

Ashish Gram Rachna Trust (AGRT/)

Institute of Health Management, Pachod, (IHMP)

Annual Report

2011 - 2012

**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. The Institute undertakes various activities in the context of providing services, innovating, research, training and policy advocacy. 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, 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 which is reflected in all its programmes.

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

The Institute of Health Management, Pachod, (IHMP) is the executive body of the Ashish Gram Rachna Trust (AGRT), which 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 of Maharashtra, 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 the 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

The 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

Key projects and activities during the period 1st April 2011 to 31st March 2012

1. Safe Adolescent Transition and Health Initiative (SATHI)
Part I: Scaling up SATHI interventions as innovations in “Communitization” under the National Rural Health Mission
Part II: Implementation of the SATHI project in one PHC area
2. Urban Health Project
Part I: A rights based approach to people centered advocacy for increased access to rationally planned health care services by the urban poor
Part II Scaling up and advocacy of a model PHC care program for urban poor
3. HIV/AIDS - Project
4. Primary Health Care
5. Training
6. Study - Impact of surveillance and monitoring system on the utilization of maternal and newborn services in the slums of Navi Mumbai Municipal Corporation area
7. Study - Impact of need specific Behavior Change Communication (BCC) on individual, household and service utilization behaviours in the context of maternal and neonatal health
8. Study on HIV testing by pregnant women in collaboration with Johns Hopkins University, Baltimore
9. Address stigma and discrimination related to HIV, sexual minorities and gender through Faith Based Organizations
10. Study on Perception, Attitude and Discrimination towards Arunthathiyar (DALIT Community) and its effects on Quality of Life of Arunthathiyar in Theni district.

1. Safe Adolescent Transition and Health Initiative (SATHI)

Introduction:

The Safe Adolescent Transition and Health Initiative (SATHI) project) that is being supported by MacArthur Foundation was implemented at two levels.

- a. Scaling up the SATHI intervention in one block of Aurangabad district
- b. Implementing the SATHI intervention in one PHC

a. Scaling up the SATHI intervention

The project interventions that are well defined were scaled up in one block through Government PHCs. AGRT/IHMP proposed a model wherein the 5 SATHI innovations were to be scaled up in one block having 7 primary health centers and two rural hospitals. The objective was to demonstrate the efficacy of the SATHI innovations, through Government primary health centers, with a special focus on married adolescent girls.

b. Implementing the SATHI intervention in one PHC

AGRT/IHMP continued to implement the SATHI interventions in one PHC. The key purpose of this was to maintain a pilot site that could be used for the purpose of advocacy by demonstrating SATHI innovations to policy makers and other key stakeholders. The other purpose of the Pilot site was to use it for the purpose of capacity building while the interventions were being scaled up. This site proved to be invaluable for both these functions. This year's annual report is presented in two parts.

Part I - Scaling up SATHI interventions as innovations in "Communitization" under the National Rural Health Mission

Broad Objective - Scaling up a focused intervention for married adolescent girls (SATHI) integrated with the Reproductive and Child Health program, in the context of NRHM, in one block through Government Primary Health Centers.

Project Description - The five components of the SATHI intervention package that have been successfully demonstrated at a pilot site and scaled up in 5 districts through NGOs, were scaled up to a block level through Government PHCs. The 5 innovations of the SATHI project that were integrated with Reproductive and Child Health (RCH) through NRHM:

1. Surveillance – ASHAs conducted a comprehensive assessment of health needs of all households on a monthly basis during household visits, in seven PHCs of Paithan Block
2. Monthly Micro-planning – On the basis of the needs assessed during monthly house visits ASHAs prepared a list of beneficiaries and clients that needed BCC and health services.
3. Primary Level Care – ASHAs actively linked clients to the ANM on the monthly Village Health and Nutrition Day (VHND) in the village, or at the SC and PHC.
4. Behavior Change Communication – ASHAs provided need specific BCC based on information needs identified and behavioral diagnosis made during household visits. BCC was implemented with the aim to increase demand for health services and modify key health utilization behaviors among all the households under 7 PHCs of Paithan block.
5. Village Health Nutrition Water Supply and Sanitation Committees – Monthly review meetings were held in the villages. In the meetings health needs identified by ASHAs were compared with the services provided by the ANM. The committees monitored service utilization and generated demand by motivating resistant families.

Details of the project site – Paithan block: *Paithan* block has a population of 322,734 (including the urban population of Paithan town) with a sex ratio of 925 females per thousand women as against the national average of 933. There are a total of 108 Panchayats in 196 villages of the block. The population is provided health services through 7 Primary Health Centers (PHCs) and 38 Sub- Centers (SCs). There are two CHCs or Rural Hospitals. The Crude Birth Rate is 23.39 and Infant Mortality Rate is 37.7.

The implementation process followed the sequential activities presented below:

- Recruitment and training of NGO staff
- Training of selected ASHAs
- Orientation of VHSC members
- Training of ANM, MPW, PHC staff - To strengthen institutional capacity
- Monthly surveillance of health needs
- Preparation of monthly micro-plans
- Demand generation through BCC
- Monthly monitoring of primary level health services by VHSCs
- Triangulation of data for preparing MPR for the village
- Regular monitoring of health facilities
- Strengthening the existing health care management system
- Providing support to the current administrative monitoring
- Opening space for dialogue between provider and beneficiaries

Capacity building - The following trainings were conducted:

1. Training of trainers
2. Training of block and PHC facilitators
3. Training of 200 ASHAs
4. Orientation of health providers from 7 PHCs and 2 CHCs
5. Training of VHSC members at the PHC level in the respective PHCs.

Expected outcomes of the project:

- Integration of ARSH with RCH
- Special focus on married adolescent girls / young women less than 19 years
- Increase in contraceptive use and sterilization
- Increase in utilization of services delivered by the public health institutions
- Increase in antenatal service coverage
- Increase in institutional deliveries
- Increase in post natal service coverage
- Increase in immunization coverage
- Increase in treatment of childhood illnesses
- Reduction in RTI/STI
- Increase in utilization of ICTC services

Outputs and Outcomes of Scaling up at the Block Level:

The data from the monthly surveillance and monitoring system was used for assessing the outcome of the project. External investigators were hired to validate the information collected through the management information system. The data were utilized to do a trend analysis through a time series research design comparing the situation prior to the intervention (July 2010) with the situation after the intervention; in March 2011 and March 2012.

Description of the Paithan Block

Sr. No.	Details	July 2010	March 2011	March 2012
1.	No. of PHCs	7	7	7
2.	No. of ASHAs	152	169	138
3.	Population covered	154,070	175,847	139,989

About 90 percent households are covered by ASHAs through surveillance and monitoring undertaken during monthly house visits. The coverage of households for surveillance and monitoring is marginally higher for women over 20 years of age as compared to married adolescent girls less than 19 years.

There is a significant increase in all the 7 maternal health care service related indicators. For each of the 7 indicators the increase is greater for married adolescent girls ≤ 19 years as compared to women > 20 years.

Both for women over 20 and married adolescent girls less than 19 years the proportion of children weighed immediately after birth increased from 82 and 85 per cent to 100 percent. There is a significant reduction in the proportion of low birth weight babies which is more among married adolescent girls less than 19 years as compared to women over 20 years.

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

The current use of temporary contraceptives increased significantly among married adolescent girls as well as women over 20 years. Whereas, there is a preference for condoms among married adolescent girls, women over 20 years prefer oral pills. The increase in contraceptive use can be attributed to demand generation through BCC, better monitoring of unmet need and behavior tracking.

Vaccination coverage of children 12-23 months of age has gone up. The greatest increase is seen for Hepatitis B and measles. Proportion of children completing primary vaccination on time increased significantly from 66.2 percent to 87.5 percent.

Project – Inputs:

One-day training of ASHAs from Nander PHC was organized on 4th July 2011. For the ASHAs of remaining six PHCs, it was organized from 7th September to 9th September 2011. ASHAs transferred information about married women 15-45 years and children under two years to the new registers. In-service training was conducted on how to do surveillance and how to record information in the register. A household visit plan for monthly surveillance was prepared for each ASHA.

Surveillance: ASHAs conducted household visits as per the monthly visit plan given to them. During house visit the ASHA assessed health needs of married women 15-45 years and children under two years. She recorded this information in the surveillance register. ASHAs also recorded information on the vital events (Births, Deaths and Marriages). Average number of ASHAs who were expected to do the surveillance was 181, out of which 140 ASHAs actually did the surveillance during the reporting period.

Micro-planning: Every month the ASHAs prepared micro planners based on the surveillance register for pregnant women and children. This micro-planner was given to the ANM when she visited the village for conducting the Village Health and Nutrition Day (VHND). The ASHA also used the planner to remind and collect her clients on the Village Health and Nutrition Day.

On an average 129 villages were visited once and 42 villages were visited twice every two months. On an average 147 ASHAs were visited once in two months and given feedback on surveillance and micro-planning.

Primary Level Care: ANMs from primary health centers conducted Village Health and Nutrition Days (VHND) on a fixed day in the villages under their sub-centre. Based on the micro-planner prepared by the ASHA, she informed pregnant women and mothers of children less than two years to come to the clinic. The ANM also checked whether all the clients as per the micro-planner availed services or not. This has helped to improve both coverage and quality of services.

Need Based Behavior Change Communication: During household visits, ASHAs assessed information needs of every client and make a behavioral diagnosis. Based on their diagnoses the ASHAs give specific messages to the households using BCC cards and undertake counseling where necessary. Each ASHA was given two sets of BCC cards (Maternal & Newborn Health and Family Planning) designed and developed by AGRT/IHMP .

Simultaneously, other BCC inputs were given at the community level to establish an environment which is conducive for the project and for introducing new social norms like age at first conception, birth interval, institutional delivery, etc.

Information Centre: A total of 225 information centers were established in the villages of Paithan Block. BCC materials for the centers were made available by the IEC Bureau, Pune. During the reporting period, community based male and female volunteers continued to have the information center open in their village.

Review Meetings of the Village Health, Nutrition, Water Supply and Sanitation Committees (VHNWSC): Once in two months, a meeting of VHNWSC was facilitated by the program coordinators. In this meeting, health needs assessed by the ASHA's and services provided by the ANM were reviewed by the VHNWSC. The committee certified the work of the ASHA on the basis of whether she had completed surveillance for the month; prepared micro-planners for maternal and child health services and immunization, given need specific BCC, was present for the Village Health and Nutrition Day (VHND) and prepared her monthly progress report. The ASHAs were given their monthly honorarium by a cheque during the monthly meeting held at the PHC only if they brought the stipulated format signed by the VHNWSC President or Secretary. On an average 69 percent of the committee meetings were conducted once every two months.

During this period 37 neonatal deaths, 55 infant deaths and 0 maternal deaths were recorded.

The project outputs and outcomes are encouraging and indicate that systems like monthly surveillance and micro-planning are efficacious.

Part II

Implementation of the SATHI project in one pilot PHC area

Broad Objective: To improve the sexual and reproductive health of married adolescent girls in 24 villages; use the project site for demonstration and capacity building during scaling up.

Specific Objectives:

1. The treatment seeking behavior for post abortion complications will increase.
2. The average age at first conception will be delayed.
3. The proportion of low birth weight babies will be reduced.
4. Treatment seeking for RTIs among married adolescents will increase.
5. The proportion seeking treatment for post-natal complications will increase.

Project Innovations: The project activities conducted during the reporting period

- a) Surveillance
- b) Micro-planning
- c) Need specific IPC and group BCC through community based workers.
- d) Linking MAGS with primary level and referral services.
- e) Community based monitoring through Village Health, and Sanitation Committees

Demonstration for scaling-up: The project site was used very effectively for demonstration and advocacy for scaling up the SATHI innovations. The five innovations mentioned above were demonstrated to organizations such as UNICEF, International Institute of Population Sciences (IIPS), Tata Institute of Social Sciences (TISS) and NGOs that came for training.

Capacity building for Scaling up: The SATHI project was scaled up at a block level in Paithan Taluka. The objective of scaling up at a block level was to demonstrate the efficacy of the five innovations in the public health sector (Government PHCs). The ASHAs, PHC and project staff was imparted practical skills through field practice at the pilot site.

Implementation of the five Innovations:

A. Surveillance Coverage: On an average of 85.8 percent MAGs were covered under monthly surveillance.

B. Need specific IPC:

Need specific IPC by community based workers and supervisors

At the time of surveillance visit, community organizers detected health education needs and gave MAGs and their house hold members need based IPC. During house visits, supervisors visited MAG's and gave them information regarding immunization, importance of antenatal registration and examinations, complementary feeding, ICTC, RTI clinics and information centre. On an average, during each village visit 12 MAG's were given need specific IPC.

C. Village Level Meetings conducted by social workers:

Under the BCC intervention, village level meeting are conducted with MAGs and their spouses. 71 percent of the planned MAGs meeting were conducted. This particular input covered about 40 percent of the registered MAGs. Similarly, 71 percent of the planned group meetings for spouses of MAGs were conducted. In comparison to the planned attendance, 83 percent spouses of MAGs attended the meetings.

Project outputs according to each of original specific objectives

Objective 1: Treatment seeking behavior for post abortion complications will increase.

22 abortions were reported during the reporting period. The abortion rate at baseline was 16 abortions per 100 pregnancies. None of the MAGs experienced any post abortion complications. This indicates a sharp decline of post abortion complications from 68 percent in baseline in 2003 to 0 percent in 2012.

Objective 2: The average age at first conception will be delayed by one year

On an average 20 percent young married couples were using any one family planning method. Contraceptive use increased from 11 percent at baseline to 19.9 percent.

Objective 3: The proportion of low birth weight babies will reduce.

100 percent newborn babies (delivered at in laws) were weighed at birth. Among the neonates that were weighed at birth, 22.7 percent had low birth weight. The proportion of LBW babies is comparatively less than at baseline (36 percent). 100 percent LBW babies had received thermal bags.

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

On an average 6.3 percent MAGs reported any one symptom of RTIs during the monthly surveillance. This prevalence rate is lower than baseline (2003). An average 85 percent MAGs suffering from RTIs sought treatment. This proportion is significantly higher than at baseline survey 2003.

Objective 5: To increase treatment seeking for post-natal complications among married adolescent girls by 20 percentage points.

8.3 percent MAGs reported symptoms of post natal complications. The proportion of MAGs with post natal complications is significantly lower compared to the baseline survey 2003 (50 percent). 100 percent of MAGs with the post natal complications sought treatment.

A total of 405 MAGs were eligible for IFA supplementation. A total of 337 MAGs (83.2 percent) were covered with IFA supplementation.

2. Urban Health Project

Institute of Health Management Pachod is working in the slums of Mundhwa and Ghorpadi area of Pune since 1998. Oxfam approved a grant for one year from September 2010 to August 2011 for developing interventions from a rights based perspective that can be offered to the Public Health Sector for scaling up in the Primary Urban Health Centres (PUHC).

The pilot project was implemented for one year i.e. from September 2010 to August 2011. During this period, AGRT/IHMP designed and pre-tested 6 distinct interventions that can be introduced as a Public Private Partnership Model in the primary urban health care centres proposed to be established in future under National Urban Health Mission (NUHM) by the Government.

In October 2011, Oxfam approved a grant for three years to demonstrate these 6 innovations in a public 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. The project is being implemented in one PUHC sanctioned by the Pune Municipal Corporation from 1st October 2011.

A rights based approach to people centered advocacy for increased access to rationally planned health care services by the urban poor

The project was implemented in 27 slums of Mundhwa and Ghorpadi area of Pune city. The health care services were provided through a 'D' Type Health Post to a slum population of about 30,000 individuals. Following key activities were carried out during 1st April to 31st August 2011:

1. System Development: During the reporting period, AGRT/IHMP has designed, pre-tested and developed following materials for a health care delivery system for the urban poor.

- Surveillance registers for Community Health Workers (CHWs) with guidelines.
- Micro-planners for CHWs
- Register for recording the vital events – Births, deaths and marriages
- Service registers for ANM with guidelines
- Format for the Monthly Progress Report with guidelines
- BCC materials – Protocols for need specific BCC
- Guidelines and materials for conducting BCC group meetings

Needs assessment through monthly surveillance was carried out by the 22 Community Health Workers. Surveillance coverage was 94.8 percent during the reporting period. During monthly surveillance visits, 133 women were detected with amenorrhea, 375 women with reproductive tract infections (RTIs), 425 pregnant women received antenatal care, out of which 93 were detected with danger signs and 81 women received post-natal care by the ANM after delivery.

Under child health care 10 cases of pneumonia were detected and treated, 255 children suffering from diarrhoea episodes were detected during surveillance, they were referred to the project clinics and treated. 577 children having acute respiratory infection (ARI) were detected, referred to the facility and treated.

A total of 516 individuals were referred to secondary and tertiary care centers from the primary level facilities. Out of 516 referrals, 413 received follow up visits by the project staff to monitor the utilization of the referral.

22 CHWs were able to detect 82 individuals with symptoms of Tuberculosis, of which 72 were referred for confirming diagnosis and treatment. Also, 34 individuals were detected with symptoms of malaria, 117 individuals were detected with symptoms of diabetes and 268 individuals were detected with symptoms of hypertension. All of them were referred for diagnosis and treatment.

3. Vasti Level Clinics Conducted by Project ANMs: A total of 140 Vasti level clinics were planned & organized and 947 antenatal check-ups were done.

4. OPD at Mundhava Kutir Rugnalaya: A total of 635 individuals from the project area received treatment from OPD at the Mundhava Kutir Rugnalaya during the reporting period.

5. Vasti Level Satellite Clinics: A total of 20 satellite clinics were planned, of which 19 clinics were organized and 361 patients were treated at the Satellite Clinics.

6. In-service Training: Seven in-service training sessions were conducted during the reporting period. CHWs and project staff participated in these training sessions.

6. Supportive Supervision by the Project Staff: Each supervisor was responsible for the supervision of 8-9 vastis. Two supervision visits per month were planned for each slum. A total of 226 supervision visits were planned, of which 176 (77.8 percent) visits were conducted.

7. Vasti Level Meetings Conducted by Project ANMs: A total of 140 group meetings for BCC for women were planned and organized during April to August 2011. A total of 2867 women from 27 vastis attended group meetings.

8. Information Centre: Information Centres have been functioning in all 27 vastis.

10. Vasti Development Committees (VDCs): 25 VDCs were functioning in the 27 slums. A total of 104 VDC meetings were planned during the reporting period, of these 73 (70.1 percent) meetings were conducted. A total of 767 VDC members attended the meetings.

11. Project Closure Meeting: A project closure meeting was organized in Ghorpadi, in the month of August 2011. All CHWs and VDC members were invited for the meeting.

Scaling up and advocacy of a model primary health care programme for the urban poor”

A new project was initiated from October 2011 in the slums of Yerwada under Late Galande Patil Urban Health Post in Pune Municipal Corporation. The broad objective of the project is to build evidence of the efficacy of 6 innovations developed by AGRT/IHMP by demonstrating the innovations through a Primary Urban Health Centre (PUHC) and advocating replication of these in the urban public health sector.

Selection of Primary Urban Health Centre (PUHC): “Late Galande Patil Health Post, Shastri Nagar, Yerwada” was selected as the UHP for the project.

House Listing and Modified Social Mapping: A total of 5233 structures were numbered and listed in the 18 slums.

Census Data Collection: The actual census data collection was carried out from 3rd December 2011 to 14th January 2012. A total of 4770 families were visited and the census information from 4009 households (85 percent) was collected. Fifteen percent of the households were locked at the time of census, and were not available for enumeration.

Community Meetings - Formation of Slum Health & Development Committees and Selection of CHWs: During the reporting period, 39 out of 46 community meetings planned were carried out in 18 slum areas. A total of 467 community members participated in the 46 meetings.

Formation of Slum Health & Development Committees: Formation of 15 SHDCs was planned during the reporting period, of these 12 (80 percent) SHDCs have been formed.

Orientation Workshop for Slum Health & Development Committee Members: Orientation workshop for SHDC members was organized in the month of January 2012. A total of 79 SHDC members (11 male and 68 female) attended the workshop.

Monthly Slum Health & Development Committee Meetings: Monthly SHDC meetings were planned for each slum area from March 2012. A total of 15 SHDC meetings were planned, of these 13 (87 percent) meetings were conducted. A total of 117 (out of 198) SHDC members were present at the monthly SHDC meetings.

Selection and Induction Training of CHWs - Eleven CHWs were selected. Induction training of the first batch of selected CHWs was conducted in the month of March 2012.

Slum Level BCC Group Meetings Conducted by Project ANMs: BCC group meetings were planned from March 2012, a total of 17 meetings were organized at the slum level by the project ANMs during the reporting period. 324 women from the slums (on an average 20 women per meeting) attended these meetings.

Supportive Supervision by the Project Staff: Sixteen out of 27 supervision visits planned (60 percent) were conducted.

Baseline Survey: A detailed research protocol was prepared for the baseline survey. A structured interview schedule was designed and pre-tested to collect the information from:

- Ever married women 15-45 years of age
- Household – to collect the information on general morbidity, communicable and non communicable diseases

The baseline data collection was completed on 6th March 2012. Out of 600 sampled households from 18 slums, 571 were covered. A total of 178 ever married women 15-45 years of age and 170 mothers with children under three years of age were interviewed.

3. HIV/AIDS - Project

Institute of Health Management Pachod (AGRT/IHMP) has undertaken a HIV AIDS project for implementing and mainstreaming HIV with maternal health, women's health, RTIs/STIs and family planning. This project focuses on men and women in the age group of 15 to 45 and pregnant women. The project is implemented in the Nander PHC area covering population of 31208 in 24 villages.

The intervention includes reaching the 15 to 45 age group population and pregnant women at the household and group level. Specific inputs are planned for men and women. This includes home visits, group meetings, couple workshops, information centers, and separate Reproductive Tract Infections (RTIs) /Sexually Transmitted Infections (STIs) clinics for men and women, referral for needy individuals, care and support for People Living with HIV/AIDS (PLHAs), and decentralized Voluntary Counseling & Testing Centre (VCTC) /Prevention of Parent To Child Transmission (PPTCT) services up to the sub centre level.

The project activities undertaken during the reporting period of April 2011 to March 2012 are broadly categorized under the following heads:

A) Behaviour change communication

B) Surveillance, Primary level care, referral and support

A) Behaviour change communication:

The project has given intensive BCC to the community through various ways. To implement the BCC component, female and male social workers of the project conduct village level meetings with VHNWSC (Village Health, Nutrition, Water and Sanitation Committees) and Women on a monthly basis and with Youth once in two months. The topics for the village level meetings were decided with the target groups.

The coverage of VHNWSC (Village Health, Nutrition, Water and Sanitation Committees) meetings is 90.5 percent. In which, on an average 61.1 percent VHNWSC members attended the meetings.

- The coverage of meetings with men is 98.4 percent. On an average 77.3 percent of the expected number of men attended the meetings.
- The coverage of youth meetings is 86.5 percent. On an average 81.4 percent of the expected number of youth attended the meetings.
- The coverage of women's meetings is 73.1 percent. On an average 40.3 percent of the expected number of women below the age of 25 years attended the meetings.
- On an average 92.5 percent household visits were conducted by community organisers for monthly surveillance and Inter Personal Communication (IPC) and counseling.
- Every village has one (in larger villages more than one) information center for providing information and reading material to the community. Peer educators run the information centers. The peer educators (male and female) are trained by AGRT/IHMP .
- On average 33 (91.7%) information centers functioned every month. On an average 97.2 percent follow up visits were made to the information centers.

B) Care and services:

• Surveillance:

Average 92.5 percent household visits were conducted by community organisers for monthly surveillance.

85 percent of the planned antenatal clinics were conducted at the village level and 84 percent women received antenatal care during the reporting period.

85.3 percent women sought treatment for RTIs. This proportion is comparatively higher than at baseline survey 2003.

40 clinics were conducted at sub-centre and village level. 236 women have benefited from these clinics for RTIs, STIs, Gynecological problems, and follow up.

45 RTI / STI clinics for male were conducted at sub-centers and in selected villages, and 58 men benefited from these clinics for treatment of RTIs, STIs, sexual health and other problems.

536 hemoglobin tests were done at the village, sub-centre and primary health centre level during RTI / STI clinics. The results indicate that 1.7 percent people were suffering from severe anemia, 40.9 percent were suffering from moderate anemia, 56.2 percent were suffering from mild anemia and 1.3 percent had a normal level of hemoglobin

531 individuals received pre-test counseling, for 531 individuals HIV test was done and 409 individuals received post-test counseling during the reporting period at the ICTC / PPTCT clinics conducted at sub-centre and in selected villages.

Total numbers of old PLHA are 45 of which are 20 males and 25 females. The newly detected PLHA is one male. The total number of PLHA is 46 out of which 21 are males and 25 are females. Out of 46 PLHA, 3 male PLHAs and 4 female PLHAs migrated outside project area and one female PLHA died in this reporting year.

The total number of PLHA for care and support are 39 (18 males and 29 females) and these 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 29 (6 times in male and 13 times in female). 18 people are on ART (9 males and 9 females). 10 patients visited the PLHA network office (4 males and 6 females).

4. Primary Health Care

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

Project Inputs and Outputs from April 2011 to March 2012

1. Monthly In-service of Community Organisers (COs): Every month on fixed day 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.

2. Monthly surveillance and IPC through Community Organisers: COs collected information on childhood diseases, pregnant women, gynaecological problems in women and family planning. On an average 92.5 percent household visits were 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. During these clinics ANM does systematic head to toe examination and records the necessary information of all the pregnant women. She provides iron folic acid tablets and TT injections. If she detects high-risk cases she refers them to a hospital. During the reporting period 945 new pregnant women were registered for antenatal services.

Deliveries and Postnatal visits: During the reporting period 891 deliveries and 96 abortions were recorded. 39 mothers received one post natal visit, 34 mothers received two post natal visits, and 158 mothers received three or more post natal visits.

Maternal health care services taken during the reporting period: During the reporting period out of 891 deliveries 864 women (97 percent) delivered in a hospital; 870 (97.6 percent) deliveries were conducted by a trained person.

4. Minor Ailments treatment at the village level: The total number of patients treated for minor ailments was 257. Since most of the COs have become ASHAs and they received medicine kits during the year.

5. 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 also give nutritional counseling to parents of malnourished children. During the reporting period on an average 84 percent children were weighed every month. On an average 2.2 percent children were suffering from severe malnutrition.

6. Health check-ups of 1st std. to 4th std. students in school: Twenty camps were held for health check-up of 1st std. to 4th std. students in the schools. 84.6 percent children were weighed at the camps conducted for children in the schools. 17.5 percent children were normal, 35.1 percent had 1st degree malnutrition (mild) and 30.5 percent had 2nd degree malnutrition (moderate), 14.4 percent had 3rd degree and 2.3 percent had 4th degree malnutrition (severe).

Illnesses detected in Students: 517 illness episodes were detected. Out of 517 illness episodes, 11 were URI, 82 were dental carries, 119 were vitamin A deficiencies, 10 were skin infections, 264 were anemia and 31 were other illnesses.

Children treated and referred: 996 children were examined during the health check-up camps in the schools. Out of 996 children, 384 were treated and 48 referred. There is difference between total number of cases detected & total number of treated & referred because 4 Children had three illnesses & 22 Children had two illnesses.

5. Training

Institute of Health Management Pachod conducts training for Non - Government Organizations (NGOs) and government officials on health management since 1986. During the reporting period - April 2011 to March 2012, a 10-day course was conducted on Planning, Monitoring and Evaluation of Community Health and Development Programmes for NGO functionaries.

Planning, Monitoring and Evaluation of Health and Development Programmes:

A ten-day course for organizational heads and programme coordinators was conducted in English from 17th to 27th August 2011. Six participants from different states attended the course. Different teaching methods used during the course were lecture - discussions, field visits, group work and presentation on group work. The course focused on developing cognitive and practical skills of participants related to Logical Framework of Analysis, which can be used as a management tool.

Course Evaluation: Participants evaluated the course content, faculty and rating against the expectation listed by them on first day.

Rating Against Expectation:

Six Participants had listed 10 expectations (5 related to programme planning, one about monitoring, one about supervision, two about evaluation and one about finance management) on the first day of the course. Participants rated against each expectation their level of satisfaction. All the participants rated more than 70% against each expectation as being met satisfactorily from the training course.

Content Evaluation:

Participants expressed that 89% of the Course Content covered was relevant.

Faculty Evaluation:

Five AGRT/IHMP faculty members were involved in the training course; most of the participants rated excellent especially on the organization of the session, presentation and facilitation of group discussion by faculty members.

Feedback from the participants:

- Most of the participants reported that they liked the session on quantitative analysis, logical framework of analysis and planning.
- Most of the participants reported that they acquired the skills of preparing logical framework of analysis for their projects, doing task analysis & work load estimation and using PRA techniques for the community diagnosis.
- Most of the participants stated that time allotted to the topics of monitoring and evaluation was not adequate.
- Most of the participants stated that duration of the course was adequate.

6. Study - Impact of surveillance and monitoring system on the utilization of maternal and newborn services in the slums of Navi Mumbai Municipal Corporation area

'PATH' (Program for Appropriate Technology in Health) initiated a program known as 'Sure Start' in 2005, which is supported by the Bill and Melinda Gates Foundation, as part of the 'Community Health Solutions'. Sure Start aims to help fulfill the Government of India's commitment to improving maternal and newborn health by focusing on the National Rural Health Mission (NRHM) and Reproductive and Child Health (RCH) II. The Sure Start project is concerned with sustainable improvement in maternal and newborn health through effective household and community action in seven selected urban sites of Maharashtra.

The Institute of Health Management, Pachod (AGRT/IHMP) is a 'cross-site' partner for the Sure Start project. Part of its responsibility was to develop a manual Management Information System (MIS); the Behaviour Change Communication (BCC) component of the Sure Start project, and to build the capacity of the seven partner-NGOs in the use of these tools.

During the reporting period, AGRT/IHMP was involved in completing study report on – "Impact of surveillance and monitoring system on the utilization of maternal and newborn services in the slums of Navi Mumbai Municipal Corporation area"

Research Objective: To determine the impact of the community based, monthly surveillance and monitoring system on early detection of maternal and neonatal health needs, linkage of clients with service providers and health facilities, utilization and effective coverage with MNH services, and timely referral and treatment of complications.

Research Hypothesis: Surveillance and monitoring will lead to improved utilization and effective coverage of MNH services and reduction in maternal and neonatal morbidity.

Research Questions:

- a. Did the monthly surveillance and monitoring by link workers / CHWs result in a change in health seeking behaviour of beneficiaries residing in NMMC project area?
- b. Did the surveillance and monitoring system have an impact on the early detection of self-reported maternal and neonatal morbidity and utilization of referral services?

Study Design and Methodology:

The study was conducted in the slums of the NMMC Sure Start project area. Change in the clients' health seeking behaviour was assessed by:

- Comparing health behaviour/service utilization in the last pregnancy (i.e., the one occurring in the last one year) with the previous pregnancy.
- Comparing the level of positive health behaviour/service utilization across levels of exposure to surveillance and monitoring, i.e., dose response.

Exposure Levels: Three levels of exposure to surveillance were considered:

- 1) High: ≥ 4 surveillance visits during pregnancy by the LW in the last pregnancy;
- 2) Low: ≤ 3 surveillance visits during pregnancy by LW;
- 3) No exposure: It was assumed that there was no exposure to surveillance for the previous pregnancy.

Rational Utilization of Health Services: The operational definition of rational utilization of health services that was used in this study was - availing of health services by the respondents at the appropriate level of health care facilities.

Sample size: The sample size for this study was 200 recently delivered mothers. This was calculated in order to detect a 10 percent difference in coverage with minimum standard antenatal care, using an alpha value of 0.05 and a two tailed test to achieve 80 percent power. (Fleiss et al, 2003)

Socio-demographic Characteristics of the Respondents

The majority of the respondents were less than 29 years of age with five years or more of formal education. Over 95 percent were participating in the workforce. The majority of the husbands were over 30 years of age, had 8 years or more of formal education and were either employed in some service or had a small petty trade. The majority of the households were nuclear with less than 5 members, and were living in one room tenements. The majority had one earning member and most households were Hindus.

Conclusions and Implications

Conclusions: Surveillance has resulted in a measurable and significant increase in utilization of MNH services. A substantive increase from the previous to the last pregnancy was observed in the utilization of government health care services over that of private services. This being said, the level of rational utilization of government primary health care facilities (Outreach Clinics and UHP) continues to be low. Pregnant women still prefer to go to the MCH clinic for most services in spite of the fact that these are available at a more decentralized level such as UHPs and outreach clinics.

Pregnancy confirmation and registration for antenatal care services: There was a significant increase in women accessing urine pregnancy testing and an equally robust increase in early (within 12 weeks) antenatal care registration. What is significant is the fact that the service providers for both these processes were increasingly government rather than private. There is a significant association between exposure to surveillance and early registration for antenatal care services.

Utilization of antenatal care: Increase in utilization of 'minimum standard antenatal care' was associated with the level of exposure to surveillance. Respondents availing of minimum care were typically those who were exposed to 'high' levels (four and more visits) of surveillance.

Antenatal complications and treatment: A significant increase was observed in the early detection of antenatal complications among those who had a 'high' level of exposure to surveillance as compared to those who did not.

Significant increase in the utilization of MCH clinics for the treatment of antenatal complications was observed in the last pregnancy as compared to the previous pregnancy. There was a shift in the place of treatment for symptoms of antenatal complications from private institutions to government facilities in the last pregnancy as compared to the previous one.

Intra-natal care: A significant reduction in home deliveries was observed in the last pregnancy as compared to the previous one. Also, a significantly higher proportion of hospital deliveries were conducted at MCH clinics in the last pregnancy as compared to the previous one. There was also a shift in the place of delivery from private institutions to government hospitals in the last pregnancy.

Post-natal care: A significant increase was observed in the proportion of those in the last pregnancy who reported that they were visited at least once by the government ANM, as compared to those in the previous pregnancy who did so. No significant change was observed in the early detection of symptoms of at least one post-natal complication in the last pregnancy as compared to the previous one. No significant increase was observed in the utilization of UHP and MCH centers for the treatment of post-natal complications with 'high' level of exposure to surveillance (such as in the last delivery) as compared to a low level of exposure (such as in the last delivery) and no exposure to the surveillance (such as in the previous delivery). The two reasons for respondents seeking treatment at the MCH clinics were 'convenience' and 'affordability'.

Neonatal care: The majority of mothers reported that their newborns were weighed within 24 hours after birth. Two out of four respondents received surveillance visits within 28 days after the delivery, by the Link Worker/Community Health Worker, for detection of neonatal complications and referral for treatment. No significant difference was observed in the early detection of any one symptom indicative of a neonatal complication between the last and previous pregnancy. Among those who gave a positive history of neonatal complications, an increase in early treatment was observed in the last pregnancy as compared to the previous one. There was no significant association between the utilization of MCH clinics for the treatment of neonatal complications and the level of exposure to surveillance. There was a shift in the utilization of private facilities as compared to government ones for the treatment and management of neonatal complications, from the previous pregnancy to the last one.

Perceptions about coverage of services provided by the Link Worker and perceived benefits of those services: The majority of the respondents reported that the Link Worker provided follow up visits to ensure utilization of the MNH services. The majority of the respondents reported that they strongly perceived benefit from the services provided by the Link Worker.

Perceptions about coverage of services provided by the Community Health Worker and perceived benefits of those services: A low proportion of respondents reported being visited by the CHW during pregnancy and the post-natal period.

Perception of respondents regarding health services provided by outreach clinics: Those respondents, who attended 'Outreach Clinics', reported that services received at these clinics were immunization of children, information on general health, antenatal checkups and BCC on diet etc. They strongly felt (67-100 paise) that they had benefited from services provided at these clinics.

Perception of respondents regarding health services provided by the UHP: The majority of respondents were aware of the UHP. They reported that services they received at the UHP were treatment for minor ailments, antenatal check - ups, immunization of children, and information on general health and diet.

Perception of respondents regarding health services provided by the MCH clinics: The majority of the respondents were aware of the MCH clinics. Those who had attended an MCH clinic reported that the services that they had received were antenatal checkups, delivery services, HIV testing, sonography etc. They strongly felt (67 -100 paise) that they had benefited from services provided at these clinics.

Perception of respondents regarding health facilities provided by first referral units: A very low proportion of the respondents were aware of the FRU. Among those who were, a majority reported that the services they had received were delivery services and family planning services (tubal ligation and vasectomy).

Conclusions and Implications:

- By documenting the mechanisms through which the program attained success, it is hoped that the study will help to replicate the program in other urban areas of Maharashtra.
- The study explicates the importance of surveillance in the success of the MNH program. In general, surveillance serves the purpose of 1) Needs-assessment, and 2) Follow up on service utilization.
- Since the ANMs have to serve a large slum population, surveillance conducted by community based link workers becomes an important program management tool.
- Community based women undertaking monthly surveillance results in a significant increase in the utilization of MNH services, effective coverage of pregnant women with standard MNH services and effective and timely referral for those who need specialist care.
- Referral services for MNH are more effective if there is a regular surveillance for maternal morbidity, improved primary level care and timely advice for utilizing referral services.
- Anganwadi Workers collect a lot of information on MNH. However, this information is not being used by the health sector for micro-planning, provision of MNH services or for monitoring utilization and coverage with MNH services.
- In the urban slum scenario, there is a lack of service utilization at the primary level and an inordinate utilization of secondary and tertiary level services. Women continue to utilize secondary and tertiary level institutions for primary level MNH care because delivery services are available only at the secondary and tertiary levels of care. Pregnant women prefer to go for ANC to the facility where they will finally have to go for delivery.

7. Study - Impact of need specific Behavior Change Communication (BCC) on individual, household and service utilization behaviors in the context of maternal and neonatal health

Institute of Health Management, Pachod (AGRT/IHMP): is a 'cross-site' partner for the Sure Start project. A key component of the Sure Start intervention is 'need-specific Behaviour Change Communication' (BCC).

Need-specific Behaviour Change Communication (BCC): The needs specific Behaviour Change Communication (BCC) concept was developed by the Institute of Health Management, Pachod, in 1996, in the context of the National Reproductive and Child Health Program for the Government of India. Need-specific BCC is a paradigm shift in modifying health behaviours where the focus has been shifted from generalized mass communication to need and behaviour-specific information dissemination and counseling based on a combined health-needs and behavioural diagnosis.

BCC Toolkit: Comprised of 1) BCC flash cards; and 2) 'Checklist'. The toolkit was designed by AGRT/IHMP and adapted for the Sure Start project.

Sure Start project at Nagpur: The project caters to a population of about 150,000. Community based volunteers '*arogyasakhis*' cover 2500 -3000 slum population. They provide BCC at the household level. 60 *arogyasakhis* work at the Nagpur project.

Research Study on Behaviour Change Communication: AGRT/IHMP conducted a study of the Nagpur Sure Start project with the aim to assess impact of the BCC program

Research Objective: To study the pathways and impact of need-specific Behaviour Change Communication on knowledge, generating demand and changing maternal and neonatal health utilization behaviours at the individual and household levels.

Research questions:

1. Did the BCC program result in increased knowledge and awareness in terms of maternal and neonatal health issues?
2. Did the BCC program increase inter-spousal, intra-family and peer-group communication in terms of maternal and neonatal health issues?
3. Did the BCC program improve maternal and neonatal health related household-level behaviours?
4. Did the BCC program increase utilization of maternal and neonatal health services?

Hypothesis: Need specific BCC will respond to the changing needs of an individual and household, thereby increasing utilization of Maternal and Neonatal Health (MNH) services. Need specific BCC will lead to knowledge and awareness resulting in desired change in individual and household behaviour.

Research design: The study is a post-intervention evaluation of the impact of the need-specific BCC program.

Study Population: The study comprised recently-delivered women whose pregnancy resulted in a live birth between March and July 2010.

Methodology: The study used both quantitative and qualitative methods of data collection. Quantitative research methods were used to study the extent of behavioural change and qualitative research methods were used to map out why this change has occurred and the possible pathways through which the change occurred.

Quantitative Method: A semi structured questionnaire for the interviews of 200 recently-delivered mothers was developed and pre tested before the actual data collection began. The questionnaire had ten sections.

Qualitative Methods: Focus Group Discussion (FGD) and In-depth Interview guides were developed and used to collect qualitative data. Three FGDs were conducted, one each for the *arogyasakhi*, the Community Health Organizers and the Team Leaders. An in-depth interview was taken for the project director of Amhi Amchya Arogya Sathi.

Sample Size and Sampling Procedure

Sample size: Sample size was calculated to detect a 10 percent difference in the utilization of minimum, standard, antenatal care services by assuming an alpha of 0.05 and using a two-sided test to achieve 80 percent power. The sample size was 200 recently-delivered women.

Sampling Unit: A list of 625 women who delivered a live birth between the periods March – July 2010 from the intervention area was prepared. A computer generated random sample of 200 of these women was generated.

Tools used for data collection: A uniform semi-structured interview schedule was designed for data collection. The interview schedule was prepared in Marathi, and pre-tested by the AGRT/IHMP staff in the slum area around MMH, Nagpur. Appropriate modifications were made before being used for the final survey.

‘Pachod Paisa Scale’: This is a scale used to measure the intensity of perceptions. Questions were framed as, “How many ‘paise in a rupee’ do you feel that you have benefited from (say) antenatal care?”, or “How many ‘paise in a rupee’ do you feel that you have been able to follow the dietary advice given to you by the *arogyashakhi*?”

‘High level of exposure to BCC’ in pregnancy: Defined as “the first BCC visit by the *arogyasakhi* occurring within the first 3 months of pregnancy, and six or more such BCC visits during the pregnancy of the respondent.

‘Low level of exposure to BCC’ in pregnancy: Defined as the first BCC visit by the *arogyasakhi* occurring in or after 4th month of pregnancy.

‘High level of exposure to BCC’ in post natal period: Defined as “the first BCC visit by the *arogyasakhi* within seven days after delivery and two or more such BCC visits during post natal period of the respondent.

‘Low level of exposure to BCC’ in post natal period: Defined as one or no BCC visit by the *arogyasakhi* after seven days of delivery.

Section 1: Socio-demographic characteristics

1.a: Characteristics of the respondents: The mean age of the respondents was 23.6 years. 2 out of 3 had attained an educational level of at least standard 8. The majority were housewives.

1.b: Characteristics of the respondents' husbands: The mean age of the husbands was 28.5 years. The majority worked as laborers. About 61 percent of them had an education of at least standard 8.

1.c: Family Information of the respondents: Half of the respondents lived in a joint family. The majority were Hindus, followed by Muslims and Buddhists.

Household Characteristics: Approximately 31 percent of the respondents were living in one-room houses indicating low economic status, whereas one out of 5 of them have four & more rooms. The majority had access to their own toilet and to electricity. **Respondents' native place:** Most of the respondents reported to have hailed from Maharashtra, followed by Madhya Pradesh, Chattisgarh, Uttar Pradesh, Jharkhand and Orissa and Raipur.

General reproductive health information of the respondents: Most of the respondents had experienced one or two pregnancies and had one or two live births. However a small proportion had experienced 4 or more pregnancies (9.5 %) and 18 percent had three or more surviving children.

Conclusions and Implications

- Study findings indicate that *arogyasakhis* were visiting pregnant women and post natal mothers at home to give BCC.
- Majority of pregnant women were contacted for the first time in the first trimester and little over half of the respondents reported being visited more than six times during pregnancy by the *arogyasakhi*.
- When asked who gave you information regarding various issues of pregnancy like confirmation of pregnancy, registration for the antenatal services, antenatal examinations, TT immunization, consumption of IFA tablets, danger signs in pregnancy, diet in pregnancy, anaemia and birth preparedness, a large majority of the respondents cited having received information on these issues at home from the *arogyasakhi*. Also, majority of the respondents reported having discussed information received from the *arogyasakhi* with their husbands.
- Except for registration for antenatal services, in all other issues very small proportion of women had prior knowledge about those issues before being informed by the *arogyasakhi*.
- These findings indicate that BCC was given by the *arogyasakhi* during home visits. Since majority of the women reported having visited six or more times during pregnancy by the *arogyasakhi*, these pregnant women were asked as to what information was given and did the information satisfy specific need. In order to determine how need specific the information was respondents were asked to rate the information on the 'Pachod Paise Scale':

- ❖ Respondents mentioned having received information on antenatal examinations, diet in pregnancy, consumption of IFA, danger signs during pregnancy and treatment seeking, and rest during pregnancy, which was rated very high for satisfying their needs and helped them to adopt positive behaviours.
- ❖ Similarly respondents have reported having received information on breastfeeding, routine care of post-natal mother, routine care of newborn and treatment for danger signs, diet in the post-natal period and birth weight in the post-natal period, which again was rated very high as specific to their needs and they could utilize this information when needed.
- During focus group discussions with the *arogyasakhis* and community health organizers (Supervisors) it was reported by the separate groups that earlier when *arogyasakhis* used to give all BCC messages regarding care during pregnancy in one visit to pregnant women. Mostly they never used to pay attention. But now we find out what information they need and give BCC according to their needs. Since we focus on their needs, they listen and even ask questions. With need specific BCC we feel they are more likely to adopt behaviours suggested by us.
- Very often decisions to seek treatment or not are taken by the husbands and in laws. Therefore, it was planned as part of the BCC strategy in the project to encourage discussion of the information received with the husband and other family members. Study findings indicate that most women have shared information received with husbands followed by in-laws. This also has been reflected in the women getting support from their husbands for increasing number of meals in a day during pregnancy or for seeking early treatment for the complications.
- Study findings indicate that need specific BCC was given by the *arogyasakhis* in the project which has resulted into increased knowledge and change in the MNH behaviours at the individual and household level. Also, it has resulted into increased demand and utilization for MNH services.
- This study has also indicated that women with moderate educational background can give need specific interpersonal BCC if appropriate training inputs are given.

8. Study on HIV testing by pregnant women in collaboration with Johns Hopkins University, Baltimore

A small grant was received from the Johns Hopkins University, Baltimore for conducting a study on HIV testing by pregnant women and HIV care and support, in 50 villages of Paithan Taluka, Aurangabad district, Maharashtra.

9. Address stigma and discrimination related to HIV, sexual minorities and gender through Faith Based Organizations

AGRT/IHMP received a small grant from ICCO to support the National Council of Churches of India (NCCI) for addressing stigma and discrimination associated with HIV /AIDs, sexual minorities and gender. NCCI implemented this programme in Churches, theological colleges, schools and development organizations.

NCCI used the PARC and KAP tools designed by AGRT/IHMP to address HIV stigma in 40 different sites. The outcome of this programme was a measurable reduction in HIV stigma.

Based on the experience described above NCCI has started the following initiatives.

1. Mainstreaming through National Ecumenical Organisations, to prepare an '*Organisational Workplace Policy*' in NCCI -affiliated Institutions.
2. Develop a tool for measuring the impact of the project on social inclusion of HIV infected and affected and of sexual minorities.
3. Mainstreaming by preparation of a "*Policy Guideline for Human Sexuality*". *Since this is a sensitive topic for the Church, it is expected that a Study Process can begin, using existing sources and material.*" This would be a preliminary meeting - to bring about more theological papers and greater acceptance for alternative sexual lifestyles - with a view to ultimately bring out a 'Church Policy' which can include others.
4. Mainstreaming through Website: A Website for NCCI's HIV-work, highlighting the ESHA project is being prepared. It is expected that all Member Churches and institutions can use it for empowering themselves and in order to share its experiences and 'best practices' with others through this forum.

10. Study of perceptions, attitudes and discrimination towards Dalits - Arunthathiyar in Theni district, Tamilnadu, effect on the quality of life

Arogya Agam Study was conducted in fifty three villages in the Theni district of Tamil Nadu, India which were governed by forty three Gram Panchayats. Majority (95.2 percent) of respondents reported that they were living in rural areas and a negligible proportion (4.8 percent) of respondents reported that they were living in urban areas.

Respondents and Household Characteristics

Almost half of the respondents were male 49.4 percent and females were 50.5 percent. Mean age of the respondents was 37.5 years. The vast majorities (87.9 percent) of respondents were married. Majority (58.5 percent) of respondents reported that they were illiterate and a negligible proportion (2.7 percent) of respondents reported they had received Secondary school level of education. A vast majority (91.4 percent) of respondents reported “Coolie” as their main occupation. Mean of monthly income from the main occupation was Rs.2,155. Majority (60.6percent) of respondents reported that they were BPL card holders and 39.3 percent reported that were not BPL card holders. Majority (99.6 percent) of respondents reported that they were Hindus by religion.

Approximately 85 percent of the respondents reported that they were having their own house. A large proportion (43.0 percent) of the respondents reported that there were more than 5 household members in their house.30.9 percent of the respondents reported that there were 4 household members in their house. 14.6 percent of the respondents reported that there were less or equal to 2 household members.

Social Factors

More than 32 percent of the respondent’s parents, grandparents or family members worked as Coolies and a negligible proportion (0.2 percent) of the respondents reported that they were involved in decoration for non-dalit festivals. 28.8 percent of them were involved in work of digging burial pits.20.6 percent of them in work of carrying death message.18.1 percent were involved in disposing dead animals.5.2 percent were involved in disposing dead animals.3.2 percent were involved in cleaning toilets.

Almost 28 percent of the respondent’s community or family members reported that they were forced to work as “Coolie”. Around 18 percent of the respondents were forced to dispose waste and dig burial pits. 33.3 percent reported that they were not compelled for any work by the community. Majority (90 percent) of the respondents reported that the family members did not work with the same employer for a long time. O

Children’s education: Out of all children 6-14 years of age, around 80 percent were currently school going and remaining i.e. 19.8 percent were not going to school. More than 68 percent of the respondents’ perceived that 6 to 10 out of 10 Arunthathiyar children may have completed primary education. A vast majority (90.3 percent) of the respondents’ reported that their children did not face any problem in the school. Mean ideal age for girl getting married in Arunthathiyar community is approximately 18 years.

Mobility

Majority (62.4 percent) of the respondents reported that they could move around freely everywhere in their village as they like and remaining 37.5 percent reported that they could not move around freely. Among those who said they could not move freely in their village as

they liked, more than three quarters (76.8 percent) of them reported they cannot go to the common temple, (58.1) percent could not move freely through non dalit streets; 11 percent reported that they could not move freely through common place like Chavadi. More than 85 percent respondents reported that they never experienced abusive language. Among those who experienced abusive language, 16.4 percent tolerated it because of the caste system.

Sexual abuse

More than 95 percent of the respondents said that women of their community did not face any sexual harassment. A vast majority (98.9 percent) of the respondents reported that they or their community members did not face any atrocities. Majority (73.1 percent) of the respondents reported that Arunthathiyar community did not face any problem by non-dalits. When the respondents were asked for their response/reactions, if they would have been in the above situations, Majority (80.9 percent) of the respondents reported that they would not have verbally objected. 95.1 percent said they would not have withdrawn from the situation.

Utilization of resources

53.1 percent of the respondents reported that they did not have access to the community hall. A majority (87 percent) of the respondents reported that they could access the water point. More than 87 percent could access the school and 87.8 percent could access the ration shop. A vast majority (84.2 percent) of the respondents reported that they could access basic amenities like housing. Almost 92 percent of the respondents reported that they could access basic amenities like street light. More than half the respondents could avail greens weekly, 21.1 percent obtained greens daily whereas only 14.6 percent availed it once in a month.

Savings, Expenditures and Loans

Savings: Almost 54 percent of the respondents reported that they were not a member of any saving schemes. More than 31 percent of the respondents reported to be the members of the SHG saving schemes.

Expenditure: Majority of the respondents (more than 70 percent) spent less than Rs.100 daily and a negligible proportion (0.7 percent) of the respondents spent more than Rs.200. All the respondents (100%) have spent on medical expenses in the last one year. Highest mean medical expenditure spent by the respondents was Rs. 4,506 in the last one year followed by Rs.1741.3 in the last six months and Rs.805.5 in the previous month.

Loans: Majority (almost 44 percent) of the respondents reported that they took loan from money lenders, 12.2 percent took loan from SHG and 6.1 percent loan from the bank. Almost 34 percent of the respondents reported that they didn't take loan from anybody. More than 30 percent of the respondents reported that they took loan for the purpose of some specific occasion or for education. More than 40 percent of the respondents reported that they got a loan for the purpose of housing and availing of medical facilities. A majority (76 percent) of the respondents reported that the mode of repayment for the loan was on a monthly basis.,

Assets

Majority (90.7 percent) of the respondents said they had their own house. A vast majority (96.6 percent) of the respondents reported that they didn't have any agricultural land.

Awareness of Rights, Legal affairs

More than 29 percent of the respondents were aware of employment guarantee scheme and 27.5 percent respondents said they had utilized the employment guarantee scheme. Majority (60.5 percent) of the respondents reported that they would approach the police station if they had to face any physical violence, exploitations, discriminations and other property issues. A

majority (92.5 percent) of the respondents reported that they were unaware about legislations for atrocities against dalits. Almost 90 percent of the respondents never used this legislation.

Assessment of self-esteem of the respondents

Communication skills: More than half of the respondents were satisfied with their communication skills.

Negotiation skills: Respondents were asked whether they were able to negotiate with the president of panchayat for accessing the local resources, to which 47.4 percent of the respondents reported “34-66 paise”(felt moderately), and 22.7 percent reported “67-100 paise” (felt strongly) about the same.

Mobility: When asked whether respondents could enter in a common temple along with others. 38.5 percent of the respondents answered in the affirmative. (“67-100 paise”)

On an average nearly 50 percent of the respondents felt that they could sit in the common place equally as others.

Decision making: When asked if they thought that decisions made by them were as good as those made by others, 44.8 percent of the respondents felt moderately (“34-66 paise”) followed by 42.8 percent who felt strongly (“67-100 paise”) about the same.

Nearly 47 percent of the respondents felt moderately (“34-66 paise”) and 38.7 percent of the respondents felt strongly (“67-100 paise”) that their opinion was considered when family decisions were taken.

Social network: 50 percent reported “34-66 paise” and 30.7 percent reported “67-100 paise” that the respondent’s participation was liked by their community members.

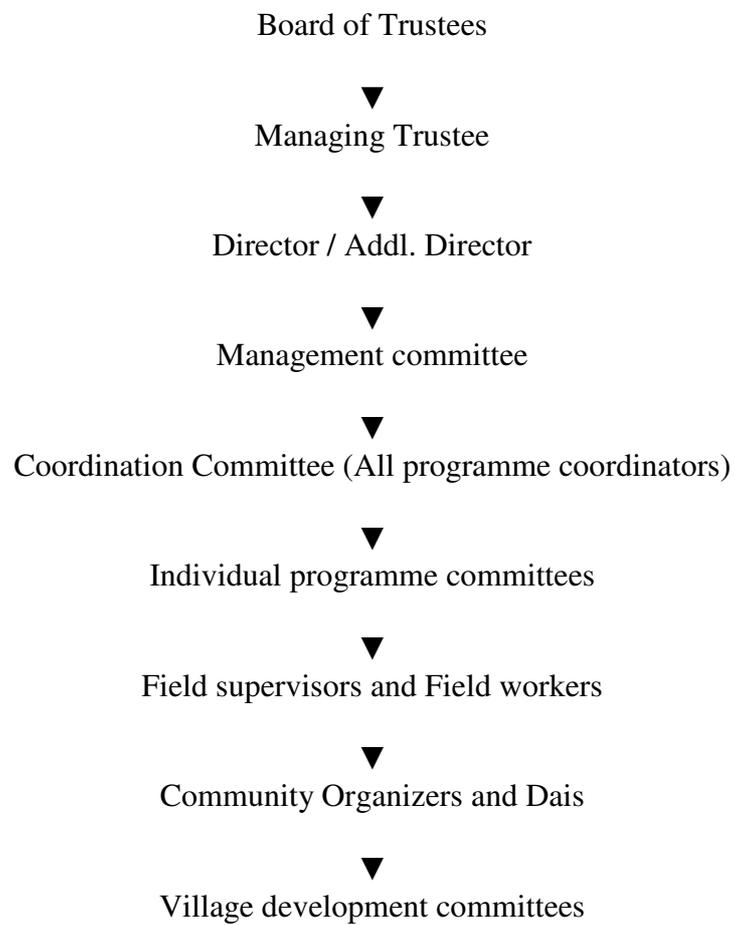
Assessment of self-capacity: The respondents were asked if they thought that they had as many good qualities as their friends. Majority (46.1 percent) of the respondents reported “67-100 paise”, followed by 42.0 percent, who reported “34-66 paise” regarding their perception on having good qualities as their friends.

Key Organizational Initiatives

1. Provide health and related services with a focus on the poorest and most marginalized
2. Organize and mobilize communities toward self-reliance and sustainability
4. Modeling and demonstration of innovative health and development programs
3. Dissemination of innovations in the Government and NGO sectors
5. Process evaluation and applied research
4. Development of replicable systems and strategies
6. Conduct training for Government and NGO functionaries
5. Policy analysis, research and advocacy
7. NGO networking - training and resource centre

Governance

Organization Structure



Board of Trustees

Sr.No.	Name	Age	Gender	Occupation	Position in the Board
1	Dr. CAK Yesudian	58	Male	Dean, School of Health Systems, Studies, TISS, Mumbai	Chairperson
2	Ms. Manisha Khale	58	Female	Additional Director, IHMP	Managing Trustee
3	Dr Sudha Kaldate	78	Female	Retd. Prof. & Head, Dept of Sociology, Aurangabad University	Trustee
4	Prof Kalindi Mazumdar	79	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 Chairman 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 2011-2012 as follows:

Sr. No.	Date
1	16.7.2011
2	10.12.2011
3	28.1.2012
4	25.2.2012
5	24.3.2012

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 April 2010 to March 2011 on 10.12.2011. The budget for the period April 2012 to March 2013 was reviewed and approved on 25.2.2012.

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. 1500/-
- No international travel happened during the year.

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 in the Board of Trustees meeting held on 19th February 2011.
- Audited statements of accounts and balance sheet for the financial year 1st April 2011 to 31st March 2012 were accepted and approved in the Board of Trustees meeting held on 15th December 2012.

Salary Distribution by Gender as on March 31, 2012

Salary Distribution as on March 31, 2012			
Monthly Salary of Staff Members (in Rs.)	Men	Women	Total
≤5,000	16	6	22
5,001 – 10,000	10	8	18
10,001 – 25,000	4	2	6
25,001 – 50,000	2	1	3
≥50,001	1		1
Total	33	17	50

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	MSc Nutri., MSc 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. DM Chaudhari	Social Scientist	AGRT/IHMP 28 years	MSW	Community mobilization
6	Mr. SM Shinde	Coordinator Integrated ARSH.	AGRT/IHMP 26 years	MSW	Rural drinking water supply & sanitation
7	Mr HB. Pawar	Coordinator Child health	AGRT/IHMP 24 years	MSW	Child nutrition & development
8	Mr SL. Mohite	Coordinator PHC and RCH	AGRT/IHMP 22 years	MSW	PHC and RCH
9	Mr JJ. Rupekar	Integrated Counselor	AGRT/IHMP 22 years	MSW/ HIV Counseling	Integrated counseling
10	Mr. GR. Kulkarni	Research Coordinators Biostatistician	15 years	MSc 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. P 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

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

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

AUDIT REPORT

Date : 02/09/2012

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

: FOR THE YEAR ENDING 31ST MARCH, 2012 :

We have completed the Audit of the accounts of your Trust. We enclose herewith the consolidated Balance Sheet as on 31st March 2012, 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.

3) TRANSFER TO RESERVE :

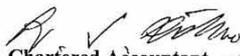
As per the decision of the Trustees in the past, a portion of interest on Fixed Deposits and Indian Income is being transferred to Trust fund Corpus Account of the Trust in order to build up its own corpus. These are being kept invested in Fixed Deposits.

We hereby suggest that all the investments of Fixed Deposits may not be kept in one bank only. They should be spread up.

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.



INCOME AND EXPENDITURE

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

ASHISH GRAM RACHANA TRUST, PACHOD, DIST. AURANGABAD.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDING 31ST MARCH 2012

Regd.No. E-249, Aurangabd

EXPENDITURE	RS.	RS.	INCOME	RS.	RS.
To Expenses in respect of Properties		Nil	By Rent Accrued / Realised		Nil
Rates, taxes, and cesses			Buildings		
Repairs and maintainance			Lands		
Salaries			By Interest - Accrued / Realised		
Insurance			On loans	Nil	
Depreciation by way of provision or adjustment			On securities : F.D's.	2605790.00	
Other expenses			On Bank account	260100.00	2865890.00
To Establishment expense -		Nil	By Dividends		Nil
To Remuneration to trustees -		Nil	By Donations in cash or kinds :		Nil
To Remuneration to the head of the math including		Nil	By Grants : As per details		
his household expenditure if any -			Previous Adv. Grant Tr. From B/S	4977600.00	
To Legal expenses		Nil	Receipts during the year	8631050.00	12708650.00
To Audit fees		Nil	By Income from other Sources :		
To Contribution and fees		Nil	As per details -		617771.00
To Amounts written off -		Nil	Profit on sale of Equipments		13481.00
a) Bad debts			By Transfers from Reserves		Nil
b) Loan scholarships					
c) Irrecoverable rents					
d) Other items					
To Miscellaneous expenses :		Nil			
To Depreciation ; As per details		981738.00			
To Amounts transferred to reserve or to specific funds		979447.00			
To Expenditure on objects of the trust ; As per details					
Medical Relief	4590365.00				
Secular Education	8194907.11	13149306.11			
Other Objects	354034.00				
To Being the excess of income over expenditure		1095300.89			
carried over to balance sheet					
Total Rs.		16205792.00	Total Rs.		16205792.00

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



Dated at 2-9-12

M. I. Chale
Trustees

Aurangabad
02/09/2012

Managing Trustee
Ashish Gram Rachana Trust
Pachod, Aurangabad Dist.

Consolidation of Accounts

M/S R. S. LOTKE & Co.
 CHARTERED ACCOUNTANTS
 17 SHAKTINAGAR, BURANGABAD
 Phone 2337152

ASHISH GRAM RACHNA TRUST, PACHOD, DIST. AURANGABAD.

CONSOLIDATION OF ACCOUNTS AND DETAILS FOR THE YEAR ENDING 31ST MARCH, 2012.

GRANTS (ORDINARY) (FOREIGN)	ADVANCE GRANT AS ON 31.3.2011	GRANT TRANSFERRED TO INCOME & EXPENDITURE A/C YEAR (2011-2012)	ADVANCE GRANT BALANCE DURING THE YEAR (2011-2012)	TOTAL GRANT RECEIVED DURING THE YEAR	NON-RECURRING GRANT RECEIVED DURING THE YEAR	GRANT RECUR. TRANSFERRED TO INCOME & EXP. A/C DURING THE YEAR (2011-2012)	RECURRING ADVANCE GRANT RECEIVED DURING THE YEAR	TOTAL ADVANCE GRANT AS ON 31.3.2012 (3+7)
	1	2	3	4	5	6	7	8
a) BATHI-Health Initiative - NRHM - MacArthur grant	17,90,000.00	17,90,000.00	-	48,40,109.00	-	33,40,109.00	15,00,000.00	15,00,000.00
b) Integration of HIV with RCH-WHSP grant	-	-	-	8,64,869.00	-	8,64,869.00	-	-
c) Right based people-cent adv. urban OXFAM grant	6,89,000.00	6,89,000.00	-	-	-	-	-	-
d) Research JHU, USA grant	2,50,000.00	2,50,000.00	-	-	-	-	-	-
e) Intervention Research Scaling up NGO Training MacArthur grant	6,64,600.00	6,64,600.00	-	-	-	-	-	-
f) Corpus Donation from WHSP A/c. No. 0033 A/c	-	-	-	1,83,37,500.00	1,83,37,500.00	-	-	-
g) Scaling up & Adv. Model - Urban, OXFAM	-	-	-	10,00,000.00	-	10,00,000.00	-	-
h) Maternal and Newborn Health Training - PATH Sure Start grant	-	-	-	15,19,741.00	-	15,19,741.00	-	-
i) Training on Applied Research Christian Aid grant	6,84,000.00	6,84,000.00	-	-	-	-	-	-
TOTAL FC DETAILS	RS. 48,77,600.00	48,77,600.00	-	2,65,62,219.00	1,83,37,500.00	67,24,719.00	15,00,000.00	15,00,000.00



1. GRANTS (ORDINARY) (INDIAN)	ADVANCE GRANT AS ON 31.3.2011	GRANT TRANSFERRED TO INCOME & EXPENDITURE A/C YEAR (2011-2012)	ADVANCE GRANT BALANCE DURING THE YEAR (2011-2012)	TOTAL GRANT RECEIVED DURING THE YEAR	NON-RECURRING GRANT RECEIVED DURING THE YEAR	GRANT RECURRING TRANSFERRED TO INCOME & EXPENDITURE A/C DURING THE YEAR (2011-2012)	RECURRING ADVANCE GRANT RECEIVED DURING THE YEAR	TOTAL ADVANCE GRANT AS ON 31.3.2012 (3 + 7)
	1	2	3	4	5	6	7	8
j. Young Married Women's program (SDTT & PFI)	-	-	-	7,00,000.00	-	7,00,000.00	-	-
k. Community based monitoring NRHM-Government of Maharashtra	-	-	-	4,81,331.00	-	4,81,331.00	-	-
l. Yeshoda-Research Project Bhavashya Alliance	-	-	-	7,25,000.00	-	7,25,000.00	-	-
TOTAL (INDIAN) RS.	-	-	-	19,06,331.00	-	19,06,331.00	-	-
TOTAL FC+INDIAN RS.	140,77,600.00	140,77,600.00	-	2,84,68,550.00	1,83,37,500.00	1,86,31,050.00	15,00,000.00	15,00,000.00

Summary:

Advance Grants:

Foreign:

Advance grant kept during the year 2011-2012..... 15,00,000.00

Indian:

RS. 15,00,000.00

Grant - (Trf. to I & E A/c) during 2011-2012

Foreign A/c (previous year) C/F - 40,77,600.00

Indian A/c (previous year) C/F -

Foreign A/c (2011-2012) - 67,24,719.00

Indian A/c (2011-2012) - 19,06,331.00

Total (I + F) 1,27,06,650.00

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

	I		F		TOTAL
	S.B. A/c	F.D. A/c	S.B. A/c	F.D. A/c	
A) I.H.M.P. General A/c	33,029.00	4,76,840.00	-	-	5,09,869.00
B) I.H.M.P. General Pune Centre A/c	12,000.00	2,00,501.00	-	-	2,12,501.00
C) A.G.R.T. General A/c	7,465.00	2,88,625.00	-	-	2,96,090.00
D) Young Married Women Project SDTT A/c	3,224.00	-	-	-	3,224.00
E) Community Based Monitoring NRHM - BoM	11,806.00	-	-	-	11,806.00
F) Farm A/c	534.00	-	-	-	534.00
G) A. G. R. T. 0833 A/c	-	-	1,74,839.00	16,39,824.00	18,14,663.00
H) I.H.M.P. Pune Centre A/c (F)	-	-	-	17,283.00	17,283.00
Grand Total:	68,058.00	9,65,966.00	1,72,842.00	16,39,824.00	28,65,390.00



3. CASH AND BANK BALANCES			
Name of project (Indian A/c)	Cash	Bank	Total
1. ABRT General A/c.....	1,455.00	4,73,941.50	4,75,396.50
2. IHMP Pune Centre General A/c....	1,595.00	3,77,150.00	3,78,745.00
3. IHMP General A/c.....	6,513.00	10,90,787.08	10,97,300.08
4. Farm A/c	5,647.00	-	5,647.00
5. Young Married Women's P.(PFI)...	-	-	-
6. Community Based Monitoring	-	-	-
-NRHM -GoM.....	-	-	-
7. Yeshoda -Research Project.....	-	-	-
Total Indian A/c: Rs.15,410.00	19,41,892.58	19,57,302.58	
Foreign A/c			
8. Scaling up & Adv. Model - Urban - OXFAM.....	-	-	-
9. Maternal and new born health training- PATH Sure Start	-	-	-
10. ABRT A/c No. 0833 A/c	1,064.35	25,32,737.00	25,33,801.35
11. Right Based People-cent - Urban A/c OXFAM.....	-	-	-
12. Reproduct of child health 0833 interest A/c.....	-	-	-
13. I.H.M.P. Pune Centre A/c	374.00	1,40,851.00	1,41,225.00
14. Intervention Research-Rural-Mac.	-	-	-
15. SATHI Health Initiative - NRHM - MacArthur.....	379.00	-	379.00
16. Training on Applied Research - Christian Aid.....	-	-	-
17. Integration of HIV with RCH -WHSP	-	-	-
18. Health care for Urban Poor - - 0833 interest A/c	-	-	-
Total Foreign A/c: Rs. 1,817.35	26,73,588.00	26,75,405.35	
Grand Total (I+F): Rs.17,227.35	46,15,480.58	46,32,707.93	

4. TRUST FUND	
1. FOREIGN A/C Last Balance.....	3,69,79,174.13
Add: Profit on sale of equipments.	13,481.00
Add: Donation from WHSP, U. K....	1,85,37,580.00
Total Rs. 5,53,38,155.13	
2. INDIAN A/C Last Balance.....	1,19,74,724.60
Add: Interest on FDs	9,65,966.00
Total Rs. 1,29,40,690.60	
Grand Total (I+F) Rs. 6,82,78,845.73	
TRUST FUND	
Adds during the year	
Foreign	13,481.00
Indian	9,65,966.00
Total (I+F) Rs. 9,79,447.00	
Corpus Donation (F)	Rs. 1,85,37,580.00



5. Depreciation Statement:

	VEHICLE			COMPUTER, XEROX & OTHER EQUIPMENTS			FURNITURE & DEAD STOCK		
	I	F	I + F	I	F	I + F	I	F	I + F
Last Balances.....	-	19,63,506.00	19,63,506.00	91,259.00	17,81,211.00	18,72,470.00	8,308.00	7,76,150.00	7,84,458.00
Add: Additions during the year....	-	10,20,000.00	10,20,000.00	-	1,59,750.00	1,59,750.00	-	-	-
Total:	-	29,83,506.00	29,83,506.00	91,259.00	19,40,961.00	20,32,220.00	8,308.00	7,76,150.00	7,84,458.00
Less Sale (-)	-	(-)	(-)	-	36,519.00	36,519.00	-	-	-
Total:	-	29,83,506.00	29,83,506.00	91,259.00	19,04,442.00	19,95,701.00	8,308.00	7,76,150.00	7,84,458.00
Less: Depr. @15% (-)	-	4,47,526.00	4,47,526.00	13,689.00	2,85,666.00	2,99,355.00	(10%) 831.00	77,615.00	78,446.00
Total:- (W.D.V)	-	25,35,980.00	25,35,980.00	77,570.00	16,18,776.00	16,96,346.00	7,477.00	6,98,535.00	7,06,012.00

	BOOKS & VIDEO			GRAND TOTAL		
	I	F	I + F	I	F	I + F
Last Balances.....	-	47,115.00	47,115.00	99,567.00	45,67,982.00	46,67,549.00
Add: Additions during the year	-	-	-	-	11,79,750.00	11,79,750.00
-WHSP A/c.....	-	-	-	-	-	-
Total:	-	47,115.00	47,115.00	99,567.00	57,47,732.00	58,47,299.00
Less Sale	-	-	-	-	36,519.00	36,519.00
Total:	-	47,115.00	47,115.00	99,567.00	57,11,213.00	58,10,780.00
Less: Depr. @10% (-)	-	4,712.00	4,712.00	14,520.00	8,15,519.00	8,30,039.00
Total:- (W.D.V)	-	42,403.00	42,403.00	85,047.00	48,95,694.00	49,80,741.00

* Live Stocks: (Indian A/c) Farm A/c			* Copyright of Books (F)	25,000.00
Last Balance	Rs. 32,500.00		Add: Addition during the year.....	6,000.00
				Rs. 31,000.00



6. IMMOVABLE PROPERTIES.

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	Indian	Persion	Total I + F
A. Land at Pachod (Leased)			
Bat Nos 51 & 73 BA, 96. Last Balance.....	NIL		
Old buildings, sheds on the part of the said land:			
Balance as per last Balance sheet B/F	28,500.00	-	28,500.00
Less: Depreciation @ 10%	2,850.00	-	2,850.00
Total:	25,650.00	-	25,650.00
B. Farm Fencing (At cost)-Pachod			
Last Balance.....	410.00	-	410.00
Total:	410.00	-	410.00
C. Cow Shed (At cost)-Pachod			
Last Balance.....	1,125.00	-	1,125.00
Total:	1,125.00	-	1,125.00
D. New building Sheds, etc.- Pachod			
Balance as per last balancesheet.....	-	3,51,947.00	3,51,947.00
Less Depreciation at 10%	-	35,195.00	35,195.00
Total:	-	3,16,752.00	3,16,752.00
Sub total (A to D):	27,185.00	3,16,752.00	3,43,937.00
E. Land purchase by AGRT From A/c 0833			
Bat No.113,120 10A 156 at Talta village, Dist. Aurangabad: Last Balance	19,35,478.00	24,64,472.00	43,99,942.00
F. Land purchase at Kharadi Tq. Haveli, Dist. Pune			
17000 sq.ft. 1579.34 sq. mts. SN. 41/2A/1 Last Balance.....	22,71,820.00	-	22,71,820.00
G. Construction of Training Centre, Pachod			
Last Balance	2,16,956.00	-	2,16,956.00
Less Depreciation @ 10%.....	24,106.00	-	24,106.00
Total:	1,92,850.00	-	1,92,850.00
H. Plot at Pune, two plots measuring 642 Sq.mt each			
(Sr. No. 32/2/2/6 & /4) Kharadi, Pune - Last Balance	-	13,48,990.00	13,48,990.00
Total:	1,92,850.00	13,48,990.00	15,41,840.00
Sub Total (A to H)	44,51,431.00	41,30,214.00	85,81,645.00
I. Office building at Pune on 642 Sq.mt. plot,			
Building structure dimension of 119 X 58 ft. Sr. No. 32/2/2/4, Kharadi, Pune- Last Balance..	-	8,95,477.00	8,95,477.00
Less: Depreciation @ 10%.....	-	89,548.00	89,548.00
Total:	-	8,05,929.00	8,05,929.00
Sub Total: (I)	-	8,05,929.00	8,05,929.00
Grand Total: (A to I)	44,51,431.00	49,36,143.00	93,87,574.00



7. DEPRECIATION:

	Indian	Foreign	I + F
On Immoveable Property.....	26,956.00	1,24,743.00	1,51,699.00
On Movable Property.....	14,520.00	6,15,519.00	8,30,039.00
Total:	41,476.00	7,40,262.00	7,81,738.00

B. INVESTMENTS: (AT COST)

Bank A/c 0033

Fixed deposit with the Bank of Maharashtra, Pachod:

Certificate No.:	Amount
141564.....	2,28,000.00
141566.....	3,06,403.00
141567.....	12,29,991.00
141569.....	2,87,745.00
141570.....	5,38,036.00
141571.....	21,38,639.00
141572.....	48,873.00
141574.....	2,37,913.00
141594.....	1,00,000.00
141596.....	2,00,000.00
141597.....	9,95,930.00
141598.....	49,29,915.00
141599.....	72,43,465.00
141600.....	6,94,720.00
141601.....	20,00,000.00
141602.....	20,00,000.00
141603.....	20,00,000.00
141604.....	20,00,000.00
141605.....	20,00,000.00
141606.....	20,00,000.00
141607.....	20,00,000.00
141608.....	20,00,000.00
141609.....	23,37,200.00
Total Rs.:	3,75,16,956.00
NSC.....	1,000.00
Grand Total Rs.:	3,75,18,956.00

A/c No. 02 IHMP General A/c

Certificate No.:	Amount
141557.....	10,70,081.00
141558.....	30,14,624.00
141559.....	2,77,284.00
141562.....	16,76,351.00
Total Rs.:	60,38,460.00

A/c No. 03 AGRT General A/c

Certificate No.:	Amount
141540.....	10,70,081.00
141549.....	5,25,041.00
141550.....	1,14,400.00
141551.....	6,64,660.00
141552.....	14,72,033.00
141553.....	1,72,943.00
141556.....	1,71,599.00
141595.....	1,00,000.00
Total Rs.:	43,00,757.00

A/c No. 06 IHMP Pune Centre General A/c

Certificate No.:	Amount
141560.....	5,13,689.00
141561.....	23,22,355.00
Total Rs.:	28,36,044.00

Grand Total: (F+I) 5,06,94,217.00

9. INCOME FROM OTHER SOURCES:

	INDIAN
a) Sale of milk from Farm A/c.....	75,070.00
b) Sale of Farm products - Farm A/c.....	1,92,708.00
c) AGRT General A/c Corpus: Other Receipts..	51,100.00
d) Conveyance Refunds.....	84,505.00
e) IHMP Pune Centre other receipts (Jeevan Kaushalya, etc.).....	43,990.00
f) Staff travel refunded.....	10,596.00
g) Course fees IHMP Training.....	44,000.00
h) Refund of Salary, cost of books, etc.....	56,712.00



9. INCOME FROM OTHER SOURCES:

	INDIAN	FOREIGN	TOTAL
B/F	5,58,681.00	-	-
i) Contribution: Training/Workshop.....	59,098.00	-	-
Total:	6,17,771.00	-	-

10. EXPENSES ON THE OBJECT OF THE TRUST:

	INDIAN	FOREIGN
1) Medical Relief		
A) Health Care for Urban Poor A/c (0833 interest A/c).....	-	4,76,930.00
B) Right Based - People cent Adv. Urban DXFAM A/c.....	-	6,89,510.00
C) Reproductive & Child Health (0833 interest A/c).....	-	17,87,050.00
D) Integration of HIV with RCH-WHSP A/c.....	-	8,64,809.00
E) Scaling up & Adv. on Model PHC-Urban (DXFAM A/c).....	-	7,72,000.00
Total:	-	45,90,365.00

	INDIAN	FOREIGN
2) Secular Education		
A) I.H.M.P. General A/c.....	44,563.00	-
B) I.H.M.P. Pune Centre General A/c....	2,206.00	-
C) Community Based Monitoring (NRHM)..	6,83,306.00	-
D) Young Married Women's Program (SDTT).....	4,09,059.00	-
E) Yeshoda Research Project.....	7,25,000.00	-
F) IHMP Pune Centre A/c.....	-	330.00
G) PATH Sure Start Training (Maternal & Newborn)	-	6,63,260.00
H) Intervention Research-Rural-MacArthur..	-	6,64,761.11
I) SATHI Health Initiative-NRHM-MacArthur..	-	36,71,440.00
J) AGRT 0833 A/c ICCD Workshop.....	-	1,34,475.00
K) 5 NSO SATHI Evaluation 0833 A/c.....	-	1,51,900.00
L) JHU Survey census and endline 0833 A/c....	-	1,85,369.00
M) Training on Applied Research (C.A. A/c) -	-	6,84,471.00
N) AGRT Bank A/c 0833	-	1,74,854.00
Total: Rs. 18,64,134.00		63,30,773.11

13. TDS (I. Tax Receivable)
 IPPF (0833 A/c)
 F. Y. (2010-2011) LAST BALANCE..... **20,000.00**



<u>3. Other Objects</u>		<u>INDIAN</u>
A. Farm & cattle expenditure Farm A/c.	3,43,725.00	
B. AGRT General A/c.....	28,389.00	
Total:	3,64,834.00	

<u>Expense on Objects</u>	<u>INDIAN</u>	<u>FOREIGN</u>	<u>TOTAL</u>
1. Medical Relief.....	-	45,90,365.00	45,90,365.00
2. Secular Education.....	18,64,134.00	63,36,773.11	81,94,907.11
3. Other Objects.....	3,64,834.00	-	3,64,834.00
Total: Rs.	22,28,168.00	1,09,21,138.11	1,31,49,306.11

07TH AUGUST 2012
AURANGSABAD

M. S. Lotke
Member of Institute of
Chartered Accountants
Bombay, Maharashtra

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

R. S. Lotke
CHARTERED ACCOUNTANT



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
- Population Foundation of India, New Delhi
- PATH, Sure Start, Mumbai
- NRHM, State Health Society, Maharashtra, Mumbai
- Whiteladies Health Share Project, Bristol
- Bhavishya Alliance, Mumbai

Support our Work

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

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

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

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

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

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

Contact us at:

Ashish Gram Rachna Trust,
Institute of Health Management, Pachod
PO Pachod
District Aurangabad, 431 121
Maharashtra
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

Please visit our website – www.ihmp.org