALING UP & ADVOCACY MODEL PHC-URBAN - OXFAM A/C				2000000		2000000		
TOTAL FC DETAILS: Rs.	4817724	4038724	779000	2000000	0	2000000	0	779000

SUMMARY

ADVANCE GRANT FOREIGN	0
ADVANCE GRANT KEPT DURING THE YEAR 2013-2014	779000
INDIAN	0
GRAND TOTAL: Rs . (I+F)	779000

GRANT TRNS. to Income & Exp. A/C DURING 2013-14

FOREIGN A/C (PREVIOUS YEAR) C/F	4038724
INDIAN A/C (PREVIOUS YEAR) C/F	0
FOREIGN A/C (2013-14)	2000000
INDIAN A/C (201-14)	0
GRAND TOTAL: Rs. (I+F)	6038724

REFUND OF TRAVEL EXP. (MALASIA TRIP) (F)..... 31860

2. INTEREST RECEIVED ON SAVING BANK A/C & FIXED DEPOSITS

	I (S.B A/C)	I (F.D A/C)	F (S.B. A/C)	F (F.D A/C)	TOTAL
A) I.H.M.P GENERAL A/C	47915	0	0	0	47915
B) I.H.M.P GENERAL PUNE CENTRE A/C	16977	0	0	0	16977
C) A.G.R.T GENERAL A/C	107860	1207949	0	0	1315809
D) AROGYA MITRA YCMOU A/C	41	0	0	0	41
E) A.G.R.T 0833 A/C	0	0	187097	3385763	3572860
F) I. H. M. P PUNE CENTRE A/C	0	0	10025	0	10025
GRAND TOTAL	172793	1207949	197122	3385763	4963627

R. S. LOTKE & CO. M.No. 12895 C.A. A'bad.

Future Focus

AGRT/IHMP has decided to focus on adolescent health. The Institute has undertaken an initiative for “Integrated Adolescent Reproductive and Sexual Health and Development”.

The Institute hopes to work with young men for introducing gender equitable attitudes and for demonstrating an innovative strategy for preventing gender based violence.

Research will be undertaken to design and develop culturally appropriate scales for measuring self esteem and self efficacy in adolescent girls and young men.

Acknowledgements

Ashish Gram Rachna Trust, Institute of Health Management, Pachod, sincerely thanks all its partners, donors, supporters and well-wishers for their constant support and guidance. During this period AGRT received grants from the following funding agencies:

- MacArthur Foundation, USA
- OXFAM India, New Delhi

Support our Work

You can empower a rural adolescent girl with a donation of Rs. 7500.00.

You can ensure higher education for a rural adolescent girl by providing her with a bicycle worth Rs. 3000.00

We seek your assistance in empowering unmarried and married adolescent girls and in bringing about gender equity in our society.

Please send in your cheques/ drafts payable at Pachod to **‘Ashish Gram Rachna Trust** by mail to our head office - Ashish Gram Rachna Trust, Institute of Health Management, Pachod; PO. Pachod; District Aurangabad, 431 121; Maharashtra

All donations to **Ashish Gram Rachna Trust** are eligible for tax exemption under Section 80G of the Income Tax Act, 1961.

For more information, please write to us at admin@ihmp.org OR ihmpp_agd@bsnl.in

Contact us at:

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Maharashtra, India
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