

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

# **Annual Report**

**2012 - 2013**

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

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## **About Ashish Gram Rachna Trust, Institute of Health Management, 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 centred 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 1<sup>st</sup> April 2012 to 31<sup>st</sup> March 2013**

- 1. Safe Adolescent Transition and Health Initiative (SATHI): Focused interventions for Married Adolescent Girls - Implementation at Pilot Site and Scaling up**
- 2. Integrated Project for the Reproductive and Sexual Health and Development of Unmarried Adolescent Girls, Married Adolescent Girls and their Spouses**
- 3. Primary Health Care**
- 4. Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city**
- 5. Project for Strengthening a Primary Urban Health Centre Of Pune Municipal Corporation (PMC)**

### **1. Safe Adolescent Transition and Health Initiative (SATHI): Focused interventions for Married Adolescent Girls - Implementation at Pilot Site and Scaling up - April 2012 – December 2012**

#### **Introduction**

Institute of Health Management, Pachod initiated an innovative pilot project with focused interventions for Married Adolescent Girls in the villages under Nander PHC, in 2003. IHMP continued to implement the pilot project to delay age at first conception and avert the adverse consequences of early motherhood in married adolescent girls till December 2012. IHMP sustained implementation at the pilot site so that it could be used for the purpose of advocacy by demonstrating the five project innovations to policy makers and other key stakeholders. The other reason for maintaining the pilot site was to provide skills oriented field training to health functionaries from the sites where the project was scaled up. The interventions were up scaled through non-government organizations in 5 districts, which had a high proportion of girls getting married before 18 years and poor RCH indicators. Thereafter, the interventions were scaled up in one block, with 280,000 population, through 7 PHCs under National Rural Health Mission. Results of up scaled projects were as encouraging as the pilot site. Even though the advocacy efforts to scale up the interventions continue, IHMP decided to close down the pilot site in December 2012.

#### **The annual report is presented in four parts as follows:**

1. Report of the Pilot Project “To delay age at first conception and avert the adverse consequences of early motherhood in Married Adolescent Girls (MAGs)” for the period April 2012 to December 2012.

2. Summary report of “Scaling up a focused intervention for married adolescent girls and integration with Reproductive and Child Health, in the context of NRHM, in one block through 7 Government Primary Health Centres”-April 2010 to March 2012.
3. Summary of the external evaluation report by Gokhale Institute of Politics and Economics on “Scaling up the project ‘Reducing Reproductive Morbidity in Married Adolescent Girls in Five Districts of Maharashtra’ through the Safe Adolescent Transition and Health Initiative (SATHI) - January 2008 to June 2011.
4. Outcome of advocacy with UNICEF and Government of Maharashtra for Scaling up a focused intervention for married adolescent girls and integration with Reproductive and Child Health programme.

**Since January 2013, under No Cost Extension, IHMP is implementing an “Integrated project for the reproductive and sexual health and development of unmarried adolescent girls, married adolescent girls and their spouses”, which is being reported separately.**

## **PART 1**

**Report of the Pilot Project: “To delay age at first conception and avert the adverse consequences of early motherhood in Married Adolescent Girls (MAGs)” for the period April to December 2012.**

### **Broad Objective:**

To improve the sexual and reproductive health of married adolescent girls in villages under Nander PHC and to use the pilot project site for capacity building during scaling up and to demonstrate the 5 project innovations to policy makers and other key stakeholders.

### **Specific Objectives: (For the Period 2010 to 2012)**

1. To increase the treatment seeking behavior for post abortion complications.
2. To delay the average age at first conception.
3. To reduce proportion of low birth weight babies.
4. To increase treatment seeking for RTIs among married adolescent girls.
5. To increase proportion of MAGs seeking treatment for post-natal complications.

### **Implementation of the five Innovations (Input Indicators)**

#### **a. Surveillance Coverage:**

IHMP has established a community based surveillance system for early detection of health needs. On average 85.0 percent MAGs were covered during monthly surveillance.

#### **b. Micro-planning:**

Every month micro-planners were prepared by community organizers on the basis of health needs identified during the monthly surveillance visit.

**c. Need specific IPC and group BCC through community based workers:**

*1. Need specific IPC by community based workers*

At the time of surveillance visit, community organizers detect health education needs & do behavioral diagnosis and give MAGs and her household members need based IPC.

*2. Need specific IPC by supervisor*

Female supervisors visited MAG's during house visits and gave them and their family members need specific health counseling. On an average, during each village visit 10 MAG's were given need specific IPC.

*3. Group BCC through community based workers*

ANMs conducted monthly BCC group meetings for MAGs at the community level. 91 percent of the planned meetings were conducted with the MAGs every month and on an average each meeting was attended by 14 married adolescent girls.

Monthly BCC group meetings were conducted for spouses of married adolescent girls by male social workers. 87 percent of the planned BCC group meetings for spouses were conducted every month. Each meeting was attended on an average by 18 spouses.

**d. Linking Married Adolescent Girls with primary level and referral services:** Primary level care and referral services are provided to MAGs that are in need of health care by health functionaries through fortnightly village visits.

**Project outputs /outcomes correlated to specific objectives**

Project output and outcome indicators are presented against each specific objective of the project. This information is based on the monthly compilation of data from surveillance and service record of COs and ANMs.

**Objective 1: To increase treatment seeking behavior for post abortion complications**

During the reporting period 18 MAGs had an abortion (abortion rate was 12.8 percent). The abortion rate at baseline was 16 abortions per 100 pregnancies. Not a single woman who had abortion reported any post abortion complications. This indicates a sharp decline of post abortion complications from 68 percent at baseline to 0 percent in 2012.

**Objective 2: To delay the average age at first conception**

The average age at first conception was 18 years in 2012

**Objective 3: To reduce proportion of low birth weight babies.**

Among the MAGs delivered in the project villages, 91 percent newborns were weighed at birth. The prevalence of low birth weight babies born was 19 percent compared to 36 percent at baseline. A total of five babies were born with low birth weight whose mothers were given thermal bags to maintain body temperature.

**Objective 4: To increase treatment seeking for RTIs among married adolescent girls by 20 percentage points**

6 percent married adolescent girls reported any one symptom of RTI as compared to 36.5 percent during baseline in 2003. More than 82 percent MAGs with symptoms of RTI sought treatment, which is significantly higher than at baseline (25.0 percent) in 2003

**Objective 5: To increase proportion of MAGs seeking treatment for post-natal complications by 20 percentage points.**

Only one MAG reported post natal complications for which she sought treatment.

**The project was evaluated in 2006 and 2009. A summary of the findings:**

<b>Indicator</b>	<b>Baseline 2003</b>	<b>Study 2006</b>	<b>Study 2009</b>
Median Age at Marriage	15	16	17
Median Age at First Conception	15.8	17	18
Mean interval between age at marriage and first conception	6.6	10.3	10.7
Temporary Contraceptive use	8.9	23.0	30.4
MAGs received minimum, standard ANC	32.4	70.3	80.4
MAGs consumed Standard 100 Iron and Folic Acid tablets	12.0	32.6	45.5
Prevalence of self reported RTIs and STIs	36.5	27.3	8.5
Prevalence of Post Natal Morbidity	23.3	9.2	8.5
Prevalence of low birth weight babies	36	25.3	21.0

**Exit Strategy - Steps taken for sustainability at pilot site (Nander PHC Villages)**



Village Health, Nutrition, Water and Sanitation Committees (VHNWSCs) were informed about IHMP's decision to withdraw from the villages under Nander PHC. They were requested to continue supporting the ASHAs and ensure that Married Adolescent Girls get timely services from the PHC staff.

**Village Health, Nutrition, Water and Sanitation Committee Meeting**

With the assistance of VHNWSCs, IHMP made sure that all the Community Health Workers (CHWs) trained by the Institute were absorbed as ASHAs under NRHM.



In 2012, IHMP enrolled all the community health workers from the Nander PHC villages for the ‘Arogya Mitra’ (Health Workers Training Course) offered by the Yashwantrao Chavan Maharashtra Open University, Nashik. The ‘Arogya Mitra’ course was initiated by the University, when the ASHA scheme was launched.

**ASHAs taking the ‘Arogya Mitra’ course examination.**

The Arogya Mitra course has been designed to give comprehensive knowledge and skills of primary health care to village women who provide community based primary health services. IHMP is a recognized centre for this training course. Thirty two hours of training inputs every month, over a period of five months, were provided to the trainees at IHMP Pachod. Skills development and practical work related to the five volumes of the training course was organized in the villages where IHMP is working.

## PART 2

### **Summary report of “Scaling up a focused intervention for married adolescent girls and integration with Reproductive & Child Health, in the context of NRHM, in one block through 7 Government Primary Health Centres”-April 2010 to March 2012.**

The five components of the **Married Adolescent Girl’s** intervention were scaled up to a block level through Government PHCs. The project was implemented in Paithan block through Government PHCs as model for NRHM. The five interventions of the MAGs project were integrated with the Reproductive and Child Health (RCH) program with a special focus on married adolescent girls. The findings of the evaluation conducted in 2012 are presented below:

**Table: Maternal Health Services**

Sr. No.	Variable	Category	Average 2010 (%)	Average 2011 (%)	Average 2012 (%)
1.	Registration Within 12 week of Pregnancy	<=19 years	75.8	85.6	86.1
		>=20 years	61.0	75.8	77.5

2.	100 IFA Tablets	<=19 years	67.1	88.4	87.3
		>=20 years	64.0	87.4	85.4
3.	Minimum Standard Antenatal Care	<=19 years	67.1	84.3	86.0
		>=20 years	64.0	84.7	85.0
4.	Low Birth Weight babies (Wt. < 2.5kg)	<=19 years	21.9	15.1	11.7
		>=20 years	15.5	09.3	12.9

There was a significant increase in maternal health care related indicators. The increase was greater for married adolescent girls <= 19 years as compared to women > 20 years. There was a significant reduction in the proportion of low birth weight babies; more among married adolescent girls less than 19 years as compared to women over 20 years.

**Table: Trends in Neonatal, Post neonatal and Infant Mortality**

Sr. No.	Variable	Category	Total 2010	Total 2011	Total 2012
1.	Neonatal Deaths (0 - 28 days)	<=19 years	11	7	5
		>=20 years	24	14	7
2.	Post Neonatal Deaths (29 days – 12 months)	<=19 years	1	1	1
		>=20 years	4	6	0
3.	Infant Deaths	<=19 years	12	8	6
		>=20 years	28	20	7

The data indicate a reduction in neonatal, post-neonatal and infant deaths among women over 20 years as well as married adolescent girls less than 19 years.

**Table: Use of Temporary Family Planning Methods**

Sr. No.	Variable	Category	Average 2010 (%)	Average 2011 (%)	Average 2012 (%)
1.	Contraceptive use	<=19 years	13.0	16.9	18.5
		>=20 years	36.0	41.0	41.0

Contraceptive use increased significantly among married adolescent girls as well as women over 20 years.



### **Capacity building for Scaling up of Innovations**

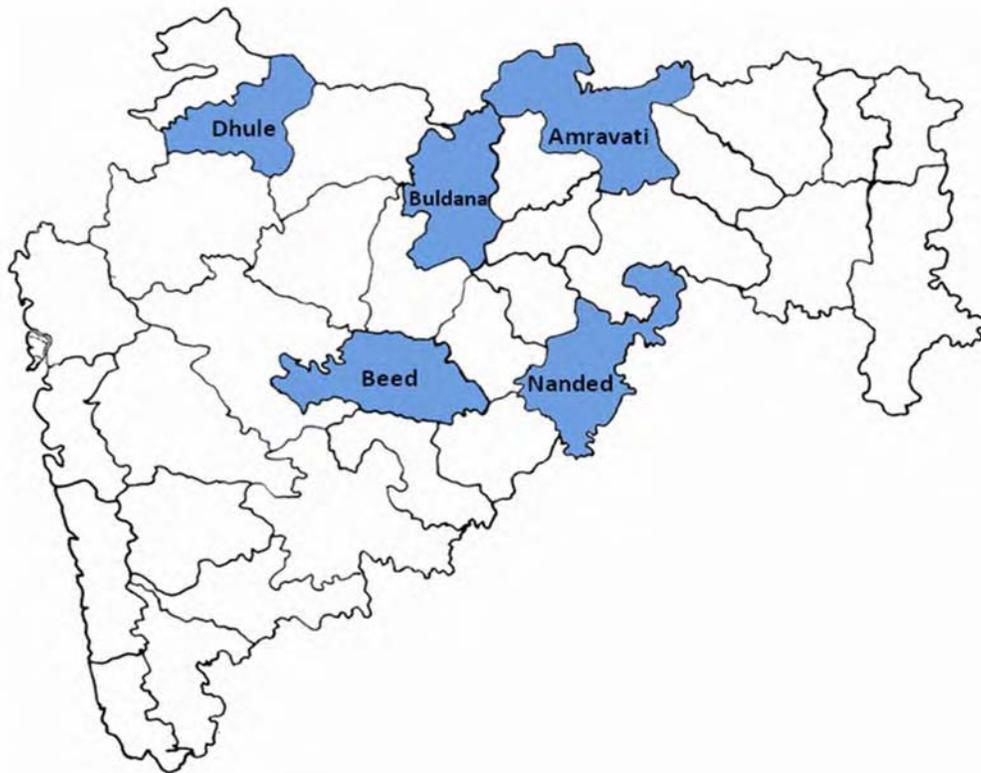
The Nander PHC pilot project site “To delay age at first conception and avert the adverse consequences of early motherhood in Married Adolescent Girls (MAGs)” played a crucial role in capacity building during the scaling up of the project in one block with 7 PHCs, from April 2010 to March 2012

### **ANMs from PHCs of Paithan Block undergoing training at IHMP**

Altogether 12 PHC medical officers, 42 ANMs, 35 MPWs, and over 200 ASHAs received field training at the pilot project site.

## **PART 3**

### **Scaling up the project ‘Reducing Reproductive Morbidity in Married Adolescent Girls in Five Districts of Maharashtra’ through the Safe Adolescent Transition and Health Initiative (SATHI) -January 2008 to June 2011**



#### **Five districts in Maharashtra where the MAGs project was scaled up**

Interventions for married adolescent girls were scaled up as the SATHI project that was implemented by five NGOs in the Districts of Beed, Nanded, Dhule, Buldhana and Amravati. A baseline survey was conducted by IHMP in 2008. An external evaluation was conducted by the Gokhale Institute of Politics and Economics (GIPE) in 2010. A summary of the findings of the external evaluation are presented below:

- Age at marriage was delayed by 1 ½ years among girls that got married in 2009, 2010.
- Mean age at first delivery increased from 16.9 years in 2008 to 17.5 in 2009 and 18.1 years in 2010.
- Change in reproductive health status of married adolescent girls between 2008 and 2010

**Table: Change in Reproductive Health Status of married Adolescent Girls**

<b>Sr. No.</b>	<b>Indicator</b>	<b>Base-line study 2008 (%)</b>	<b>End-line Evaluation 2010 (%)</b>
3.1	Contraceptive use	6.6	33.7
3.2	Early antenatal registration	60.0	78.0
3.3	Minimum, standard antenatal care	8.1	56.1
3.4	Prevalence of antenatal complications	55.0	44.0
3.5	Treatment for antenatal complications	75.0	88.0
3.6	Institutional deliveries	60.0	73.0
3.7	Post natal visits by Govt. ANM	18.0	31.6
3.8	Treatment for postnatal complications	56.0	78.8
3.9	Treatment for neonatal complications	40.2	58.2
3.10	Prevalence of menstrual problems	78.5	64.6
3.11	Treatment for UTIs	26.3	46.4
3.12	Treatment for RTIs	28.1	60.4
3.13	Treatment for self reported STIs	21.2	65.0
3.14	Tested for HIV	11.7	58.7

An external evaluation conducted by New Concepts, Delhi in 2011, compared the MIS data from the first quarter of 2009 with data from the first quarter of 2011. The findings of the external evaluation were similar to the findings of GIPE. The evaluators came to the conclusion that the scaling up of the interventions for married adolescent girls in 5 districts of Maharashtra had a measurable impact over a period of 2 years 2008 to 2010. New Concepts, Delhi also conducted a detailed process evaluation, which was a useful exercise as IHMP had a plan to scale up the interventions in the Government sector through Primary Health Centres.



**Skills Development of NGO Health Staff**

5 project coordinators, 25 field staff, and 20 ANMs from the project for married adolescent girls, implemented by NGOs, in 5 Districts of Maharashtra received skills based induction and refresher trainings at the Nander pilot project site. The participants were sent into the villages to practice the innovations that were being scaled up by the five NGOs.



**Skills Development for scaling up MAGs Innovations in 5 Districts**

## **PART 4**

### **4. Outcome of advocacy on UNICEF and Government of Maharashtra for Scaling up a focused intervention for married adolescent girls and integration with Reproductive and Child Health programme.**

Between April and December 2012, IHMP organized 4 presentations of the findings of the pilot project and outcome of the scaling up in the 5 districts as well as in one block through 7 Government PHCs. Several Government of Maharashtra (GoM) and UNICEF officials visited the pilot site to see how the innovations were operationalised in the field. GoM has decided to scale up three innovations – the surveillance and micro-planning systems and need specific BCC. UNICEF is scaling these innovations in 14 other States.

#### **Key Lesson Learnt**



NGOs that implement and research the efficacy of innovations desire to scale up these interventions.

Advocacy initiatives may culminate in adoption of the innovations at the policy level, but it is skilled based training that is required at the implementation levels to be able to implement them efficaciously.

**Capacity building through skills development**

## **2. Integrated Project for the Reproductive and Sexual Health and Development of Unmarried Adolescent Girls, Married Adolescent Girls and their Spouses - 1<sup>st</sup> January to 31<sup>st</sup> March 2013**

### **Introduction**

Institute of Health Management, Pachod initiated an innovative pilot project with focused interventions for Married Adolescent Girls in the villages under Nander PHC, in 2003, with support from MacArthur Foundation. IHMP continued to implement the pilot project to delay age at first conception and avert the adverse consequences of early motherhood in married adolescent girls till December 2012. Implementation was sustained at the pilot site so that it could be used for the purpose of advocacy by demonstrating the five project innovations to policy makers and other key stakeholders. The other reason for maintaining the pilot site was to provide skills oriented field training to health functionaries from the sites where the project was scaled up. The interventions were scaled up through non-government organizations in 5 districts, which had a high proportion of girls getting married before 18 years and poor RCH indicators. Thereafter the interventions were scaled up in one block, with 280,000 population, through 7 PHCs under the National Rural Health Mission. Even though the advocacy efforts to scale up the interventions continue, IHMP decided to close down the pilot site in December 2012.

After detailed discussions with MacArthur Foundation in July 2012, it was decided to initiate an “Integrated Project for the Reproductive and Sexual Health and Development of Unmarried Adolescent Girls, Married Adolescent Girls and their Spouses”, during the no cost extension of the project. It was felt that the integrated project, which also has an intervention for young men, should be implemented in a new area so that the proposed outcomes can be measured. A fresh project area was also found to be necessary because the IHMP proposes to develop innovative and culturally appropriate tools and scales for measuring the impact of ARSH interventions.

By September 2012, IHMP submitted a detailed project proposal to MacArthur Foundation for a no cost extension. In October 2012, it was decided that IHMP would include a control area for the measurement of outputs, outcomes and impact of the project as a mere pre-post design would be less meaningful.

After a few iterations the proposal was approved in December 2012 and Institute of Health Management, Pachod received the grant for no cost extension in January 2013. It was decided that the project will be implemented in the villages under Adul PHC, which has a sizable population of denotified tribes whose health status is lower than the general population.

The villages under Sukhapuri PHC in the adjoining Jalna district were selected as the control area. These villages are very similar to the project area villages. They are at a reasonable distance of 30 to 40 kilometers from the project villages, which will prevent contamination.

On 1<sup>st</sup> January 2013, Institute of Health Management Pachod initiated the “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.



**One of the villages where the New Project has been initiated**

**The activity report for the period January to March 2013 is presented in four parts**

Preparatory activities for initiating the project

Activities related to the 3 components of the project:

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 domestic violence and gender inequitable behaviors.

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

Preparatory activities carried out from Jan. 2013 to March 2013 for initiating the project

### **Social Mapping, Numbering of Households and Listing of Target Populations**

There are 33 villages and hamlets under the Adul PHC. Activities for village mapping, household numbering and preparing lists for three target populations were initiated on 17<sup>th</sup> Dec. 2012 and completed by 2<sup>nd</sup> Feb. 2013. There were three teams working simultaneously, each team had two members.



**Transect walk**

The teams undertook a transect walk in every village during which they identified roads, lanes and land marks e.g. location of hand pumps, stand posts, temple, approach road, Gram Panchayat office, anganwadi building, sub-center, school, etc. An outline of the village was prepared on a large piece of paper. The land marks identified during the transect walk were marked on the village outline.



**Participatory Modified Social Mapping of Villages**

After completion of the transect walk, modified social mapping was undertaken in each village. In some villages men, in others women and in still others school children participated in the participatory social mapping exercise. The participants identified each household and its members. The households were marked on the outline of the village map. Modified social mapping has been completed for 33 villages in the project area. Roads and all the houses with numbers have been shown on the map. (Refer **Annexure: 1 Example of a village map**)



**House Numbering**

One member in each team used to simultaneously write numbers on the frame of the entrance door to each household.

## Census and Listing of Target Populations in Project Villages



**Household survey – Head of household being interviewed in a project village**

During household survey the teams collected information about total members in the household, head of the household, unmarried adolescent girls, young men, married adolescent girls and marriages in the household in the last five years. Six different formats were used to collect the household level information.



**Household survey in an intervention village**

**Census Data of Project Villages:** There are a total of 5969 households with a population of 28,965 in the 33 villages under Adul PHC. A total of 1883 unmarried adolescent girls were identified from 33 villages. The project teams identified 582 adolescent married girls less than 19 years. There were 2655 youth 15-24 years of age. Out of the total marriages reported in the last five years - 1008 marriages were of girls and 966 marriages were of boys.

## Census and Listing of Target Populations in Control Villages



**Household survey in a control village**

Mapping, numbering of households and listing of three target populations was initiated in the control villages under Sukhapuri PHC from 11<sup>th</sup> February 2013 and completed on 3<sup>rd</sup> April 2013.

**Census Data of Control villages:** There are 27 villages in the control area with 6209 households and a total population of 30,422. The IHMP teams found 525 households locked during the census. The teams identified 1633 unmarried adolescent girls and 653 married adolescent girls. There were 2165 young men in the age group 15 to 24 years of age. Information on marriages which took place in the last five years was also collected. Out of the total marriages, 965 marriages were of boys and 926 were of girls.

**Village Profile:** The mapping team collected information regarding resources and facilities in each village through interviews with sarpanch, anganwadi worker, school teacher and local leaders. Information which was collected for completing the 'Village Profile' is given below:

1. Name of the village
2. Population
3. Village Health & Nutrition Day for that village
4. Name of the sub-centre which provides health services to this village
5. Name of ANM and MPW of the sub-centre
6. Number of ASHAs in the village, their names and contact phone numbers
7. Number of anganwadi centers in the village,
8. Name/s of anganwadi workers and helpers
9. Name of school/s, Number of classes /grades in the school, Number of teachers
10. Names of elected members of the Gram Panchayat

**Community Mobilization:** From 10<sup>th</sup> Jan. 2013 to 24<sup>th</sup> Jan. 2013, separate group meetings for men and women were conducted in the evenings, in each project village by three male and three female, senior, social workers. On an average 20 – 25 men and 15 women attended the meeting from each village. The key objective of the meetings was to orient the community about three components of this project and to request the community to extend co-operation. Interventions and strategies which would be introduced for three components of the project and community monitoring by VHNWSC were discussed. Roles and Responsibilities of Village Health Nutrition Water and Sanitation Committees (VHNWSC), ASHAs and IHMP were also discussed.

**Parents Meetings:** Parents meetings were conducted by three male and three female senior social workers in 33 villages of Adul PHC from 4<sup>th</sup> Feb. to 20<sup>th</sup> Feb. 2013 for orientation of parents of unmarried adolescent girls regarding 'Life Skills' education programme. On an average 20-25 mothers and fathers of the adolescent girls attended these meetings in each village. Parents were requested to suggest suitable time and make a place available for conducting Life Skills sessions for adolescent girls. They were informed that Life Skills Education for unmarried adolescent girls will be initiated after completion of the baseline survey. Facilitators, requested parents to give written consent for collection of baseline information regarding knowledge, attitudes and skills from the adolescent girls.



**Written consent of parents being taken for baseline survey of unmarried adolescent girls**

The census and household level surveys provided the sampling frame for the research studies planned for the three components of the integrated project. The census data also provided details of the target population that need to be reached once project implementation begins.

**Challenges:** Maharashtra has suffered the worst drought in the last 40 years. Aurangabad district, which is a part of the Marathwada region, was the worst effected district. Some of the villages in the project area do not have a single drop of water. The result is that either few family members or entire families have migrated to nearby cities or districts where some water is still available. The impact it had on the study was that several houses were found locked in all the villages. We are certain that some individuals from each target population have been missed out.

## PART - 1

### Empowerment of Unmarried Adolescent Girls through Life Skills Education

#### Qualitative research on the perception of adolescent girls about self esteem and local lexicon related to the concept:

Literature review was undertaken to study different scales used for measuring self-esteem and self-efficacy among adolescents. The Rosenberg Self-Esteem Scale is perhaps the most widely-used self-esteem measure in social science research. Dr Rosenberg's work on self-concept, particularly the dimension of self-esteem among adolescents, is world-renowned.

The general Self-Efficacy scale developed by Matthias Jerusalem and Ralf Schwarzer, has been revised and adapted in 26 other languages. The scale was created to assess a general sense of perceived self-efficacy with the aim in mind to predict coping with daily hassles as well as adaptation after experiencing all kinds of stressful life events. The scale is designed for the general adult population, including adolescents.

In order to use these scales with rural adolescent girls in India it was necessary to adapt and make the scale culturally appropriate and translate these into the local language. The scales were translated with the assistance of adolescent girls by using the local lexicon provided by them.

#### Examples of local lexicon related to self esteem elicited from adolescent girls

Local lexicon for confidence, brave, self reliant, independent, - **Dhit, Dhadas, Dhairya, Himat, Nischaya.**

*A girl who can take a decision in the face of adversity has “**himat**,” “**dhairya**”. A girl who has the confidence of being a leader has “**Dhadas**”. Someone who can work independently is self-reliant “**Nischaya**”. A girl who can speak in front of many people is - “**Dhit**”. “If you want to be a village sarpanch, you have to be brave “**Dhadas**”.*

#### **Q: What are the qualities of a girl who is self confident?**

*“A girl who can do her work without taking anyone else's help is self confident”. The girl does whatever she says “**je bolte te karun dhakhavate**”.*

*“If someone is creating obstacles for a girl, she should have confidence “**himat**” to overcome those obstacles by making that person understand”*

#### **Q: What are the qualities of someone who does not have self confidence?**

*Lexicon: **Laaj vatate, Apamaan hoto, Bhiti vatate, Ghabartat.***

#### **Q: Is there any difference between having arrogance and having good self confidence?**

*Arrogance is being “**tukar**”.*

A systematic qualitative research study was undertaken with 82 adolescent girls in the age group 13 to 18 years, from different villages. They participated in focus group discussions. Below we present some excerpts of their perceptions related to self esteem and self efficacy.

### **Examples of perceptions of adolescent girls related to self esteem and self efficacy**

**Q: Who has self esteem?** *“A girl who makes mistakes but tells her parents has self confidence.”*

**Q: What kind of decisions do adolescent girls make on a daily basis? How does a girl come to the conclusion that her decision is good?** *“What to cook; Meet friends or not; attend school or not; continue education or not”. “If you make a decision and you’re successful in your work, then your decision was right.”*

Only one girl expressed the opinion that decision making is not correlated with self esteem.

**Q: What does it mean to be smart (hushar)?** *A girl who can speak in front of others, answers all questions, does homework and housework regularly.*

**Q: Why are some girls not hushar/smart?** *They fear they will give the wrong answer to a question; Can’t make their own decisions; Can’t speak in front of adults.*

**Q: Who is a friend?** *“A friend is someone with whom we can share everything and speak freely.” “Whenever there is a problem a friend comes to help.”*

**Q: How does a girl come to know that she has good skills?** *“If a girl has skills, she shows them to others and receives praise. From that, she comes to know that she has skills, and it increases her self confidence.”*

**Q: How does parent’s behavior affect self-esteem in a girl?** *“When mother is not listening to the daughter, daughter thinks that “am I her daughter or not?” It makes girls feel disconnected from the family and girls become unmotivated*

**Q: Who can be a leader? What is leadership?** *Someone who can control a group is smart. Someone, who is not shy while expressing herself, Someone, who can take decisions.*

**Q: What makes a family proud of a girl?** *“Parents are proud of girls that can take care of the house, behave well.”*

**Q: Does gender discrimination affect your self esteem?** *Gender discrimination makes a girl feel she has no importance in the house. She feels her family members do not love her.*

**Q: Which changes are really noticeable in the girls who have gone through the Life Skills Education class?** *They developed a liking for higher education; Can speak against the wrong decisions of parents such as marriage before 18 and stopping education; Can express opinion without fear; have more knowledge and skills; can take decisions.*

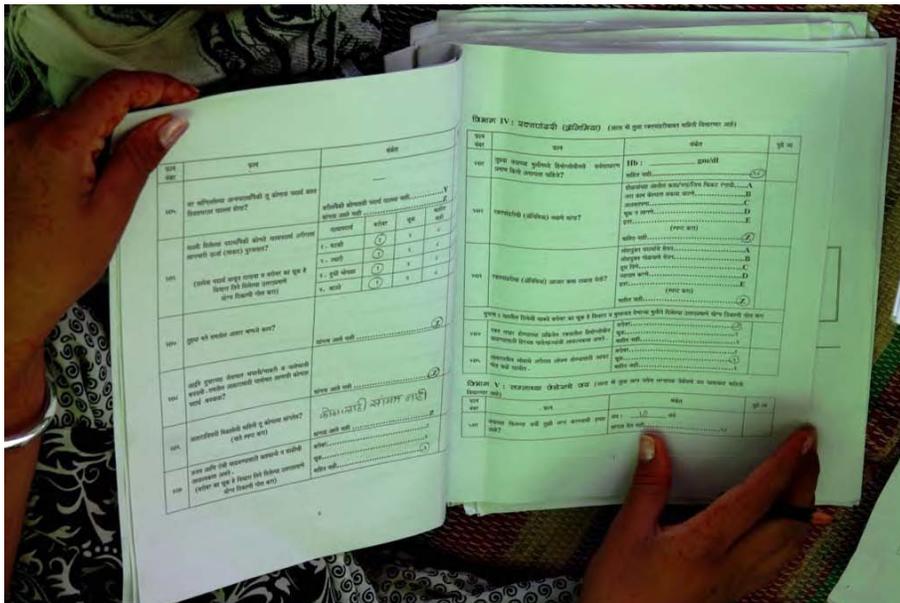
## Design & Development of Tool for Measuring Self-esteem & Self-efficacy in Adolescent Girls



**Perceptions of unmarried adolescent girls for finalizing the tool for data collection**

Once the draft instrument for data collection was designed, it was shown to a group of adolescent girls and their perceptions were sought before finalizing the tool.

A composite instrument was designed by incorporating factors from the international scales that were translated by the girls as well as factors derived from the qualitative research conducted with the adolescent girls.



**Final tool for data collection**

Since the adolescent girls found it difficult to respond to the Likert Scale - the Pachod Paisa scale was used to measure the strength of perceptions and attitudes (Source: “The Pachod Paisa Scale: A Numeric Response Scale for Health and Social Sciences” N. Kapadia-Kundu and A. Dyalchand (Demography India, June 2007)

The instrument for data collection from unmarried adolescent girls has two parts:

- a. Socio demographic data, age at marriage, knowledge, skills, perceptions
- b. Self esteem and self efficacy



**Pretesting the tool for Unmarried Adolescent Girls**

At the time of pretesting the tool for data collection the process of supervision for data quality assurance and consistency check were tried out in the field. It was decided that there will be three levels of supervision and consistency checks.

### **Processes for Data Quality Assurance**



**First level of supervision for data quality assurance and consistency check**

While the data collection is going on a supervisor will check for inconsistencies and missing values in each interview schedule. If any gap is found the supervisor will send the investigator back to the respondent to get missing data or cross verify and correct the inconsistency.



### **Second level of data quality assurance, supervision and consistency check**

At the second level, field coordinators along with the investigators, will check all the interview schedules filled each day. Any inconsistencies will be corrected the next day when investigators go for data collection to the same village.



### **Third level of data quality assurance, supervision and consistency check**

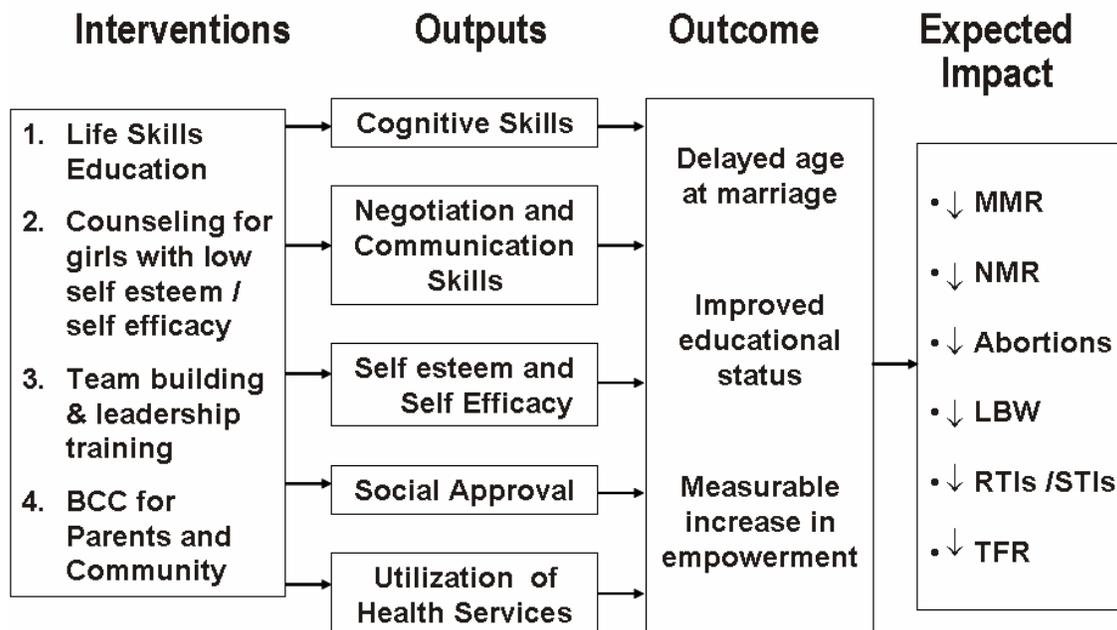
At the third level the Data Analyst will undertake consistency checks after data has been entered. In case gross inconsistencies are detected the supervisors will be asked to go back to the respondent and cross check.

The baseline survey with unmarried adolescent girls will begin in May 2013. The interview schedule includes indicators to assess the objectives presented below as well as the various components of the conceptual model:

1. Measurable increase in cognitive and practical skills in unmarried adolescent girls.
2. Measurable improvement in self esteem and self efficacy of unmarried adolescent girls.
3. Increase in formal school education of unmarried adolescent girls.
4. Reduction in the proportion of girls getting married before 18 years.

**Life Skills education for unmarried adolescent girls will be initiated as soon as the baseline study is completed.**

## Conceptual Model



### Baseline Study – Unmarried Adolescent Girl

**Project Area** - Villages under Adul PHC in Aurangabad District

**Control Area** - Villages under Sukhapuri PHC in Jalna District

### Study Design

Project area	O	X	O
Control area	O		O

**Method of Data Collection** –Unmarried adolescent girls will be interviewed using a structured interview schedule that has been prepared in Marathi and pre-tested in Pachod villages by IHMP staff. The interview schedule has two parts:

- The first part will measure the dimensions of knowledge, attitudes, perceptions and behaviour (KAPB).
- The second part will measure the dimensions of self-esteem and self-efficacy.

**Sampling Unit** – Unmarried adolescent girls aged 11-19 years from study and control area.

**Inclusion Criteria for Study Respondents** – Permanent resident, unmarried adolescent girls 11-19 years of age

**Sampling Frame** - Villages in the study and control area were mapped, and a complete census was conducted in each village. All the unmarried adolescent girls in each village were listed, and

their house location was mapped for future reference. The sampling frame consists of all unmarried adolescent girls (UAGs) ranging from 11 to 19 years.

### **Sample Size**

In order to detect a minimum difference of 10% in levels of knowledge and self esteem over three years, assuming an alpha of 0.05 and using a two-sided test to achieve 80 percent power, it was determined that a sample size of 160 would be needed for each age group i.e. 11-14 years and 15-19 years, at each site. (Fleiss et al, 2003).

To avoid replacement against non-covered individuals and to reduce non-response error a random sample of 400 unmarried girls (200 UAGs 11-14 years and 200 UAGs 15-19 years) from the study area and a similar random sample of 400 unmarried girls from control area will be selected.

### **Plan for Data Collection and Processing**

A total of 6 female investigators and five supervisors will be recruited based on their previous experience of data collection. Investigators will be trained for 5 days at IHMP, in the skills of interviewing, how to conduct oneself in the field and how to fill interview schedules. Each question in the interview schedule will be explained to the investigators. The main emphasis of the training will be to impart practical skills to each investigator. Since the interview of unmarried adolescent girls includes sensitive questions on self esteem and self efficacy, a protocol is being prepared for simulated interviews, role plays and actual interviews in a village not included in the project area. After ensuring that each investigator can conduct interviews and fill the interview schedules satisfactorily, the actual baseline data collection will be initiated in the month of May 2013.

### **Data Entry and Analysis Plan**

Collected data will be entered in EPIDATA software. Two data entry clerks will be appointed and trained. One data entry clerk will enter the data from each interview schedule and another data entry clerk will check the entries made. The data will be transferred and analyzed in 'Stata'.

Chi-squared tests for discrete and t-tests for continuous variables will be used to determine differences in the characteristics between dependent and independent variables. Multivariate analysis will be done to determine potential predictors for the outcome and output variables.

Scale for self esteem and self efficacy will be developed using factor analysis. Principal components method will be used to identify main factors. Rotated factor loadings will be computed, items with rotated factor loading higher than 0.40 will be identified. Factors with eigen value more than 1 will be considered for analysis. Cronbach's alpha will be computed to test reliability. Cronbach's alpha more than 0.70 will be considered.

After identification of factors using principal components analysis, a composite index for self esteem/and self efficacy will be created. A 50 percent cut off will be used to distinguish between girls having high and low self esteem and self efficacy. Using multivariate logistic regression analysis, characteristics of girls with low self esteem and self efficacy will be studied. After the girls with low self esteem and self efficacy have been identified they will be provided with

counseling and other special inputs. Their family members will also be provided with focused inputs if required.

## **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**

**Development of instruments for collecting data for measuring general self esteem and self efficacy, sexual self-esteem and self-efficacy and gender attitudes in young men.**

**Background and Evolution:** In 2005, Institute of Health Management, Pachod, (IHMP) conducted qualitative research with young men to find out their perceptions and attitudes related to sexual self esteem, sexual self efficacy, gender norms and sexual behaviours. The Institute developed a participatory method for collecting perceptions and attitudes about topics and issues of a sensitive nature. The method developed by IHMP is known as Participatory Anonymous Response and Consensus – “The PARC Method”.

In 2008 the PARC method was used for collecting information on sexual self esteem, sexual self efficacy, gender norms and sexual behaviours.

#### **A description of “The PARC Method”**



### **PARC Step 1: Anonymous Individual Response**

The first step of the PARC method was to ask each participant to provide responses that are based on their own knowledge and experience. The individual responses were elicited after the participants had been assured of complete and apparent anonymity and confidentiality.

The individuals were asked to drop their responses in a drop box. A foolproof mechanism was put in place whereby none of the investigators or researchers could relate the responses to a respondent.

Each participant was encouraged to provide responses to questions about sexual preferences, sexual fears, inhibitions and practices. Since the individual responses were based upon belief systems, group norms and personal experience it provided the basis for designing an instrument developed through systematic and objective data collection from the target population for which the instrument was intended.



**PARC Step 2: Combined Group Response - Free listing & Ranking**

After the individuals had provided their responses the participants undertook free-listing and ranking of the individual responses. A facilitator assisted the group in free listing of the individual responses. A response received from several participants was given a higher ranking.

The free listing and ranking of the individual responses created the group response. Thereafter it was only the group response that was discussed.



**PARC Step 3: Consensus on Group Responses**

The group discussed the responses and came to a consensus regarding the relevance and appropriateness of each response. Facilitators ensured that there was a consensus around the responses that were listed as well as the ranking that they had been given.



**PARC Step 4: In-depth Group Discussion**

Focus group discussions were conducted around the group response to determine the underlying factors associated with perceptions, attitudes related to sexual self-esteem and self-efficacy and sexual behaviors. The group responses facilitated the most lively and dynamic FGDs.

This earlier qualitative research study in which 858 young men participated in batches culminated in designing a self-administered questionnaire which had a list of 110 questions.

In January 2013, IHMP invited 25 young men for further qualitative research. The participants were requested to respond to the self-administered questionnaire after they had been assured of complete and apparent anonymity and confidentiality.

The questions for which there was significant variation were retained. Questions where there was no variation were eliminated. After modifying and editing the questionnaire was again shown to the participants to find out which questions they found to be irrelevant.

In March 2013, IHMP invited a second group of 20 young men. Their assistance was sought for finding suitable local lexicon to translate the Rosenberg Self-Esteem Scale, Matthias Jerusalem and Ralf Schwarzer general Self-Efficacy scale and the Gender Equitable Men's (GEMs) scale developed by the Rishta project.

This group of 20 young men also looked at the work of the earlier group that had provided feedback on the self-administered questionnaire on sexual self-esteem and sexual self-efficacy.

Several of these young men have volunteered to be co- researchers and will help in data collection after the instruments and protocols have been finalized.

**Expected outcomes from the interventions for young men**

1. Measurable change in the attitude and behavior of young men towards women.
2. Reduction in gender inequitable behaviors and risky sexual behaviors in young men.
3. Reduction in the proportion of young men getting married to girls less than 18 years.
4. Reduction in the proportion of young men involved in perpetrating domestic violence.

**Study Design** - Pre post test following a series of sessions for each batch of young men.

**The self administered questionnaire** - There are five parts to the instrument that has been designed for data collection from unmarried and married young men:

- a. Socio demographic data and KAP
- b. General self esteem and self efficacy
- c. Sexual self esteem and self efficacy
- d. Gender equitable men's scale
- e. Self reported sexual behaviors

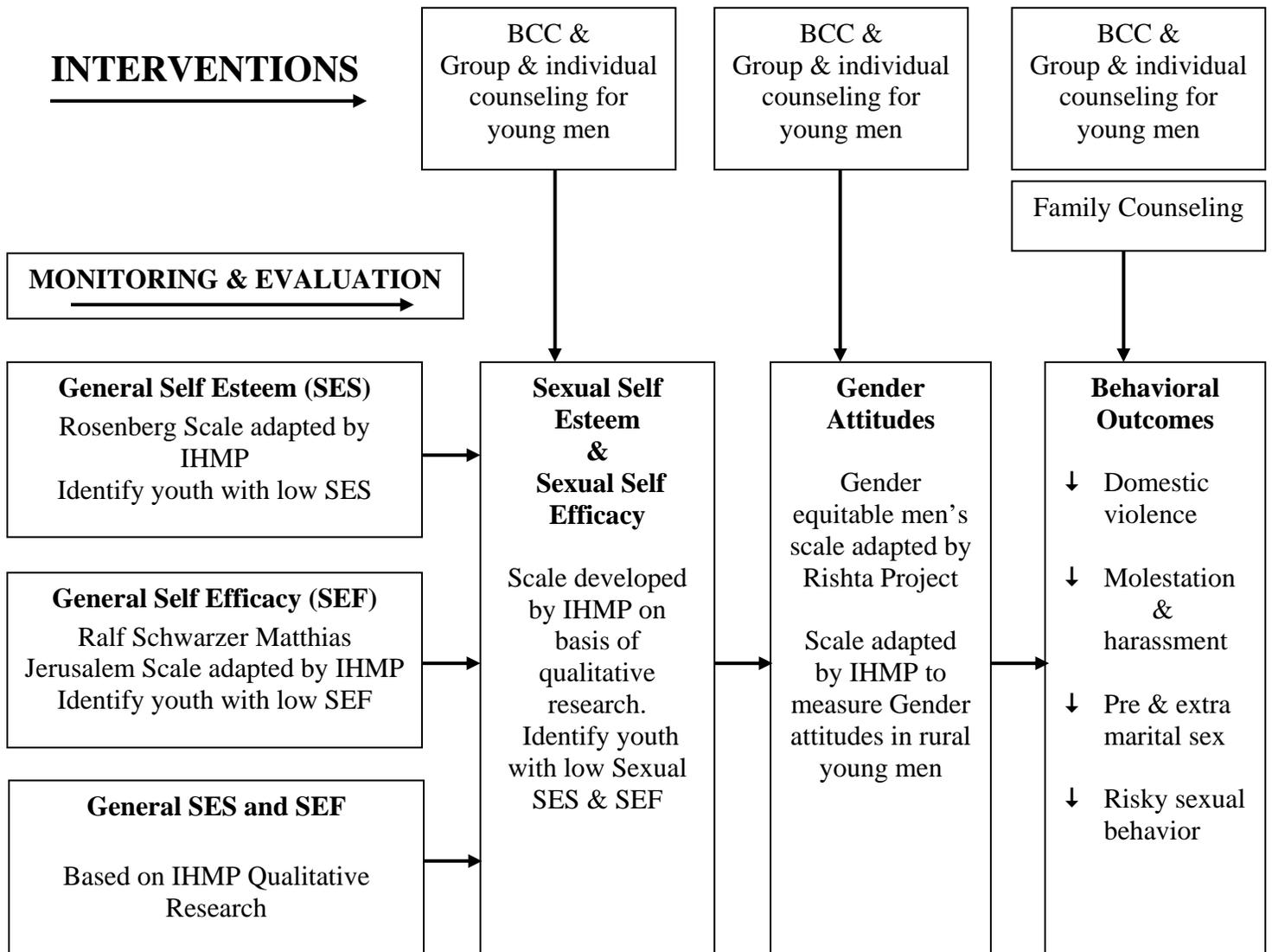
**Research Question** - Is there a significant association between self esteem, sexual self esteem, gender attitudes and self reported sexual behaviors?

The scales will be finalized using factor analysis. Principal components method will be used to identify main factors. The same cut offs will be used as are being used in the case of scales for unmarried adolescent girls. The scales will be used for identifying young men in need of individual counseling and special care.

Interventions for young men will be implemented after the study has been completed

# Interventions for Young Men and Measuring Their Impact

## Conceptual Model



## PART - 3

### Protection of young married women from the adverse consequences of early marriage

#### Baseline Survey:

Interview schedule for the baseline study with married adolescent girls was finalized and pretested in February 2013. It has 8 sections and covers indicators for all the specific objectives mentioned in the proposal. A total of 12 investigators and 5 supervisors were trained to interview and collect baseline information. Training of the investigators was conducted at the IHMP from 12th March 2013 and actual data collection began from 18th March 2013.



**Interview of young married couple**

#### Expected outcomes from Part 3 of the proposal - “Protection of young married women from adverse consequences of early marriage”

1. Increase in the proportion of women having 1<sup>st</sup> child birth after 18 years
2. Increase in the proportion of women registering for ANC before 12 weeks of pregnancy
3. Increase in proportion of women receiving minimum, standard, ante and postnatal care
4. Increase in the proportion of women taking treatment for maternal complications
5. Measurable reduction in maternal complications in married adolescent girls.
6. Reduction in prevalence of LBW babies



**Interview of a married adolescent girl**



**Interview of a spouse of a married adolescent girl**

**Project area** – Villages under Adul PHC in Aurangabad District

**Control area** - Villages under Sukhapuri PHC in Jalna District

**Study Design**

Project Villages	O	X	O
Control Villages	O		O

**Method of Data Collection**

Interview of married adolescent girls aged  $\leq 19$  years using structured interview schedule

**Sampling Unit**

Married adolescent girls aged  $\leq 19$  years from study and control area.

**Inclusion Criteria for Study Respondents**

Married Adolescent Girls (MAGs)  $\leq 19$  years of age with one child that are permanent residents of the project and control villages.

**Sampling Frame**

Villages in the study and control area were mapped. A complete census was conducted in each village. All the married adolescent girls were listed, and their house location was mapped for future reference. The sampling frame consisted of all MAGs  $\leq 19$  years having one surviving child.

**Sample Size**

Primary outcome - Utilization of minimum standard antenatal care (registered within 12 weeks of pregnancy, received three AN checkups, 2 TT injections and consumed 90 or more IFA tablets during pregnancy).

To detect a 10% increase in utilization of minimum standard antenatal care services over three years, assuming an alpha of 0.05 and using a two-sided test to achieve 80 percent power, it was determined that a sample size of 160 would be needed at each site. (Fleiss et al, 2003).

The sample size is 160 MAGs each from study and control area. To avoid replacement against non-covered individuals and to reduce the non-response error a random sample of 200 recently delivered mothers from the project area and a similar random sample of 200 recently delivered mothers from control was taken.

**Method of Data Collection - Interview Schedule**

A uniform pre-coded interview schedule was designed for data collection. The interview schedule was designed in Marathi, and pre-tested by the IHMP staff through 10 interviews completed in three villages near Pachod. Based on the pre-test, appropriate modifications were made in the interview schedule, which was then used to collect information from married adolescent girls  $\leq 19$  years. It included questions on socio-demographic profile, reproductive history, maternal health, and HIV/AIDS.

**Data Collection and Processing**

A total of 12 female investigators and five supervisors were recruited based on their previous experience of data collection.

Investigators were trained for 5 days at IHMP, Pachod Centre from 12<sup>th</sup> to 16<sup>th</sup> March, 2013. Investigators were trained in the skills of interviewing, how to conduct oneself in the field and how to fill interview schedules. Explanation was also given about each question in the interview schedule. The main emphasis of the training was to impart practical skills to each person

interviewing and filling the interview schedules. This was done with the help of simulated interviews, role plays and actual interviews in a village not included in the Project. After ensuring that each investigator could conduct interviews independently and fill the interview schedules satisfactorily, the actual baseline data collection was initiated on 18<sup>th</sup> March 2013. The data collection team included 12 investigators, 5 supervisors and one researcher for quality control.

The baseline data collection was completed on 18<sup>th</sup> April 2013. Out of 400 sampled respondents from study and control area, 329 MAGs <=19 years (164 from study area & 165 from control area were interviewed).

### **Data Quality Assurance**

During data collection at the village level, supervisors observed at least one interview of each investigator every day. At the IHMP office the filled-in interview schedules were checked by the researcher. Manual data analysis for data quality assurance was done regularly. Based on findings of the supervisor, feedback was given to the data collection team regularly to standardize data quality.

### **Data Entry and Cleaning**

A data entry program in EPI data was designed and pre-tested for data entry. A data entry clerk is entering data from each interview schedule, and a second data entry clerk is checking the entries. Data will be transferred to 'STATA' for data analysis.

### **Programme Implementation**

Protection of young married women from the adverse consequences of early conception was the first component of the integrated project for which service provision has begun.

As the baseline data collection kept getting completed in a village the medical doctor and ANMs would start service provision. Implementation of most interventions for this component of the integrated project has begun in the project villages.



### **3. Primary Health Care April 2012 to December 2012**

Institute of Health Management, Pachod has been implementing a Primary Health Care Program in 24 villages of Nander PHC area covering population of 31,208 people.

#### **Project Inputs and Outputs from April 2012 to December 2012**

##### **1. Monthly In-service Training of Community Organisers (COs)**

Every month on fixed days all the village health workers come to Institution to report their last month's activities and plan next month's work. During these monthly meetings they discuss one topic related to their work with each other to increase and share their knowledge.

##### **Subjects discussed during CO meetings.**

<b>Sr. No.</b>	<b>Month</b>	<b>Subject</b>
1.	April 2012	Care of low birth weight baby
2.	May 2012	Temporary methods of contraception
3.	June 2012	Disadvantages of early marriage & risks associated with conception before 18 years of age
4.	July 2012	Care during pregnancy and importance of antenatal services
5.	August 2012	Danger signs in pregnancy & need for HIV testing in pregnancy
6.	September 2012	Abortion & post abortion care
7.	October 2012	Birth preparedness, Danger signs during delivery & Importance of hospital delivery
8.	November 2012	Postnatal care of mother
9.	December 2012	Care of newborn

##### **2. Monthly Surveillance and IPC through Community Organisers**

Surveillance of health needs is done through COs during monthly house visits. They collect information on childhood diseases, pregnant women, gynaecological problems in women and family planning. They bring this information every month during their monthly meetings at Pachod, which is checked and used for preparing micro-planners. Health services are provided based on the micro-planners.

**Table: 1 Household visits coverage, April 2012 to December 2012**

Sr. No.	Month	Household Visits		
		Expected	Actual	%
1.	April 2012	3894	3620	93.0
2.	May 2012	3894	3623	93.0
3.	June 2012	4425	3704	83.7
4.	July 2012	4425	3717	84.0
5.	August 2012	4248	3585	84.4
6.	September 2012	4425	3612	81.6
7.	October 2012	4425	3695	83.5
8.	November 2012	4425	3607	81.5
9.	December 2012	4425	3602	81.4
<b>Average</b>		<b>4287</b>	<b>3641</b>	<b>84.9</b>

**Table: 1** indicates that during the reporting period on average 84.9 percent household visits was covered by community organisers for monthly surveillance and IPC.

### **3. Provision of antenatal and postnatal services.**

These services are provided through trained ANMs at the health post in every village. Every month, on a fixed day, a trained ANM visits each village. COs of that village detect the pregnant women of that village during house visits and bring them for a check up to the health post where the antenatal clinic is conducted. During these clinics, ANM does systematic head to toe examination and records all the necessary information of all the pregnant women. She provides iron folic acid tablets and TT injections. If she detects any high-risk cases she refers them to appropriate hospital.

**Table: 2 Total new registration from April 2012 to December 2012**

S. N.	Month	MAG			Permanent			Guest			Total		
		<12	>12	Tot	<12	>12	Tot	<12	>12	Tot	<12	>12	Tot
1.	April 12	30	19	49	14	9	23	0	7	7	44	35	79
2.	May 12	20	26	46	15	33	48	1	17	18	36	76	112
3.	June 12	22	15	37	21	38	59	0	15	15	43	68	111
4.	July 12	30	8	38	23	37	60	0	19	19	53	64	117
5.	Aug 12	23	9	32	26	17	43		18	18	49	44	93
6.	Sept 12	17	8	25	8	11	19	0	9	9	25	28	53
7.	Oct 12	24	8	32	19	16	35	0	18	20	45	42	87
8.	Nov 12	25	3	28	21	6	27	2	5	6	47	14	61
9.	Dec 12	13	6	19	13	12	25	1	5	5	26	23	49
	<b>Total</b>	<b>204</b>	<b>102</b>	<b>306</b>	<b>160</b>	<b>179</b>	<b>339</b>	<b>4</b>	<b>113</b>	<b>117</b>	<b>368</b>	<b>394</b>	<b>762</b>

**Table: 2** indicates that during the reporting period 762 new pregnant women were registered for antenatal services.

**Table: 3 Deliveries and Postnatal visits**

Beneficiaries	Deliveries			Abortions	PNC visit			
	Total	Maheri	Sasari		I st	II nd	III rd	Total
MAG	286	246	40	27	6	5	29	40
General	303	228	75	27	7	10	51	67
Guest	132	121	11	1	11	16	79	106
Total	721	595	126	55	24	31	159	213

**Table: 3** indicates that during the reporting period 721 deliveries and 55 abortions were recorded. 24 mothers received one post natal visit, 31 mothers received two post natal visits, and 159 mothers received three or more post natal visits.

**Table: 4 Maternal health care services taken during April 2012 to December 2012**

Beneficiaries	Total deliveries	Antenatal check up				T.T. injection			Place of delivery		Who conducted delivery		
		0	1	2	3+	0	1	2 and B	Hospital	Home	TD	Hospital	Other
<b>MAG</b>	286	1	24	25	236	0	4	282	284	04	02	284	00
<b>General</b>	303	0	41	36	225	1	1	301	286	17	02	286	15
<b>Guest</b>	132	0	64	34	34	0	0	132	127	05	01	127	04
<b>Total</b>	721	1	129	95	495	1	5	715	697	26	05	697	19

Table 4 indicates that during the reporting period out of 721 deliveries 697 (97 percent) were hospital delivery; 702 (97 percent) deliveries were conducted by a trained person.

#### **4. Minor Ailments treatment at the village level through Community Organisers**

At the village level COs are given medicines to treat minor ailments, especially for children and women. They have been trained to diagnose the ailments like common fever, respiratory infections and diarrhoeas. All COs have been selected as ASHAs in Nander PHC. They used drugs from the medicine kits under NRHM received by them.

#### **5. Design, development & printing of BCC cards for urban health project**

IHMP designed and developed Behaviour Change Communication (BCC) cards on Maternal & Newborn Health and Family Planning to be used by the community based volunteers of urban health project. 500 copies of each were printed with the guidelines on how to use BCC cards for giving needs specific BCC during household visit.

## 6. Growth monitoring of less than one year old children

COs take the birth weight of every child born in their area and maintain weight records. They take the weight of these children every month and maintain their growth cards. They also see to it that they are immunized on time. They detect low birth weight babies and if their weight is between 2 to 2.5 kg then they are given thermal bags and advice on how to take care of the children. If the weight is less than 2 kg they refer them to nearest hospital for special care. They also give nutritional counselling to parents of malnourished children.

**Table: 6 Proportion of children less than one year weighed during the period**

Sr. No.	Month	Proportion of Children Weighed								
		Male			Female			Total M+F		
		Total	Weighed	%	Total	Weighed	%	Total	Weighed	%
1.	April 12	241	209	86.7	200	168	84.0	441	377	85.5
2.	May 12	236	208	88.1	195	170	87.2	431	378	87.7
3.	June 12	251	224	89.2	218	176	80.7	469	400	85.3
4.	July 12	255	238	93.3	227	188	82.8	482	426	88.4
5.	Aug 12	263	225	85.6	234	198	84.6	497	423	80.1
6.	Sept 12	262	212	80.9	231	191	82.7	493	403	81.7
7.	Oct 12	273	219	81.2	241	189	78.4	514	408	79.4
8.	Nov 12	282	227	80.5	233	184	78.9	515	411	79.8
9.	Dec 12	280	226	80.7	332	187	80.6	512	413	80.7
<b>Total</b>		<b>2343</b>	<b>1988</b>	<b>84.9</b>	<b>2011</b>	<b>1651</b>	<b>82.1</b>	<b>4354</b>	<b>3639</b>	<b>83.6</b>

Table 6 indicates that during the reporting period on an average 84 percent children were weighed every month.

**Table: 7 Growth faltering in children less than one year**

Sr. No.	Month	Proportion of Children Growth Faltered								
		Male			Female			Total M+F		
		Weighed	GF	%	Weighed	GF	%	Weighed	GF	%
1.	April 12	209	06	2.9	168	00	0.0	377	06	1.6
2.	May 12	208	01	0.5	170	02	1.2	378	03	0.8
3.	June 12	224	04	1.8	176	04	2.3	400	08	2.0
4.	July 12	238	03	1.3	188	04	2.1	426	07	1.6
5.	Aug 12	225	04	1.8	198	03	1.5	423	07	1.7
6.	Sept 12	212	05	2.4	191	03	1.6	403	08	2.0
7.	Oct 12	219	00	0.0	189	04	2.1	408	04	1.0
8.	Nov 12	227	03	1.3	184	01	0.5	411	04	1.0
9.	Dec 12	226	00	0.0	187	02	1.1	413	02	1.1
<b>Total</b>		<b>1988</b>	<b>26</b>	<b>1.3</b>	<b>1651</b>	<b>23</b>	<b>1.4</b>	<b>3639</b>	<b>47</b>	<b>1.3</b>

**Table: 7** indicates that during the reporting period on average 1.3 percent children were detected as growth faltered.

**Table: 8 Severely malnourished children in less than one year**

Sr. No.	Month	Proportion of Severely Malnourished Children								
		Male			Female			Total M+F		
		Weighed	SM	%	Weighed	SM	%	Weighed	SM	%
1.	April 12	209	03	1.4	168	03	1.8	377	06	1.6
2.	May 12	208	03	1.4	170	04	2.4	378	07	1.9
3.	June 12	224	05	2.2	176	01	0.6	400	06	1.5
4.	July 12	238	00	0.0	188	05	2.7	426	05	1.2
5.	Aug 12	225	03	1.3	198	03	1.5	423	06	1.4
6.	Sept 12	212	00	0.0	191	01	0.5	403	01	0.3
7.	Oct 12	219	03	1.4	189	03	1.6	408	06	1.5
8.	Nov 12	227	01	0.4	184	06	3.2	411	07	1.7
9.	Dec 12	226	03	1.3	187	06	3.2	413	09	2.2
<b>Total</b>		<b>1988</b>	<b>21</b>	<b>1.1</b>	<b>1651</b>	<b>32</b>	<b>1.9</b>	<b>3639</b>	<b>53</b>	<b>1.7</b>

**Table: 8** indicates that during the reporting period on an average 1.7 percent children were suffering from severe malnutrition.

## **7. RTI / STI services**

During surveillance CO identifies women with the symptoms of RTI / STI and sends them to the RTI / STI clinic conducted at the village level. Lady doctor examines patients and gives necessary treatment. They are given advice and followed up in the next visit. If they don't respond to treatment then they are referred to nearest hospital for further management.

Since focus of the project was on married adolescent girls, RTI / STI clinics were held for married adolescent girls and if women 20 years & above came, they were also given services.

**Table: 9 Utilization of RTI / STI services by women**

Month	Expected No. of Clinics Held	Actual No. of Clinics Held	%	Married Adolescent Girls			20 Years & above Women			Other Patients
				No. of women with symptoms of RTI / STI	No. of women sought treatment for RTI / STI	%	No. of women with symptoms of RTI / STI	No. of women sought treatment for RTI / STI	%	
April 12	08	08	100	26	11	42	238	05	02	08
May 12	18	17	94	40	25	63	246	37	15	110
June 12	18	18	100	28	25	89	235	54	23	44
July 12	22	17	77	33	33	100	138	39	28	63
Aug. 12	21	21	100	36	36	100	230	44	19	112
Sept. 12	18	17	94	29	29	100	186	28	15	46
Oct. 12	20	20	100	32	31	97	171	38	22	35
Nov. 12	17	16	94	25	25	100	185	20	11	26
Dec. 12	17	17	100	20	10	50	170	13	08	22
<b>Average</b>	<b>18</b>	<b>17</b>	<b>94</b>	<b>30</b>	<b>25</b>	<b>83</b>	<b>200</b>	<b>31</b>	<b>16</b>	<b>52</b>

**Table: 9** indicates that during the reporting period 94 percent of the expected number of clinics were held. On an average every month 83 percent of the married adolescent girls and 16 percent of the women 20 years & above with RTI / STI symptoms sought treatment. On an average 52 other patients were examined and treated during the reporting period.

### **8. Care and support services to PLHAs**

**Counseling:** During the reporting period, 31 People Living with HIV /AIDs (PLHAs) were given counseling services. Counselors did house visit of PLHAs as per the need and motivated PLHAs to go for health check up. Counseling was done at the three levels - individual, family and institutional level. During counseling at the individual level, PLHAs were counseled for further investigations, advised about importance of Pre- ART registration, importance of maintaining good health and personal hygiene. They were also advised to continue regular work and daily activities. They were also told about importance of diet and maintaining CD4 count. PLHAs were advised not to smoke and consume alcohol. Family members were advised to cooperate and support PLHA in every aspect. 10 PLHAs (05 male and 05 female) did not go for the care and support services.

One female and one male PLHA died during the reporting period.

**Pre-ART registration:** It is necessary to get Pre-ART registration done for getting care and support services from the ART centre at Government Medical College, Aurangabad. There was no new PLHA identified during the reporting period. Those PLHAs, who were not registered with the ART center, were given counseling for getting Pre-ART registration and they have agreed to get Pre-ART registration done in the future.

**Symptomatic treatment:** 04 male PLHAs had different illnesses and infections like Herpes Zoster, piles, rashes, eye problems, stomach pain, nausea, etc. They were sent to ART center at Government Medical College, Aurangabad or referred to Rural Hospital, Pachod or to the nearest Primary Health Center.

**CD4 count:** 13 times CD4 count was done for 12 PLHAs during the reporting period. Decision regarding whether to start a person on ART treatment or not is based on the CD4 count. PLHAs with 200 or less count were started on ART medicines. Based on the CD4 count PLHAs were called either every month or after six-months for the repeat CD4 count. It took from two days to one month to get CD4 count report. PLHAs started on the ART medicines were called after 15 days for the follow up to assess responses to the medicines.

**ART treatment:** There are 17 PLHAs who received ART medicines regularly from ART center. PLHAs were given counseling for taking regular treatment. Counselors observed that health condition of PLHAs taking regular treatment was good. Now, most of the PLHAs go on their own and get medicines.

**Visit to PLHA network office at Aurangabad:** 02 female PLHAs visited network office at Aurangabad. IHMP counselor accompanied each PLHA to the network office. These visits help PLHAs to learn about how to cope with the situation. During the visit, PLHAs were given information about different modes of HIV transmission, what problems can arise if a person does not take proper care and about what government & other NGO schemes are available for PLHAs.

**Migration for work:** 7 PLHAs have migrated from their village. Reasons for the migrations were for work on daily wages, for job and for school.

**Table: 10 Care and Support to PLHAs**

<b>Sr. No.</b>	<b>Particular</b>	<b>Male</b>	<b>Male child</b>	<b>Total</b>	<b>Female</b>	<b>Female Child</b>	<b>Total</b>	<b>M + F Total</b>
1.	No. of old PLHA	17	4	21	21	3	24	45
2.	New detected PLHA	00	00	00	00	00	00	00
3.	PLHA died	01	00	01	01	00	01	02
4.	PLHA not responding for care and support services	05	00	05	05	00	05	10
5.	No. of PLHA migrated	02	01	03	03	01	04	07
6.	Total PLHA for care and support services	14	03	17	17	02	19	36
7.	PLHA regularly followed up	11	03	14	15	02	17	31
8.	No. of PLHA - first time CD4 done	03	00	03	08	01	09	12
9.	No. of PLHA - CD4 done more than twice	00	00	00	01	00	01	01
10.	No. of total CD4	03	00	03	09	01	10	13
11.	No. of total PLHA - CD4 done	03	00	03	07	02	09	12
12.	PLHA are on ART	08	01	09	07	02	09	18
13.	No. of PLHA regularly taking ART	07	01	08	07	02	09	17
14.	PLHA visited network office and community care center	00	00	00	02	00	02	02

The table above indicates that the total numbers of old PLHA followed up are 45 of which are 20 males and 25 females. Out of 45 PLHAs, 3 male PLHAs and 4 female PLHAs migrated outside project area and one male & one female PLHA died in this reporting year.

The total number of PLHA for care and support are 36 (17 males and 19 females) and 31 are followed up regularly. The total number of PLHA not responding to care and support services are 10 (5 males and 5 females). The total number of times CD 4 count done is 13 (3 times in male and 10 times in female). 18 people are on ART (9 males and 9 females). Only 2 female patients visited the PLHA network office.

**Care and Support to Male PLHAs**  
**April 2012 to December 2012**

Sr. No.	Month	PLHA		No. of PLHA received care and support	Counseling		Treatment for opportunistic infections		PLHA Network visit		Investigation for ART registration				ART received		Con nsl. visit
					No .of PLHA	No. of visits	No .of PLHA	No. of visits			Other investigation		CD4 test				
		Old	New						No .of PLHA	No. of visits	No .of PLHA	No. of visits	No .of PLHA	No. of visits			
1	Apr-12	21	-	13	13	13	00	00	-	-	01	01	-	-	09	09	-
2	May-12	21	-	14	14	14	01	01	-	-	02	02	01	02	09	09	-
3	June-12	21	-	09	09	09	-	-	-	-	01	01	01	02	09	09	-
4	July-12	21	-	09	09	09	-	-	-	-	-	-	01	02	09	09	-
5	Aug-12	21	-	08	08	08	-	-	-	-	-	-	-	-	09	09	-
6	Sept-12	21	1died	06	06	06	-	-	-	-	-	-	-	-	09	09	-
7	Oct-12	20	-	06	06	06	-	-	-	-	-	-	-	-	08	08	-
8	Nov-12	20	-	07	07	07	-	-	-	-	-	-	-	-	08	08	-
9	Dec-12	20	-	06	06	06	-	-	-	-	-	-	-	-	08	08	-
	Total	20	1 died	14	14	78	01	01	00	00	04	04	03	06	09	78	00

**Care and Support to Female PLHAs**  
**April 2012 to December 2012**

Sr. No.	Month	PLHA		No. of PLHA received care and support	Counseling		Treatment for opportunistic infections		PLHA Network visit		Investigation for ART registration				ART received		Con nsl. visit
		Old	New		No .of PLHA	No. of visits	No .of PLHA	No. of visits	No .of PLHA	No. of visits	No .of PLHA	No. of visits	No .of PLHA	No. of visits	No .of PLHA	No. of visits	
1	Apr-12	24	-	12	12	12	-	-	-	-	-	-	-	-	09	09	-
2	May-12	24	01died	12	12	12	-	-	-	-	-	-	01	02	09	09	-
3	June-12	23	-	12	12	12	-	-	-	-	-	-	01	02	09	09	-
4	July-12	23	-	17	17	17	-	-	-	-	-	-	03	06	09	09	-
5	Aug-12	23	-	11	11	11	01	01	02	01	-	-	02	04	09	09	01
6	Sept-12	23	-	06	06	06	-	-	-	-	-	-	01	02	09	09	-
7	Oct-12	23	-	11	11	11	-	-	-	-	-	-	02	04	09	09	-
8	Nov-12	23	-	11	11	11	-	-	-	-	-	-	-	-	09	09	-
9	Dec-12	23	-	09	09	09	-	-	-	-	-	-	-	-	09	09	-
	Total	23	01 died	17	17	101	01	01	02	01	00	00	10	20	09	81	01

**Care and Support to PLHAs**  
**April 2012 to December 2012**

Sr. No.	Month	PLHA		No. of PLHA received care and support	Counseling		Treatment for opportunistic infections		PLHA Network visit		Investigation for ART registration				ART received		Con sl. visit
		Old	New		No .of PLHA	No. of visits	No .of PLHA	No. of visits	No .of PLHA	No. of visits	Other investigation		CD4 test		No .of PLHA	No. of visits	
											No .of PLHA	No. of visits	No .of PLHA	No. of visits			
1	Apr-12	45	-	31	31	25	-	-	-	-	01	01	-	-	18	18	-
2	May-12	45	1died	31	31	26	01	01	-	-	02	02	02	04	18	18	-
3	June-12	44	-	31	31	21	-	-	-	-	01	01	02	04	18	18	-
4	July-12	44	-	31	31	26	-	-	-	-	-	-	04	08	18	18	-
5	Aug-12	44	-	31	31	19	01	01	02	01	-	-	02	04	18	18	01
6	Sept-12	44	1died	31	31	12	-	-	-	-	-	-	01	02	18	18	-
7	Oct-12	43	-	31	31	17	-	-	-	-	-	-	02	04	17	17	-
8	Nov-12	43	-	31	31	18	-	-	-	-	-	-	-	-	17	17	-
9	Dec-1	43	-	31	31	15	-	-	-	-	-	-	-	-	17	17	-
	Total	43	2died	31	31	179	02	02	02	01	04	04	13	26	17	159	01

#### **4. Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city - April 2012 to March 2013**

##### **Introduction:**

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 NUHM on a large scale at both the state and national levels.

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.

### Section I: Activities Carried out during 2012-13

Following key activities were carried out in the 18 slums under the Late Galande Patil Urban Health Post, Shastri Nagar, Yerwada, in Pune city during April 2012 to March 2013.

1. 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 1.1 –Training programs conducted for CHWs during April 2012 to March 2013**

Sr.	Training subject	Month	Duration – days	No. of CHWs attended	Knowledge & skills provided
1.	Induction training for newly appointed CHWs – II batch	April 2012	07 days	07	Cognitive skills – maternal health, neonatal health, child health, reproductive health, family planning. Practical skills on implementation of 6 IHMP innovations
2.	Needs specific BCC	June 2012	03 days	09	Practical skills - behavioural diagnosis, use of BCC cards, need based IPC & counseling
3.	Detection & management of maternal morbidity	Aug 2012	02 days	11	Practical skills - detection of 11 danger signs of antenatal complications, minimum standard antenatal care, and management of danger signs
4.	Induction training for newly appointed	Dec 2012	07 days	05	Cognitive skills – maternal health, neonatal health, child health,

Sr.	Training subject	Month	Duration – days	No. of CHWs attended	Knowledge & skills provided
	CHWs – III batch				reproductive health, family planning. Practical skills on implementation of 6 IHMP innovations
5.	Induction training for newly appointed CHWs – IV batch	March 2013	07 days	04	Cognitive skills – maternal health, neonatal health, child health, reproductive health, family planning. Practical skills on implementation of 6 IHMP innovations

**2. 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.

**3. Surveillance and Monitoring System:** Protocols for the surveillance & monitoring system for urban slum areas were designed and printed. These protocols were pre-tested in the field/slums during April and May 2012 by the community health worker. After the induction training; in order to develop practical skills for filling surveillance registers, IHMP staff provided on the job training to the CHWs. Needs assessment through monthly surveillance was carried out by the 12 Community Health Workers from June 2012. The surveillance system covers following broad areas;

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

**4. Behavior Change Communication (BCC):** IHMP has developed an innovative strategy for behavior change communication which signifies a paradigm shift in dissemination of information and influencing health behaviors.

Two distinct approaches are being implemented in the project area.

- Need specific behavior change communication
- Behavior change communication through a social norms approach.

**Needs specific behavior change communication:** During monthly household visits the CHW identify the information needs of the individual. Based on the behavioral diagnosis they provide information and counseling specific to the needs of the individual and family. This need specific BCC approach has brought about a measurable change in health related

behaviors. During the reporting period, 12508 household visits were undertaken by CHWs during which they provided need specific BCC. (Refer Table 1.2)

**Table 1.2: Needs specific BCC provided by the CHW at household level**

Sr.	Topic	Number of clients received needs specific IPC & counseling from CHWs at household level			
		Apr to Jun 2012	Jul to Sep 2012	Oct to Dec 2012	Jan to Mar 2013
1.	Maternal care	127	356	379	325
2.	Treatment for symptoms of maternal morbidity	17	55	46	30
3.	Use of family planning methods	704	2987	3384	2646
4.	Treatment for reproductive tract infections	62	252	167	139
5.	Child immunization & management of child morbidity	50	440	197	145
	Total	960	4090	4173	3285

**Behavior change communication through a social norms approach:** Behavior 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, etc.

252 group BCC sessions for women aged 15-44 years were conducted at the slum level, by the project ANM. They conducted these meetings using participatory methods through effective use of audio-visual material. A total of 3009 women from the 18 project slums attended the meetings. (Refer Table 1.3).

**Table 1.3: Group BCC sessions conducted at slum during April 2012 to March 2013**

Sr.	Period	Group BCC sessions conducted	Women 15-44 attended	Topics discussed during group BCC sessions
1.	April to June 2012	57	648	<ul style="list-style-type: none"> <li>Anatomy and physiology of female reproductive system</li> <li>Menstrual cycle and menstrual hygiene</li> <li>Early registration for antenatal care, components of antenatal care</li> </ul>
2.	July to September 2012	66	742	<ul style="list-style-type: none"> <li>Postnatal care, neonatal care</li> <li>Abortion &amp; post abortion complications</li> <li>Reproductive tract infections</li> </ul>
3.	October to December 2012	66	769	<ul style="list-style-type: none"> <li>Urinary tract infections</li> <li>Sexually transmitted infections &amp; HIV/AIDs</li> <li>Use of family planning methods</li> </ul>

Sr.	Period	Group BCC sessions conducted	Women 15-44 attended	Topics discussed during group BCC sessions
4.	January to March 2013	63	850	<ul style="list-style-type: none"> <li>• Minimum standard antenatal care</li> <li>• Treatment and referral for maternal morbidities</li> <li>• Availability &amp; utilization of govt. health facilities</li> </ul>
	Total	252	3009	

*Women are discussing their health related issues freely with ANMs and CHWs and they are utilizing services available at the PUHC for maternal care and treatment of other minor ailments.*

**5. Outreach clinics conducted by project ANM:** The CHWs prepare a micro-planner every month which provides details of women and children with health needs along with details of the services they require. Based on the micro-planner, the CHWs actively link their clients to the Vasti level clinics conducted by ANMs. A total of 175 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. The ANM cross-checks whether all the clients listed in the micro-planner availed services or not.

**Table 1.4: Outreach services provided by Project ANM during April 12 to March 13**

Sr.	Details	Period				Total
		April to June 12	July to Sept 12	Oct to Dec 12	Jan to March 13	
1.	Number of clinics planned	40	45	45	45	175
2.	Number of clinics conducted	40	45	45	45	175
4.	Number of antenatal examinations done	243	107	322	318	990
5.	Number of postnatal mothers examined	16	20	46	43	125

**6. Special clinic for migrant population:** A Special clinic for a large migrant population was organized for three migrant slums in Kharadi area in the month of March 2013. Since the community health workers were not appointed in these areas, primary level health care is being provided by project ANMs. Children below age of five years, women in the reproductive age group were examined at the clinic. A total of 105 children less than five years of age were examined, 60 were immunized, and TT injections were given to 82 women. Counseling on family planning was given to eligible couples. Condoms were distributed to 82 eligible couples. The special clinic was successfully organized by the PUHC in coordination with Panchshil Group of builders and Institute of Health Management Pachod, Pune centre.

## 7. Specialist Obstetric - Gynae clinic at PUHC:

Clinics for emergency obstetric and gynecological services were conducted at the Galande Patil dispensary. Treatment was provided to 275 patients by IHMP's consulting gynecologist once a week at the PUHC, since July 2012. 24 obstetrics /gynecology clinics were planned and conducted by the PUHC and IHMP project staff.

*As an outcome of IHMPs advocacy, to support the specialist clinic, laboratory facilities have been made available at the PUHC. Specialized clinics at the PUHC have resulted in a substantial increase in referral and utilization of services by women with reproductive morbidities.*

**8. Capacity building of Slum Health and Development Committee (SHDC):** 13 Slum Health and Development Committees (SHDCs) have been established. During the reporting period, two orientation meetings for SHDC members were planned and conducted. The PMC ward officer, an RTI expert and senior SHDC members from the Mundhwa project area were invited for the training program. The old SHDC members 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 new SHDC members. (Refer Table 1.5)

A participatory training session was organized at the slum level for SHDC members. Cognitive and practical skills regarding CBM were imparted to them. Participatory methods were used during the training. After the orientation, a skills development session was arranged for all the SHDCs at the slum level. (Refer Table 1.5)

**Table 1.5: Training programs organized for SHDC members during April 12 to March 13**

Sr.	Training subject	Month	SHDC members attended	Topics covered
1.	Roles and responsibilities of SHDC	July 2012	44	<ul style="list-style-type: none"> <li>• Need and importance of community participation</li> <li>• Roles and responsibilities of SHDCs</li> <li>• Functions of various departments in the PMC ward office</li> <li>• Orientation on the Right to Information Act</li> </ul>
2.	Community based monitoring – organized at 9 slums	August 12	72	<ul style="list-style-type: none"> <li>• Knowledge on functions of CHW, ANM and services provided at the PUHC</li> <li>• Practical skills – how to monitor the CHWs work</li> <li>• Practical skills - How to do community based monitoring for health service utilization</li> </ul>

**8. Slum Health and Development Committees (SHDCs):** During reporting period, 13 Slum Health and Development Committees were functioning in the 18 slums. SHDC meeting was

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 year. A total of 540 SHDC members were present at the monthly SHDC meetings. 48 planned meetings were not conducted because of poor attendance by the SHDC members.

**Table 1.6: SHDC meetings conducted during April 12 to March 13**

Sr.	Period	SHDC meetings planned	SHDC meetings conducted	Attendance at SHDC meetings	Topics discussed during meetings
1.	April to June 12	38	29	173	Capacity building of CHWs, review of CHWs work, outreach clinics conducted by ANM, vocational training for adolescents, environmental sanitation issues
2.	July to Sept 12	37	25	148	CHWs performance, Gynecological services at PUHC
3.	Oct to Dec 12	29	12	84	Refresher training of CHWs, MPR, discussion on nomination and formation of coordination committee.
4.	Jan to March 13	39	29	135	CHWs performance, MPR, services provided by the project ANM and services delivered at the PUHC
	Total	143	95	540	

SHDC members monitored the work of CHWs, and ANMs. SHDC members visited households to cross check and certify the needs assessed by the CHWs. SHDC members review the work-plans prepared by CHWs to ensure completeness and accuracy. They review 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.

*SHDCs members from several slums monitored the work of CHW's and ANM effectively; it resulted in a substantial increase in early detection of morbidities and timely referral for treatment.*

**9. Celebration of International Women's day Program by SHDCs:** A function to celebrate international women's day was planned and organized by the Slum Health and Development Committees (SHDCs). The function was organized at the PUHC. The chief guest and speakers shared their thoughts on female infanticide; current status of women in the community and empowerment of women. A total of 103 persons attended the function. A play on female infanticide was organized by the group of ICDS workers from Hadpasar & Mundwa, Pune City.

**10. Formation of "Arogya Vikas Samanvaya Samiti":** During the reporting period a coordination committee for all SHDCs known as the "Arogya Vikas Samanvaya Samiti" was

established. The Arogya Vikas Samanvaya Samiti offers a common platform for all SHDCs to discuss their slum level health and development issues and take collective action.

36 members from 12 SHDCs were elected to form an Arogya Vikas Samanvaya Samiti. The first orientation meeting of the Arogya Vikas Samanvaya Samiti (AVS) was conducted during the reporting period. Of 36 AVS members, 12 members participated in the meeting. Following topics were discussed during the meetings:

- Need and importance of formation of Arogya Vikas Samanvaya Samiti
- Roles and responsibilities of Arogya Vikas Samanvaya Samiti
- How to increase community involvement to support SHDCs and participation in the project
- Discussion on identity cards to be issued for SHDC members
- Discussion on how to monitor the work of CHWs and ANMs
- Difficulties faced by the SHDC members while monitoring the work of CHWs and ANMs
- How to monitor the work of CHWs and ANMs effectively

During the meeting, some Samanvaya Samiti members asked information on secondary and tertiary care centers. Detail information on secondary and tertiary hospitals i.e. – in which situations referral should be given, where to refer, whom to refer, contact details of functionaries at secondary and tertiary centers has been given.

**11. 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 assess skills of the CHW, and provide 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 434 Supervisory visits were planned during the reporting period out of which 356 (82 percent) visits were conducted.

**12. Meetings with PMC officials:** Several meetings with PMC officials were conducted during the reporting period. Sanction for upgrading services at PUHC, installation of MCTS software, supply of drugs, management of referral tracking system, linkages with secondary & tertiary care facilities, review of activities under the project etc. topics were discussed during the meetings.

Following key decisions were taken by the PMC officials during the meetings;

- PMC agreed to clarify roles and responsibilities of community link worker in provision of outreach services
- PMC officials gave permission to upgrade services at the PUHC
- PMC agreed to get actively involved in the management of the interventions and gave approvals for a laboratory technician, for upgrading services at the PUHC, and sanctioned a data operator for the use of the MCTS software and for tracking referrals.
- PMC assistant MOH agreed to discuss with PMC ward officer to solve the water problem faced by the PUHC staff
- Assistant MOH, PMC agreed to take the review of referred cases on a monthly basis. PMC took a decision to install the MCTS software at the PUHC.

- PMC officials agreed to conduct a workshop with PMC MOH and other key personnel to discuss a strategy for addressing maternal and child morbidity at the PMC level.

## Section II: Services Provision and Coverage during 2012-13

**Table 2.1: 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 12	12	1794	1242	69.2
July to Sept 12	12	8381	6200	73.9
Oct to Dec 12	09	6868	5999	87.3
Jan to March 13	08	5634	4855	86.2
<b>Total</b>	<b>---</b>	<b>22677</b>	<b>18296</b>	<b>80.7</b>

The average percentage of ECs who had been covered by monthly surveillance was 80.7 percent.

**Table 2.2: Coverage of Antenatal Care.**

Month	Reporting for Number of CHW areas	Number of Antenatal examinations planned	Number of Antenatal examinations carried out	Percent received antenatal care
April to June 12	12	127	101	79.5
July to Sept 12	12	331	280	84.6
Oct to Dec 12	09	352	299	84.9
Jan to March 13	08	282	235	83.3
<b>Total</b>		<b>1092</b>	<b>915</b>	<b>83.8</b>

The proportion of pregnant mothers who received antenatal care was 83.8%.

**Table 2.3: Reported Symptoms of Antenatal Complications.**

Month	Reporting for Number of CHW areas	Number of Currently pregnant mothers	Number of pregnant mothers with antenatal complications	Percent pregnant mothers with antenatal complications
April to June 12	12	127	17	13.4
July to Sept 12	12	331	52	15.7
Oct to Dec 12	09	352	44	12.5
Jan to March 13	08	282	27	09.6
<b>Average</b>		<b>273</b>	<b>35</b>	<b>12.8</b>

The proportion of pregnant mothers reporting any one antenatal complication was 12.8%.

**Table 2.4: Reported Treatment Seeking for Symptom of Antenatal Complications.**

Month	Reporting for Number of CHW areas	Number of pregnant mothers with antenatal complications	Number of pregnant mothers sought treatment for antenatal complications	Percent pregnant mothers sought treatment for antenatal complications
April to June 12	12	17	10	58.7
July to Sept 12	12	52	35	67.3
Oct to Dec 12	09	44	36	81.8
Jan to March 13	08	27	24	88.8
<b>Total</b>		<b>140</b>	<b>105</b>	<b>75.0</b>

The average proportion of pregnant mothers those with symptoms of antenatal complications who had sought treatment was 75.0 percent. Substantial increase in utilization of treatment for antenatal complications is observed in the third & fourth quarter as compared to first two quarters.

**Table 2.5: Institutional Deliveries.**

Month	Reporting for Number of CHW areas	Total deliveries	Institutional deliveries	Percent institutional deliveries
April to June 12	12	Na	na	na
July to Sept 12	12	30	23	76.7
Oct to Dec 12	09	40	38	95.0
Jan to March 13	08	28	27	96.4
<b>Total</b>		<b>98</b>	<b>88</b>	<b>89.8</b>

A substantial increase is observed in proportion of institutional deliveries (96.4% in the fourth quarter Vs 76.7% in the first quarter).

**Table 2.6: Coverage of Postnatal Care.**

Month	Reporting for Number of CHW areas	Number of post natal mothers identified	Home based post natal care by CHW	Post natal visits by ANM	Post natal mothers with post natal complications
April to June 12	12	Na	na	na	na
July to Sept 12	12	28	25	20	03
Oct to Dec 12	09	38	27	22	02
Jan to March 13	08	56	43	39	03
<b>Total</b>		<b>122</b>	<b>95</b>	<b>81</b>	<b>08</b>

122 postnatal mothers were identified, CHWs provided home based post natal care to 95 mothers and 81 mothers were examined after delivery by the ANM, at home, within 42 days.

**Table 2.7: Reported Use of Family Planning Methods.**

Month	Reporting for Number of CHW areas	Currently non sterilized ECs	ECs using any temporary FP method	Percent ECs using any temporary FP method
April to June 12	12	1953	329	16.8
July to Sept 12	12	2586	401	15.5
Oct to Dec 12	09	2835	549	19.4
Jan to March 13	08	2186	460	21.1
<b>Total</b>		<b>9560</b>	<b>1739</b>	<b>18.2</b>

The average proportion of non-sterilized ECs using any form of temporary contraception/family planning was 18.2 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 (21.1% Vs 19.4% Vs 15.5%).

**Table 2.8: Reported Prevalence of Diarrhoea among Children Under Three Years of Age**

Month	Reporting for Number of CHW areas	Number of children under three years of age visited by the CHW	Number of under three children with symptoms of diarrhoea	Prevalence of diarrhoea among children under three years of age
April to June 12	12	676	30	04.3
July to Sept 12	12	1614	66	04.1
Oct to Dec 12	09	1661	56	03.4
Jan to March 13	08	1209	40	03.3
<b>Average</b>		<b>1290</b>	<b>48</b>	<b>03.7</b>

The average reported prevalence of diarrhoea among children under three years of age was 3.7 percent. 192 children that were suffering from diarrhoea episodes were referred and treated.

**Table 2.9: Reported Prevalence of ARI among Children Under Three Years of Age**

Month	Reporting for No. of CHWs	No. of children under 3 years visited by CHW	No. of children under 3 with ARI symptoms	Prevalence of ARI in children under 3 years
April to June 12	12	676	04	00.6
July to Sept 12	12	1614	219	13.5
Oct to Dec 12	09	1661	141	08.5
Jan to March 13	08	1209	105	08.6
<b>Average</b>		<b>1290</b>	<b>118</b>	<b>09.1</b>

The average reported prevalence of ARI among children under three years of age was 9.1 percent. 469 children that were suffering from ARI episodes were referred and treated.

### **Section III: Research, monitoring and policy advocacy activities carried out during April 2012 to March 2013**

**Baseline survey** – The data collection for the baseline survey was completed in the previous year. During the reporting period, data entry, data cleaning, and analysis of baseline data was carried out. A report of the baseline survey was prepared. A fact sheet based on the data is prepared for dissemination of the findings to health officials of Pune Municipal Corporation. Key findings and conclusions from the baseline survey are;

- A substantially large proportion of women, in urban slums of Pune, utilize maternal health care services but the coverage with standard, minimum ante-natal and post natal care is low.
- Considerably high proportions of children are immunized with individual vaccines but the proportion of children with complete coverage with primary vaccination continues to be low.
- Prevalence of maternal and reproductive morbidity is high and majority of the respondents utilize private clinics for treatment. About 15 percent of deliveries continue to be conducted at home.
- A substantially high proportion of girls are married off before they reach 18 years of age. This could be one of the factors responsible for the prevalence of pre term deliveries and the high prevalence of low birth weight babies.
- The couple protection rate in urban slums of Pune is much lower than the average for Maharashtra state. There appears to be a large unmet need for family planning services. A large proportion of respondents continue to have three or more children.
- The health seeking and utilization behaviors of the urban poor are heavily biased in favor of the private sector despite the costs involved. A very small proportion of the respondents sought treatment at the UHP. The individuals that utilize public health services prefer to go to tertiary centers for their health needs.
- Further research is required to determine people's perceptions and reasons for utilization of private and various public health facilities for the treatment of maternal, neonatal and childhood morbidities and to estimate the direct and indirect expenditure incurred on health care services.

#### **Dissemination of Baseline finding with PMC officials –**

The findings of the baseline survey were shared with the Commissioner, PMC, Medical officer Health, PMC, Medical officers at MCH clinics and the PUHC. The following findings and inferences from the baseline survey were discussed with the PMC officials during the meetings:

- Need and strategies for outreach services and linkages with the PUHC
- Need and strategies for ensuring rational utilization of health services
- Need and strategies for reducing dependency on the private sector
- Need and strategies for reducing out of pocket expenditure for health care

*At the end, feasibility for scaling up IHMP innovations in other PUHCs was discussed by the PMC officials. Commissioner, PMC asked IHMP to take up more PUHCs for introducing its innovations. Instead IHMP has offered capacity building of the staff of PMC and other NGOs in Pune city to establish the standards that are being demonstrated at the model PUHC (Galande Patil).*

**Dissemination of the 5 IHMP innovations:** A poster on urban health was prepared and displayed at NGO Asia Expo – Exhibition, which was held at World Trade Centre, Mumbai from 20-21 November 2012. More than 500 representatives from different NGOs, CSR representatives visited the IHMP stall. Information on IHMP innovations for universal health care for urban poor was disseminated.

**Meeting with IBM professionals:** A meeting with IBM professionals from UK was organized at IHMP, Pune centre. Information on 6 IHMP innovations for universal health care for urban poor was disseminated to the IBM professions who in turn recommended these to the PMC health officials.

**Meeting with Oxfam GB:** During the reporting period, a team of experts from Oxfam GB visited IHMP, Pune. The 6 IHMP innovations were shared through power point presentations and field visits to the slums. The Oxfam GB donor expressed interest in linking IHMP with Tech Mahindra for converting the existing manual MIS system into a computerized management system and linking it to the Government MCTS. Simultaneously, IHMP has explored the possibility of using mobile phones and introducing a GIS system along with mHealth and eHealth based on the surveillance system designed by IHMP. This has the potential of a most innovative development in public health.

#### **Challenges:**

- Attrition of CHWs has been a major challenge in this project, which was never experienced to this extent earlier. This could be because of the availability of other occupational opportunities for women living in urban slums of Pune. The aspirations of these women have certainly undergone a huge change since the last project implemented by IHMP. Repeated attrition of CHWs results in under expenditure. On the other hand training new CHWs repeatedly results in a waste of resources.
- There has been similar attrition of SHDC members. IHMP is inviting SHDC members from its previous project area to orient and motivate the present SHDC members.
- Reaching migrant populations at construction sites is a problem as they are available only at night or early morning depending on their work shift. IHMP is contemplating a camp strategy for reaching this population.

#### **Conclusions:**

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 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.

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

The innovative strategy of “Community Based Monitoring” by slum health and development committees (SHDCs) wherein they review the completeness of health needs assessed by CHWs and compare it to services provided through outreach and at the PUHC is an effective system for ensuring accountability to civil society.

Advocacy of innovations can result in early scaling up if opportunities arising locally are identified and seized on a timely basis. Scaling up essentially requires capacity building for the adoption and implementation of innovations. Effective advocacy must be a long term goal. It takes considerable time to achieve successfully.

## Case studies:

**Case study – 1:** Vidya Savane is a 25 year old woman from Chandramanagar. She was six months pregnant when she came to her natal home, in one of our slums, for her delivery.

The community link worker from Chandramanagar registered her name during monthly surveillance and took her for antenatal check up at the Vasti Level Clinic. IHMP's ANM registered her name at the clinic and conducted an examination. IHMP's ANM asked the mother about foetal movements. Vidya replied that she was experiencing reduced foetal movements since the last 4-5 days.

IHMP's ANM immediately referred Vidya to Sasoon Hospital for treatment for reduced foetal movement. The community link worker accompanied Vidya to the hospital. Doctors at Sasoon Hospital examined Vidya and found that the amniotic fluid had reduced and Vidya was admitted for treatment.

She was discharged after a week with medicines to be taken at home. Vidya delivered a healthy baby after completion of the 9<sup>th</sup> month of pregnancy.

The case study demonstrates the importance of monthly surveillance. Maternal and neonatal morbidity occurs at the primary level. The delay in detecting it and reaching a medical facility are the prime causes of mortality. A robust, community based surveillance system can avert many maternal and neonatal deaths.

**Case study 2:** Sadhana Randive is a 20 year old young woman from Rajiv Gandhi Slum, Yerwada. She got married six months ago. Her husband works as a driver. She was interviewed about her experience with the outreach services being provided by Institute of Health Management, Pachod. She provided this information:

“Two months back, Surekha Arde the Community Health Worker (CHW) in our slum came to my house and enquired about problems related to menstruation, checked my eyes, nails, she asked whether I had suffered from any disease but I answered that I did not have any problem.

However, last month when she visited my house I told her about my missed periods and white discharge from the vagina. Before her visit I had taken treatment from a private hospital, but my symptoms persisted.

The CHW took me to the clinic organized by IHMP's ANM at our slum. At the clinic the ANM conducted a urine test for pregnancy. The urine test was positive and the project ANM told me I was three months pregnant. The project ANM examined and I was given folic acid tablets.

For white discharge, the CHW guided me to attend the specialist clinic at the Galande Patil Hospital Primary Urban Health Centre (PUHC) with my husband. Accordingly I attended the clinic at the PUHC with my husband where we were examined and treated. The lady doctor at the PUHC told us about the need for personal hygiene and cleanliness. During the specialist clinic at the PUHC they conducted abdominal examination, blood and urine tests. I am completely cured now.

Initially I could not discuss my health problems with the CHW but after taking treatment from the PUHC I am regularly going for antenatal check-ups. Now I do not have any hesitation to talk to the CHW and IHMP's ANM regarding my health problems".

**Case study 3** - Manjula (Name and personal details changed to ensure confidentiality) is a 28 year old woman from Rajiv Gandhi Vasti, Yerwada Pune. Rajiv Gandhi Slum is an undeclared slum. Manjula has two children. Her husband works as a casual labourer.

Surekha Arde is the community health worker trained by Institute of Health Management, Pachod for providing outreach services in the Rajiv Gandhi Vasti, Yerwada. She visits all the households in her slum once a month.

Manjula was interviewed recently regarding her experience with the services being provided by Institute of Health Management, Pachod and this is what she had to say:

"I experienced pain and swelling at the time of sexual intercourse for several months. When Surekha Arde the Community Health Worker for our slum came to my house she asked me about problems during menstruation, white discharge, itching in private parts, foul smelling discharge and other general health problems. I told her about my health problems like white discharge, abdominal pain, itching while passing urine and pain during sexual intercourse. I had taken treatment for these ailments from several private hospitals but these were not cured".

"Surekha Adre the CHW from our vasti had a detailed discussion with me and my husband regarding my ailments. She told me that every Wednesday a specialist doctor visits the Galande Patil, Primary Urban Health Centre at Yerawada. Surekha asked me to attend the specialist clinic along with my husband. She accompanied me and my husband to the PUHC. The gynaecologist at the PUHC examined me and prescribed tablets for both me and my husband. Thereafter the CHW visited me at my home every two days to ask if I was better. It has been over a month since I took the treatment and I am fully cured. I am really grateful to the CHW for her valuable guidance and support that she gave to me and my husband.

This case study demonstrates the importance of surveillance, need specific BCC and referral. Manjula was suffering from a sexually transmitted infection (STI) since the last two months for which she was treated at the Ob. Gynae clinic conducted by IHMP at the PUHC. Had it not been for the CHW, Manjula would have probably continued getting re-infected by her husband. Since the CHW insisted that the husband should also undergo treatment, Manjula was spared the ordeal of repeated infections

## 5. Strengthening a Primary Urban Health Centre of Pune Municipal Corporation (PMC)

April 2012 to March 2013

### 1. Strengthening a Primary Urban Health Centre of PMC

**Meetings with Primary Urban Health Centre (PUHC):** During the reporting period several meetings with Medical officer PUHC were organized. Participatory planning of the gynecologist clinic at PUHC, review of outreach activities, upgrading the services at the PUHC was discussed during the meeting. During the reporting period, following tasks were completed by IHMP at the PUHC:

- One sterilizer for sterilization of instruments and gloves were purchased by IHMP and handed over to the PUHC. Since IHMP is conducting special obstetrics and gynecology clinics at the PUHC it was necessary to provide this basic facility.
- One of the rooms in the PUHC was converted into a laboratory for performing routine tests. A platform and wash basin for the laboratory was provided by IHMP. As a result of this small investment by IHMP, laboratory facilities have been started at the PUHC by the municipal corporation.
- A small cubicle has been constructed and a computer has been donated to the PUHC by IHMP to utilize the software for the Mother and Child Tracking System (MCTS) in the project area. This will culminate in an important innovation by IHMP to demonstrate a community based MCTS.

### 2. Laboratory and Reproductive Health Services at the PUHC

*Inputs provided by AGRT/ IHMP resulted in the successful provision of laboratory services and installation of Mother and Child Tracking System (MCTS) software at the PUHC. IHMP provided the services of a gynecologist at the PUHC for treating Reproductive Tract Infections and Sexually Transmitted Diseases*

**Table 1.1: Reported Symptoms of Reproductive Tract Infections.**

Month	Reporting for No. of CHWs	No. of ECs visited	Number of ECs with symptoms of RTIs	Percent ECs with symptoms of RTIs
April to June 12	12	1242	62	04.9
July to Sept 12	12	6200	252	04.1
Oct to Dec 12	09	5999	167	02.8
Jan to March 13	08	4855	139	02.8
<b>Average</b>		<b>18296</b>	<b>620</b>	<b>03.4</b>

The proportion of ECs detected with RTI symptoms was 3.4%.

**Table 1.2: 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 12	12	62	32	51.6
July to Sept 12	12	252	167	66.3
Oct to Dec 12	09	167	103	61.7
Jan to March 13	08	139	86	61.8
<b>Average</b>		<b>620</b>	<b>388</b>	<b>62.5</b>

The average proportion of women with RTIs who had sought treatment was 62.5 percent.

### **3. Capacity Building**

**Request from the Municipal Corporation, Aurangabad:** The Aurangabad Municipal Corporation requested IHMP to orient its PUHC medical officers, ANMs and administrative staff in the 6 IHMP innovations for health care delivery to the urban poor living in slums of Aurangabad. During the reporting period, 35 medical officers, and 70 ANM were trained on use of 6 IHMP innovations for management of public health interventions implemented by the Aurangabad Municipal Corporation.

### **4. Action Research**

Intervention research to strengthen processes: Two short term intervention research studies were carried out during the reporting period to strengthen the process – maternal morbidity surveillance and community based monitoring by SHDCs.

Knowledge, Attitude and Practice of community health worker on antenatal morbidity: A KAP study to assess the knowledge, attitude and practices of CHWs was carried out during the reporting period. Majority CHWs demonstrated knowledge regarding minimum standard antenatal check-ups and importance of early antenatal registration.

The research indicated a need to provide special intensive training to the CHWs on detection of antenatal morbidity. Research findings were used to develop training curricula and an in-depth training manual. A one day training program was organized at IHMP Pune centre.

After one month, the impact of the intervention was assessed by conducting a post-test. The results of the evaluation showed substantial increase in the knowledge and attitudes regarding signs and symptoms of antenatal morbidity and referral for antenatal morbidity.

Knowledge, Attitude and Practice of SHDC members on community based monitoring: A KAP study to assess the knowledge, attitude and practices regarding community based monitoring of SHDC members was carried out during the reporting period.

Of the 56 SHDC members interviewed, only 14 percent SHDC members were aware of community based monitoring, 21 percent members were not aware of services provided by the CHW, a little more than half of the members did not know how to monitor the work of CHWs, only 1 out of three members said that they monitored the work of CHW.

The findings of the KAP study were used to design a training curriculum and training manual for SHDC members. Training of SHDC members was conducted at the slum level. After one month, the impact of the intervention was assessed by conducting a post-test. The results of the evaluation showed a substantial increase in the knowledge of SHDC members regarding their roles and responsibilities and knowledge regarding CBM.

*A concerted effort is being made to document manuals, training material and evaluation findings so that they can be used for scaling up the innovations being advocated by IHMP.*

**Research on out of pocket expenditure:** A detailed research protocol was prepared for the study on Out of Pocket Expenditure study. Five structured interview schedules were designed and pre-tested to collect information on out of pocket expenditure. Investigators were trained for 4 days at IHMP, Pune Centre from 4<sup>th</sup> to 7<sup>th</sup> February, 2013. After ensuring that each investigator could conduct interviews and fill the questionnaires satisfactorily, the actual data collection was initiated on 8<sup>th</sup> February 2013 and completed on 30<sup>th</sup> March 2013. A total of 463 respondents were interviewed out of which 160 respondents were ill in the last 15 days, 66 persons were admitted for treatment in a hospital in last 3 month, 143 cases of hypertension, 81 diabetes cases and 13 mothers who delivered in last 3 months. A data entry program in EPI data was designed and pre-tested for data entry. In the reporting period, out of 463 filled questionnaires, data entry for 423 cases was completed.

## **5. Participation in the Asia - India NGO Expo – 2012**

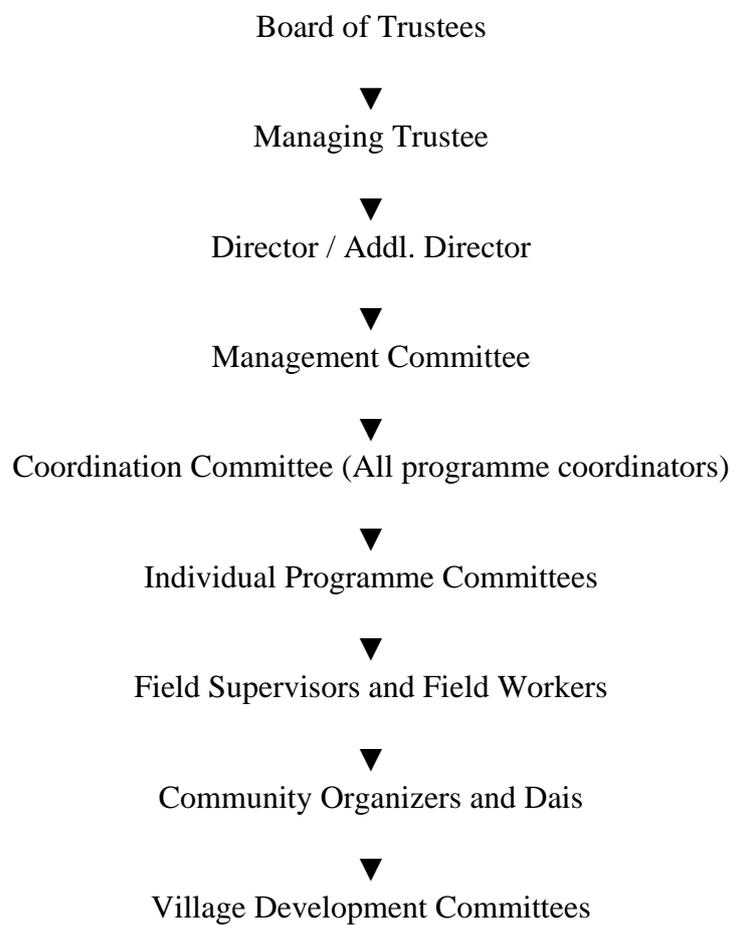
IHMP was invited to participate in the Asia – India NGO Expo – 2012, which was held in Mumbai. IHMP had put up a stall to display its work. Seven large posters on flex material about projects and activities of the Ashish Gram Rachna Trust, Pachod / Institute of Health Management Pachod were prepared. Also, leaflets on the projects and activities were printed, which were distributed to the people visiting the stall. IHMP received a very positive response to its display of materials.

## **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

Sr. No.	Name	Age	Gender	Occupation	Position in the Board
1	Dr. C. A. K. Yesudian	58	Male	Dean, School of Health Systems, Studies, TISS, Mumbai	Chairperson
2	Ms. Manisha Khale	59	Female	Additional Director, IHMP	Managing Trustee
3	Dr. (Mrs.) Sudha Kaldate	78	Female	Retd. Prof. & Head, Dept of Sociology, BAMU, Aurangabad	Trustee
4	Prof. (Mrs.) Kalindi Mazumdar	81	Female	Retd. Prof. Nirmala Niketan, Mumbai	Trustee
5	Mr. David Gandhi	50	Male	Development Consultant, Pune	Trustee
6	Dr. A. Dyalchand	64	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 2012-2013 as follows:

Sr. No.	Date
1	21.07.2012
2	15.12.2012
3	16.02.2013

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 1<sup>st</sup> April 2012 to 31<sup>st</sup> March 2013 on 12<sup>th</sup> October 2013. The budget for the period 1<sup>st</sup> April 2013 to 31<sup>st</sup> March 2014 was reviewed and approved on 16<sup>th</sup> February 2013.

## 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 amount to Rs. 550/-
- Mr. G. Kulkarni and Ms. M. Khale received scholarships to present papers at the Global Maternal Health Care 2013 conference at Arusha, Tanzania.

## 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 21<sup>st</sup> July 2012.
- Audited statements of accounts and balance sheet for the financial year 1<sup>st</sup> April 2012 to 31<sup>st</sup> March 2013 were accepted and approved in the Board of Trustees meeting held on 12<sup>th</sup> October 2013.

## Salary Distribution by Gender as on March 31, 2013

<b>Salary Distribution as on March 31, 2012</b>			
<b>Monthly Salary of Staff Members (in Rs.)</b>	<b>Men</b>	<b>Women</b>	<b>Total</b>
≤5,000	09	02	11
5,001 – 10,000	07	14	21
10,001 – 25,000	05	03	08
25,001 – 50,000	02	01	03
≥50,001	01	00	01
<b>Total</b>	<b>24</b>	<b>20</b>	<b>44</b>

## 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	Specialisation
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 Univ.	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. D. M. Chaudhari	Social Scientist	AGRT/IHMP 28 years	MSW	Community mobilization
6	Mr. S. M. Shinde	Coordinator, Integrated ARSH.	AGRT/IHMP 26 years	MSW	Rural drinking water supply & sanitation
7	Mr. H. B. Pawar	Coordinator, Child health	AGRT/IHMP 24 years	MSW	Child nutrition & development
8	Mr. S. L. Mohite	Coordinator, PHC and RCH	AGRT/IHMP 22 years	MSW	PHC and RCH
9	Mr. J. J. Rupekar	Integrated Counselor	AGRT/IHMP 22 years	MSW / HIV Counseling	Integrated counseling
10	Mr. G. R. Kulkarni	Research Coordinators, Biostatistician	AGRT/IHMP 15 years	M.Sc. Statistics; Training in Epidemiology at Johns Hopkins.	Biostatistics / research
11	Ms. Kalpana Sanas	In-charge Desk Top Publishing (DTP)	AGRT/IHMP 15 years	DTP & website designing	Designing and production of BCC material
12	Ms. Rohini Sanap	Coordinator, urban health	AGRT/IHMP 15 years	MSW; Training in ARSH	Health services in urban slums
13	Ms. Rupa Takale	Field coordinator Life skills Education for Adolescent girls	AGRT/IHMP 13 years	MSW; Training in ARSH	Life skills Education for Adolescent girls
14	Ms. Pushpa Kharat	Integrated Counselor	AGRT/IHMP 10 years	MSW/ HIV Counseling	Integrated counseling
15	Dr. K. Bharucha	Consultant	Retd. Prof. Ob. Gynae. BJMC, Pune	MBBS, MD	Ob. Gynae. RTI / STI / HIV AIDS
16	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)
5. 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**

**BALANCE SHEET**

**INCOME AND EXPENDITURE**

**Consolidation of Accounts**

## AUDIT REPORT

Date : 14/09/2013

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

### : FOR THE YEAR ENDING 31<sup>ST</sup> MARCH, 2013 :

We have completed the Audit of the accounts of your Trust. We enclose herewith the consolidated Balance Sheet as on 31<sup>st</sup> March 2013, 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.

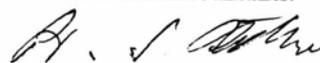
The Grants used for projects are taken as income of the year and the remaining portion of the Grant is treated as Advance grants and shown in the Balance Sheet. This portion is again transferred to Income and Expenditure A/c with the progress of the project.

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.



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 2013**

FUNDS AND LIABILITIES		PROPERTIES AND ASSETS		
RS.	RS.	RS.	RS.	
<b>Trust Fund or Corpus :</b> As per details		69852433.21	<b>Immovable Properties : (At cost)</b> (As per details)	9332645.00
<b>Other Earmarked Funds</b> (Created under the provisions of the Trust Deed or scheme out of the income)		Nil	<b>Investment : (At cost) : As per details</b>	49191903.00
Depreciation Fund			<b>Furniture and Fixtures : (At cost) :</b> As per details	4023993.00
Sinking Fund			Copy rights of Books : Last bal.	31000.00
Reserve Fund			<b>Loans - (Secured / Unsecured / Good / Doubtful)</b>	Nil
Any other Fund :			Loans Scholarships	
<b>Loans - (Secured / Unsecured)</b>		Nil	Other Loans	
From the Trustees			<b>Advances -</b>	Nil
From others			To trustees	
<b>Liabilities -</b>			To employees	
For expenses	Nil		To contractors	
For advances - Grant	4817724.00		To Lawyers	
For rent and other deposits	Nil		To others	
For sundry credit balances	Nil	4817724.00	<b>Income Outstanding :</b>	
			Rent	Nil
			Interest	Nil
			Other Income : T.D.S.	25525.00
1) Income Outstanding :			<b>Cash and bank balance -</b>	
2) Accounts were maintained on cash basis.			As per details	10584024.29
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			<b>Income and Expenditure A/c</b>	
			Deficit for the year	1488961.12
			Less : surplus as per last balance sheet	7894.20
				1481066.92
<b>TOTAL RS.</b>		<b>74670157.21</b>	<b>TOTAL RS.</b>	<b>74670157.21</b>

Dated at 14-9-13

M. I. Chale  
Trustees  
Ashish Gram Rachana Trust  
Pachod, Aurangabad Dist.

Aurangabad  
14/09/2013

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



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 2013**

Regd.No. E-249, Aurangabd

EXPENDITURE	RS.	RS.	INCOME	RS.	RS.
<b>To Expenses in respect of Properties</b>		Nil	<b>By Rent Accrued / Realised</b>		Nil
Rates, taxes, and cesses			Buildings		
Repairs and maintenance			Lands		
Salaries			<b>By interest - Accrued / Realised</b>		
Insurance			On loans	Nil	
Depreciation by way of provision or adjustment			On securities : F.D's.	4907702.00	
Other expenses			On Bank account	235586.00	5143288.00
<b>To Establishment expense :</b>		Nil	<b>By Dividends</b>		Nil
<b>To Remuneration to trustees -</b>		Nil	<b>By Donations in cash or kinds :</b>		Nil
<b>To Remuneration to the head of the math including his household expenditure if any -</b>		Nil	<b>By Grants : As per details</b>		4570049.00
<b>To Legal expenses</b>		Nil	<b>By Income from other Sources :</b>		1418759.00
<b>To Audit fees</b>		Nil	As per details		
<b>To Contribution and fees</b>		Nil	<b>By Transfers from Reserves</b>		Nil
<b>To Amounts written off -</b>		Nil	<b>By Being the excess of expenditure over income carried over to balance sheet</b>		1488961.12
a) Bad debts					
b) Loan scholarships					
c) Irrecoverable rents					
d) Other items					
<b>To Miscellaneous expenses :</b>		Nil			
<b>To Depreciation : As per details</b>		801221.00			
<b>To Amounts transferred to reserve or to specific funds</b>		Nil			
<b>To Expenditure on objects of the trust :</b>					
Medical Relief	7003322.12				
Secular Education	4588490.00				
Other Objects	234824.00	11826636.12			
<b>Total Rs.</b>		<b>12627857.12</b>	<b>Total Rs.</b>		<b>12627857.12</b>

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



Dated at 14-9-13

M. K. Chale  
Trustees  
Managing Trustee  
Ashish Gram Rachana Trust  
Pachod, Aurangabad

Aurangabad  
14/09/2013

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 2013

	ADVANCE GRANT AS ON 31-3-13	GRANT TRANSFERED TO INCOME & EXP.(2012-13)	ADVANCE GRANT BALANCE DURING 2012-13)	TOTAL GRANT RECEIVED DURING THE YEAR	NON-RECURRING GRANT RECEIVED DURING THE YEAR	GRANT RECURRING TRANSF. IN. & EXP. A/C DURING THE YR.	RECURRING ADVANCE GRANT RECEIVED	TOTAL ADVANCE GRANT AS ON 31-03-2013
	1	2	3	4	5	6	7	8
<b>1. GRANTS (ORDINARY)</b>								
FOREIGN								
SAFE ADOLESCENT (SATHI) -NRHM A/C MACARTHUR A/C	1500000	1500000		232276.00		232276		
REPRODUCTIVE & SEXUAL HEALTH & DEV. OF UNMARRIED ADOLESCENT GIRLS - MACARTHUR A/C				5662297.00		844573	4817724	4817724
CORPUS DONATION FROM-WHSP BANK A/C 0833				1581587.48	1581587.48			
SCALING UP & ADVOCACY OF MODEL PHC- URBAN - OXFAM A/C				2000000.00		2000000		
<b>TOTAL FC DETAILS:</b>	<b>Rs. 1500000</b>	<b>1500000</b>	<b>0</b>	<b>9476160.48</b>	<b>1581587.48</b>	<b>3076849</b>	<b>4817724</b>	<b>4817724</b>

SUMMARY

GRANT TRNS. TO I & E A/C DURING 2012-13

ADVANCE GRANT FOREIGN	0	FOREIGN A/C (PREVIOUS YEAR) C/F	1500000
ADVANCE GRANT KEPT DURING THE YEAR 2012-2013	4817724	INDIAN A/C (PREVIOUS YEAR) C/F	0
INDIAN	0	FOREIGN A/C (2012-13)	3076849
<b>GRAND TOTAL: Rs. (I+F)</b>	<b>4817724</b>	INDIAN A/C (2012-13)	0
		<b>GRAND TOTAL: Rs. (I+F)</b>	<b>4576849</b>



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	46436	0	0	0	46436
B) I.H.M.P GENERAL PUNE CENTRE A/C	15308	0	0	0	15308
C) A.G.R.T GENERAL A/C	29343	1360947			1390290
D) AROGYA MITRA YCMOU A/C	14	0	0	0	14
E) COMMUNITY BASED MONITORING NRHM A/C	1802	0	0	0	1802
E) A.G.R.T 0833 A/C (F)	0	0	132088	3546755	3678843
F) I. H. M. P PUNE CENTRE A/C (F)	0	0	10595	0	10595
<b>GRAND TOTAL</b>	<b>92903</b>	<b>1360947</b>	<b>142683</b>	<b>3546755</b>	<b>5143288</b>

3. CASH & BANK BALANCES

INDIAN A/C	CASH	BANK	TOTAL
1) A.G.R.T GENERAL A/C	0	2623859.50	2623859.50
2) I. H. M. P PUNE CENTRE GEN. A/C	0	413886	413886.00
3) I.H.M.P GENERAL A/C	2988.00	1183268.08	1186256.08
4) FARM A/C	0	0	0.00
5) YCMOU AROGYA MITRA A/C	0	1014.00	1014.00
6) COMMUNITY BASED MONITORING A/C	0	0	0.00
<b>TOTAL INDIAN A/C</b>	<b>2988.00</b>	<b>4222027.58</b>	<b>4225015.58</b>

FOREIGN A/C	CASH	BANK	TOTAL
7) SCALING UP & ADV. MODEL - URBAN - OXFAM	0.0	0.0	0.0
8) A.G.R.T 0833 A/C (F)	41268.23	6049781.48	6091049.71
9) REPRODUCTIVE & CHILD HEALTH 0833 INTEREST A/C	0.0	0.0	0.00
10) I. H. M. P PUNE CENTRE A/C (F)		267728.00	267728.00
11) SATHI HEALTH INITIATIVE-NRHM MACARTHUR A/C	0.0	0.0	0.00
12) PROJ. FOR RSHD OF UAG AMG & SPOU: MACARTHUR A/C	231.00	0.0	231.00
13) HEALTH CARE FOR URBAN POOR 0833 INTEREST A/C	0.0	0.0	0.00
<b>TOTAL FOREIGN A/C</b>	<b>41499.23</b>	<b>6317509.48</b>	<b>6359008.71</b>

<b>GRAND TOTAL: Rs. (I+F)</b>	<b>44487.23</b>	<b>10539537.06</b>	<b>10584024.29</b>
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4. TRUST FUND

	AMOUNT
1. FOREIGN A/C LAST BALANCE	55330155.13
ADD: PROFIT ON SALE OF EQUIPMENT	0
ADD: DONATION FROM WHSP ,U.K	1581587.48
TOTAL RS.	56911742.61

2. INDIAN A/C LAST BALANCE	12940690.60
ADD: INTEREST ON FDs	0
TOTAL RS.	12940690.60

GRAND TOTAL (I+F) 69852433.21

TRUST FUND ADDED DURING THE YEAR

FOREIGN	1581587.48
INDIAN	0
GRAND TOTAL (I+F)..... Rs.	1581587.48

CORPUS DONATION (F)..... Rs. 1581587.48

5. DEPRECIATION STATEMENT:

	VEHICLE		
	INDIAN	FOREIGN	I+F
LAST BALANCE	0	2535980	2535980
ADD: ADITION DURING THE YEAR	0	0	0
TOTAL RS.	0	2535980	2535980
LESS :SALE	0	315806	315806
TOTAL RS.	0	2220174	2220174
LESS: DEPRECIATION (15%)	0	333026	333026
TOTAL (W.D.V)	0	1887148	1887148

COMPUTER XERX OTHER EQUIPMENTS

INDIAN	FOREIGN	I+F
77570	1618776	1696346
0	0	0
77570	1618776	1696346
0	0	0
77570	1618776	1696346
11635	242816	254451
65935	1375960	1441895



**FURNITURE & DEAD STOCK**

	INDIAN	FOREIGN	I+F
LAST BALANCE	7477	698535	706012
ADD: ADITION DURING THE YEAR	0	23750	23750
<b>TOTAL RS.</b>	7477	722285	729762
LESS: SALE	0	0	0
<b>TOTAL RS.</b>	7477	722285	729762
LESS: DEPRECIATION (10%)	747	72229	72975
<b>TOTAL (W.D.V)</b>	6730	650057	656787

**BOOKS AND VIDEOS**

	INDIAN	FOREIGN	I+F
	0	42403	42403
	0	0	
	0	42403	42403
	0	0	0
	0	42403	42403
	0	4240	4240
	0	38163	38163

**GRAND TOTAL -DEPRECIATION**

	INDIAN	FOREIGN	I+F
LAST BALANCE	85047	4895694	4980741
ADD : ADITION DURING THE YEAR	0	23750	23750
<b>TOTAL RS.</b>	85047	4919444	5004491
LESS: SALE DURING THE YEAR	0	315806	315806
<b>TOTAL RS.</b>	85047	4603638	4688685
LESS :DEPRECIATION	12382	652311	664693
<b>TOTAL (W.D.V)</b>	72665	3951327	4023993

**6 . LIVE STOCK (INDIAN A/C)**

	INDIAN		FOREIGN
FARM A/C LAST BALANCE.....	32500	COPY RIGHT OF BOOKS(F)	31000
LESS: SOLD DURING THE YEAR	32500	ADD: DURING THE YEAR	0
<b>BALANCE</b>	0	<b>TOTAL: Rs.</b>	<b>31000</b>



7. IMMOVEBALE PROPERTIES

	INDIAN	FOREIGN	TOTAL (I+F)
<b>A. LAND AT PACHOD (LEASED)</b>			
GAT NO.51 &73 8A 9G LAST BALANCE			
OLD BUILDING SHEDS ON THE PARTY OF THE SAID			
LAND : BALCE AS PER LAST BALANCE SHEET B/F	25650	0	25650
LESS DEPRECIATION 10%	2565	0	2565
<b>TOTAL RS.</b>	<b>23085</b>	<b>0</b>	<b>23085</b>
<b>B. FARM FENCING (AT COST) PACHOD</b>			
LAST BALANCE	410	0	410
<b>TOTAL RS.</b>	<b>410</b>	<b>0</b>	<b>410</b>
<b>C. NEW COW SHED (AT COST) -PACHOD</b>			
LAST BALANCE	1125	0	1125
<b>TOTAL RS.</b>	<b>1125</b>	<b>0</b>	<b>1125</b>
<b>D. OPEN WELL - PACHOD</b>			
<b>TOTAL RS.</b>	<b>0</b>	<b>81600</b>	<b>81600</b>
<b>E. NEW BUILDING SHED,ETC. -PACHOD</b>			
BALANCE AS PER LAST BALANCE SHEET B/F	0	316752	316752
LESS DEPRECIATION 10%	0	31675	31675.2
<b>TOTAL RS.</b>	<b>0</b>	<b>285077</b>	<b>285077</b>
<b>SUB TOTAL (A TO E)</b>	<b>24620</b>	<b>366677</b>	<b>391297</b>



<b>F. LAND PURCHASED BY AGRT FROM A/C 0833</b> GAT NO.113,120 10A 15G AT ZALTA VILLAGE DIST. AURANGABAD : LAST BALANCE	1935470	2464472	4399942
<b>G. LAND PURCHASED AT KHARADI TQ.HAVELI</b> DIST.PUNE 17000 st.ft, 1570.34 sq. mts SN.41/2A/1 LAST BALANCE:	2271820	0	2271820
<b>H. CONSTRUCTION OF TRAINING CENTRE -PACHOD</b> LAST BALANCE: 216956 LESS DEPRECIATION 10% 21696	195260	0	195260
<b>I. PLOT AT PUNE TWO PLOTS MEASURING</b> 642 Sq. mt EACH (SR.NO.32/2/2/6 & /4) KHARADI,PUNE : LAST BALANCE	0	1348990	1348990
<b>SUB TOTAL (F TO I)</b>	4402550	3813462	8216012
<b>SUB TOTAL (A TO I)</b>	<b>4427170</b>	<b>4180139</b>	<b>8607309</b>
<b>J. OFFICE BUILDING AT PUNE ON 642 Sq. mt.PLOT</b> BUILDING STRUCTURE DIMENSION OF 119x58 ft. (SR.NO.32/2/2/4), KHARADI,PUNE: LAST BALANCE	0	805929	805929
LESS DEPRECIATION 10%	0	80593	80593
<b>SUB TOTAL ( J )</b>	0	725336	725336
<b>GRAND TOTAL (A TO J)..... Rs.</b>	<b>4427170</b>	<b>4905475</b>	<b>9332645</b>



**8. DEPRECIATION**

	INDIAN	FOREIGN	TOTAL (I+F)
ON IMMOVEABLE PROPERTY	24261	112268	136529
ON MOVEABLE PROPERTY	12382	652310	664692
<b>TOTAL RS.</b>	<b>36643</b>	<b>764578</b>	<b>801221</b>

**9. INVESTMENTS: (AT COST)**

**BANK ACCOUNT 0833**

FIX DEPOSIT WITH BANK OF MAHARASHTRA

CERTIFICATE No.	AMOUNT
451743.....	2,355,762
451744.....	53,834
451745.....	261,957
451763.....	1,581,587
451597.....	995,930
451598.....	4,929,015
451599.....	7,243,465
451600.....	694,720
451601.....	2,000,000
451602.....	2,000,000
451603.....	2,000,000
451604.....	2,000,000
451605.....	2,000,000
451606.....	2,000,000
451607.....	2,000,000
451608.....	2,000,000
451609.....	2,337,500
<b>TOTAL:</b>	<b>36,453,770</b>

**A/C NO.03 AGRT GENERAL- S/B 0888 A/C**

CERTIFICATE No.	AMOUNT
451746.....	1,168,741
451747.....	584,371
451748.....	126,015
451749.....	732,138
451750.....	1,621,479
451751.....	190,501
451752.....	189,021
451753.....	1,168,741
451754.....	3,320,680
451755.....	305,347
451756.....	565,841
451757.....	2,558,129
451758.....	107,129
451760.....	100,000
<b>TOTAL:</b>	<b>12,738,133</b>



**TOTAL: I+F** **49,191,903**

**10. INCOME TAX RECEIVABLE**

IPPF DELHI (2010-11) LAST/BAL.	20000	(F)
ADD: (2012-13) (TDS) AMC , ACF	11525	(I)
<b>TOTAL:</b>	<b>31525</b>	
LESS: I.TAX REFUNDED	6000	(F)
<b>GRAND TOTAL (I+F)</b>	<b>25525</b>	

**11. INCOME FROM OTHER SOURCES:**

A : INDIAN A/C	AMOUNT
A) SALE OF MILK FROM FARM A/C	69010
B) SALE OF FARM PRODUCTS - FARM A/C	60767
C)AGRT GENERAL A/C CORPUS OTHER RECEIPTS	38645
C)AGRT GENERAL A/C GVS REFUNDS	170848
D)PROFIT ON SALE OF LIVE STOCK FARM	82000
E)IHMP PUNE CENTRE OTHER RECEIPTS (JEEVAN KAUSHALYA ETC).....	29515
F)AROGYA MITRA YCMOU A/C COURSE FEE	20700
G)COURSE FEE AMC-A'BAD IHMP GEN	30000
H)DATA MANAGE. FEE FROM ACF IHMP GEN	170975
I) REF SALARY,COST BOOKS ETC. IHMP GEN	63909
<b>TOTAL RS.(I)</b>	<b>736369</b>

**11. INCOME FROM OTHER SOURCES**

**B: FOREIGN A/C BANK A/C 0833**

A) SALE OF SCRAP	20866
B) PROFIT ON SALE OF VEHICLE	661194
C)INTERESTON I.TAX REFUNDED	330
<b>TOTAL RS.(F)</b>	<b>682390</b>

GRAND TOTAL: Rs. (I + F)

**1418759**

**12. EXPENSES ON THE OBJECT OF THE TRUST**

**1. MEDICAL RELIEF**

	INDIAN	FOREIGN
A) HEALTH CARE FOR URBAN POOR A/C -PUNE 0833 INTEREST A/C		755447.00
B) SCALING UP ADVOCACY MODEL URBAN A/C - OXFAM		2033778.00
C) REPRODUCTIVE & CHILD HEALTH 0833 INTEREST A/C		4214097.12
<b>TOTAL RS. (I+F)</b>	<b>0</b>	<b>7003322.12</b>

2. SECULAR EDUCATION

	INDIAN	FOREIGN
A) I.H.M.P GENERAL A/C	80353	
B) I.H.M.P PUNE CENTRE GENERAL A/C	7591	
C) COMMUNITY BASED MONITORING A/C	18251	
D) AGRT GENERAL A/C	18576	
E) YCMOU AROGYA MITRA A/C	21014	
F) I.H.M.P PUNE CENTRE A/C		392
G) PROJ. FOR RSHD OF UAG AMG & MAC A/C		842366
H) SATHI HEALTH INITIATIVE MAC A/C		3290194
I) AGRT 0833 A/C ICCO WORKSHOPS A/C		107409
J) AGRT 0833 BANK A/C		202344
<b>TOTAL RS. (I+F)</b>	<b>145785</b>	<b>4442705</b>

3. OTHER OBJECTS

	INDIAN	FOREIGN
A) FARM & CATTLE EXPENDITURE A/C	234824	0
<b>TOTAL RS. (I+F)</b>	<b>234824</b>	<b>0</b>

EXPENSES ON OBJECTS OF THE TRUST	INDIAN	FOREIGN	TOTAL
1. MEDICAL RELIEF.....	0.00	7003322.12	7003322.12
2. SECULAR EDUCATION.....	145785.00	4442705.00	4588490.00
3. OTHER OBJECTS.....	234824.00	0	234824.00
<b>TOTAL RS. (I+F)</b>	<b>380609.00</b>	<b>11446027.12</b>	<b>11826636.12</b>

14-Sep-13  
AURANGABAD

*M. I. Chale*  
Managing Trustee  
Arshish Gram Rachna Trust  
Pachod, Aurangabad Dist.

EXAMINED & FOUND CORRECT  
For and on behalf of  
M/s R.S Lotke & Co.  
Chartered Accountants

*R. S. Lotke*  
CHARTERED ACCOUNTANT  
PROPRIETOR



## 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.

In collaboration with Tata Institute of Social Sciences, Mumbai; AGRT/IHMP has planned to offer a Diploma in Public Health Practice course of one year duration. The short courses offered by the Institute will be expanded.

## 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
- Whiteladies Health Share Project, Bristol
- 

## 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](mailto:admin@ihmp.org) OR [ihmpp\\_agd@bsnl.in](mailto:ihmpp_agd@bsnl.in)

**Contact us at:**

Ashish Gram Rachna Trust,  
Institute of Health Management, Pachod  
PO Pachod  
District Aurangabad, 431 121  
Maharashtra, India  
Tel. 91 2431 - 221 382 / 221 419  
Fax 91 2431 - 221 331

Ashish Gram Rachna Trust,  
Institute of Health Management, Pachod (IHMP)  
32/2/2; Sonai Park  
Kharadi Road, Chandannagar;  
Pune 411014;  
Maharashtra, India.  
Tel. 91 20 6410 0790 / 91 20 2026 4833

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