

Safe Adolescent and Health Initiative (SATHI)

Annual Report - April 2010 to March 2011

Introduction

Institute of Health Management Pachod, submitted a proposal to the MacArthur Foundation in February 2010, with the following broad objective:

Broad Objective

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

Rationale

It was felt that scaling up the SATHI interventions and advocating large scale replication of these would be facilitated if the innovations are integrated with the National Rural Health Mission and the Reproductive Child Health project. During the reporting period the following scaling up initiatives were undertaken which are presented in the report.

- a. Scaling up SATHI interventions as “Innovations in “Communitization” under National Rural Health Mission
- b. Advocating the scaling up of the 5 SATHI interventions in 5 districts of Maharashtra
- c. Advocating the scaling up of the 5 SATHI interventions in Madhya Pradesh
- d. Advocating the scaling up of the 5 SATHI interventions in Bihar
- e. Advocating scaling up of the 5 SATHI interventions in the Village Health and Nutrition Day (VHND) through UNICEF

Simultaneously, IHMP implemented the program directly in the pilot project area in 24 villages under one PHC. This pilot site was most useful in demonstrating the SATHI interventions to policy makers and administrators. The pilot site was also used as a training site for developing practical skills in ASHAs, Government ANMs, supervisory staff and medical officers.

A key lesson that was learnt was that scaling up can be accomplished effectively if the health providers and implementers at the scaled up level can be imparted with the same skills that are required for implementing the innovations at a pilot level.

The first section of this annual report presents the initiatives undertaken by Institute of Health Management Pachod and the outcome of those efforts during scaling up. The second section of the report presents the activities undertaken at the pilot site.

Section 1

a. Scaling up SATHI interventions as “Innovations in Communitization” under National Rural Health Mission

Introduction:

The project proposal for “Innovations in Communitization” under the National Rural Health Mission (NRHM) was submitted by the Institute of Health Management, Pachod (IHMP) to the Government of Maharashtra in 2009. A Memorandum of Understanding was signed with the Government of Maharashtra in December 2009, and project implementation began in January 2010.

The “Innovations in Communitization” under the National Rural Health Mission, proposed to introduce the five components of the SATHI intervention in 7 Government Primary Health Centres (PHCs) of Paithan block, in the Aurangabad district of Maharashtra. It was proposed to study the outcome of the 5 SATHI interventions on reproductive and child health with a special focus on married adolescent girls. More importantly the aim was to scale up and demonstrate the efficacy of these interventions in the public health sector.

IHMP proposed a model of “Communitization” to be implemented through the following functionaries- the ASHA, a key member of civil society; the ANM, MPW and PHC staff as frontline health providers; the Anganwadi worker (AWW) caring for child nutrition; the village health and sanitation committees as representatives of civil society; NGO staff as facilitators. These people function as a team to improve the management and governance of maternal and child health services.

Broad Objective:

To introduce the 5 SATHI innovations to enable the community and public health providers to become equal partners in the planning process, thereby ensuring guarantees and entitlements under the NRHM to their communities, with a special focus on young married women.

Specific Objectives:

1. To conduct monthly surveillance of health needs of all households through ASHA in 7 PHCs of Paithan Block in order to prepare micro-plans.
2. To increase demand for health services and modify key health utilization behaviours, among all household, in 7 PHCs of Paithan Block in one year.
3. To increase utilization of primary health services in 7 PHCs of Paithan Block in one year by improving linkages between ASHA, ANM, MPW, PHCs and CHCs.

4. To establish a community based monitoring system through the Village Health Nutrition Water and Sanitation Committees in 7 PHCs, with a focus on the marginalized, for ensuring access and equity.
5. To create an enabling environment for the 'Community Based Monitoring' process by conducting training for ASHAs and all health providers viz. ANM, MPW (M), HA (M), LHV and MO, of the 7PHCs of Paithan Block.

Details of the Project Area:

Paithan Block has a population of 3,22,734 with a sex ratio of 925 females per 1000 males as against the national average of 933. There are a total of 108 Panchayats in the 196 villages of this block. Literacy as per 2001 census in Paithan is less than that of Aurangabad. Aurangabad has a literacy rate of 72.9% -male literacy stands at 84.9% and female literacy is 60.1%. The population is provided health services through seven Primary Health Centres (PHCs) and thirty eight Sub-Centres (SCs). There are also two Rural Hospitals at Bidkin and Pachod and one Rural Health Training Unit at Paithan which provides diagnostic services to around 45,000 urban population of Paithan town. It has 253 Anganwadis, instead of 328 as per population norms.

SATHI innovations that were introduced:

1. Surveillance – ASHA identifies health needs every month during household visits.
2. Monthly Micro-planning – ASHA prepares a list of clients.
3. Primary Level Care – ASHA actively links clients to ANM at the time of monthly Mother and Child Protection Session in the village and PHC.
4. Behaviour Change Communication – ASHA provides need specific BCC based on informational need identified and behavioural diagnosis done during household visits.
5. Village Health Nutrition Water Supply and Sanitation Committees – Monthly review meetings are held in the villages. In the meetings health needs identified by ASHAs are compared with the services provided by the ANM. Thus committee monitors service utilization and generates demand by motivating resistant families.

Project - Outputs and Outcomes

Data from management information system has been utilized to compare situation prior to the intervention with the situation nine months after introduction of the intervention.

Table 1: Description of Paithan Block

Sr. No.	Details	July 2010	March 2011
1.	No. of PHCs	7	7
2.	No. of ASHAs	152	169
3.	Population covered	154070	175847

Table: 1 presents the number of PHCs and ASHAs functioning and the population covered in Paithan Block.

Table 2: Maternal Health Services

Sr. No.	Indicators	July 2010 %	March 2011 %
1.	New antenatal registrations in the reporting month	33.3	63.7
2.	Percentage Registration before 12 weeks of pregnancy	74.6	86.2
3.	Proportion receiving three antenatal examinations	75.2	72.3
4.	Proportion who received two or booster doses of Tetanus Toxoid injections	89.7	92.2
5.	Proportion who consumed 100 IFA tabs	68.6	81.0
6.	Proportion who received minimal antenatal care	61.6	74.3
7.	Percentage of Institutional deliveries	88.8	98.0

Table 2 presents indicators for the maternal health services. The registration of pregnant women increased from 33.3 percent to 63.7 percent. Early registration (Before 12 weeks) increased from 74.6 percent to 86.2 percent. Proportion of women with minimal antenatal care increased from 61.6 percent to 74.3 percent. Institutional deliveries increased from 88.8 percent to 98.0 percent.

Table 3: Vaccination Coverage of Children 12-23 months:

Sr. No.	Vaccine	July 2010 %	March 2011 %
1.	BCG	90.4	95.0
2.	Three doses of DPT	82.5	90.4
3.	Three doses of Polio	82.5	90.4
4.	Three doses of Hepatitis - B	71.8	88.1
5.	Measles Vaccination	78.5	88.4
6.	Completed Primary Immunization	66.2	83.9

Table: 3 presents immunization coverage of children 12-23 months. Data indicates that vaccination coverage of each vaccine has gone up. Proportion of children with complete vaccination increased from 66.2 percent to 83.9 percent, which is statistically significant.

Table 4: Current Use of Temporary Contraceptives

Sr. No.	Indicators	July 2010 %	March 2011 %
1.	Current use of temporary contraceptives	13.5	15.9
2.	Oral contraceptive pills	3.9	4.8
3.	Condoms	8.0	9.3
4.	Cu-T	1.6	1.7

Table 4 presents current use of temporary contraceptives. Current use of temporary contraceptives increased from 13.5 percent to 15.9 percent.

Table 5: Births and Deaths during July 2010 to March 2011

Month	Population Covered by ASHAs	Live Births	Neonatal Deaths*	Post-Neonatal Deaths**	Maternal Deaths
July 2010	154070	231	13	1	0
Aug. 2010	178254	293	14	1	0
Sept. 2010	179134	284	8	3	2
Oct. 2010	180717	294	12	3	0
Nov. 2010	189512	269	6	0	0
Dec. 2010	183760	225	7	3	0
Jan. 2011	181955	242	2	1	0
Feb. 2011	182015	196	6	0	0
Mar. 2011	175847	203	5	0	1
Total		2237	73	12	3

*Neonatal Deaths: Any death within 28 days of birth

**Post Neonatal Deaths: Any death during 29th day – less than 12 months

Table 5 shows a trend in reduction of neonatal and post neonatal deaths.

Table 5 presents births and deaths during July 2010 to March 2011. During this period 73 neonatal deaths, 85 infant deaths and 3 maternal deaths were registered

Outputs and outcomes are encouraging and indicate the efficacy of systems like monthly surveillance and micro-planning. These interventions have contributed towards improving performance. These innovations helped ASHAs to identify clients, assess health needs of the clients, provide need specific BCC, link clients to the primary level services and ensure timely referrals.

Project – Inputs: Project implementation was initiated from January 2010.

1. **Surveillance:** ASHAs undertake household visits as per the monthly visit plan given to them. During the visit ASHA assesses the health needs of married women between 15-45 years with a focus on married adolescent girls, and children under two years. She records this information in the surveillance register. ASHA also records information on vital events (Births, Deaths and Marriages) in her village. Details of the surveillance done during the period July 2010 – June 2011 is presented in Table 6. ASHAs prepare a ‘Monthly Progress Report’ at the end of the month and submit it at the monthly review meeting at Primary Health Centre.

Table 6: Monthly Surveillance done by ASHAs at the Village Level

Sr. No.	Month	Total Number of ASHAs	Expected No. of ASHAs for doing Surveillance	Actual No. ASHAs that Completed Surveillance
1.	July 2010	201	194	155
2.	Aug. 2010	201	194	171
3.	Sept. 2010	201	194	173
4.	Oct. 2010	201	195	175
5.	Nov. 2010	201	192	180
6.	Dec. 2010	210	192	176
7.	Jan. 2011	210	193	175
8.	Feb. 2011	213	189	174
9.	Mar. 2011	213	188	171
10.	Apr. 2011	213	187	157
11.	May 2011	199	171	153
Average		206	190	169

Average number of ASHAs who were expected to do the surveillance was 190, out of which 169 ASHAs actually undertook surveillance during the reporting period.

2. Micro-planning:

ASHAs prepare a monthly micro planner based on the surveillance register for pregnant women and children. This micro-planner is given to the ANM when she visits the village for conducting a ‘Mother and Child Protection’ session. The ASHA also uses the planner to call the clients.

PHC facilitators visit each village fortnightly. During the first visit they check surveillance registers and micro-planners prepared by the ASHAs. They also conduct BCC group meetings. In the next visit they facilitate review meetings with the Village Health Nutrition Water Supply and Sanitation Committees. Details of the supervision visit are given below in the Table 7.

Table 7: Supervision of ASHA's Work by PHC Facilitator:

Sr. No.	Month	No.of Villages Under PHCs	No. of Supervisory Visits during Reporting Period		No. of Visits Given to ASHAs	
			1 st visit	2 nd visit	1 st visit	2 nd visit
1.	July 2010	188	149	58	161	52
2.	Aug. 2010	188	176	119	189	130
3.	Sept. 2010	188	179	115	186	113
4.	Oct. 2010	188	177	119	185	129
5.	Nov. 2010	188	172	121	184	113
6.	Dec. 2010	188	172	111	191	116
7.	Jan. 2011	188	172	118	184	130
8.	Feb. 2011	188	176	93	189	95
9.	Mar. 2011	188	171	135	187	139
10.	Apr. 2011	188	173	143	183	145
11.	May 2011	188	162	114	156	100
12.	June 2011	188	163	123	166	128
Average		188	170	114	180	116

On an average 114 villages were visited twice in the month. On an average 116 ASHAs were visited twice in the month and given feedback on surveillance and micro-planning.

3. Primary Level Care:

The ANMs conduct 'Mother and Child Protection Sessions' on a fixed day in each village under their sub-centres. Based on the micro-planner ASHAs inform pregnant women and mothers of less than two years children to come to the clinic. The ANMs check whether all the clients on the micro-planner availed services or not. This has helped to improve the quality of services.

4. Need Specific Behaviour Change Communication:

i. During household visits, ASHAs assess informational need and do behavioural diagnosis. Based on the behaviour diagnosis the ASHAs give need specific messages to the households using BCC cards. Where ever necessary they provide counseling. ASHAs have been given two sets of BCC cards (one each on Maternal & Newborn Health and Family Planning) prepared by IHMP.

Simultaneously other BCC inputs are given to establish an environment which is conducive for the project and help to establish new social norms.

ii. Group Meetings: PHC facilitators conduct group meetings of community members every month (alternate month with women & men) using participatory methods. The following topics were covered.

- Orientation to the innovative project – Communitization under NRHM in Paithan Block and roles and responsibilities of village health nutrition water supply and sanitation committee.
- Antenatal Care and danger signs that can occur during pregnancy.
- Birth preparedness, importance of conducting delivery in the hospital and intra-natal complications.
- Care of post-natal mother
- Newborn care
- Care of low birth weight baby and immunization.
- Reproductive Tract Infections and Sexually Transmitted Infections – Prevention and treatment.

iii. Distribution of Pamphlets: ASHAs distribute pamphlets during household visits. The objective behind distribution of pamphlets is to make health related information available to people at their door steps to maximize full utilization of health services. Pamphlets on nine topics have been developed, printed and distributed:

- Information about innovative project under NRHM in Paithan Block
- Danger signs that can occur during pregnancy
- Intra natal complications
- Routine care of the newborn
- Care of low birth weight baby
- Family Planning methods
- Janani Suraksha Yojana
- Citizen's rights to health services.

iv. Posters: Five posters are displayed in public places like gram panchayat office, anganwadi centre, etc. The prime objective of this activity is to inform people about the project and create awareness about health services available from the sub-centre and PHC and citizens rights to health services. Posters on the following three topics have been developed and printed:

- Information about the innovative project in Paithan Block.
- Health services available from the sub-centre and PHC
- Citizen's rights to health services

v. Information Centre: A total of 225 information centres have been established in the villages of Paithan Block. Materials for the centres were made available by the IEC Bureau, Pune.

One male and one female volunteer are selected from each village to run the information centre. The volunteers receive orientation on how to run the information center by the

PHC facilitators. The volunteers open the information center at a suitable place in the village on a fixed day in the week. Posters are displayed and reading material is made available. Materials can be borrowed and taken home to read. A record of the people visiting centre is kept by the volunteers.

Table 8: Materials Distributed to Information Centres:

Sr. No.	Month	No. of Information Centres	No. of Information Centres which received material	No. of Materials Distributed
1.	July 2010	151	151	2352
2.	Aug. 2010	222	69	981
3.	Sept. 2010	222	168	1554
4.	Oct. 2010	225	51	179
5.	Nov. 2010	225	216	457
6.	Dec. 2010	225	182	245
7.	Jan. 2011	225	136	167
8.	Feb. 2011	225	104	104
9.	Mar. 2011	225	205	205
10.	Apr. 2011	225	194	276
11.	May 2011	225	73	73
12.	June 2011	225	182	197
Total				6790

Above table shows that a total of 6790 materials (brochures, pamphlets, booklets and posters) were distributed to 225 information centres.

5. Village Health Nutrition Water Supply and Sanitation Committees (VHNWSC):

a. Orientation of the Committees:

An initial meeting was conducted in 188 villages of the block to inform people about the objectives of the innovative project under NRHM. During these visits lists of committee members were collected. There are 160 VHNWS committees in the block. Subsequently during committee meetings in the next three months the following topics were discussed:

1. National Rural Health Mission – Objectives, guarantees, entitlements and different schemes under NRHM.
2. Structure, roles and responsibilities of the VHNWSC
3. Roles and responsibilities of ASHAs.

A one day orientation was organized for the office bearers of the committees at the PHC in July 2010. A total of 176 office bearers attended the meeting. Following topics were discussed using participatory methods:

1. National Rural Health Mission – Objectives, services available under NRHM.
2. Innovative project on “Communitization” under NRHM.
3. Roles and responsibilities of PHC facilitators appointed by the Institute.
4. Roles and responsibilities of ASHA
5. Roles and responsibilities of VHNWSC
6. Roles and responsibilities of committees at the PHC, Block and District level.

After the Gram Panchayat elections in 2010, a one-day orientation was organized in April 2011 for the new committee members. It was attended by 87 office bearers.

b. Monthly Review Meetings of the VHNWS Committees:

Every month, a meeting of VHNWSC is facilitated by the PHC facilitators. In this meeting, health needs assessed by the ASHA’s and services provided by the ANM are reviewed. The ASHA’s work is certified by the committee on the basis of whether she has completed surveillance for the month; prepared micro-planners for MCH services and immunization, given need specific BCC, was present for the Mother and Child Protection session and prepared the report. After reviewing the ASHA’s work the President or Secretary sign on the letter/form recommending that honorarium for these activities is paid. The ASHA is given her honorarium by a cheque at the monthly meeting at PHC only if she has brought the letter/form signed by the President or Secretary.

Table 9 below gives details about the VHNWSC monthly meetings conducted during the reporting period. On an average 79 percent of the committee meetings were conducted each month and average attendance in this meeting was five.

Table 9: Meetings of Village Health, Nutrition, Water & Sanitation Committees:

Sr. No.	Month	No. of VHNWS Committees	No. of Meetings of VHNWSC Conducted	No. of Members Attended Meeting	No. of Committee Members Visited
1.	July 2010	160	101	547	115
2.	Aug. 2010	160	109	600	84
3.	Sept. 2010	160	130	727	51
4.	Oct. 2010	160	137	780	33
5.	Nov. 2010	160	135	759	16
6.	Dec. 2010	160	137	745	12
7.	Jan. 2011	160	129	652	26

8.	Feb. 2011	160	123	626	32
9.	Mar. 2011	160	133	627	12
10.	Apr. 2011	160	135	648	23
11.	May 2011	160	125	606	24
12.	June 2011	160	135	683	34
Average		160	127	667	39

7. Capacity Building Inputs:

a. Training of PHC Facilitators: For each PHC one male and one female facilitator with a post-graduate degree in social work were appointed. Following capacity building inputs were given:

1. A five-day training was conducted in March 2010. The training included objectives of the project and how it would be operationalised to increase community participation; objectives of the NRHM; roles and responsibilities of the ASHA, Anganwadi Worker, ANM, MPW and VHNWSCs.
2. A three-day workshop on preparing Plan of Action for the project in April 2010.
3. A three-day training on BCC was organized in July 2010. The training included the definition of BCC; health behaviours related to maternal and newborn health; how to give need specific BCC; how to conduct group meetings; how to run information centers.
4. A seven-day training on the first module of ASHA.

b. ASHA Training: A list of 225 ASHAs selected from the 7 PHC areas was obtained from District Health Officer (DHO), Aurangabad and it was decided that IHMP would undertake the initial seven-day training of ASHAs since the latter's role was crucial for the innovative project under NRHM. The ASHAs were trained in the first seven day module, in batches, till April 2010. Skills were imparted for the conduct of monthly surveillance for needs assessment of maternal and child health and for preparing micro-planners for maternal health and immunization. Training on developing skills for inter-personal communication, need based BCC for generating demand for the primary health care services and for changing health utilization behaviours. Participatory training methods like role play, group work, body mapping, field work, etc. were used for the training.

Table 10 below gives the dates of training and number of ASHAs who attended the first seven-day training modules.

Table 10: Training Batch and Number of ASHAs Trained

Sr. No.	Training Period	No. of ASHAs Trained
1.	19.12.2009 to 25.12.2009	30
2.	16.01.2010 to 22.01.2010	30
3.	28.01.2010 to 03.02.2010	30

4.	16.02.2010 to 22.02.2010	30
5.	20.02.2010 to 26.02.2010	30
6.	06.04.2010 to 12.04.2010	29
7.	10.04.2010 to 16.04.2010	22

The surveillance register was field-tested by the ASHAs of the Nander PHC. Changes were made as per their suggestions.

Training on transfer of information to the surveillance register was given to the ASHAs. Details of this one-day training inputs are given in Table 11.

Table 11: Training for Transferring Information in the Surveillance Register:

Sr. No.	Primary Health Centre	Date of Training	Expected Number of ASHAs	Actual No. of ASHAs Present
1.	Pimpalwadi	08.07.2010	29	27
2.	Vihamandawa	07.07.2010	32	24
3.	Adul	09.07.2010	25	24
4.	Nander	06.07.2010	34	30
5.	Balanagar	06.06.2010	21	21
6.	Dhakephal	07.07.2010	27	27
7.	Nilajgaon	08.07.2010	33	29
Total			201	182

Out of a total of 201 ASHAs invited for the training 182 attended and completed recording information in the surveillance register.

A one-day training was also given to the ASHAs on methods of imparting need specific BCC in March 2011. BCC cards developed by IHMP on Maternal & Newborn Health and Family Planning were given to them.

c. Orientation of the PHC staff: A One-day orientation of the PHC staff was organized in two batches at Pachod and Paithan in July 2010. The objective of the workshop was to orient the PHC staff about the innovative project to increase community participation, to be implemented in the Paithan Block. The expected roles and responsibilities of ANMs, MPWs, Health Supervisors, Lady Health Visitors and Medical Officers under this project were discussed. The roles and responsibilities of the ASHA and VHNWS Committees along with the expected outcomes were also presented. The crucial role of ASHA in improving the quality of services and meeting objectives of the NRHM was emphasized. Both the workshops were inaugurated by the Taluka Medical Officer.

The list of topics discussed was:

- Innovative model project in 'communitization' under National Rural Health Mission included in the State Project Implementation Plan and its components
- Surveillance and micro-planning by ASHAs

- Need specific BCC by ASHAs
- Linking health services for the health needs identified through the surveillance
- Committees at various levels –Village, PHC, Block and District
- Roles and Responsibilities of the various stakeholders
- Expected outcomes

d. Coordination with the District Level Authorities:

A One-day workshop for the District Health Officer (DHO), Principal, Health Family Welfare Training Center, Taluka Medical Officer, Medical Officer, District Training Team and Medical Officers (MOs) of seven PHCs in Paithan Block was organized at the Health & Family Welfare Training Centre to discuss the proposal of the innovative project and the roles & responsibilities of the various stakeholders.

Another meeting was organized at the DHO's office to discuss various issues and timeline related to the ASHA training. This meeting was attended by MO, District Training Team, Taluka Medical Officer (TMO) and seven MOs of the PHCs. The following decisions were taken in that meeting:

- IHMP would undertake ASHA training for first seven-day module in batches at Pachod and Paithan.
- Training would be conducted by the trainers from IHMP who had attended training of trainers organised at the Health & Family Welfare Training Center, Aurangabad
- The Taluka Medical Officer would arrange for the stationery and payment of TA & DA of ASHAs on the last day of the training
- Orientation of the all PHC staff to be organized in two batches
- Medical Officer, PHCs would arrange for the training venue at the PHC headquarters for the VHNWS committee members.

Issues requiring coordination were discussed every month with the DHO and TMO.

Live examples of people's participation and ASHA's role have been given as case studies.

Case study 1:

The village of Kekat Jalgaon comes under the Vihamandawa, Primary Health Centre (PHC) and has a population of 2550. Two women from the village were selected and trained as ASHAs. The village has a sub-centre and two anganwadi centres. Smt. Darade, ANM of Kekat Jalgaon sub-centre resigned in June 2010. Therefore Arogya Seva Satras (Mother and Child Protection Sessions) were not conducted in the village subsequently.

The ASHAs and anganwadi workers brought up this issue in the monthly meeting at the Primary Health Centre but no action was taken. Later this issue was raised at the monthly meeting of Village Health, Nutrition, Water Supply and Sanitation Committee

(VHNWSC) by a facilitator from IHMP who was present. It was decided that office bearers of the committee would discuss this issue with the medical officer at the primary health centre. So the committee members went and met Dr. Tupe and requested him to make alternate arrangements. Four months later regular Arogya Seva Satras were restarted in the village.

A similar situation occurred in another village - Warwandi Khurd, which has a population of 1176 and is served by the Balanagar, Primary Health Centre. The ANM of the village went on maternity leave from January 2011. Arogya Seva Satras were not conducted in the village for two months. The ASHA brought this to the notice of VHNWSC members. They met the medical officer of the Balanagar PHC and alternate arrangements were made for conducting the Arogya Seva Satra.

These case studies are a good illustration of how empowered committee members ensure that primary level health care services are made available in the village on a regular basis.

Case study 2:

Smt. Vandana Kisan Arakh works as an ASHA in Adul a village under Adul PHC. Maya Kisan Jadhav, a 20 year old pregnant woman from her village, was not coming for antenatal check-ups. During her routine household visits for the surveillance and need specific BCC, Vandana explained the benefits of regular antenatal check-ups to Maya and her mother-in-law. After the visit Maya started coming for regular antenatal check-ups.

When Maya's due date for delivery drew near her mother-in-law told Vandana that they would have her delivery conducted at home by a Dai. She explained to the mother-in-law the risks of home delivery and convinced her to have the delivery in the hospital. She also told her that Maya's delivery at the PHC would be conducted free of cost. The mother in law agreed. When Maya went into labour, Vandana took her to the Adul PHC for delivery, where she delivered normally. After delivery, the mother-in-law did not allow Maya to start breast-feeding immediately. The Doctor and Vandana intervened and explained the importance of colostrum to her after which she allowed the baby to be breast fed.

This case study illustrates the importance of providing need specific BCC. If information is provided to the people when it is needed most, people are willing to listen, utilize health services and change behaviours.

Case study 3:

Sompuri village is under Nilajgaon PHC and has a population of 770. There is one anganwadi worker and one ASHA in the village. During her monthly surveillance visit the ASHA came across a 29 year old person with symptoms suggestive of tuberculosis. She asked him since when he had the cough. He said that he had it for a long time and admitted to being a TB patient. He said that since he was poor he couldn't afford the

treatment. He was under the impression that TB could not be cured. He also feared that if it got around that he had TB he would be ostracized.

The ASHA told him that free treatment for TB was available in the government hospital and that it could easily be cured. She also said that the information would be kept confidential. She accompanied him to the PHC and got his name registered. He has been put on treatment and is continuing the treatment regularly.

This case study illustrates the importance of doing surveillance, identifying health needs and giving BCC based on the needs. It also highlights that at times people need to be assured of confidentiality and that it might be necessary to accompany the patient to the hospital.

Case study 4:

Kadethan Budruk village is under Adul primary health centre. This village succumbed to an epidemic of Chikungunya fever in March 2011. The ASHA informed the VHNS committee that number of patients suffering from Chikungunya fever in the village has been increasing. A facilitator from IHMP who was present for the meeting suggested to committee members that they should inform the medical officer at PHC. The committee wrote a letter to the medical officer who took immediate action and sent a team to Kadethan village. The Patients were treated. A door to door survey was carried out by the MPWs and people were asked to empty all the containers with stored water. Information about the disease was also disseminated. Thus because of ASHA's alertness and quick action on the part of the committee & PHC staff, the epidemic was immediately brought under control.

Akhwadwada village, under Nander PHC had an epidemic of Dengue fever in May 2011. The VHNS Committee members and ASHAs met to discuss this problem. They took the decision to inform the Taluka Medical Officer and request him to arrange for medical help. He arranged for a team to come from the Nader PHC. Patients were provided treatment and were requested to empty all containers containing stagnant water. Within a short time the epidemic was brought under control.

This case study illustrates that empowered committee members, and responsive staff of a PHC can bring epidemics under control effectively.

Case study 5:

Smt. Nirmal Ghule is ASHA of Thergaon village which is under the Nander primary health centre. Suwarna Bappa Takpeer, a pregnant woman belonging to a family in the 'below poverty line category' had taken a complete antenatal check up and went to the government hospital for her delivery. She however forgot to take the documents through which she could get the benefits of Janani Suraksha Yojana.

After seven days of delivery her husband went with all the documents to nurse but the nurse refused to compensate him as per the JSY. He went to the ASHA and told her his problem. She took all the papers and went to the nurse but the nurse again refused. She then informed the village Sarpanch about this. The next day, the Sarpanch and ASHA met the medical officer at the PHC and told him about nurse's refusal to pay the JSY entitlement to the delivered mother. The medical officer checked all the papers. Since Suwarna was eligible to get the JSY benefit and all necessary documents were in place, he arranged for the payment.

This case study illustrates the ASHA's role in ensuring that eligible women get JSY benefit in time. In this case, ASHA had to take the help of the committee members in ensuring that the delivered woman received the entitlement due to her.

Materials Distributed to the Information Centers by IHMP

Name and Type of Materials	Name and Type of Materials
Sarpanch Margadarshika (Booklet)	Swine flu (Poster & Sticker)
Loksankhya Wadh Ek Drushtikhep (Brochure)	Mulagi Ojha Nahi (Brochure)
Prashna Tumche Uttar Aamche (Brochure)	Jansanwad (Brochure)
Mulagich Aahe Jivnachi Shilpakar (Poster)	Vayat Yetanna (Booklet)
Balvivah Kaydyane Gunha Aahe (Poster)	Arogya Patrika - Jan. 2010 & June 2010 to May 2011*
Galgand Talata Yeto (Poster)	Prajanan Margache Jantu Sansarg va Laingik Sambandhatun Honare Aajar (Brchure)
Prajanan Aarogya (Poster)	AIDS Jana AIDS Tala (Booklet)
Chikungunya (Brochure)	Surakshit Matrutva (Brochure)
Jagtik AIDS Din Mohim – 2004 (Booklet)	Janmaka Upyukt Samay (Poster)
Sickle cell Aajar (Booklet)	Raktadaan (Brochure)
Ek Themb Raktacha Fulvito Ankur Jivanacha (Brochure)	Aapalya Balache Shatru – Polio, Dhanurvati, Ghatsarp, Dangya Khokala (Sticker)
Madhura Ek Nav Naat (Pamphlet)	Prevention of Thyroid (Poster)
Vayat Yetanna (Poster)	Introduction to Communitization under NRHM Programme (Poster)**
Jaga Aani Jagu Dya (Poster)	Services provided by PHC and Sub-centre (Poster)**
Stri Shakticha Ekach Nara (Poster)	Communitization under NRHM (Pamphlet)**
Taap: Gambhriya Olkha (Poster)	Symptoms of Risks During Pregnancy (Pamphlet)**
Immunization (Poster)	Complications During Delivery (Pamphlet)**
Mala Shikun Savarun Motha Vhayachay (Poster)	Post natal Complications (Pamphlet)**
Swine Flu, Influenza H1N1 (Brochure)	Routine Care of Newborn (Pamphlet)**
Jiwnacha Mantra (Poster)	Special Care of Low Birth Weight Baby (Pamphlet)**
Sickle Cell Aajar (Brochure)	Methods of Family Planning (Pamphlet)**
Polio (Poster)	Janani Suraksha Yojana (Pamphlet)**
Janma Nondani Pratyek Balacha Pahila Adhikar (Brochure)	Nagrikanche Arogya Hakka Sanad (Poster)**
Loksankhya Wadh Ek Drushtikshep (Booklet)	Nagrikanche Arogya Hakka Sanad (Pamphlet)**

* IHMP subscribed to Arogya Patrikas for one-year

** Posters and Pamphlets prepared and printed by IHMP

b. Advocating scaling up of 5 SATHI interventions in Maharashtra

IHMP organized a series of meetings with the regional and district administrators in the 5 districts where the SATHI project was implemented. In three out of the five districts where the SATHI project was implemented the District Collectors, NRHM Project

Coordinators and District Health Officers have sent a request to the State Director NRHM to permit them to replicate the SATHI project in their districts.

Replication of the SATHI project requires approval from the State NRHM Director for the reimbursement of ASHAs as per the following schedule proposed by IHMP:

- Rs. 150 per month for accurate and complete Surveillance of reproductive and child health needs
- Rs. 150 per month for ensuring that all the clients come to the ANM on the monthly Village Health and Nutrition Day (VHND).
- Rs. 150 for convening the VHSNC meeting and getting them to review the monthly health needs assessment and delivery of RCH services.
- Rs. 250 for providing home based neonatal care
- The remaining reimbursement is for outcomes as per NRHM norms.

The district administrators are awaiting the approval from the State Director NRHM

c. Advocating scaling up of 5 SATHI interventions in Madhya Pradesh

Two meetings have been held in Bhopal with the Director NRHM to scale up the SATHI interventions in Madhya Pradesh. In the first meeting, Dr. Dyalchand, Director IHMP met Dr Manohar Agnani, Director NRHM, Madhya Pradesh. Dr Agnani requested IHMP to make a detailed presentation of the 5 SATHI interventions to about 40 NRHM and Directorate of Health Services (DHS) staff of Madhya Pradesh. The Director and Additional Director, IHMP made power point presentations on each of the 5 SATHI interventions. The meeting was attended by the sectional heads of NRHM and staff of the DHS. Replication of the SATHI innovations in Madhya Pradesh is under consideration.

d. Advocating scaling up of the 5 SATHI interventions in Bihar

Efforts similar to those undertaken in Madhya Pradesh have been made in Bihar as well. The Director NRHM in Bihar has been contacted. IHMP has received a letter from him to submit a formal proposal. The Director IHMP is scheduled to meet with the Chief Minister of Bihar to follow up with the proposal to scale up SATHI in Bihar.

e. Advocating the scaling up of the 5 SATHI interventions for the VHND strategy of NRHM through UNICEF

UNICEF has shown interest in the SATHI interventions for the recent NRHM initiative to strengthen the Village Health and Nutrition Day (VHND). Meetings are going on to negotiate a modus operandi which is acceptable to UNICEF and IHMP.

Section – 2

Married Adolescent Girls’ program – Pilot Site

Introduction:

Institute of Health Management Pachod is implementing an integrated intervention for Married Adolescent Girls (MAGs), which addresses their reproductive and sexual health needs. The project design was based on the fact that a large number of adolescent girls in Maharashtra get married before the legal age of 18 years. It is a known fact that early marriage and motherhood are associated with adverse reproductive health outcomes. This group has special needs, which are not addressed by the formal health system.

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

Project interventions:

The intervention involves reaching young married couples at the household and group level. A detailed surveillance system formulates the basis of the intervention. Health services are provided at the primary level on the basis of needs assessed during surveillance. Specific BCC inputs are conducted for both husbands and wives. These include home visits and group meetings. The project interventions are monitored by the VHSCs (Village Health, Nutrition, Water and Sanitation Committees).

Project Inputs (Activities):

The project activities conducted during the reporting period - April 2010 to March 2011 are broadly categorised as follows:

- A. Surveillance
- B. Need specific Inter Personal Communication (IPC) by community based workers.
- C. Village Level Meetings of married adolescent girls and their spouses.
- D. Primary level care and referral
- E. VHSC (Village Health, Nutrition, Water and Sanitation Committees) review and monitoring meetings

A. Surveillance Coverage:

The project has established a community based surveillance system for early detection of health needs and for provision of primary reproductive health services. The surveillance covers detection of reproductive health problems, family planning, menstrual surveillance and pregnancy status.

Table 1: Surveillance Coverage, April 2010 to March 2011

Month of Reporting	Reporting for No. of CO areas	Number of registered MAGs	Number of MAGs visited	Percent MAGs Visited
April 2010	24	910	780	85.71
May 2010	24	929	803	86.43
June 2010	25	559	519	92.84
July 2010	25	601	525	87.35
August 2010	25	605	523	86.44
September 2010	25	615	525	85.36
October 2010	25	630	526	83.49
November 2010	25	638	515	80.72
December 2010	25	644	537	83.32
January 2011	25	645	533	82.63
February 2011	25	666	574	86.18
March 2011	25	690	570	82.60
Average	25	678	578	85 %

Table 1 indicates that during the reporting period on an average of 85 percent MAGs were covered under monthly surveillance.

B. Need specific Inter Personal Communication (IPC):

1. Need specific IPC by community based workers.

During surveillance the community organizer identifies the information needs, makes a behavioral diagnosis and gives MAGs and her household members need specific IPC.

2. Need specific IPC by supervisor.

During their morning household visits, the supervisors visit the MAG's and give them information on the importance of early antenatal registration and examination, hospital delivery, post natal care, immunization, complementary feeding, ICTC, RTI clinics and information centre. She gives them need specific health education, and encourages them to attend the Life Skills classes conducted for MAG's. They also give them information for health checkups and sometimes accompany them when necessary. During the year, 319 village visits were made, 3246 MAG's were visited and given information. Thus on an average, during each morning village visit, 10 MAG's have been visited.

C. Village Level Meetings conducted by social workers:

Under the Behaviour Change Communication (BCC) intervention, village level meetings are conducted with MAGs and their spouses. The topics for the village level group meetings were decided with MAGs and their spouses. There is a fixed schedule and topics for the group meetings. Meetings with MAGs are conducted by female social workers and the male social workers conduct monthly meetings with the spouses.

Table 2: Village Level Meetings of MAGs, conducted by female social workers from April 2010 to March 2011

Subject(s) Discussed	Group meetings			Attendance in the meetings		
	Expected	Held	%	Expected	Attended	%
Anatomy and physiology of reproductive system	38	31	81.57	620	329	53.06
Antenatal care	38	35	92.10	700	376	53.71
Birth preparation and importance of hospital delivery	38	32	84.21	640	340	53.12
Care of newborn	38	27	71.05	540	303	56.11
Care of low birth weight baby	38	33	86.84	660	333	50.45
Management of cold, cough and pneumonia in less than 5 year child.	38	34	89.47	680	370	54.55
Why and when HIV testing?	38	20	52.63	400	191	47.75
Meeting with mothers in law about MAGs classes and meeting.	38	26	68.42	520	186	37.76
Reproductive tract infection: signs and symptoms, check-up, treatment and prevention.	38	31	81.57	620	326	52.58
Menstrual hygiene	38	37	97.36	740	404	54.59
Prevention of Parent to Child Transmission of HIV	38	35	92.10	700	431	61.58
Average	38	31	82	620	326	52

Table 2 shows that 82 percent of the planned MAGs meeting were conducted. This particular input covered about 52 percent of the expected MAGs.

Table 3: Meetings of spouses of MAGs conducted by male social worker from April 2010 to June 2010

Subject(s) Discussed	Group meetings			Attendance in the meetings		
	Expected	Held	%	Expected	Attended	%
Anatomy and physiology of reproductive system	38	38	100	760	671	81.18
Antenatal care	38	38	100	760	606	79.73
Reproductive tract infection: signs and symptoms, check-up, treatment and prevention.	19	17	44.73	340	277	81.47
Average	32	31	97	620	518	84

Table 3 indicates that 97 percent of the planned group meetings for spouses of MAGs were conducted. Similarly when analyzing the expected attendance it was found that 84 percent spouses of MAGs attended the meetings.

D. Primary level care and referral:

Primary level care and referral is provided to MAGs that are identified in need of health care. These services are provided during the fortnightly and monthly village visits of health care providers.

Project outputs according to each specific objective

The project outputs are presented against each of the specific objectives of the project. This information is based on the monthly compilation of data from surveillance and service record of Community Organizers.

Objective 1: The proportion of treatment seeking behaviour for post abortion complications will increase by 20 percentage points.

Table 4: Output 1a - Reported abortion rate among MAGs

Month	No. of MAGs visited	No. of MAGs with pregnancy outcome	No. of MAGs who had abortion	Abortion rate among MAGs
April 2010	780	19	3	15.8
May 2010	803	23	4	17.4
June 2010	519	15	5	33.3
July 2010	525	27	3	11.1
August 2010	523	23	0	00.0
September 2010	525	36	5	13.9
October 2010	526	15	0	00.0
November 2010	515	22	0	00.0
December 2010	537	20	2	10.0
January 2011	533	27	4	14.8
February 2011	574	14	1	07.1
March 2011	570	17	1	05.9
Total		258	28	10.9

Table 4 indicates that 28 abortions were reported during the reporting period, about 10.9 percent of total pregnancies ended in an abortion. The abortion rate at baseline was 16 abortions per 100 pregnancies.

Table 5: Output 1b - Reported post abortion complications

Month	No. of MAGs visited	No. of MAGs who had abortion two months prior to reporting	No. of MAGs reported post abortion complications*	% MAGs with post abortion complications*
April 2010	780	4	0	0.0
May 2010	803	6	0	0.0
June 2010	519	3	0	0.0
July 2010	525	4	0	0.0
August 2010	523	5	0	0.0
September 2010	525	3	0	0.0
October 2010	526	0	0	0.0
November 2010	515	5	0	0.0
December 2010	537	0	0	0.0
January 2011	533	0	0	0.0
February 2011	574	2	0	0.0
March 2011	570	4	0	0.0
Total		36	0	0.0

Post abortion complications can occur up to one month after an abortion. This table indicates that 0 percent MAGs reported post abortion complications. In the baseline survey the MAGs were asked, if they had suffered any complication after abortion and whether they had to seek medical treatment from a doctor for the complication. 68 percent MAGs reported some post abortion complication (within a month of abortion), out of which 42 percent got treatment within 6 days after occurrence of complications.

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

Table 6: Output 2a - Reported Use of Family Planning Methods

Month	No. of MAGs visited	Currently non pregnant MAGs	MAGs using any FP method	Percent MAGs using any FP method	MAGs using any spacing method	Percent MAGs using spacing method
April 10	780	614	187	30.45	152	24.75
May10	803	616	207	33.60	171	27.75
June 10	519	408	83	20.34	81	19.85
July 10	525	383	86	22.45	84	21.93
August 10	523	402	75	18.65	73	18.15
Sept.10	525	417	76	18.22	74	17.74
Oct.10	526	415	78	18.79	77	18.55
Nov.10	515	423	90	21.27	83	19.62
Dec.10	537	422	105	24.88	102	24.17
Jan.11	533	410	99	24.14	96	23.41
Feb.11	574	443	108	24.37	103	23.25
March 11	570	433	105	24.24	104	24.01
Average	577	448	108	24	100	22

Table 6 indicates that on an average 24 percent young married couples are using any one family planning method. The contraceptive use for spacing methods has increased from 11 percent at baseline to 22 percent.

Table 7: Output 2b - Reported Use of Any Spacing Methods by Type of Method

Month	Currently non pregnant MAGs	MAGs using any spacing method	Number of MAGs currently using following type of spacing method					
			Condom	%	Pills	%	Cu T	%
April 10	614	152	133	21.66	12	1.95	7	1.14
May10	616	171	147	23.86	17	2.75	7	1.13
June 10	408	81	72	17.64	7	1.71	2	0.49
July 10	383	84	69	18.01	4	1.04	11	2.87
August 10	402	73	59	14.67	11	2.73	3	0.74
Sept.10	417	74	57	13.66	14	3.35	3	0.71
Oct.10	415	77	71	17.10	3	0.72	3	0.72
Nov.10	423	83	74	17.49	6	1.41	3	0.70
Dec.10	422	102	87	20.61	13	3.08	2	0.47
Jan.11	410	96	87	21.21	7	1.70	2	0.48
Feb.11	443	103	91	20.54	9	2.03	3	0.67
March 11	433	104	89	20.55	12	2.77	1	0.23
Average	448	100	86	19	10	2	4	0.89

Table 7 indicates that on an average 19 percent, young married couples were using condoms, 2 percent were using oral pills and less than one percent was using a copper T.

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

Table 8: Output 3a - Reported proportion of newborn weighed at birth

Month	Number of MAGs visited	MAGS delivered live births		No. of neonates weighed at birth	Percent neonates weighed at birth
		Maheri	Sasari		
April 2010	780	14	2	2	100
May 2010	803	18	0	0	0.0
June 2010	519	6	4	4	100
July 2010	525	15	10	10	100
August 2010	523	21	2	2	100
September 2010	525	27	4	4	100
October 2010	526	12	3	3	100
November 2010	515	16	6	6	100
December 2010	537	16	3	3	100
January 2011	533	23	0	0	0.0
February 2011	574	12	1	1	100
March 2011	570	12	4	4	100
Total		192	39	39	100

Table 8 indicates that about 100 percent of newborn babies (delivered at in laws) were weighed at birth.

Table 9: Output 3b - Reported proportion of low birth weight babies.

Month	No. of MAGs visited	No. of newborns weighed at birth	No. of newborns were LBW	Percent LBW newborns to MAGs
April 2010	780	2	0	0.0
May 2010	803	0	0	0.0
June 2010	519	4	1	25.0
July 2010	525	10	2	20.0
August 2010	523	2	0	0.0
September 2010	525	4	0	0.0
October 2010	526	3	0	0.0
November 2010	515	6	1	16.66
December 2010	537	3	0	0.0
January 2011	533	0	0	0.0
February 2011	574	1	0	0.0
March 2011	570	4	1	25.0
Total		39	5	13

Among the neonates that were weighed at birth, 13 percent had low birth weight. The proportion of LBW babies is comparatively less than at baseline (36 percent).

Table 10: Output 3C – Thermal Bags provided to low birth weight babies

Month	MAGS delivered live births at Sasari	No. of newborns weighed at birth	No. of newborns were LBW	No. of LBW babies received thermal bag	% LBW babies received thermal bag
April 2010	2	2	0	0	0.0
May 2010	0	0	0	0	0.0
June 2010	4	4	1	1	100.0
July 2010	10	10	2	2	100.0
August 2010	2	2	0	0	0.0
September 2010	4	4	0	0	0.0
October 2010	3	3	0	0	0.0
November 2010	6	6	1	1	100.0
December 2010	3	3	0	0	0.0
January 2011	0	0	0	0	0.0
February 2011	1	1	0	0	0.0
March 2011	4	4	1	0	0.0
Total	39	39	5	4	80.0

Table 10 indicates that 80 percent LBW babies received thermal bags.

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

Table 11: Output 4a - Detection of Reproductive Tract Infections

Month	No. of MAGs visited	No. of MAGs with symptoms of RTIs	Percent MAGs with symptoms of RTIs
April 2010	780	33	4.23
May 2010	803	37	4.60
June 2010	519	23	4.43
July 2010	525	29	5.52
August 2010	523	17	3.25
September 2010	525	34	6.47
October 2010	526	33	6.27
November 2010	515	28	5.43
December 2010	537	21	3.91
January 2011	533	40	7.50
February 2011	574	44	7.66
March 2011	570	36	6.31
Average			5.41

Table 11 indicates that on an average 5.41 percent MAGs reported any one symptom of RTIs during the monthly surveillance. This detection rate is lower than baseline.

Table 12: Output 4b - Reported treatment seeking for RTIs

Month	Number of MAGs visited	Number of MAGs with symptoms of RTIs	Number of MAGs sought treatment for RTIs	Percent MAGs sought treatment for RTIs
April 2010	780	33	14	42.42
May 2010	803	37	14	37.83
June 2010	519	23	21	91.30
July 2010	525	29	27	93.10
August 2010	523	17	16	94.11
September 2010	525	34	29	85.29
October 2010	526	33	32	96.96
November 2010	515	28	28	100.0
December 2010	537	21	21	100.0
January 2011	533	40	30	75.0
30February 2011	574	44	34	77.27
March 2011	570	36	27	75.0
Total		375	293	78

Table 12 indicates that on an average 78 percent of MAGs sought treatment for RTIs. This proportion is significantly higher than at baseline.

Objective 5: To increase the proportion of treatment seeking for post-natal complications among married adolescents by 20 percentage points

Table 13: Output 5a - Reported prevalence of post natal complications

Month	No. of MAGs visited	No. of post natal MAGs*	No. of MAGs reported post natal complications	% MAGs with post natal complications
April 2010	780	2	0	0.0
May 2010	803	5	1	20.0
June 2010	519	2	0	0.0
July 2010	525	1	0	0.0
August 2010	523	4	0	0.0
September 2010	525	9	0	0.0
October 2010	526	2	0	0.0
November 2010	515	4	1	25.0
December 2010	537	3	0	0.0
January 2011	533	6	0	0.0
February 2011	574	3	0	0.0
March 2011	570	0	0	0.0
Total		41	2	5

* MAGs-delivered two months prior to the reporting month

Table 13 indicates that 5 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).

Table 14: Output 5b - Reported treatment seeking for post natal complications

Month	No. of MAGs visited	No. of MAGs reported post natal complications	No. of MAGs sought treatment for post natal complications	% MAGs sought treatment for post natal complications
April 2010	780	0	0	00
May 2010	803	1	1	100
June 2010	519	0	0	00
July 2010	525	0	0	00
August 2010	523	0	0	00
September 2010	525	0	0	00
October 2010	526	0	0	00
November 2010	515	1	1	100
December 2010	537	0	0	00
January 2011	533	0	0	00
February 2011	574	0	0	00
March 2011	570	0	0	00
Total		2	2	100

Table 14 indicates that both the MAGs with post natal complications sought treatment for post natal complications.

Case studies:

These case studies are documented for married adolescent girls who were enrolled in this project aimed at delaying age at first conception and averting the adverse consequences of early motherhood in married adolescent girls.

Case Study: 1

Manisha Dadasaheb Thombare was 17 years old when she got married in 2008. At present, she is 20 years old and lives in a village – Salwadgaon, which is about 15 kms. from Pachod. She had attended the Life Skills programme and sexuality module in her natal village before her marriage.

Manisha used to participate in the BCC group meetings conducted for married adolescent girls in Salwadgaon. When she got married, she was not getting her periods regularly and used to get severe pain in the lower abdomen. She discussed this with Sangeeta Wakade, the Community Organizer (ASHA) of her village.

As part of the project intervention, a gynecologist visits every sub-centre for conducting RTI clinics. The Community Organizer took her to the RTI clinic in that village. The gynecologist referred her to the Medical College in Aurangabad where several tests were done. She was given treatment and she started getting her periods regularly.

She conceived about six months after her treatment was completed. She registered for antenatal check-ups before 12 weeks of pregnancy, with the ANM as per the community organizer's advice. She went for regular check-ups during pregnancy and took Iron Folic Acid supplementation. She also increased her diet during pregnancy. She went to her natal home for delivery. She had a normal delivery in the hospital and her baby weighed 2.7 kg. at birth. Manisha and her husband are using condoms to keep the birth interval of at least three years between the first and next child.

Case Study: 2

Heena Javed Sheikh is married and 17 years old. She lives in village Thergaon which is at a distance of 7 km. from Pachod. She got married in 2009 when she was 16 years old. She conceived after 9 months of marriage.

During their house visit the field supervisor and community organizer (ASHA) found out that she was pregnant for the first time. She had gone to a private hospital where a urine pregnancy test and blood tests were done. She showed these reports to the field supervisor and community organizer.

The field supervisor explained to Heena and her mother-in-law that it is essential for Heena to go for regular antenatal check-ups because she is pregnant at a young age and also anemic, which increases her risk. They were explained the complications which can occur during pregnancy.

Her mother-in-law said that Heena is shy and does not eat properly. They were explained that she needs to increase her diet as well as include foods like sprouted pulses, jaggery-peanut ladu and misl roti with green vegetables, etc. They were also told about services available for pregnant women at the village level.

After that, every month the mother-in-law took Heena for the antenatal check up to the mother and child protection centre. Heena took two TT injections and 100 Iron Folic Acid tablets during her pregnancy, which helped to improve her hemoglobin level. She also took nutritional supplementary food from the anganwadi.

Heena went to her natal home in the ninth month of pregnancy. She delivered in the hospital there. Now baby is three months old. Both mother and baby are doing fine.

Case Study: 3

Vaishali Sanjay Bankar lives in Pachod Khurd. She is 21 years old and has two children. Her older son is 3 years old and younger son is 9 months old. She is educated up to 7th standard. She is one of the married adolescent girls enrolled in the project.

She used to attend BCC group meetings organized for married adolescents in her village. In one such meeting, which was attended by Vaishali, information regarding use of contraceptives was discussed. There were ten women present for that meeting. Vaishali requested Shivganga Wagh, Community Organizer (ASHA) to give her BCC cards she had used during the group meeting to take home and show her husband. She promised Shivganga that she would return the BCC cards next morning.

After taking the BCC cards home, Vaishali discussed various temporary contraceptive options with her husband. They took a decision that they would use condoms till their younger son is five years old and after that they would adopt a permanent method of family planning since their desired family size is complete.

Primary Health Care

Annual Report April 2010 to March 2011

Institute of Health Management, Pachod has been implementing Primary Health Care Program in Nandar PHC area covering 31208 populations of 24 villages.

Project Inputs and Outputs from April 2010 to March 2011

1. Monthly In-service of Community Organizers (COs)

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

Subjects discussed during CO meetings.

Sr. No.	Month	Subject
1	April 2010	HIV/AIDS testing and treatment
2	May 2010	Ways of HIV transmission
3	June 2010	Why and when HIV testing?
4	July 2010	Water-borne diseases
5	August 2010	Malnutrition in children
6	September 2010	Abortion and post abortion care
7	October 2010	Care of newborn baby
8	November 2010	Care of low birth weight baby
9	December 2010	Scabies and treatment
10	January 2011	HIV/AIDS testing and treatment
11	February 2011	Prevention of parent to child transmission of HIV
12	March 2011	Reproductive tract infection and treatment

2. Monthly surveillance and IPC through Community Organisers

This work is done through COs during monthly household visits. They collect information on childhood diseases, pregnant women, gynaecological problems in women and family planning. They bring this information every month during their monthly meetings, which is checked and this information is used for providing services.

Table 1: Household visits coverage, April 2010 to March 2011

Sr. No.	Month	Household visits		
		Expected	Actual	%
1	April 2010	4425	4425	100
2	May 2010	4425	4425	100
3	June 2010	4425	4425	100
4	July 2010	4425	4425	100
5	August 2010	4425	4425	100
6	September 2010	4425	4377	98.9
7	October 2010	4425	4425	100
8	November 2010	4425	4259	96.2
9	December 2010	4425	4425	100
10	January 2011	4425	4361	98.5
11	February 2011	4425	4369	98.7
12	March 2011	4425	4425	100
Average		4425	4397	99.3

Table 1: indicates that during the reporting period on an average 99.3 percent household visits were covered by community organisers for monthly surveillance and IPC.

3. Provision of Antenatal and Post natal services

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

Table 2: Total new registration during last one year: (From April 2010 to March 2011)

Sr. No.	Month	MAG			General			Guest			Total		
		<12	>12	Tot	<12	>12	Tot	<12	>12	Tot	<12	>12	Tot
1	April 10	35	18	53	10	13	23	00	14	14	45	45	90
2	May 10	25	13	38	07	14	21	01	13	14	33	40	73
3	June 10	35	45	80	09	23	32	02	15	17	46	83	129
4	July 10	29	13	42	06	22	28	01	11	12	36	46	82
5	Aug 09	18	14	32	04	15	19	01	18	19	23	47	70
6	Sept 09	20	18	38	11	18	29	01	14	15	32	50	82
7	Oct 09	36	12	48	11	09	20	00	19	19	47	40	87
8	Nov 09	12	09	21	08	03	11	00	11	11	20	23	43
9	Dec 09	32	29	61	11	17	28	01	12	13	44	58	102
10	Jan 10	43	26	69	18	19	37	01	09	10	62	54	116
11	Feb 10	49	17	66	10	16	26	02	09	11	61	42	103
12	Mar 10	29	17	46	18	09	27	02	17	19	49	43	92
	Total	363	231	594	123	178	301	12	162	174	498	571	1069

Table 2: indicates that during the reporting period 1069 new pregnant women were registered for antenatal services. Out of the general 40 percent and out of the Married Adolescent Girls 61 percent were registered before 12 weeks of pregnancy.

Table 3: Deliveries and Post natal visits

Beneficiaries	Deliveries			Abortions	PNC visit			
	Total	Maheri	Sasari		1 st	2 nd	3 rd	Total
MAG	496	419	77	45	19	6	55	80
General	264	208	56	30	17	2	46	65
Guest	157	147	10	1	12	25	76	113
Total	917	774	143	76	48	33	177	258

Table 3: indicates that during the reporting period 917 deliveries and 76 abortions were recorded. 48 mothers received one post natal visit, 33 mothers received two post natal visits, and 177 mothers received three or more post natal visits.

Table 4: Maternal health care services taken during the reporting period

Beneficiaries	Total deliveries	Antenatal check up		T.T. injection		Place of delivery		Who conducted delivery		
		2	3+	1	2 or B	Hospital	Home	TD	Hospital	Other
MAG	496	141	389	16	474	470	26	7	470	19
General	264	78	178	5	251	247	17	7	247	8
Guest	157	125	30	2	154	145	12	8	145	4
Total	917	344	597	23	879	862	55	22	862	31

Table 4: indicates that during the reporting period, out of 917 deliveries 862 (94 percent) were hospital delivery; 884 (96 percent) deliveries were conducted by a trained person. Out of the total deliveries, 65 percent women had undergone three or more antenatal checkups and 95 percent had received two TT injections or booster.

4. Minor Ailments treatment at the village level through Community Organizers

At the village level COs are given medicines to treat minor ailments, especially for children and women. They have been trained to diagnose the ailments like common fever, respiratory infections and diarrhoeas. Following medicines were used from April 2010 to March 2011 by COs.

Table 5: Minor ailment treatment given by Community Organizers.

Sr. No.	Medicines	Number of patients treated	Number of tablets consumed	Community contribution in rupees
1	Paracetamol	1091	4952	1238
2	Septran	568	1935	1190
Total		1659	6887	2428

Table 5: indicates that total number of patients treated for minor ailments was 1659.

5. Growth monitoring of less than one year old children

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

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

Sr. No.	Month	Proportion weighed (W) Children								
		Male			Female			Total M+F		
		Total	W	%	Total	W	%	Total	W	%
1	April 10	222	189	85.13	179	154	86.03	401	343	85.53
2	May 10	231	207	89.61	168	149	88.69	399	356	89.22
3	June 10	224	201	89.73	178	148	83.14	402	349	86.81
4	July 10	223	198	88.78	194	164	84.53	417	362	86.81
5	Aug 10	226	192	84.95	194	166	85.56	420	358	85.23
6	Sept 10	250	205	82.00	210	170	80.95	460	375	81.52
7	Oct 10	252	191	75.79	216	164	75.92	468	355	75.85
8	Nov 10	139	184	76.98	222	175	78.82	461	359	77.87
9	Dec 10	266	208	78.19	216	172	79.62	482	380	78.83
10	Jan 11	257	204	79.37	213	171	80.28	470	375	79.78
11	Feb 11	250	202	80.8	217	178	82.02	467	380	81.37
12	Mar 11	257	206	80.15	209	176	84.21	466	382	81.97
Total				85.34			82.24			82.32

Table 6: indicates that during the reporting period on an average 82 percent children were weighed every month.

Table 7: Growth faltering in children less than one year

Sr. No.	Month	Proportion Growth Faltered Children								
		Male			Female			Total M+F		
		W	GF	%	W	GF	%	W	GF	%
1	April 10	189	05	2.64	154	05	3.24	343	10	2.91
2	May 10	207	08	3.86	149	05	3.35	356	13	3.65
3	June 10	201	02	0.99	148	01	0.67	349	03	0.85
4	July 10	198	06	3.03	164	02	1.21	362	08	2.20
5	Aug 10	192	03	1.56	166	03	1.80	358	06	1.67
6	Sept 10	205	08	3.90	170	04	2.35	375	12	3.2
7	Oct 10	191	05	2.61	164	03	1.82	355	08	2.25
8	Nov 10	184	01	0.54	175	02	1.14	359	03	0.83
9	Dec 10	208	04	1.92	172	02	1.16	380	06	1.57
10	Jan 11	204	02	0.98	171	03	1.75	375	05	1.33
11	Feb 11	202	07	3.46	178	04	2.24	380	11	2.89
12	Mar 11	206	10	4.85	176	03	1.70	382	13	3.40
Total				2.55			1.86			2.24

Table 7: indicates that during the reporting period on average 2.24 percent children detected as growth faltered.

Table 8: Severely malnourished in children less than one year

Sr. No.	Month	Proportion Severely Malnourished Children								
		Male			Female			Total M+F		
		W	SM	%	W	SM	%	W	SM	%
1	April 10	189	00	0.00	154	01	0.64	343	01	0.29
2	May 10	207	03	1.44	149	01	0.67	356	04	1.12
3	June 10	201	02	0.99	148	02	1.35	349	04	1.14
4	July 10	198	03	1.51	164	03	1.82	362	06	1.65
5	Aug 10	192	00	0.00	166	00	0.00	358	00	0.00
6	Sept 10	205	02	0.97	170	01	0.58	375	03	0.8
7	Oct 10	191	00	0.00	164	04	2.43	355	04	1.12
8	Nov 10	184	02	1.08	175	02	1.14	359	04	1.11
9	Dec 10	208	04	2.40	172	03	1.74	380	07	1.84
10	Jan 11	204	05	2.045	171	02	1.16	375	07	1.86
11	Feb 11	202	04	1.98	178	05	2.80	380	09	2.36
12	Mar 11	206	07	3.39	176	04	2.27	382	11	2.87
Average		198	3	1.51	166	3	1.8	365	5	1.37

Table 8: indicates that during the reporting period on an average 1.37 percent children were suffering from severe malnutrition.

6a. Health check-up of children less than six years in Anganwadis: (May - June 2010)

Health check-ups of children was organised in 24 villages of Nandar PHC. Following tables give the details of the children covered in the first round.

Table 9: Weight taken at the clinics of children less than six year of age

Month	No. of clinics held	Male			Female			Total		
		No.	Weighed	%	No.	Weighed	%	No.	Weighed	%
May 2010 to June 2010	31	2588	573	22.1	2143	507	23.7	4731	1080	22.8

Table 9: indicates that 22.8 percent children were weighed at the clinics conducted for children under-six years.

Table 10: Nutritional status of children less than six year of age

Age Group	Sex	Total	Nutritional Status									
			Normal		Grade I		Grade II		Grade III		Grade IV	
			No.	%	No.	%	No.	%	No.	%	No.	%
0-6 months	M	54	38	70.3	14	25.9	0	0	1	1.8	1	1.8
	F	46	26	56.5	15	32.6	3	6.5	2	4.3	0	0
6-12 months	M	76	35	46.0	29	38.1	10	13.1	2	2.6	0	0
	F	57	23	40.3	24	42.1	9	15.7	1	1.7	0	0
12-36 months	M	226	78	34.5	98	43.3	43	19.0	5	2.2	2	0.8
	F	203	73	35.9	76	37.4	46	22.6	8	3.9	0	0
> 36 months	M	217	65	29.9	88	40.5	51	23.5	10	4.6	3	1.3
	F	201	57	28.3	101	50.2	42	20.8	1	0.4	0	0
Total	M	573	215	37.5	230	40.1	104	18.1	18	3.1	6	1.0
	F	507	180	35.5	215	42.4	100	19.7	12	2.3	0	0
Grand Total		1080	395	36.5	445	41.2	204	18.8	30	2.7	6	0.5

Table 10: indicates that the nutritional status of children was as follows: 36.5 percent children were normal, 41.2 percent had Grade I malnutrition (mild) and 18.8 percent had Grade II malnutrition (moderate), 2.7 percent Grade III malnutrition (severe) and 0.5 percent Grade IV malnutrition (severe). There has been a measurable reduction in the prevalence of malnutrition with nutrition education and counselling at the household levels.

Table 11: Illnesses detected in children less than six years

Month	Total no. of children examined	Cases detected												
		URI		Diarrhoea		Dental		Vitamin A deficiency		Skin diseases		Other		Total
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
May 10	679	75	11.0	31	4.5	11	1.6	4	0.5	24	3.5	59	8.6	204
June 10	401	51	12.7	30	7.4	6	1.4	14	3.4	12	2.9	53	13.2	166
Total	1080	126	11.6	61	5.6	17	1.5	18	1.6	36	3.3	112	10.3	370

Table 11: indicates that 370 children were detected with illnesses. Out of 370 children detected with illnesses, 126 children had URI, 61 children had diarrhoea, 17 children had dental carries, 18 had vitamin A deficiencies, 36 had skin infections and 112 had other illnesses.

Table 12: Children treated and referred

Month	Total No. of Children Examined			No. of Children Treated			No. of Children Referred		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
May 2010	364	315	679	94	76	170	13	15	28
June 2010	209	192	401	87	69	156	7	5	12
Total	573	507	1080	181	145	326	20	20	40

Table 12: indicates that 1080 children were examined during the health check-up clinics at the Anganwadi. Out of 1080 children, 326 were treated and 40 referred for various illnesses. In four cases children had more than one complaint at the same time.

6b. Health check-up of children less than six years in Anganwadis: (January - March 2011)

Two rounds of health check-ups were organized in 23 villages of Nandar PHC.

Table 13: Weight taken at the clinics of children less than six years of age

Month	No. of clinics held	Male			Female			Total		
		Population	Weighed	%	Population	Weighed	%	Population	Weighed	%
May 2010 to June 2010	45	2564	844	32.9	2147	700	32.6	4711	1544	32.8

Table 13: indicates that 32.8 percent children were weighed at the clinics conducted for children less than six years.

Table 14: Nutritional status of children less than six years of age

Age Group	Sex	Total	Nutritional status									
			Normal		Grade I		Grade II		Grade III		Grade IV	
			No.	%	No.	%	No.	%	No.	%	No.	%
0-6 months	M	96	64	66.6	24	25.1	6	6.25	1	1.0	1	1.0
	F	71	56	78.8	9	12.6	4	5.63	1	1.4	1	1.4
6-12 months	M	98	52	53.0	31	31.6	11	11.2	4	4.0	0	0
	F	75	51	68	17	22.6	6	8.0	1	1.3	0	0
12-36 months	M	316	127	40.0	142	44.9	40	12.6	7	2.2	0	0
	F	252	100	39.6	111	44.0	33	13.0	7	2.7	1	0.3
> 36 months	M	334	150	44.9	133	39.8	47	14.0	2	0.5	2	0.5
	F	302	108	35.7	134	44.3	53	17.5	7	2.3	0	0
Total	M	844	393	46.5	330	39.0	104	12.3	14	1.6	3	0.3
	F	700	315	45.0	271	38.7	96	13.7	16	2.2	2	0.2
Grand Total		1544	708	45.8	601	38.9	200	12.9	30	1.9	5	0.3

Table 14: indicates that the nutritional status of children was as follows: 45.8 percent children were normal, 38.9 percent had Grade I malnutrition (mild) and 12.9 percent had Grade II malnutrition (moderate), 1.9 percent had Grade III malnutrition (severe) and 0.3 percent had Grade IV malnutrition (severe). There has been a measurable reduction in the prevalence of malnutrition with nutrition education and counselling at the household levels.

Table 15: Illnesses detected in children less than six years

Month	Total no. of children examined	Cases detected												
		URI		Diarrhoea		Dental		Vitamin A deficiencies		Skin diseases		Other		Total
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Jan. 11	233	41	17.5	12	5.1	-	-	30	12.8	9	3.8	22	9.4	114
Feb. 11	736	115	15.6	24	3.2	23	3.1	59	8.0	12	1.6	130	17.6	363
Mar. 11	575	58	10.0	26	4.5	13	2.2	35	6.0	19	3.3	187	32.5	338
Total	1544	214	13.8	62	4.0	36	2.3	124	8.0	40	2.5	339	21.9	815

Table 15: indicates that 815 children were detected with illnesses. Out of these children, 214 children had URI, 62 children had diarrhoea, 36 children had dental carries, 124 had vitamin A deficiencies, 40 had skin infections and 339 had other illnesses.

Table 16: Children treated and referred

Month	Total No. of Children Examined			No. of Children Treated			No. of Children Referred		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Jan. 2011	122	111	233	49	48	97	04	05	09
Feb. 2011	414	322	736	179	117	296	25	21	46
Mar. 2011	308	267	575	156	111	267	13	12	25
Total	844	700	1544	384	276	660	42	38	80

Table 16: indicates that 1544 children were examined during the health check-up clinics at the Anganwadi. Out of 1544 children, 660 were treated and 80 referred for various illnesses. Fifty-three children had two complaints and eleven children had three complaints at the same time.

Working in the clinic for children less than 6 years in the villages under Nandar PHC

Case Study 1:

A male child 2 year old of banjara community, resident of village Thergaon, came to anganwadi with complaint of cough, fever, running nose since 3 days (history given by grandmother and was reliable).

To rule out any complication doctor asked whether patient has any ear discharge, any type of noise while breathing or fast breathing etc. She replied that there are no such complaints at present. But last time before two months he had similar complaint of cough, fever along with fast breathing. Then doctor asked what she did at that time, she replied that they kept a hot steel utensil around umbilicus to treat the episode as it was fourth time similar episode since birth. They did so because they were thinking that it is something related to the black magic and so child is getting repeated infections and it was an abdominal problem rather than a respiratory. Doctor couldn't imagine such method of treating Pneumonia. But all that doctor was able to do was counseling and explain that child is getting repeated infection because the child is malnourished and has not completed yet immunization.

Case Study 2:

A female child 3 year old resident of Salwadgaon came to anganwadi with complaint of not able to see properly during night time (history given by mother and was reliable).

Doctor examined the eye of baby and there was conjunctival xerosis in left eye and Bitot spot in the other. When doctor inquired about the Vitamin A immunization of the child, the government ANM sitting next to him replied that baby is given Vitamin A every 6 month. Though baby was immunized with Vitamin A regularly, there was severe Vitamin A deficiency in the child. Then doctor prescribed her:

Syrup- Vitamin A, 2 Lakh IU Stat
Syrup- Vitamin A, 2 lakh IU next day
Syrup- Vitamin A, 2 Lakh IU after 1 month.

(Above schedule of treating Xerophthalmia is given in Ghai's textbook of essential Pediatrics) Along with the above Vitamin deficiency there was grade 3 malnutrition so multivitamin syrup was prescribed as there may be some other vitamin deficiency also and counselling about diet was done. Patient was called for review after 2 month. After 2 month doctor was happy to see the baby responding well to the medicine and eating well.

HIV/AIDS

Annual Report 2010 to 2011

Institute of Health Management, Pachod has undertaken HIV /AIDS research 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 Nandar PHC area covering a population of 31,208 in 24 villages.

Project intervention:

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 centres, 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.

Project inputs:

The project activities undertaken during the reporting period of April 2010 to March 2011 are broadly categorized under the following heads:

A) Behaviour Change Communication (BCC)

- IPC during home visits
- Village Health, Nutrition, Water Supply and Sanitation Committees' meetings
- Youth meetings
- Men's meetings
- Women's meetings
- Information centres

B) Surveillance, Primary level care, referral and support

- Surveillance
- Maternal health clinics
- RTI, STI clinics
- VCTC clinics
- PPTCT clinics
- Community based access to condoms
- Linking PLHAs to ART centres and positive peoples' network in Aurangabad
- Care and support to PLHA

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 VHSC (Village Health, Nutrition, Water Supply and Sanitation Committees) and Women on a monthly basis and with Youth once in two months basis. The topics for the village level meetings were decided with the target groups. There is fixed schedule for group meetings.

Subjects discussed during meetings.

Sr. No.	Month	Subject
1	April 10	Anatomy and physiology of reproductive system
2	May 10	Antenatal care
3	June 10	Birth preparation and importance of hospital delivery
4	July 10	Care of new born
5	Aug 10	Care of low birth weight baby
6	Sept 10	Management of cold, cough and pneumonia in less than 5 year child.
7	Oct 10	Why and when HIV testing?
8	Nov 10	Prevention of Parent to Child Transmission of HIV
9	Dec 10	Meetings with mothers in law about Life Skills classes for the Married Adolescent Girls
10	Jan 11	Reproductive tract infection: signs and symptoms, check-up, treatment and prevention.
11	Feb 11	Menstrual hygiene
12	March 11	Prevention of Parent to Child Transmission of HIV

Table: 1 Village level meetings of VHSC (Village Health, Nutrition, Water and Sanitation Committees) conducted by social workers.

Sr. No.	Month	VHSC Meetings			Attendance in the meetings		
		Expected	Held	%	Expected	Attended	%
1	April 10	21	21	100	185	110	59.5
2	May 10	21	21	100	185	113	61.1
3	June 10	21	21	100	185	108	58.4
4	July 10	21	21	100	185	97	52.4
5	Aug 10	21	21	100	185	99	53.5
6	Sept 10	21	21	100	185	104	56.2
7	Oct 10	21	18	85.7	161	76	47.2
8	Nov 10	21	20	95.2	178	117	65.7
9	Dec 10	21	21	100	185	92	49.7
10	Jan 11	21	20	95.2	178	89	50.0
11	Feb 11	21	18	85.7	161	74	46.0
12	March 11	21	16	76.2	142	54	38.0
Average		21	19.9	94.8	176.3	94.4	53.1

Table 1 indicates that during the reporting period the coverage of VHSCs (Village Health, Nutrition, Water and Sanitation Committees) meetings is 95 percent. In which, on an average 53 percent VHSC members attended the meetings.

Table: 2 Village level meetings of Men conducted by male social workers

Sr. No.	Month	Group Meetings			Attendance in the meetings		
		Expected	Held	%	Expected	Attended	%
1	April 10	38	38	100	760	671	88.3
2	May 10	38	38	100	760	606	79.7
3	June 10	19	17	89.5	340	277	81.5
Average		31.7	31	96.5	620	518	83.2

Table 2 indicates that during the reporting period the coverage of group meetings conducted for men is 96.5 percent. On an average attendance of the men for the meetings was 83.2 percent. Meeting with men were discontinued after June 10.

Table: 3 Village level meetings of youth conducted by male social workers

Sr. No.	Month	Group Meetings			Attendance in the meetings		
		Expected	Held	%	Expected	Attended	%
1	April 10	38	38	100	760	621	81.7
2	May 10	38	38	100	760	608	80.0
3	June 10	39	38	97.4	760	616	81.9
4	July 10	20	11	55.0	220	188	85.5
5	Aug 10	19	19	100	380	316	83.2
6	Sept 10	20	15	75.0	300	243	81.0
7	Oct 10	19	4	21.1	80	73	91.3
8	Nov 10	20	16	80.0	320	273	85.3
9	Dec 10	19	12	63.2	240	208	86.7
10	Jan 11	20	15	75.0	300	240	80.0
11	Feb 11	19	13	68.4	260	220	84.6
12	March 11	20	11	55.0	220	187	85.0
Average		24.3	19.2	74.2	383.3	316.1	83.9

After June 10 youth meetings were conducted once in two months in every village. Table 3 indicates that during the reporting period the coverage of youth meetings is 74.2 percent. On an average 83.9 percent youth attended the meetings.

Table: 4 Village level meetings of women conducted by female social workers

Sr. No.	Month	Group Meetings			Attendance in the meetings		
		Expected	Held	%	Expected	Attended	%
1	April 10	38	26	68.4	520	271	52.1
2	May 10	43	34	79.1	680	370	54.4
3	June 10	44	38	86.4	760	408	53.7
4	July 10	38	21	55.3	420	232	55.2
5	Aug 10	40	32	80.0	640	331	51.7
6	Sept 10	38	32	84.2	640	353	55.2
7	Oct 10	47	29	61.7	580	282	48.6
8	Nov 10	3	3	100	60	31	51.7
9	Dec 10	38	26	68.4	520	186	35.8
10	Jan 11	38	26	68.4	520	274	52.7
11	Feb 11	42	41	97.6	820	449	54.8
12	March 11	35	33	94.3	660	355	53.8
Average		37	28.4	78.7	568.3	295.2	51.6

Table 4 indicates that during the reporting period the coverage of women's meetings is 78.3 percent. On an average 51.6 percent women below the age of 25 years attended the meetings.

Table: 5 Household visits coverage, April 2010 to March 2011

Sr. No.	Month	Household visits		
		Expected	Actual	%
1	April 10	4425	4425	100
2	May 10	4425	4425	100
3	June 10	4425	4425	100
4	July 10	4425	4425	100
5	Aug 10	4425	4425	100
6	Sept 10	4425	4377	98.9
7	Oct 10	4425	4425	100
8	Nov 10	4425	4259	96.2
9	Dec 10	4425	4425	100
10	Jan 11	4425	4361	98.6
11	Feb 11	4425	4369	98.7
12	March 11	4425	4425	100
Average				99.4

Table 5 indicates that during the reporting period on an average 99.4 percent household visits were conducted by community organizers for monthly surveillance and Inter Personal Communication (IPC) and counseling.

Information Centres

Every village has one (in larger villages more than one) information centre for providing information and reading material to the community. Peer educators run the information centres. The peer educators (male and female) are trained by IHMP. These peer educators are given posters, booklets and other reading materials.

Table: 6 Information Centre

Sr. No.	Month	information centre expected to function	Information centre functioned	Follow up to information centre
1	April 10	37	36	34
2	May 10	37	37	36
3	June 10	36	36	32
4	July 10	36	35	35
5	Aug 10	36	36	36
6	Sept 10	36	36	36
7	Oct 10	36	36	36
8	Nov 10	36	36	35
9	Dec 10	36	36	36
10	Jan 11	36	36	27
11	Feb 11	36	36	25
12	March 11	36	36	28
Total		434	432	396

Table 6 indicates that during the reporting year on average 36 information centres functioned every month. Information centre were expected to be functional 434 times, and these functioned 432 times during the year (99 percent). 396 follow up visits were made to the information centres (91.0 percent).

Table: 7 Information Centres

Sr. No.	Month	Information centre functioning	Visits to information centre		
			Male	Female	Total
1	April 10	36	97	174	271
2	May 10	37	52	83	135
3	June 10	36	111	76	187
4	July 10	35	140	115	255
5	Aug 10	36	320	190	510
6	Sept 10	36	142	81	223
7	Oct 10	36	75	50	125
8	Nov 10	36	215	119	334
9	Dec 10	36	182	102	284
10	Jan 11	36	209	110	319
11	Feb 11	36	133	93	226
12	March 11	36	61	57	118
Total		432	1737	1250	2987

Table 7 indicates that, out of 2987 individuals, 1737 males and 1250 females visited the 432 times functional information centres during the year and have received information.

B) Care and services:

• Surveillance:

The project has established a community based surveillance system for early detection of health needs and for provision of primary health care services. The surveillance covers detection of reproductive health problems, family planning, menstrual surveillance and pregnancy status.

Table 5 indicates that during the reporting period on an average 99 percent household visits were conducted by community organisers for monthly surveillance.

• Provision of Antenatal services:

Antenatal service is provided by trained ANMs at the health post in every village. During these clinics ANMs conduct systematic head to toe examination and record the necessary information of all the pregnant women. ANMs ensure that all these women get iron folic acid tablets and TT injections. If ANMs detect any high-risk cases they refer them to the nearest PHC or hospital. ANMs give information about PPTCT to the pregnant women and refer them to the Integrated Counseling & Testing Centre (ICTC).

Table: 8 ANC Check up

Sr. No.	Month	Antenatal Clinics			ANC Examination		
		Expected	Actual	%	Expected	Actual	%
1	April 10	57	56	98.0	532	461	86.7
2	May 10	52	39	75.0	449	329	73.3
3	June 10	57	46	80.0	667	453	67.9
4	July 10	58	46	79.0	638	432	67.7
5	Aug 10	52	52	100.0	618	424	68.6
6	Sept 10	56	53	94.0	553	441	79.7
7	Oct 10	54	52	96.0	508	459	90.4
8	Nov 10	52	44	84.0	440	309	70.2
9	Dec 10	55	51	92.0	518	430	83.0
10	Jan 11	53	52	98.0	543	488	89.9
11	Feb 11	61	59	96.0	612	583	95.3
12	March 11	66	59	89.0	683	581	85.0
Total		673	609	90.1	6761	5390	79.8

Table 8 indicates that 90 percent of the planned antenatal clinics were conducted at the village level and 80 percent women received antenatal care during the reporting period.

- **Provision of condoms:**

Table: 9 Condoms distributed from Information centre through male and female peer educators.

Sr. No.	Month	Condom utilization					
		No. of Beneficiaries			No. of Condoms Distributed		
		Married	Unmarried	Total	Married	Unmarried	Total
1	April 10	36	4	40	210	20	230
2	May 10	24	2	26	185	10	195
3	June 10	28	5	33	140	25	165
4	July 10	28	3	31	140	15	155
5	Aug 10	32	3	35	160	15	175
6	Sept 10	30	2	32	150	10	160
7	Oct 10	30	4	34	130	20	150
8	Nov 10	22	4	26	110	20	130
9	Dec 10	23	4	27	115	20	135
Total		253	31	284	1340	155	1495

Table 9 indicates that during reporting period, 253 married men used 1340 condoms and 31 unmarried youth used 155 condoms.

RTI / STI services:

During surveillance CO identifies clients and sends them to the primary health care centre. In primary health care centre patients are examined and given necessary services. They are given advice and followed up in the next visit. If they don't respond to treatment then they are referred to nearest hospital for further management.

Table: 10: Utilization of RTI / STI services by women

Sr. No.	Month	Women with symptoms of RTIs	Women sought treatment on RTIs	Percent Women sought treatment for RTIs
1.	July 10	273	121	44.3
2.	Aug 10	449	195	43.4
3.	Sept 10	419	193	46.1
4.	Oct 10	382	187	49.0
5.	Nov 10	403	176	43.7
6.	Dec 10	365	191	52.3
7.	Jan 11	381	250	65.6
8.	Feb 11	391	230	58.8
9.	March 11	407	265	65.1
Average		386	201	52.0

Table 10 indicates that on an average 52 percent women sought treatment for RTIs. This proportion is comparatively higher than at baseline survey 2003.

Provision of RTI/STI services for men:

RTI / STI, ICTC clinic are conducted once a month at each sub-centre and in selected villages for men. Male supervisor during male and youth meeting identifies clients and brings them to the clinic. In these clinics patients are examined and given necessary services. They are given advice and followed up in the next visit. If they don't respond to treatment then they are referred to nearest hospital for further management.

Table: 11: Utilization of RTI / STI treatment at clinics by men

Sr. No.	Month	Clinic Held	Utilization of services at Male clinic				
			RTIs	STIs	Sexual problem	Other	Total
1.	April 10	17	0	0	0	19	19
2.	May 10	19	10	1	1	26	38
3.	June 10	23	0	1	0	5	6
4.	July 10	24	3	0	0	17	20
5.	Aug 10	25	0	2	2	61	65
6.	Sept 10	23	1	1	1	49	51
7.	Oct 10	23	1	1	0	19	21
8.	Nov 10	19	0	0	0	0	9
9.	Dec 10	18	0	3	0	13	16
10.	Jan 11	0	0	0	0	0	0
11.	Feb 11	0	0	0	0	0	0
12.	March 11	0	0	0	0	0	0
Total		191	15	9	4	209	245

Table 11 indicates that 191 RTI / STI male clinics were conducted at sub-centres and in selected villages, and 245 men benefited from these clinics for treatment of RTIs, STIs, sexual health and other problems.

Table: 12 Haemoglobin test done during RTI / STI clinics

Female: N=12gm+, Mild=10.0gm to 11.9gm, Moderate=8.0gm to 9.9gm, Severe= <8.0gm
Male: N=13gm+, Mild=11.0gm to 12.9gm, Moderate=9gm to 10.9gm, Severe= <9.0gm

Sr. No.	Month	Haemoglobin level				
		Normal	Mild	Moderate	Severe	Total
1	April 10	0	16	21	3	40
2	May 10	5	12	19	3	39
3	June 10	0	60	62	0	122
4	July 10	1	34	44	2	81
5	Aug 10	0	19	31	0	50
6	Sept 10	0	24	27	3	54
7	Oct 10	2	29	39	0	70
8	Nov 10	0	6	10	1	17
9	Dec 10	0	32	28	2	62
10	Jan 11	0	19	8	0	27
11	Feb 11	0	62	44	1	107
12	March 11	0	31	27	1	59
Total		8	344	360	16	728

Table 12 indicates that during the reporting period 728 hemoglobin tests were done at the village, sub-centre and primary health centre level during RTI / STI clinics. The results

indicate that 2.2 percent people were suffering from severe anemia. 47.2 percent were suffering from moderate anemia, 49.5 percent were suffering from mild anemia, and 1.1 percent had a normal level of hemoglobin

Table: 13: ICTC and PPTCT Coverage

Sr. No.	April 10 Mar. 11	Pre test counseling				HIV test done				Post test counseling			
		Male	Pregnant Women	Female	Total	Male	Pregnant Women	Female	Total	Male	Pregnant Women	Female	Total
1.	Apr. 10	9	40	1	50	9	40	1	50	4	38	1	43
2.	May 10	9	28	2	39	9	28	2	39	2	26	2	30
3.	June 10	11	114	9	134	11	114	9	134	4	91	9	104
4.	July 10	5	72	3	80	5	72	3	80	13	81	3	97
5.	Aug 10	36	48	1	95	18	48	1	67	13	34	1	48
6.	Sept 10	8	48	2	58	6	48	2	56	5	44	0	49
7.	Oct 10	16	64	6	86	12	64	6	82	11	58	6	75
8.	Nov 10	4	17	1	22	4	17	1	22	6	9	1	16
9.	Dec 10	5	61	1	67	5	61	1	67	4	45	1	50
10.	Jan 11	0	18	2	20	0	18	2	20	0	37	3	40
11.	Feb 11	11	104	3	118	11	104	3	118	4	67	2	73
12.	Mar 11	3	57	6	66	3	57	6	66	9	51	2	62
Total		117	671	37	835	93	671	37	801	75	581	31	687

Table 13 indicates that 835 individuals received pre-test counseling, for 801 individuals HIV test was done and 687 individuals received post-test counseling during the reporting period at the ICTC / PPTCT clinics conducted at sub-centre and in selected villages.

Care and Support to PLHA
Report of care and support activity

Sr. No.	Particular	Male	Male child	Total	Female	Female Child	Total	M + F total
1	No. of old PLHA	15	04	19	20	03	23	42
2	New detected PLHA	02	00	02	03	00	03	05
3	Total PLHA	17	04	21	23	03	26	47
4	PLHA died	01	00	01	01	00	01	02
5	Total PLHA for care and support service	17	04	21	23	03	26	47
6	PLHA regularly followed up	17	04	21	23	03	26	47
7	PLHA not responding for care and support service	07	02	09	06	00	06	15
8	No. of PLHA got CD4 done - first time	02	00	02	07	00	07	09
9	No. of CD4 tests done - First time	02	00	02	07	00	07	09
10	No. of PLHA got CD4 done - more than Two times	06	01	07	08	03	11	18
12	Second time and above CD4 done	13	01	14	20	07	27	41
13	Total no. of PLHA got CD4 done	08	01	09	15	03	18	27
14	Total no. of CD4 test done	15	01	16	27	07	34	50
15	PLHA are on ART	07	01	08	07	03	10	18
16	PLHA visited network office and community care centre.	03	01	04	08	00	08	12
17	PLHA migrated for work	01	01	02	01	00	00	03

The table above indicates that the total numbers of old PLHA are 42 of which are 19 males and 23 females. The newly detected PLHA are 5 with 2 males and 3 females. The proportion is relatively more in females. The total number of PLHA is 47 out of which 21 are males and 26 are females. One male and one female PLHA died in this reporting year.

The total number of PLHA for care and support are 47 (21 males and 26 females) and these are followed up regularly. The total number of PLHA not responding to care and support services are 15 (9 males and 6 females). The total number of times CD 4 count test done is 50 (16 times in male and 34 times in female). 18 people are on ART (8 males and 10 females). 12 patients are visiting the PLHA network office (4 males and 8 females).

Care and Support Services for Male PLHAs
April 2010 - March 2011

Sr. No.	Month	PLHA		No. of PLHA received care and support	Counseling		Treatment for opportunistic infections		PLHA Net work visit		Investigation for ART registration				ART received		Counselor's visit
		Old	New		No. of PLHA	No. of visits	No. of PLHA	No. of visits	No. of PLHA	No. of visits	Other investigation		CD4 test		No. of PLHA	No. of visits	
1	Apr-10	19	-	09	09	09	01	01	-	-	02	02	03	06	07	07	-
2	May-10	19	1 died	09	09	09	-	-	-	-	01	01	01	02	07	07	-
3	June-10	18	-	07	07	07	01	01	-	-	-	-	-	-	07	07	-
4	July-10	18	-	11	11	11	-	-	-	-	-	-	-	-	07	07	-
5	Aug-10	18	01	09	09	09	01	01	-	-	01	02	-	-	07	07	-
6	Sept-10	19	-	12	12	12	-	-	-	-	-	-	03	06	07	07	-
7	Oct-10	19	01	09	09	09	02	02	02	02	01	01	04	07	07	07	01
8	Nov-10	20	-	15	15	15	-	-	-	-	01	01	02	04	07	07	-
9	Dec-10	20	-	10	10	10	-	-	01	01	01	03	-	-	08	08	-
10	Jan-11	20	-	16	16	16	-	-	-	-	-	-	-	-	08	08	-
11	Feb-11	20	-	13	13	13	-	-	-	-	-	-	01	02	08	08	-
12	Mar-11	20	-	11	11	11	-	-	01	01	-	-	02	03	08	08	01
	Total		new 2 1 died	21	21	131	05	05	04	04	07	10	16	30	08	88	02

Care and Support Services for Female PLHAs
April 2010 - March 2011

Sr. No.	Month	PLHA		No. of PLHA received care and support	Counseling		Treatment for opportunistic infections		PLHA Net work visit		Investigation for ART registration				ART received		Counselor's visit
		Old	New		No. of PLHA	No. of visits	No. of PLHA	No. of visits	No. of PLHA	No. of visits	Other investigation		CD4 test		No. of PLHA	No. of visits	
1	Apr-10	23	01	10	10	10	-	-	-	-	02	04	04	08	07	07	00
2	May-10	24	-	10	10	10	02	02	-	-	01	02	02	04	07	07	01
3	June-10	24	-	11	11	14	02	02	-	-	-	-	03	06	07	07	01
4	July-10	24	01 died	08	08	09	-	-	-	-	-	-	01	02	07	07	01
5	Aug-10	23	-	12	12	13	-	-	-	-	-	-	05	10	007	07	01
6	Sept-10	23	-	08	08	09	-	-	02	02	-	-	02	04	07	07	01
7	Oct-10	23	02	09	09	15	-	-	02	02	01	03	03	06	08	10	01
8	Nov-10	25	-	08	08	10	-	-	-	-	01	03	03	06	08	08	01
9	Dec-10	25	-	10	10	12	-	-	-	-	-	-	05	10	10	14	01
10	Jan-11	25	-	11	11	14	-	-	-	-	-	-	0	0	10	10	00
11	Feb-11	25	-	10	10	14	-	-	03	03	-	-	05	10	10	10	01
12	Mar-11	25	-	13	13	21	02	02	01	01	-	-	01	02	10	10	01
	Total		New 31 died	26	26	151	06	06	08	08	05	12	34	68	10	104	10

Care and Support Services for Total PLHAs: April 2010 – March 2011

Sr. No.	Month	PLHA		No. of PLHA received care and support	Counseling		Treatment for opportunistic infections		PLHA Net work visit		Investigation for ART registration				ART received		Counselor's visit
		Old	New		No. of PLHA	No. of visits	No. of PLHA	No. of visits	No. of PLHA	No. of visits	Other investigation		CD4 test		No. of PLHA	No. of visits	
1	Apr-10	42	01	19	19	19	01	01	00	00	04	06	07	14	14	14	0
2	May-10	43	Died 01	19	19	19	02	02	00	00	02	03	03	06	14	14	01
3	June-10	42	-	18	18	21	03	03	00	00	00	00	03	06	14	14	01
4	July-10	42	Died 01	19	19	20	00	00	00	00	00	00	01	02	14	14	01
5	Aug-10	41	01	21	21	22	01	01	00	00	01	02	05	10	14	14	01
6	Sept-10	42	-	20	20	21	00	00	02	02	00	00	05	10	14	14	01
7	Oct-10	42	03	18	18	24	02	02	04	04	02	04	07	13	15	17	02
8	Nov-10	45	-	23	23	25	00	00	00	00	02	04	05	10	15	15	01
9	Dec-10	45	-	20	20	22	00	00	01	01	01	03	05	10	18	22	01
10	Jan-11	45	-	27	27	30	00	00	0	00	00	00	00	00	18	18	0
11	Feb-11	45	-	23	23	27	00	00	03	03	00	00	06	12	18	18	01
12	Mar-11	45	-	24	24	32	02	02	02	02	00	00	03	05	18	18	02
	Total		5 new 2 died	47	47	282	11	11	12	12	12	22	50	98	18	192	12

Case studies

Case study: 1

Name: Sunil (name changed)

Sunil is a 24 years old male, who tested positive in 2009 during RTI / STI camp at the village level. At first he refused to accept and denied his HIV status. He was disturbed and was thinking of committing suicide. After several interactions, IHMP counselor realized that Sunil was aware about his positive status even before he came to IHMP for testing. Sunil also mentioned that he had shared information about his being HIV positive with his brother and parents.

IHMP counselor motivated Sunil and accompanied him for pre-ART registration at the Government Medical College at Aurangabad. IHMP counselor also helped him to get all the required investigations & check ups done and got registered at the medical college. He was put on ART. Initially he had some adverse reaction with medicine. Then IHMP counselor took him to ART counselor and Network office for PLHAs in Aurangabad. There was regular follow up with him about his health status. He started taking medicine regularly and his health condition improved. His family supports him.

His friends used to ask him when he is planning to get married. Because of such questions from his friends and others, he used to feel depressed. Again, he visited IHMP counselor and discussed his problem. He was also interested in getting married. Counselor told him about the advantages, disadvantages, and what precautions he must take if he decided to get married during several interactions. He was taken to network office of PLHA, they counseled him again. After several rounds of counseling with him, he agreed to get married to a HIV positive girl.

Case study: 2

Name: Chaya (name changed)

She is a 25 years old female and has 4 years old boy. She was pregnant again. She used to come to rural hospital at Pachod for antenatal check ups. Her HIV testing was done and she was found to be positive. Her husband and son were also called for HIV test. Both tested positive.

Counselor at the rural hospital told them about IHMP's care and support work with the PLHAs. Both husband and wife visited IHMP and spoke to the counselor. Counselor counseled Chaya and her husband about the advantages and disadvantages of continuing with this pregnancy. She was taken to ART centre at Aurangabad. Doctor advised her to get abortion done. She agreed and got her abortion done. Later IHMP counselor helped them to get all the investigations and pre- ART registration done at the Government Medical College, Aurangabad. They have gone three times for the follow up and CD4 count since then.

Case study: 3

Name: Shivganga (name changed)

She is a widow and has a boy & a girl. Her husband died one year back. After the death of her husband, she realized that he was HIV positive. So she did her HIV test at the village level RTI clinic and was found to be positive. IHMP counselor helped her to get registered after all investigations at the ART centre of the Government Medical College, Aurangabad.

IHMP counselor also motivated her to get HIV test for her children done. On testing, her daughter was found to be positive. IHMP counselor helped Shivhanga to get her daughter's registration done at the ART centre. Her daughter needed ART and is taking medicine regularly. Her daughter is also getting nutrition supplement from the PLHA network office on monthly basis. Her daughter is now 13 years old. Her relatives are asking when she plans to get her daughter married. She visited IHMP and discussed her problem with the counselor. After counseling, she decided to continue her education and tell others that she is not interested in her marriage till she completes her education. Now Shivganga goes alone to the Government Medical College and brings medicines for her daughter regularly.

Urban Health Project

Activity Report - April 2010 to March 2011

Introduction:

Institute of Health Management Pachod has been working in the slums of Mundhwa and Ghorpadi area of Pune since 1998. The urban health project provides the services through a 'D' Type Health Post to a slum population of about 30,000 individuals.

The broad objective of the urban health project was to demonstrate innovations for ensuring effective access and utilisation of health services by the urban poor and empowering civil society in slum settings to ensure accountability of health providers. The key innovations which are demonstrated are;

- Monthly surveillance, micro-planning and monitoring of health needs by Urban Link Workers (ULWs) combined with outreach services to create effective linkages of health needs with primary, secondary and tertiary levels of health care.
- Need and situation specific BCC combined with a social norms approach.
- 'Vasti (Slum) Development Committees' empowered to demand health rights and monitor identification of health needs and services provided at all levels.

The specific objectives of the urban health program are;

- Demonstrate appropriate systems to improve access and utilisation of health services by the urban poor living in slums.
- Demonstrate a need and situation specific "Behaviour Change Communication" strategy to generate demand and modify health seeking and utilisation behaviours.
- Empowering Civil Society for generating demand for services and ensuring accountability of health providers and facilities.
- Designing and developing appropriate resources for a health care delivery system for the urban poor.

Section I: Activities Carried Out During April 2010 – March 2011

Following key activities were carried out during April 2010 – March 2011 through the urban health project.

1. Surveillance and Monitoring System: During the reporting period, existing surveillance system for maternal and reproductive health was reviewed with Urban Link

Workers (ULWs) and project staff, and necessary modifications were made to strengthen the surveillance and monitoring system. Modified surveillance register was pre-tested at the community level by the ULWs for two months and after that surveillance register was finalized. During the reporting period, a separate surveillance register for hypertension, diabetes, malaria and tuberculosis was designed, pre-tested and introduced. The modified surveillance system covers following broad areas;

- Maternal health
- Neonatal health
- Reproductive health – Reproductive tract infections
- Child health – Immunization, Diarrhoea, Fever, and ARI
- Malaria
- Tuberculosis
- Diabetes
- Hypertension

2. Complete Enumeration of the Project Area: Complete enumeration of the project area was carried out in the month of October 2010 through ULWs. A two-day orientation on how to collect the information and fill up the census form was given to the ULWs. A total of 5788 households were enumerated from 27 slums under project area. This information was used to update the lists of target population and also to set the benchmarks for the monitoring of the program.

3. Refresher Training of ULWs: A total of 27 ULWs participated in the refresher training organized by the IHMP. Following cognitive and practical skills were provided during the refresher training;

- Maternal and child health
- Reproductive tract infections
- Communicable and non communicable diseases
- How to fill up surveillance forms?
- How to prepare micro-planners for service provision?
- Linkage of clients to the primary level of health care
- Linkage of referrals to secondary and tertiary levels of care
- Preparation of monthly progress report (MPR)
- Interpretation of MPR

4. In-service Training: During the reporting period, 27 in-service training sessions were organized for the ULWs and project staff. Weekly in-service training was conducted from April to August 2010 and once in a month from September 2010. Following activities were carried out during the monthly in-service trainings;

- Preparation of MPRs
- Preparation of micro-planners

- Planning the activities i.e. primary level care, BCC group meetings, satellite clinics, etc.
- Review of the work done by ULWs
- Feedback and guidance by the project staff to the ULWs
- Distribution of honorarium to ULWs

5. Systems Development: During the reporting period, IHMP has designed, pre-tested and developed following materials for the urban project. Required copies of the material were provided to the ULWs.

- Micro-planners for ULWs
- Format for the Monthly Progress Report with guidelines
- BCC materials – Protocols for needs specific BCC
- Guidelines and materials for conducting BCC group meetings

6. Vasti Development Committees (VDCs): Twenty-five VDCs were functioning in the slums during the reporting period. An orientation program for newly nominated VDC members was organized. In which roles and responsibilities of VDC members and functions of VDCs were discussed.

For each slum area, it was planned that monthly VDC meeting to be conducted. A total of 316 VDC meetings were planned during the reporting period, of these 242 (76 %) meetings were conducted. Following issues were discussed during the meetings;

- Review of health status of the slum
- Review of work done by the ULWs
- Issues related to ration card and availability of the grains, kerosene etc. through the government fair price shop
- Health services provided by Pune Municipal Corporation
- Environment and sanitation issues
- Demand for ICDS centre at vasti level
- Discussion on Right to Information ACT and it's use for development

Four meetings of “Arogya Vikas Samanvya Samiti” were planned and carried out during the reporting period.

A one day workshop on “Right to Information (RTI) Act” was organized for VDC members, which was attended by sixty VDC members. Resource persons from “YASHADA” and Pune Municipal Corporation (PMC) were invited for the training. Following topics were covered during the workshop;

- What is RTI act?
- How to use RTI act?
- Follow ups for denial cases

- Orientation on how to fill up application forms to get information through RTI act
- Skills to write an application for RTI
- Orientation by officials of the Pune Municipal Corporation on various schemes implemented by PMC, and discussions on how the community members can apply and get the benefits from the schemes

7. Information Centers: Twenty-five information centers were established during the reporting period. These centers were run by vasti level volunteers. An orientation was organized for volunteers on functioning of the information centre. Reading materials for the centre was provided by the project on monthly basis.

8. Supportive Supervision by the Project Staff: Each supervisor was allotted 8-9 vasti's. To each slum, two visits in a month for the supervision were planned. A total of 589 visits for the supervision was planned during the reporting period, of these 473 (80.3 %) visits were done. Following activities were carried out by the supervisors during the supervision visits;

- **Review of project activities – inputs, outputs and quality**
- **Demonstration to the ULWs on – how to record information in the surveillance register and prepare micro-planners, how to provide needs specific BCC and conduct group meetings**
- **Observation of work being done by the ULWs and inputs on – Recording of information in the surveillance register and needs specific BCC given by the ULW**
- **Provision of primary health care services**
- **Community based monitoring through Vasti Development Committees (VDCs)**

9. Vasti Level Clinics Conducted by the Project ANMs: Project ANMs were conducting once in a month clinics at the Vasti level for providing primary level care & referral for maternal health, child health and reproductive health. A total of 322 clinics were planned and organized during the reporting period in the project area. On an average 205 pregnant mothers were examined each month.

10. BCC Group Meetings Conducted by the Project ANMs: A total of 185 BCC group meetings for women were conducted by the ANMs during September 2010 to March 2011. These meetings were attended by 2252 women from the vastis. In these meetings, participatory methods were used to provide information on maternal health, child health and reproductive health.

11. OPD at Mundhava Kutir Rugnalaya: A doctor was appointed to provide the OPD services at Kutir Rugnalaya, Mundwa. OPD services were initiated from November 2010 and 939 individuals from the project area received the services.

12. Vasti level Satellite Clinics: All the slums were divided into 3-4 clusters and satellite clinics were organized in centrally located one of the slums of the cluster. Project doctor provided services through satellite clinics, which were initiated from November 2010. The visiting doctor examined and treated, referrals sent by the project ANMs to the satellite clinics. During the reporting period, a total of 19 satellite clinics were organized and 626 patients were treated at the satellite clinics.

Section II: Service Provision and Coverage during April 2010 – March 2011

Table 1: Surveillance Coverage

Month	Reporting for Number of ULW areas	Number of registered eligible couples	Number of eligible couples visited	Percent of eligible couples visited
Apr – 10	27	3920	3541	90.3
May – 10	27	3849	3614	93.9
June – 10	26	3835	3665	95.6
July – 10	27	3787	3596	94.9
Aug – 10	27	3387	3042	89.8
Sept – 10	23	3717	3364	90.5
Oct – 10	25	3095	2686	90.0
Nov – 10	25	3997	3866	96.7
Dec –10	25	3102	2028	65.4
Jan – 11	24	2518	2325	92.3
Feb – 11	24	2546	2390	93.8
Mar – 11	22	2272	2125	93.5
Average	25	3335	3020	90.6

Table 1 indicates that on an average 90.6 percent of Eligible Couples (ECs) was covered by the monthly surveillance.

Table 2: Reported Symptoms of Reproductive Tract Infections (RTIs)

Month	Reporting for Number of ULW areas	Number of ECs visited	Number of ECs with reported symptoms of RTIs	Percent of ECs with reported symptoms of RTIs
Apr – 10	27	3541	102	02.9
May – 10	27	3614	85	02.4
June – 10	26	3665	85	02.3
July – 10	27	3596	74	02.0
Aug – 10	27	3042	72	02.3
Sept – 10	23	3364	94	03.9
Oct – 10	25	2686	58	02.1
Nov – 10	25	3866	82	02.1
Dec –10	25	2028	110	05.4
Jan – 11	24	2325	100	04.3
Feb –11	24	2390	122	05.1
Mar –11	22	2125	101	04.7
Average	25	3020	90	03.2

Table 2 indicates that average monthly prevalence of the reported symptoms of RTI was 3.2 percent.

Table 3: Reported Treatment Seeking for Reproductive Tract Infections (RTIs)

Month	Reporting for Number of ULW areas	Number of ECs visited	Number of ECs with reported symptoms of RTIs	Number of ECs sought treatment for RTIs	Percent of ECs sought treatment for RTIs
Apr – 10	27	3541	102	51	50.0
May – 10	27	3614	85	33	38.8
June – 10	26	3665	85	40	47.5
July – 10	27	3596	74	55	74.3
Aug – 10	27	3042	72	49	68.5
Sept – 10	23	3364	94	38	40.4
Oct – 10	25	2686	58	30	51.7
Nov – 10	25	3866	82	47	57.3
Dec –10	25	2028	110	62	56.4
Jan – 11	24	2325	100	47	47.0
Feb – 11	24	2390	122	79	64.7
Mar –11	22	2125	101	97	96.0
Average	25	3020	90	52	57.7

Table 3 indicates that the average proportion of women who sought treatment each month was 57.7 percent out of the women who had reported symptoms of RTIs.

Table 4: Reported Current Use of Family Planning Methods

Month	Reporting for Number of ULW areas	Currently non - pregnant ECs	ECs currently using any FP method	Percent of ECs currently using any FP method
Apr – 10	27	673	275	40.8
May – 10	27	752	334	44.4
June – 10	26	778	416	53.5
July – 10	27	844	353	41.8
Aug – 10	27	816	365	44.7
Sept – 10	23	888	390	43.9
Oct – 10	25	671	314	46.8
Nov – 10	25	954	396	41.5
Dec – 10	25	1076	320	29.7
Jan – 11	24	1246	362	29.0
Feb – 11	24	1315	378	28.7
Mar – 11	22	1274	345	27.1
Average	25	940	354	37.6

Table 4 indicates that the average proportion of ECs currently using any contraceptive methods was 37.6 percent.

Table 5: Reported Use of Family Planning Methods by Type of FP methods

Month	Reporting for Number of ULW areas	Currently non-pregnant ECs	ECs currently using oral pills		ECs currently using condoms		ECs currently using Copper T	
			No	%	No	%	No	%
Apr – 10	27	673	84	12.5	161	23.9	30	04.4
May – 10	27	752	96	12.7	204	27.1	34	04.5
June – 10	26	778	137	17.6	236	30.3	43	05.5
July – 10	27	844	125	14.8	198	23.4	30	03.5
Aug – 10	27	816	134	16.4	201	24.6	31	03.8
Sept – 10	23	888	182	20.5	240	27.0	32	03.6
Oct – 10	25	671	105	15.6	183	27.3	26	03.9
Nov – 10	25	954	131	13.7	228	23.8	37	03.9
Dec – 10	25	1076	92	08.5	214	19.9	12	01.1
Jan – 11	24	1246	117	09.49	224	17.9	21	01.7
Feb – 11	24	1315	117	08.9	239	17.4	22	01.7
Mar – 11	22	1274	108	08.5	214	16.8	23	01.8
Average	25	940	119	12.6	211	22.4	28	02.9

Table 5 indicates that the average proportion of ECs currently using oral pills was 12.6 percent, 22.4 percent ECs was currently using condoms and around 2.9 percent was currently using copper T for spacing.

Table 6: Reported Symptoms of Antenatal Complications

Month	Reporting for Number of ULW areas	Number of Currently pregnant mothers	Number of pregnant mothers with antenatal complications	Percent of pregnant mothers with antenatal complications
Apr – 10	27	161	16	09.9
May – 10	27	184	06	03.3
June – 10	26	274	09	03.3
July – 10	27	188	03	01.6
Aug – 10	27	187	06	03.2
Sept – 10	23	209	10	04.8
Oct – 10	25	167	08	04.8
Nov – 10	25	189	08	04.2
Dec – 10	25	191	06	03.1
Jan – 11	24	202	12	05.9
Feb – 11	24	239	14	05.8
Mar – 11	22	265	10	03.8
Average	25	205	09	04.4

Table 6 indicates that the average proportion of pregnant mothers reporting any one antenatal complication each month was 4.4 percent.

Table 7: HIV Testing during Pregnancy

Month	Reporting for Number of ULW areas	Number of Currently pregnant mothers	Number of pregnant mothers tested for HIV	Percent of pregnant mothers tested for HIV
Apr – 10	27	161	23	14.3
May – 10	27	184	42	22.8
June – 10	26	274	64	23.3
July – 10	27	188	46	24.5
Aug – 10	27	187	32	17.1
Sept – 10	23	209	31	14.8
Oct 10	25	167	28	16.8
Nov 10	25	189	46	24.3
Dec – 10	25	191	53	27.7
Jan - 11	24	202	48	23.8
Feb – 11	24	239	52	21.7
Mar – 11	22	265	46	17.3
Average	25	205	42	20.5

Table 7 indicates that the average proportion of pregnant mothers who had undergone an HIV test each month was 20.5 percent.

Table 8: Reported Symptoms of Post Natal Complications

Month	Reporting for Number of ULW areas	Number of Post natal mothers visited by ULW at home	Number of mothers with symptoms of post natal complications	Percent of mothers with symptoms of post natal complications
Apr – 10	27	15	10	66.7
May – 10	27	51	20	39.2
June – 10	26	13	03	23.1
July - 10	27	27	05	18.5
Aug – 10	27	10	03	30.0
Sept – 10	23	36	00	00.0
Oct – 10	25	38	00	00.0
Nov –10	25	32	00	00.0
Dec –10	25	44	00	00.0
Jan – 11	24	38	02	05.3
Feb –11	24	35	00	00.0
Mar –11	22	23	04	17.4
Average	25	30	04	13.3

Table 8 indicates that the average monthly prevalence of women reporting post natal complications was 13.3 percent.

Table 9: Reported Prevalence of Diarrhoea among Children Under-Three Years of Age

Month	Reporting for Number of ULW areas	Number of children under-three years of age	Number of under- three children visited by the ULW	Number of under- three children with symptoms of diarrhoea	Prevalence of diarrhoea among children under-three years of age
Apr – 10	27	931	784	74	09.4
May – 10	27	885	678	62	09.1
June – 10	26	927	837	98	11.7
July – 10	27	1100	1027	42	04.1
Aug – 10	27	1157	1078	113	10.5
Sept – 10	23	647	576	58	10.1
Oct – 10	25	602	495	45	09.1
Nov – 10	25	806	709	60	08.5
Dec – 10	25	791	590	56	09.5
Jan – 11	24	843	703	58	08.2
Feb – 11	24	919	817	64	07.8
Mar –11	22	878	835	65	07.8
Average	25	874	761	66	08.6

Table 9 indicates that the average reported monthly prevalence of diarrhoea among children under- three years of age was 8.6 percent.

Table 10: Reported Treatment Seeking for Symptoms of Diarrhoea

Month	Reporting for Number of ULW areas	Number of under-three children with symptoms of diarrhoea	Treatment sought for the number of under- three children with diarrhoea	Treatment sought for percent of under- three children with diarrhoea
Apr – 10	27	74	72	97.3
May – 10	27	62	59	95.2
June – 10	26	98	88	89.8
July – 10	27	42	42	100.0
Aug – 10	27	113	109	96.5
Sept – 10	23	58	58	100.0
Oct – 10	25	45	42	93.3
Nov – 10	25	60	58	96.7
Dec – 10	25	56	56	100.0
Jan – 11	24	58	56	96.6
Feb – 11	24	64	61	95.3
Mar –11	22	65	56	86.2
Average	25	66	63	95.5

Table 10 indicates that treatment sought for the average proportion of under- three children with symptoms of diarrhoea each month was 95.5 percent.

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

Month	Reporting for Number of ULW areas	Number of under- three children visited by the ULW	Number of under- three children with symptoms of ARI	Prevalence of ARI among under-three children
Apr – 10	27	784	169	21.6
May – 10	27	678	155	22.9
June – 10	26	837	187	22.3
July – 10	27	1027	255	24.8
Aug – 10	27	1078	352	32.6
Sept – 10	23	576	280	48.6
Oct – 10	25	495	145	29.3
Nov – 10	25	709	90	12.7
Dec –10	25	590	143	24.2
Jan – 11	24	703	215	30.5
Feb –11	24	817	193	23.6
Mar –11	22	835	148	17.7
Average	25	761	194	25.9

Table 11 indicates that the average reported monthly prevalence of ARI among children under-three years of age was 25.9 percent.

Table 12: Reported Treatment Seeking for ARI

Month	Reporting for Number of ULW areas	Number of under-three children with symptoms of ARI	Treatment sought for number of under-three children with ARI	Treatment sought for percent of children with ARI
Apr – 10	27	169	135	79.9
May – 10	27	155	98	63.2
June – 10	26	187	165	88.2
July – 10	27	255	205	80.4
Aug – 10	27	352	272	77.3
Sept – 10	23	280	213	76.1
Oct – 10	25	145	133	91.7
Nov – 10	25	90	81	90.0
Dec – 10	25	143	137	95.8
Jan – 11	24	215	205	95.3
Feb – 11	24	193	142	73.6
Mar – 11	22	148	120	81.1
Average	25	194	159	81.9

Table 12 indicates that the average proportion of children with symptoms of ARI who had sought treatment was 81.9 percent.

Table 13: Reported Treatment Seeking for Symptoms of Pneumonia

Month	Reporting for Number of ULW areas	Number of under-three children with symptoms of pneumonia	Treatment sought for number of under- three children with pneumonia	Treatment sought for percent of under- three children with pneumonia
Apr – 10	27	50	50	100.0
May – 10	27	22	22	100.0
June – 10	26	22	20	90.0
July – 10	27	18	15	83.3
Aug – 10	27	15	11	73.3
Sept – 10	23	03	03	100.0
Oct – 10	25	03	03	100.0
Nov – 10	25	06	06	100.0
Dec – 10	25	05	05	100.0
Jan – 11	24	03	03	100.0
Feb – 11	24	05	05	100.0
Mar – 11	22	03	03	100.0
Average	25	13	12	92.3

Table 13 indicates that the average reported prevalence of pneumonia among children under-three years of age was 1.7 percent. Treatment sought for the average proportion of under- three children with symptoms of pneumonia was 92.3 percent.

1. Problems with Public Distribution System (PDS) in 5 vastis;

In five vastis (Panchsheel Nagar I & II, Gawaliwada, Rajiv Gandhi Nagar and Milind Nagar) where the programme is being implemented (i.e., the project area), communities have been facing problems in accessing their monthly household quota of food grains and kerosene. Also, they have been experiencing rude behaviour on the part of the ration shop owner, whom they suspect is hoarding supplies, selling it at a higher price in the black market etc. The Vasti Development Committee, Panchsheel Nagar and members of the community took up the issue and conducted a survey in three of the above vastis, to understand the problem, to ascertain whether there was indeed any illegal hoarding on the part of the ration shop owners, to ascertain if there was diminished supply of food grains & other items etc. A report was prepared on the basis of this survey and submitted to the Food Distribution Office as well as the Zonal Officer, and they were asked to provide the following information under the 'Right to Information' Act (2005):

[illegible]

प्रती:

मा. आरोग्य विकास समिती
रुस्मिटर डोंफ देव्या मैनेजमेंट पावोड
पुणे सेक्टर अंनं ३२१/१२ ब्रारका रोड
-वरन नगर पुणे ४११०१४
फोन नं. २०२०६४८२३

विषय:- माहिती अधिकांश कावरां २००५ आणखे
मरिती आदर करुण बावतः

रांकी:- आपणास दिनांक १३/०८/२०१९ रोजीचा अर्ज

महोदय,

सोडवित् आर्मीनचे उपस्थित केल्या फुल्लार व्वाली ३ प्रमाण
माहिती आदर करुण बावतः

१) दोषपंडी भागामदेव एक पुरवठा निरीक्षण निष्पत्ती आहे.
२) प्रत्येक वर्तमानचे लेखणी विवेककरीत भेटी देणे बावतः.
उदित निश्चित केलने नाही.
३) तालुका वर्तमानेमा तपशील देणे आवश्यक नाही तथापि
मोठे म्हूत २०२० पाऊन प्रेकीणीय फवरेल व ३ खख धाव
डुकांतता (परवना धारकंना) पुरवठा निरासक योनी भेटी
दिलेल्या आहेत.

४) मुळा व धोरणधी भागाले एक लेखणीय डुकां चौवी संख्या
६ इतकी अलून कार्शत खल धाव डुकांभां का तपशील आदर
आसित् प्रमाण आहे:

अ. फ. १ ५२५०१ ७६ परवना धारकाले नाव.
१) ६/३७ जेवरलात पयरीणी (मुळा)
२) ६/३८ जालकोवार् पयरीणी (मुळा)

The Zonal Officer and the Food Distribution Officer were asked to interact with the communities regularly in order to understand the community's grievances

1. They were asked to provide information on the number of yellow ration cards in the community
2. The number of PDS inspectors in the Panchsheel Nagar, and the number of visits each of them have paid the community in the last one year; also the details of each of these visits and the points and issues taken up during the same.
3. A list of all the ration shops in Panchsheel Nagar.

4. Malfunctioning of Toilets; Shahu Vasti (Hadapsar Railway Station Slum); December 2010 to April 2011:



Toilets in Vasti

This slum is serviced by two toilet complexes – one for men and one for women. There are several problems with these toilets: they are at least 10 years old, they lack water and electric supply and more importantly, they get blocked. This last problem is due to the fact that women often throw sanitary pads into the toilets. The problem of blockage was getting so serious that the Vasti Development Committee decided to call a meeting to discuss the disposal of sanitary pads in the toilets. It was learnt, that women dispose off sanitary pads in the toilets as they are embarrassed to carry them (albeit wrapped in paper)

and dispose it in the dustbin outside. They are afraid people will see them and realize that they are menstruating. The Vasti Development Committee got the community to gather together to discuss what needed to be done to avert this inconvenience. The community decided that there was nothing to be done except to get people to throw their used sanitary pads in the garbage bin provided outside the toilet. To this end, the community decided that it would monitor itself, and levy checks on its members. If a choke up occurred, the toilet would be shut down and the whole community would pay the price, thus making it incumbent for people to monitor each other's behaviour. A committee was set up to monitor the community's behaviour in this regard. Likewise a collection was set up to fund the provision of a larger garbage bin. This is a good example of community mobilization for behaviour change and self governance and monitoring facilitated by a Vasti Development Committee.



**Women's toilet in Shahu Vasti: Choke-up
due to disposal of sanitary napkins**

5. Non-performance of medical officer; Bhim Nagar;

The medical officer at the Chhatrapati Shahu Maharaj clinic at Bhim Nagar had been neglecting his duties. Patients complained that the doctor wasn't coming in time, wasn't spending enough time at the clinic, and was rude to the patients. There were instances of patients being refused ANC and PNC check-ups and children being refused vaccinations. The Vasti Development Committee members along with some community elders decided to



Chhatrapati Shahu Maharaj clinic- Bhimnagar

meet up the medical officer. They decided that they would first speak to him, rather than go directly to his senior. The strategy worked. The medical office immediately became conciliatory and promised to redress the community's grievances. He also asked if the community could do something about the lack of sanitation in the environment in which the clinic was located. He shared with the Vasti Development Committee members the fact that the reason he left work early was because of the unbearable stench that arose from the nearby areas where people were urinating. It was found out that this area was frequented by young men who would come to play cards and drink, and would often use this spot to relieve themselves. The Vasti Development Committee members promised the medical officer that they would take up the issue. They spoke to the youth leaders, and felt that the youth needed counseling service for substance abuse (e.g. Alcohol, tobacco, mishri, mawa, pan, gutka etc.). The Vasti Development Committee, with assistance from IHMP arranged for an orientation program on substance dependence lead by experts from such organizations as Mukhtangan and Sarva Seva Sangh. It was decided at this orientation, that if the youth wanted on going counseling /therapy with professional therapists, it could be arranged for them. The youth not only ceased to use the premises of the clinic as a urinal, but they also got together and cleaned up.

6. Re-opening of Anganwadi; Aagwali Chawl, Ghorpadi;



Closure of Anganwadi

The Anganwadi Centre in this vasti had been functioning effectively for the past five years. However, by mid year 2010, the centre closed down abruptly. Some of the community elders as well as members of the Vasti Development Committee went to the Child Development Officer to enquire as to why this had happened. They were informed that the centre had been transferred to another vasti. Therefore members of the community would have to travel to this other vasti if they wanted to avail of ICDS services. They were informed that the demand for services. This decision

reason for this is that there was low demand for services. This decision had been taken by the Anganwadi field supervisor. This surprised the community members, since in their estimation many families depended on the AWC. The community decided to document their needs and present a case for re-opening the centre. They collected information on the number of families in the community with 1) Young children; 2) Lactating mothers; 3) Pregnant women; & 4) Adolescent girls. When the CDPO was presented with this information, she was surprised. She personally visited the site and found the situation in keeping with the community's report. She assured the community she would include re-opening of the anganwadi in the budget of the coming quarter.

Sure Start Project

Annual Report – January to December 2010

Introduction:

Sure Start Project is being implemented in seven cities of Maharashtra – Mumbai, Navi Mumbai, Pune, Solapur, Nanded, Malegaon and Nagpur by seven lead partners. The main aim of the project is to improve survival of mother and newborn through Behaviour Change Communication (BCC) for changing behaviors at the individual, household and community level and generating demand for the maternal and new born health services.

Institute of Health Management, Pachod (IHMP) is one of the cross site partners for the capacity building of trainers from all seven sites and all staff of three sites for the technical issues on maternal and newborn health, BCC and Management Information System.

Activities carried out by the IHMP team from January to December 2010.

Trainings:

A three day refresher training for supervisors was conducted by IHMP at the IHMP training centre. The training program was organized in two batches, since the number of participants was 50. Training for the first batch was conducted from 6th January to 8th January, 2010 and the second batch was conducted from 11th January to 13th January, 2010. Ms. Manisha Khale, Mr. G. Kulkarni, Mr. D.M. Chaudhary, Mr. S. Mohite and Ms. Shreya Manjrekar from IHMP facilitated the training program. Dr. Kranti Raymane and Mr. Jitendra Sawakar from PATH were also present for the first batch of training and facilitated some of the sessions. The training program was conducted for the supervisors of all the partners with the 4 main objectives of:

- Reinforcing the importance of supervision
 - Roles and responsibilities of the supervisor / functions of the supervisor
 - Conducting an analysis of 5A and 5B forms
 - Analyzing and interpreting data from MPR to give feedback to the workers
-
- A two and half day refresher training of the supervisors of Halo Medical Foundation was conducted at Solapur from 18th to 20th January, 2010. The training program was facilitated by Mr. G. Kulkarni and Ms. Shreya Manjrekar from IHMP.
 - A two-day refresher training of the supervisors of PCI, (Project Concern International) Pune and its collaborating partners was organized on the 27th and 28th January, 2010. Mr. G. Kulkarni from IHMP facilitated the session on MPR, clarified queries regarding MPR and use & analysis of 5A and 5B forms of all the participants on 28th January, 2010.

- Mr. G. Kulkarni and Mr. S. Mohite conducted a two-day training on the 3rd and 4th March 2010 at Malegaon for the Swaasthya team on BCC and MIS.

Workshops and Orientation Programs:

- Sixth sharing workshop was attended by Ms. Manisha Khale and Ms. Shreya Manjarekar from 9th – 11th February 2010 at Ratnagiri. Dr. A. Dyalchand was present only for the first day of the workshop and gave feedback on the presentations of the Peer Process Review.
- Mr. S. Mohite attended the workshop for the first batch of Community Health Volunteers at Panhala from 15th to 17th February 2010. Mr. G. Kulkarni attended the second batch of the workshop for Community Health Volunteers from 18th – 20th February 2010.
- Mr. S. Mohite participated in the Community Health Volunteers' workshop at Panhala from 8th to 10th March 2010.
- Orientation of the new staff was done about the common minimum package for the Sure Start Project. Also, orientation was given to the new staff regarding two research studies.
- Mr. G. Kulkarni conducted the refresher training for MIS on 24th and 25th June 2010 for the CHWs at Navi Mumbai. Mr. Nishant Chavan and Ms. Sonali Kokate participated in the refresher training.
- In July 2010 Orientation of new staff regarding MIS and BCC strategy was done.
- Mr S. Mohite and Mr Nishant Chavan participated in MIS review workshop on 5th to 7th July 2010.
- Ms. Manisha Khale and Dr. Naomi Patrao participated in the 7th sharing workshop at Igatpuri from 6th to 8th September 2010. Dr. A. Dyalchand facilitated the session on 'Resource Mobilisation- what next?' in the context of Sure Start, Project on the last day of the workshop.
- Attended review meeting at PATH Mumbai office for International Conference on Urban Health.

Documentation:

- Documentation of the peer process review of Society for Nutrition Education and Health Action (SNEHA), Sure Start Mumbai was done by Dr. Benazir Patil and Ms. Shreya Manjarekar at IHMP, Pune centre from 22nd to 24th January, 2010 and was submitted to PATH.

- Documentation of peer process review of Shri Samarth Shikshan Prasark Mandal (SSSPM), Sure Start Nanded was done by Ms. Manisha Khale and submitted to PATH.
- Peer process review reports for the SSSPM, Nanded and SNEHA, Mumbai were finalized after getting feed back at the sixth sharing workshop.
- Report of the sixth sharing workshop was finalized and sent to PATH
- Report of the refresher training conducted at Halo Medical Foundation, Solapur was finalized and sent to PATH.
- DTP work of the service register was finalized and sent for printing.
- Final report of the two-day training on BCC and MIS conducted at Malegaon was sent to PATH.
- Draft of the conceptual model for the BCC study to be undertaken at Nagpur was prepared.
- Minutes of the meeting regarding surveillance study at Navi Mumbai Municipal Corporation were prepared and sent to PATH.
- Abstracts for the study on the surveillance and BCC were prepared and sent to PATH.
- Report of two-day training held at Navi Mumbai for Community Health Workers was finalized and sent to PATH in August 2010.
- Research Protocol for Surveillance study at Navi Mumbai was sent to PATH in July 2010.
- Research Protocol for BCC study at Nagpur was finalized and sent to PATH in August 2010.
- Documentation of information collected through SWOT analysis was done in August 2010.
- Report of the 7th sharing workshop held at Igatpuri was finalized and sent to PATH.
- Information collected through Focus Group Discussions with arogyasakhi, Community Health Organizers and team leaders was documented in November 2010.
- In depth interview of Dr. Satish Gogulwar was documented in November 2010.

Research Studies:

- A one-day meeting was organized on the 27th January, 2010 at IHMP, Pune centre to discuss the research studies, which would be undertaken by IHMP. Dr. A. Dyalchand, Ms. Manisha Khale and Mr. G. Kulkarni from IHMP were present for the meeting. Dr. Benazir Patil, Dr. Kranti Raymane, Dr. Ashish Malekar, Mr. Jitendra Sawakar and Mr. Manoj Bhavsar from PATH attended the meeting.
- Conceptual framework for the study on surveillance to be undertaken at Navi Mumbai was prepared and this was discussed with the PATH team on 19th April 2010.
- Dr. A. Dyalchand and Mr. G. Kulkarni visited Navi Mumbai Municipal Corporation on 26th April 2010 to discuss the research design with the Sure Start, Navi Mumbai team. Sources for the secondary information needed for the study were also identified.
- Preliminary information on the Ahmi Amachya Arogya Sathi, Nagpur project was collected to start preparing the conceptual frame work for the BCC study.
- Ms. Manisha Khale visited Nagpur and had preliminary meeting with the Nagpur team on the research study on BCC which is to be undertaken.
- Ms. Manisha Khale participated in the meeting on end-line study on 1st and 2nd June 2010.
- Worked on further refining of the conceptual frame works of the studies on surveillance and BCC.
- SWOT analysis was conducted on 30th and 31st July 2010 with four different groups- Medical Officers, Community Health Workers, Link Workers, ANMs and Public Health Nurses. The information gathered from SWOT was used in finalizing tools for NMMC surveillance study.
- Preparations such as sampling, selection of investigators, pretesting and printing of the questionnaires were completed. Finally data collection at Navi Mumbai for surveillance study was done in the last week of August – first week of September 2010.
- Qualitative data collection at Nagpur such as FGDs of arogyasakhi, CHO and team leaders and in depth interview of Dr. Satish Gogulwar was conducted on 20th and 21st September 2010.
- In September 2010, logistics for the survey team were finalized with the AAAS team. Pretesting and finalization of the questionnaire was done. Information for the sampling frame for the BCC study was collected.

- Investigators were trained from the 28th to 30th September 2010 for BCC study, Nagpur.
- Structure for data entry of the NMMC data was prepared and orientation of data entry clerks was done in September 2010.
- In October 2010 data entry, cleaning, and primary data analysis of NMMC study was done.
- Data collection for BCC study, Nagpur was done from 1st to 8th October 2010.
- Orientation of data entry clerks, data entry, preliminary analysis for BCC study, Nagpur was done in October 2010.
- Power Point Presentations for surveillance study and BCC study were prepared for International Conference on Urban Health, in October 2010.
- In November 2010 further analysis, coding and entry of open ended questions for NMMC study was done.
- In November 2010 further analysis of data for BCC study was done.
- Listing and coding of the open ended questions of BCC stud was done in December 2010.
- In December 2010 the coded open ended questions of BCC study Nagpur were entered.

Miscellaneous :

- Mr. G. Kulkarni and Mr. D. M. Chaudhari visited Malegaon on 29th April 2010 to give feed back to Swaasthya team on how to analyze the collected information.
- Ms. Manisha Khale participated in Maharashtra Partner's meet on 12th May 2010.
- Meeting with Mr. Steve Davis, Director, PATH was held in August 2010, which was attended by Ms. Manisha Khale.

Study of Perceptions and Attitudes of Youth on Transition, Gender and Life Skills

International Planned Parenthood Federation (IPPF)

Introduction

International Planned Parenthood Federation (IPPF) is an organization that works in the area of sexual and reproductive rights of young people in 189 countries of the world. This study was conducted with the objective of gaining more information with regard to the knowledge and attitudes of young people from Maldives and Sri Lanka towards reproductive and sexual Health issues.

A self administered anonymous questionnaire was used to collect this information by encouraging the respondents to reflect on their emotions, feelings, and perceptions of risks and vulnerabilities related to their sexual and reproductive health. The questions in the tool were direct and indirect in nature and assessed the attitudes of the respondents.

Quantitative Analysis

Socio-demographic characteristics of the respondent

The study was conducted in two countries namely, Sri Lanka and Maldives. 200 respondents from each country were asked to fill a self administered, anonymous questionnaire. The mean age of the respondents was 23.3 years; half of the respondents were below 19 years of age and 34 percent were less than 24 years.

Of the respondents from Maldives, 60.5 percent were below 19 yrs of age, 9 percent were above 25 yrs of age and the rest between 20-24 yrs. The mean age of respondents from Maldives was 18.8 yrs. Of the Srilankan respondents, 40 percent were below 19 years of age, 22 percent were above 25 years and the rest between 20-24 years. The mean age of respondents from Srilanka was 21.8 yrs.

The sex distribution is 56 percent females and 44 percent males. More females were interviewed from Maldives (67 percent) as compared to Sri Lanka (45 percent). (Table 1)

Table 1: Socio-demographic characteristics of the respondent

Variable	Category	Maldives % (n=200)	Srilanka % (n=200)	Total % (n=400)
Current age	14-19	60.5	40.0	50.3
	20-24	30.5	38.0	34.2
	25 & above	09.0	22.0	15.5
	Mean	18.8	21.865	20.33
	SD	4.38	6.69	5.85
Sex	Male	33.0	54.5	43.8
	Female	67.0	45.5	56.2

The respondents were required to rank their perceptions and attitudes using a five point Likert scale.

Attitudes Related to Education

In this section the respondent's perceptions and attitudes towards school education were assessed through their responses to five statements.

A small proportion - 12.3 percent stated that school was boring, 30.4 percent did not find school boring while 23.3percent did not have any opinion on the issue. About half the students (48 percent) felt they gave of their best for school while 28.5 percent felt they put in some effort.

Almost 60.0 percent of the students stated that they were regular in submitting their homework (27.5 percent strongly agreed with the statement while 32 percent agreed somewhat, while 18.5 percent were neutral).

About two thirds of the students were proud of their school and cared for it (45 percent strongly agreed while 20.8 percent agreed somewhat, and 17 percent disagreed with the statement.

A similar proportion perceived books and magazines as a source of knowledge and pleasure (39.3 percent respondents strongly agreed and 24.3percent agreed somewhat; while a small proportion (7.5percent) did not feel so. (See table 2)

Table 2: Attitude related to education

Variable	Strongly disagree %	Somewhat disagree %	Neutral %	Somewhat agree %	Strongly agree %	Percent (n=400)
I usually feel studying at school boring	30.4	14.0	23.3	19.7	12.5	100.0
I work hard to do my best	03.8	06.0	13.7	28.5	48.0	100.0
I am regular at submitting homework	10.5	11.5	18.5	32.0	27.5	100.0
I care about my school & feel proud to be a part of it	11.7	05.3	17.3	20.8	45.0	100.0
I read reference books, magazines etc. for pleasure & also gaining knowledge	07.7	07.5	21.2	24.3	39.3	100.0

In order to prepare a composite index the five possible responses were given values ranging from 1 to 5. The median value was then ascertained and the respondents were then classified as having positive attitudes (greater than the median) or negative values (equal to or lesser than the median value).

As a result it is seen that 59 percent respondents have a positive attitude towards education while 41 percent displayed negative attitudes. A higher proportion of respondents from Sri Lanka (64 percent) have positive attitudes towards education as compared to respondents from Maldives (54 percent). Importantly, a higher proportion (53 percent) of younger respondents (below 19 years) have negative attitudes towards education as compared to older respondents (aged 20 years and above). There was no significant sex related difference in attitudes towards education. (See table 3)

Table 3: Attitudes related to education – Composite scale

Variable	Category	Attitude towards education		n	p value
		Negative %	Positive %		
Country	Maldives	46.0	54.0	200	0.033
	Srilanka	35.5	64.5	200	
Current age	14-19 years	52.7	47.3	201	0.000
	20+ years	28.6	71.4	199	
Sex	Male	45.1	54.9	175	0.115
	Female	37.3	62.7	225	
	All	40.8	59.2	400	

Hobbies and interest

In this section three attitudinal statements were presented to the respondents. They were asked to rate their interest and involvement in sports activities, social activities etc.

More than 61 percent of the respondents are perceive that they are actively involved in sports activities - 37.5 percent strongly agreed, 24 percent agreed somewhat while 7.7 percent strongly disagreed. 41.5 percent respondents reported that they enjoy watching movies and partying with friends, while 6.5 percent expressed a strong disagreement and 20.7 percent were neutral about it. 30.7 percent respondents reported that they do not like to stay out late or go to pubs while 37 percent felt it was normal for young people to do so (24 percent strongly agreed and 13 percent agreed somewhat). (See table 4)

Table 4: Hobbies and interest

Variable	Strongly disagree %	Somewhat disagree %	Neutral %	Somewhat agree %	Strongly agree %	Percent (n=400)
I am actively involved in sports and other related activities	07.7	08.8	22.0	24.0	37.5	100.0
I love partying and watching movies with friends	06.5	06.7	20.5	24.7	41.5	100.0
I don't mind attending late night parties and going to pubs, etc.	30.7	14.0	18.3	13.0	24.0	100.0

A composite index was prepared by giving values 1 to five to the five possible responses. The median value was ascertained and the respondents were classified as having positive attitude (greater than median) or negative values (equal to or lesser than median value).

About half of the respondents exhibit positive attitudes towards hobbies and other interests. There does not appear to be a significant difference in attitudes when analysed after categorisation by country or by age of respondent. However, more male respondents (60 percent) showed positive attitudes towards hobbies and interest as compared to female respondents (44 percent). (See table 5)

Table 5: Attitudes related to hobbies and interest – Composite scale

Variable	Category	Attitude towards hobbies and interest		n	p value
		Negative %	Positive %		
Country	Maldives	52.5	47.5	200	0.089
	Srilanka	44.0	56.0	200	
Current age	14-19 years	52.2	47.8	201	0.109
	20+ years	44.2	55.8	199	
Sex	Male	39.4	60.6	175	0.002
	Female	55.1	44.9	225	
	All	48.3	51.7	400	

Attitudes towards family

In this section thirteen attitudinal statements were presented to the respondents. They were asked about their perceptions of their family and the extent to which the respondent perceives receiving care and support during health related events, when personal problems occur and during conflict situations.

The vast majority (84.5 percent) of the respondents were of the opinion that their parents give them love and support (70.5 percent strongly agreed, 14 percent agreed somewhat) while 3.0 percent strongly disagreed. About 8 percent respondents stated that they do not get along with their parents while 66 percent respondents appear to have a good relationship with their parents (45.5 percent respondents reported that they strongly agree to the fact that they get along with their parents, 20.5 percent somewhat agree and 20 percent were neutral about it) (See table 6)

A large proportion of respondents (48.8 percent) reported good communication with their parents while 5.8 percent were of the opinion that their parents do not listen to them. Similarly, 63.7 percent perceived a strong sense of family support while 3.2 percent do not think their parents support them in adverse situations (See table 6). About 71 percent respondents said that their parents are interested in their movements and companions. (53 percent strongly agree, 18 percent agree somewhat and 5.3 percent deny being monitored.

A majority of respondents perceive that their families take care of their health (74 percent) while 1.2 percent respondents did not agree. Similarly, 73 percent respondents have a strong sense of security as they feel that they have three or more adults to look up to for support; but 5.5 percent respondents were in strong disagreement. (See table 6)

A larger number of respondents report being punished by their parents (47.8 percent) while 27.9 percent did not agree that they were punished. (See table 6)

Most of the respondents (62.3 percent) perceive their parents as good role models (being responsible and caring individuals) while only 1 percent do not see their parents as good role models. Most respondents agree to the fact that their parents stimulate them to give of their best while a small proportion (1.7 percent) strongly disagree. (See table 6)

As regards parental interest in homework and other school related activities 49.5 percent were in strong agreement while 5 percent were in strong disagreement that parents take adequate interest (See table 6)

Whereas 34 percent respondents strongly agreed that their parents assign them work that needs proper handling 5 percent strongly disagreed with this perception. (See table 6)

About 66 percent respondents perceive that their parents believe they will be successful in future, 2.5 percent respondents do not feel their parents think they will succeed and 12.7 percent responses were neutral. (See table 6)

Table 6: Attitudes related to family environment

Variable	Strongly disagree %	Somewhat disagree %	Neutral %	Somewhat agree %	Strongly agree %	Percent (n=400)
My parents give me love & support when I need it	3.0	3.5	09.0	14.0	70.5	100
I get along with my parents	08.0	06.0	20.0	20.5	45.5	100
My parents listen to me & we have lots of good conversations	05.8	05.5	17.5	22.5	48.8	100
In an adverse situation, my family is with me	03.7	05.5	12.3	14.7	63.7	100
My family takes care of my health needs	01.2	02.2	08.2	14.3	74.0	100
3 or more adults are there to support and help me	05.5	05.5	16.0	18.3	54.7	100
If I break one of my parents rules, I usually get punished	15.7	12.2	24.3	22.3	25.5	100
My parents inquire about where do I go & with whom I will be	05.3	06.0	17.7	18.0	53.0	100
My parents & other adults show responsible behavior & care for me	01.0	02.0	15.0	19.7	62.3	100
My parents push me to be the best I can be	01.7	03.0	15.8	20.5	59.0	100
My parents help me with my homework and go to events & meetings at my school	05.0	04.0	19.3	22.2	49.5	100
My parents usually assign me work which needs proper handling	05.2	06.2	24.3	30.3	34.0	100
My parents feel I will be a successful person in future	02.5	02.2	12.7	16.3	66.3	100

A composite index was developed for Attitudes related to family environment, as described earlier.

Out of all 400 respondents, 55 percent have a positive attitude towards their family. When sex differentials were analysed, it was found that more females showed positive attitudes (60 percent) as compared to males (49 percent). Age is not statistically associated with attitudes related to family. (See table 7)

Table 7: Attitudes related to family – Combined scale

Variable	Category	Attitude towards family		n	p value
		Negative %	Positive %		
Country	Maldives	49.5	50.5	200	0.089
	Srilanka	39.5	60.5	200	
Current age	14-19 years	44.8	52.2	201	0.109
	20+ years	41.2	58.8	199	
Sex	Male	50.3	49.7	175	0.002
	Female	40.0	60.0	225	
	All	44.5	55.5	400	

Attitudes towards environment

In this section eleven attitudinal statements were presented to the respondents and they were asked to rate them using the Likert type scale.

This set of questions explores the perceptions the respondent has of his/her friends, teachers and neighbours opinion and attitudes.

Even though a majority of respondents (65 percent) said that their teachers feel that they have good career prospects, one in four gave it a neutral score and one in ten respondents reported that their teachers did not feel they will have a good career.

A majority of the respondents (68 percent) said that those who know them perceive them as being capable and competent, 23 percent said they were not sure and 7.8 percent respondents do not think their acquaintances have a good opinion of them.

About 60 percent respondents felt their schools has clear rules as to what students can or cannot do, 27 percent were not sure; 12 percent felt their school did not have clear rules.

While enquiring about their neighbourhood, 9 percent respondents said that they do not feel safe in their neighbourhood or own homes, 10 percent respondents do not think their neighbours would bother if they were committing any wrong-doing and 16 percent do not think people in the neighbourhood care about them.

Even though 75 percent said their parents and neighbours perceive them as responsible and capable of performing a task successfully, 17 percent were not sure, while 7 percent respondents do not think their parents and neighbours consider them responsible or capable. Similarly 8 percent respondents felt that their acquaintances do not perceive them as competent and capable individuals.

About 68 percent respondents feel that their friends are good role models, a considerable proportion (11.2 percent) do not perceive that their friends provide guidance or model positive behaviour.

Upon questioning about their teachers and school environment, 12 percent do not think the school places adequate limits on the students behaviours, 7 percent do not think their teachers provide enough guidance and encouragement and 10 percent do not think the teachers have a high opinion of their prospects. In fact 12.8 percent do not think their teachers care about them at all

Table 8: Attitudes related to environment

Variable	Strongly disagree %	Somewhat disagree %	Neutral %	Somewhat agree %	Strongly agree %	Percent (n=400)
My teachers feel I will have a good career	04.2	06.0	24.5	23.0	42.3	100
Those who know me see me as a capable and competent individual	02.8	05.0	23.2	30.2	38.8	100
My school has clear rules regarding what students can & cannot do	05.3	07.2	27.0	23.3	37.3	100
If one of my neighbors saw me do something wrong, he/she would tell my parents	05.7	04.3	20.7	22.3	47.0	100
My friends guide me & model positive Behavior	04.7	06.5	21.0	33.3	34.5	100
My teachers guide me & encourage me to do well	02.3	04.5	17.3	25.7	50.3	100
In my neighborhood, there are people who care about me	09.2	07.2	23.0	30.3	30.3	100
My teachers really care about me	04.7	08.0	24.0	30.0	33.3	100
I feel safe at my home, school and neighborhood	03.2	06.5	20.5	22.5	47.3	100
My neighbors sometimes ask me to help them with some work	13.0	06.0	17.0	29.7	34.3	100
My parents and neighbors feel that I am responsible and capable enough to perform a task successfully	03.0	04.2	17.3	30.7	44.7	100

A composite index was developed for attitudes related to environment as described earlier.

About 59 percent respondents had a positive attitude towards their environment but a considerably large proportion of respondents (41 percent) reported negative attitudes.

In their attitude towards environment, there was a statistically significant difference between respondents from Maldives as compared to Srilanka. A higher proportion of respondents from Maldives (46 percent) had negative attitudes towards their environment as compared to respondents from Srilanka (35.5 percent).

Attitudes towards environment appear to be significantly associated with age as a higher proportion (52 percent) of younger respondents (age group 14-19 years) displayed negative attitudes as compared to the older respondents above 20 years (28 percent).

No significant difference is observed between male and female respondents. (See table 9)

Table 9: Attitudes related to environment – Combined scale

Variable	Category	Attitude towards environment		n	p value
		Negative %	Positive %		
Country	Maldives	46.0	54.0	200	0.033
	Srilanka	35.5	64.5	200	
Current age	14-19 years	52.7	47.3	201	0.000
	=>20 years	28.6	71.4	199	
Sex	Male	45.1	54.9	175	0.115
	Female	37.3	62.7	225	
	All	40.8	59.2	400	

Values

In this section eight attitudinal statements were asked to the respondents to assess their attitude towards other people, attitude towards work and taking responsibility of ones actions, belief in truth and ability to face consequences of ones beliefs and actions. They were asked to rate each statement using the Likert type scale.

About 88 percent respondents said that they care about other peoples feelings and 8 percent were not sure. Similarly 68 percent said they treat all people equally, whereas 26 percent were not sure. However a significant proportion do not have equitable attitudes towards people - 8 percent said that they do not treat all people equally, 3.7 percent said that they do not care about other's feelings and 3.9 percent do not believe that everybody has a right to good living.

A majority of respondents (81 percent) feel they have the courage of their convictions to believe in what is right even in the face of opposition, but 13.5 percent are not sure and a significantly large proportion (5.0 percent) accede that they to not having the courage of conviction to stand up for what is right, if opposed.

About 65 percent respondents said that they would tell the truth even if it affected them or their loved ones negatively, 23 were not so sure and 12 percent said they would not mind lying in situations that would affect them or their loved ones.

About 77 percent respondents said they know what is expected of them and they try and work towards it; 18 percent were not sure and 5 percent appear to be directionless as they do not know what is expected of them and cannot work towards it.

A large majority (81 percent) said they would accept the responsibility of their action even if they were to make a mistake, 13 percent were not so sure and about 6 percent respondents felt that they would not be able to accept responsibility for their actions.

Table 10: Values

Variable	Strongly disagree %	Somewhat disagree %	Neutral %	Somewhat agree %	Strongly agree %	Percent (n=400)
I care about other people's feelings	01.5	02.2	07.7	24.0	64.5	100
I treat all people equally	03.0	05.0	26.5	27.3	38.3	100
I believe that everybody has a right to good living	01.7	02.2	10.2	12.5	73.3	100
I believe what is right even if others are against me	01.3	03.7	13.5	28.2	53.2	100
I would tell the truth even if it would negatively effect me or my loved ones	06.5	05.0	22.5	30.5	35.5	100
I know what is expected from me and thus try to work towards it	01.2	03.5	17.7	34.2	43.2	100
I accept responsibilities for my actions when I make a mistake	02.0	04.2	13.0	25.7	55.0	100

A composite index was developed for values as described earlier.

There appears to be an almost equal distribution of respondents (52 percent that reported positive values and 48 percent reporting negative values). A higher proportion of younger respondents, less than 19 years, reported negative values (53 percent) as compared to 42 percent among the older age group above 20 years. More boys (56 percent) reported negative values as compared to girls (41 percent).

Those who showed positive attitude towards education reported positive values. Reported values are significantly associated with attitude towards family. Those who had a positive attitude towards family also had positive values. Values are also significantly associated with attitude towards environment. Those who had positive attitude towards environment also had positive values. (See table 11)

Table 11: Combined Index – Values

Variable	Category	Attitude towards values		n	p value
		Negative %	Positive %		
Country	Maldives	50.0	50.0	200	0.423
	Srilanka	46.0	54.0	200	
Current age	14-19	53.2	46.8	201	0.035
	20+	42.7	57.3	199	
Sex	Male	56.0	44.0	175	0.005
	Female	41.8	58.2	225	
Attitudes towards education	Negative	62.6	37.4	163	0.000
	Positive	38.0	62.0	237	
Attitude towards family	Negative	65.7	34.3	178	0.000
	Positive	33.8	66.2	222	
Attitude towards environment	Negative	64.3	35.7	196	0.000
	Positive	32.3	67.7	204	
	All	48.0	52.0	400	

Negotiation skills

In this section, 16 attitudinal statements assessed the respondent's negotiation skills.

When asked about their attitudes toward social drinking and smoking, a large proportion (59 percent) said they would not like to indulge in social drinking and smoking, 19 percent were not sure and 22 percent said they would indulge in social drinking and smoking. About 56 percent respondents said they would be able to resist peer pressure to smoke or drink, 24 percent were not sure of their ability to resist and 20 percent felt that they would not be able to restrain themselves.

Half the respondents said that they evaluate the pros and cons of different alternatives before deciding or planning, but 42 percent were not sure they would do so and about 7 percent said they do not evaluate the effects of their actions before they take them.

A majority of respondents (67 percent) feel they have good communication skills and are able to persuade others to go along with their point of view, but 29 percent are not sure they have this ability and 4 percent feel they cannot persuade others. About 63 percent feel that they have adequate negotiation skills to lead a group by taking others along, 31 percent are not sure of this ability and 7 percent feel they lack such negotiation skills.

Similarly, 36 percent are not sure that they have the ability to resolve conflicts non-violently by discussing with others, whereas a fair proportion of students appear to lack negotiation skills in that 8 percent said that they do not have the ability to settle issues non-violently and by discussion.

A majority of respondents (65 percent) feel that they know how to plan their time and resources so as to make the best use of them, a substantial proportion (27 percent) do not know if they have this ability and a significant proportion (8 percent) said that they do not know how to manage their time and resources.

Whereas 60 percent respondents said that they enjoy being with people of a different race or ethnic group, 32 percent were not sure and a significant proportion (8 percent) said that they are not comfortable with persons from a different ethnic background.

About 71 percent respondents feel they have the ability to say 'No' for any actions that are unsuitable for their age, 19 percent are not sure and 10 percent feel they cannot say no even if they know what has been asked is wrong or unsuitable for their age.

About 21 percent are not sure if they can decide about their future and other important aspects of life whereas 5 percent feel they simply do not have that ability.

A significant proportion of respondents do not think they have agency (control over their lives) in that 21 percent are not sure and 5 percent respondents do not think they can decide about their future. Further, 31 percent are not sure and 6 percent do not think they have a say in decisions that affect them. About 23 percent are not sure and 5 percent do not think they have the freedom to say what they feel.

Whereas 22 percent are not sure that they are glad of being what they are, 7 percent are apparently not glad of what they are. A large proportion (37 percent) said that they feel depressed and good for nothing, and 39 percent said that sometimes they do not do not feel their lives have any purpose. About 23 percent were not sure whether they would have a good life as adults and 7 percent were sure that when they became adults, they would not have a good life.

Table 12: Negotiation skills

Variable	Strongly disagree %	Somewhat disagree %	Neutral %	Somewhat agree %	Strongly agree %	Percent (n=400)
If it's a friends get together, I don't mind smoking or having alcohol	53.0	6.3	19.0	06.8	15.0	100
If my friends/relatives indulge in smoking and drug intake & force me for the same, I would restrain myself	15.0	05.0	24.0	08.8	47.3	100
I evaluate the pros & cons of different alternatives before deciding or planning	03.0	03.8	42.0	20.3	31.0	100
I can communicate my views & obtain agreements of others	01.3	03.0	29.0	34.8	32.0	100
I know how to plan my time & resources so as to make the best use of them	03.0	04.5	27.0	30.0	35.5	100
I enjoy being with people who are of a different race/ethnic group	03.3	05.0	31.5	29.0	31.3	100
I can negotiate/lead a group by taking others along	02.0	05.0	30.8	32.8	29.5	100
I can say 'no' if someone wants me to do things I know are wrong or not suitable for my age	05.3	05.0	18.5	14.5	56.8	100
I try to resolve conflicts non-violently by discussing with others	02.3	05.8	36.3	20.5	35.3	100
I can decide about my future & other important aspects of life	02.3	02.8	21.3	26.3	47.5	100
I have a say in decisions affecting me	01.8	04.0	30.5	22.3	41.5	100

I have freedom of saying what I feel	02.3	04.8	23.0	17.3	52.8	100
All in all, I am glad of being what I am	02.0	05.0	22.0	18.5	52.5	100
I often feel depressed & good for nothing	24.8	12.3	23.3	16.8	13.0	100
Sometimes I feel my life has no purpose	25.5	13.8	26.3	17.8	16.8	100
When I am an adult, I'm sure I will have a good life	03.0	04.0	23.3	21.3	48.5	100

A composite index was developed as described earlier

An equal proportion of respondents appear to have high and low negotiation skills (51 percent high and 48.5 percent low).

Older respondents over 20 years of age display better negotiation skills compared to respondents aged 14-19 years.

No significant difference is observed in negotiation skills between male and female respondents.

Attitude toward education is associated with negotiation skills of the respondent. Respondents who showed positive attitude towards education have better negotiation skills (57 percent) as compared to respondents with negative attitudes towards education.

Respondents who have a positive attitude towards family have better negotiation skills as compared to respondents with negative attitudes towards family.

Respondents who showed a positive attitude towards their environment have better negotiation skills as compared to respondents with negative attitudes towards environment.

Respondents who have positive values also have better negotiation skills compared to respondents with negative values. (See table 13)

Table 13: Combined Index – Negotiation skills

Variable	Category	Negotiation skills		n	p value
		Low %	High %		
Country	Maldives	49.0	51.0	200	0.841
	Srilanka	48.0	52.0	200	
Current age	14-19 years	56.7	43.3	201	0.001
	=> 20 years	40.2	59.8	199	
Sex	Male	51.4	48.6	175	0.301
	Female	46.2	53.8	225	
Attitude toward education	Negative	57.7	42.3	163	0.002
	Positive	42.2	57.8	237	
Attitude toward family	Negative	60.7	39.3	178	0.000
	Positive	38.7	61.3	222	
Attitude toward environment	Negative	59.2	40.8	196	0.000
	Positive	38.2	61.8	204	
Values	Negative	60.9	39.1	192	0.000
	Positive	37.0	63.0	208	
	All	48.5	51.5	400	

NCCI /ESHA Activity Report:

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.

A. Update on '40 Pilot Sites' as on July 1st, 2011:

a) Church Life Sector:

To get the full value of the ESHA program in the Church Sector, a standard methodology for building HIV Awareness in Church Life was introduced:

One Session -Awareness building of Pastors in the region

One Session -Awareness building for Women's Fellowships in that church

One Session -Empowerment of Youth - and Peer Trainers programs- in that church

- For this PARC and KAP tools will be used [as 'pre' & 'post' questionnaires] to mirror the knowledge, fears and biases of each of these groups
- Wherever possible a Positive Person (PLWA) will speak- to allow their voice to be heard by the congregation.

b) Theology Sector:

A compulsory course on HIV/AIDS is being implemented in over fifty theological seminaries affiliated to Senate of Serampore University as of 2010-11. This is expected to ensure a programmatic approach for mainstreaming HIV in the Church life in India. It is expected that the Seminarians will go to the Churches in this country with a new understanding of HIV, better equipped in pastoral care and the healing ministry of the Church. In order to obtain data on how much this course has been valuable in the Seminary and to help it to be a cross cutting theme with other subjects, ESHA plans to have sessions for students and with faculty.

c) Education Sector:

A Standard Training Procedure for AIDS awareness and peer- training in schools is to be conducted in almost all Pilot Schools-allowing them to use their initiative during the course and innovate as per need. It would be as follows:

One Session -Empowerment of Students

One Session -Training of teachers

One Session -Awareness building among Parents during PTA meetings

- For this PARC and KAP tools will be used as 'pre' & 'post' questionnaires each has to fill
- Wherever possible the forms will be analyzed by an expert who will help to bring out the hidden biases within the focal group (students/staff/parents)
- Wherever possible an HIV- Positive Mother and child will be present to allow their voice to be heard

d) Development Sector:

Sites in the **Development Sector** have been proceeding with their on-going programs, while incorporating the ESHA foci.

- *Madras Christian Council of Social Studies*: MCCSS has been working in this field with awareness modules and behaviour change programs in the slums of Chennai for several decades. They have on-going Federation Meetings of their SHG's every 2 weeks. Three (3) leaders from 20 selected SHG's will gather for awareness on HIV and AIDS, with ESHA's speciality focus areas (care and support/gender/stigma/human sexuality). ESHA will support 8 such meetings. The process has begun.
- *Dayabhavan*: In Tumkur near Bangalore, it has regular programs for over 200 Positive People- both women and children. They also have an ongoing 'homestay' program for children of PLWA's, which is now being expanded to include senior PLWA's without families.
- *Navjeevan Centre*: They specialise in rescuing CSW's from Kamathipura, the 'Red Light district' of Mumbai and rehabilitating them- and their children. Navjeevan supports by offering alternative lifestyles and methods of earning (e.g., tailoring classes with sewing machines; training women as taxi drivers.) They also have programs church congregations where CSW's tell their story –and help to remove stigma and fear from society.
- *VCLC (Vidharba Centre for Labour Concerns)* has a history of concern for the needs of these unorganised labour and marginalised people. It has selected two field workers who have started to work among the Migrant Labour in the industrial townships of Butibori (outside Nagpur), and Chandrapur (2 hours away). These labour are often away from their homes for 8-12 months at a time and are at greater risk of infection
- *NCCI-URM's* contact person is the Director of the Church of North India Church's Social Service wing in Nagpur, who heads the "Urban –Rural Mission". They work among the marginalised and give them skills training for their livelihood. Into this they will impress the ESHA foci.
- The *Nagaland Development Organisation* (Nagaland) and the *Calvary Counselling Centre* (Manipur) have been working among the HIV populations in the North East. They have agreed to focus on the issues of ESHA and have already started their operations.
- *Orissa Urban Rural Service* is a multi-dimensional organisation that works in urban and rural Orissa. The Field Director, Mr PC Jena felt the greatest need was among the youth- both in the city and the village- and his idea is to use the concept of "*mela*" (village fair) to spread awareness of AIDS among them.
- *Tamil Nadu Council of Churches* (TNCC) self-employment project, which began as a Pilot Site has been upgraded to a Mainstreaming Program.
- *Archad Trust* is an organisation which was dropped by the ESHA project when their director died suddenly and there was no one to take his place in the organisation.

B. 5 National Mainstreaming Programs: (See Separate Paper on Mainstreaming- Appendix B and C)

1- Mainstreaming through National Ecumenical Organisations, to prepare an 'Organisational Workplace Policy' in NCCI -affiliated AICOS/Institutions.

2 – **Mainstreaming by preparation of ‘Bible Study Material for Youth’(on HIV)** : The idea is to select 10-15 youth from different churches all over India- this will include young theologians and Positive people - and prepare a ‘Bible Study Handbook on HIV for Youth’.

3 – **Mainstreaming by preparation of a “Policy Guidelines 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 **Support and Rehabilitation of about 25 PLHIV’s** (in the first phase), partnering with the *Tamil Nadu Council of Churches (TNCC)* in a deeply affected area on TN- Andhra Pradesh border.

5. **Mainstreaming through Website Designing and Maintenance:** A Website for NCCI’s HIV-work, highlighting the ESHA project, is due to be released on August 5th. 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. It would also be a place for knowledge on latest scientific developments.

C. **The impact of ‘KAP’ and ‘PARC’ tools:** Two visits in April by the General Coordinator to meet Dr Ashok Dyalchand of ICCO in Pune, (the Sectoral Coordinator, Mr Among Jamir, joined for the second), and understand the important role of ‘KAP’ and ‘PARC’ and ‘KAP’, the two tools used for measuring both the knowledge of the target group and the bias/discrimination within them (that leads to stigmatization of PLHIV). Translation of “PARC” and ‘KAP’ into Hindi was done as desired by some of the Church and Development Sites

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. Research Findings were as follows:

Table 1. Selected sociodemographic and HIV-related characteristics of recently-pregnant women in rural Maharashtra, India¹

<i>Characteristic</i>	<i>Pre- Intervention (n=400)</i>	<i>2 years' Post- Intervention (n= 400)</i>	<i>2 years' Post- Control (n= 400)</i>	<i>P-value</i>
<u>Sociodemographic</u>				
Mean age, years	20.1 (3.8)	21.9 (3.05)	22.36 (3.5)	0.000
Time since delivery, months (No., %)				
≤3	88 (22%)	85(21.3%)	79(19.7%)	0.000
4-6	112 (28%)	112(28.0%)	116(28.9%)	
7-9	77 (19.3%)	106(26.5%)	132(32.9%)	
10-12	123 (30.7%)	97(24.3%)	74(18.5%)	
Demonstrated literacy (No., %)	282 (70.5%)	339 (84.7%)	318(79.3%)	0.000
Occupation (No., %)				
Home-based	110 (27.5%)	74 (18.5%)	41 (10.2%)	0.000
Working outside the home	290 (72.5%)	326 (81.5%)	360 (89.8%)	
Mean number of rooms in home	2.6	2.4	2.20	0.000
Mean household size	7	7	7	0.892
Weekly access to media	146 (36.5%)	210 (52.5%)	191(47.6%)	0.000
<u>HIV Awareness and Knowledge</u>				
Ever heard of HIV or AIDS	349 (87.2%)	381 (95.3%)	360 (89.8%)	0.000
Know an HIV-infected person	38 (9.5%)	48 (12.0%)	38 (9.5%)	0.403
Aware of condoms	336 (84%)	367 (91.8%)	337 (84.0%)	0.001
Know consistent condom use prevents HIV	289 (72.3%)	303 (75.8%)	247 (61.6%)	0.000
Know HIV can be transmitted by sexual contact	334 (83.5%)	366 (91.5%)	325 (81.1%)	0.000
Know HIV can be transmitted by a contaminated blood transfusion	335 (83.8%)	377(94.3%)	362(90.3%)	0.000
Aware STIs can increase HIV susceptibility	227 (56.8%)	231(57.8%)	215(53.6%)	0.469
<u>Clinical HIV Risk Factors</u>				
History of STI symptoms ³	27 (6.5%)	69(17.3%)	66(16.5%)	0.000

History of treatment seeking for STI symptoms	(n=27) 13 (48.1%)	(n=69) 38 (55.1%)	(n=66) 47 (71.2%)	0.06
History of TB Symptoms ⁴	8 (2%)	33 (8.3%)	38 (9.5%)	0.000

Table 1 (con'd). Selected sociodemographic and HIV-related characteristics of women in rural Maharashtra, India¹

Characteristic	Pre- Intervention (n=400)	2 years' Post- Intervention (n= 400)	2 years' Post- Control (n= 400)	P- value ²
<u>Antenatal Care Utilization</u>				
Any antenatal care during last pregnancy	381 (95.2%)	392(98.0%)	375(93.5%)	0.008
Any antenatal care in first trimester	190 (47.5%)	281(70.3)	204(50.8)	0.000
Source of antenatal care	(n=381)	(n=392)	(n=375)	
Private sector Auxiliary Nurse Midwife	237 (62%)	182(46.4%)	na	
Public sector Auxiliary Nurse Midwife	227 (59%)	140(35.7%)	171(45.6%)	0.000
Private sector Physician	173 (45.4%)	141(35.9%)	216(57.6%)	0.000
<u>HIV Testing Awareness and Utilization</u>				
Discussion of HIV during antenatal care	30 (7.5%)	282(70.5%)	135(33.7%)	0.000
Awareness of any HIV testing facility ⁵				
Reported	56 (14%)	327(81.7%)	249(62.1%)	0.000
Correct	24 (6%)	306(76.5%)	203(50.6%)	0.000
Aware of Voluntary Counseling and Testing (VCT)	8 (2.1%)	173(43.3%)	83(20.7%)	0.000
History of antenatal HIV testing utilization	13 (3.3%)	292(73.0%)	174(43.4%)	0.000

¹ Women with known completed pregnancy in the prior 12 months. Samples assessed 1 year prior to Intervention and 6 months Post-Intervention with a concurrent post-intervention Control group.

²P-values calculated using two-tailed t-test for comparison of means and z-tests for two independent proportions.

³Defined as malodorous vaginal discharge or genital ulcer in the last 12 months

⁴Defined as cough, weight loss, sweats for more than 3 weeks in the last 12 months

⁵Initial reported awareness measured, then responses were checked for actual provision of services. Correct responses reported for actual awareness.

Table 2: Characteristics of HIV testing utilizers among a community sample of retained pregnant women in rural Maharashtra, India.

* More than one source of antenatal care could be reported by each participant.				
Characteristic	Pre- Intervention (n=13)	2 years' Post- intervention (n=292)	2 years' Post- Control (n=174)	P- value
Received testing during antenatal care (No., %)	13 (100)	288(98.6)	173(99.4%)	0.668
Number of HIV test sessions during last pregnancy				
One	1 (100)	174(59.6)	113(64.9)	
Two+	0	118(40.4)	61(35.1)	
Source of Antenatal care*(No., %)				
Private sector Auxiliary Nurse Midwife (ANM)	5 (38)	127(43.5)	00(00.0)	na
Public sector ANM	3 (23)	110(37.7)	64(36.8)	0.56
Private sector physician	7 (54)	137(46.9)	119(68.3)	0.000
Other	2 (15)	11(3.7)	08(4.6)	
Site(s) for HIV testing (No., %)				
Private sector:				
Local private hospital	8 (62)	30(10.3)	38(21.8)	
District-level private hospital	4 (31)	20(6.8)	38(21.8)	
Private hospital other district	0	35(11.9)	20(11.5)	
Public sector:				
District-level government hospital	1 (7.7)	11(03.7)	16(9.2)	
Government ICTC, Rural hospital/Block level	0	49(16.8)	48(27.5)	
Intervention Integrated Clinic	0	134(46.9)	na	
Government Hospital Other District		13(4.5)	14(8.1)	
Known ICT center (No., %)	1 (7.7)	152 (52.1)	56(32.2)	
District /Government Hospital	1 (7.7)	22(7.5)	23(13.2)	
Block level government ICT center	0(0.0)	87(29.8)	33(18.9)	
Intervention Clinic-Integrated Services:	na	43(14.7)	na	
Reasons for testing (No., %)				
Antenatal care provider-recommended	10 (76.9)	06(2.1)	12(6.8)	
Mandatory hospital test	2 (15.4)	29(9.9)	48(27.5)	
To prevent mother to child transmission	00(0.0)	35(11.9)	53(30.5)	
Curiosity	00(0.0)	179(61.3)	57(32.8)	
Community Health Worker-recommended	1 (7.7)	49(16.8)	na	
Recommended by the family	00(0.0)	06(2.1)	04(2.3)	
Received Pre-test counseling including informed consent (No., %)	7 (54)	263(90.1)	141(81.0)	0.000
Returned for test result/Post-test counseling (No.,%)	2 (15)	211(72.3)	91(52.3)	0.000
Disclosed that she was tested to someone (No.,%)	9 (69)	264(90.4)	159(91.2)	0.034

Annexure

Safe Adolescent Transition and Health Initiative (SATHI) Evaluation Report - Executive Summary Gokhale Institute of Politics and Economics, Pune Dr. R Nagarajan, Dr. Anjali Radkar, Dr. Sanjeevane Mulay

Introduction

The **Safe Adolescent Transition and Health Initiative (SATHI)** project is a multi site intervention project for improving the reproductive health of married adolescent girls and averting the adverse consequences of early motherhood.

The SATHI project that has been scaled up by the Institute of Health Management, Pachod (IHMP) in collaboration with the Population Foundation of India, in 5 districts of Maharashtra.

‘Gokhale Institute of Politics and Economics’, Pune, evaluated the project in April, 2010.

The Pilot SATHI project 2003-2006: Institute of Health Management, Pachod, with the support from the MacArthur Foundation, implemented a pilot intervention from 2003-2006 to improve the reproductive and sexual health of married adolescent girls (MAGs). The project aimed at averting the consequences of early motherhood that have a bearing on the reproductive health of adolescent girls. Results of the pilot project indicated – delay in age at first conception, increase in the mean interval between age at marriage and first conception, increase in contraceptive use, reduction in prevalence of self reported Reproductive Tract Infections (RTI) and prevalence of Low Birth Weight (LBW) babies, contributing to the achievement of two key Millennium Development Goals (MDG) of reduction in child mortality and improvement in maternal health. Since then the MacArthur Foundation has been supporting the IHMP to scale up this intervention.

Scaling up the SATHI project in 5 Districts since 2008: In January 2008, Sir Dorabjee Tata Trust approved the proposal for scaling up the interventions of SATHI pilot project through a coalition of NGOs in 5 Districts of Maharashtra. The proposed action research project was implemented in four of the lowest ranking districts and one average ranking district of Maharashtra. The criteria used for the selection of the districts were districts with the lowest RCH index and the lowest median age at marriage. The other selection criterion was the existence of an NGO with established credibility working in the district. The SATHI project for married adolescent girls is being implemented in a rural population of 20,000, at each site, by the following five NGOs, since February, 2008:

- Sanskruti Samvardhan Mandal, Nanded
- Gram Vikas Mandal, Beed
- Apeksha Homoeo Society, Amaravati

- Youth Welfare Association of India, Buldana
- Late Shriram Ahirrao Memorial Trust, Dhule

Situational Analysis

Adolescents constitute approximately 22 percent of the total population of Maharashtra -- 11.9 percent boys and 10.5 percent girls (Census of India 2001). In rural Maharashtra, 49 percent of girls get married before the age of 18 years (NFHS 3, 2006). The median age at marriage among adolescent girls is 15 years, and the median age at first birth is 17 years (NFHS 3, 2006).

A mere 4.6 percent of married adolescent girls had received minimal antenatal care and 42 percent reported home deliveries (NFHS 3, 2006)

According to the NFHS-3, Maharashtra, a high proportion of married adolescent girls reported maternal complications. Thirty-five percent girls, who had delivered reported at least one complication during the antenatal period, and 12 percent reported at least one postnatal complication (NFHS 3, 2006). A high proportion of married adolescent girls (38.6 percent) gave birth to at least one low birth weight baby and 7.8 percent married adolescent girls reported at least one non-live birth (NFHS 3, 2006).

Only 9.8 percent of married adolescent girls in Maharashtra practice contraception (NFHS 3, 2006).

In 2003, IHMP study in Aurangabad district during which 36.5 percent married adolescent girls reported symptoms indicative of a reproductive tract infection (IHMP 2003). In the NFHS 3, 2006 survey, 4.6 percent married adolescent girls reported symptoms indicative of a sexually transmitted illness (NFHS 3, 2006)

While 68.6 percent girls had some knowledge of HIV-AIDS, only 29.4 percent knew of local testing centres, 0.7 knew about the ICTC services, and a mere 1.3 percent had ever been tested for HIV (NFHS 3, 2006)

The SATHI Project

Project Objective

To demonstrate effective interventions to improve the sexual and reproductive health of married young women in 5 districts of Maharashtra.

Specific Project Objectives

1. To delay median age at first conception.
2. To increase contraceptive use to delay first conception.
3. To reduce prevalence of anemia among young married women.

4. To increase treatment utilization behaviour for RTI, post abortion complications and post natal complications.
5. To increase proportion of pregnant young women receiving minimum ANC.
6. To increase proportion of institutional deliveries.

The first 6-8 months of the project were spent on capacity building, baseline survey and other preparatory activities. The SATHI interventions were introduced in September 2008.

Project intervention – 5 Components

1. **Monthly Surveillance** – Is a process of assessing reproductive health needs of married adolescent girls on a monthly basis. One ASHA was appointed for every 1000 population or 200 households. The ASHA would visit 10 households a day, covering 200 households in 20 days to identify the health and information needs of married adolescent girls on a monthly basis. They were provided with a simple tool that enabled them to collect this information.
2. **Micro-planning** – Data collected by the ASHAs on the specific health and information needs of each married adolescent girl, forms the basis of micro-planning. ASHAs prepare a list of MAGs with their reproductive health needs every month which they hand over to the ANMs. Examples of health needs are: pregnancy confirmation, ANC care, contraceptives, RTI treatment, etc. Examples of information needs are: delaying first conception, birth spacing, adequate diet, treatment of RTIs / sexually transmitted infections (STI), location of ICTC facility, etc. ANMS plan their work and logistics on the basis of the monthly micro-plans prepared by ASHAs.
3. **Behaviour Change Communication (BCC)** - A new paradigm in behavior change communication has been developed by Institute of Health Management, Pachod. During monthly household visits the AHSAs use simple algorithms to assess the information needs of each client and make a behavioral diagnosis. ASHAs provide need specific BCC and counseling based on her behavioural diagnosis. For example – ASHA visits a household where marriage of an adolescent girl is being considered. She tells them about the risks involved in early marriage and first birth and counsels them to delay her marriage till 18 years of age. ASHA visits the home of an anaemic married adolescent girl and provides dietary advice and asks her to consume IFA tablets. A married adolescent girl with an RTI is informed about the danger her condition poses and why she must get treated, etc.
4. **Primary level care** – The ASHAs inform all their clients that were identified during surveillance about the date and time when the ANM will hold the village clinic. On the stipulated date she gathers all her clients and takes them to the ANM. During surveillance if an ASHA comes across a married adolescent girl who reports any danger sign or symptom, the ASHA counsels her to go to a referral facility and accompanies the girl if necessary.

- 5. Community Based Monitoring** – At the end of each month the ASHA convenes a Village Health and Sanitation Committee meeting. During the meeting the ASHA submits the list of married adolescent girls in need of services compiled by her and the ANM submits the list of married adolescent girls to whom she has provided services as well as the list of girls that were referred and the girls that actually utilized referral services. By comparing the health needs assessed by ASHA and the health needs addressed by the ANM, the VHSC monitors the health delivery system, in their community, on a monthly basis.

Evaluation of the SATHI project

The baseline study was conducted in 2008 and the evaluation in 2010, 2 years after the start of the project and 18 months after implementation of the intervention. The evaluation was conducted in each of the 5 districts where the program had been implemented.

Study design

5 Intervention sites:	O	X	O
5 Control sites:	O		O

A quasi-experiment study design was adopted with pre-post test of both study and control groups. Following the selection of the five NGO intervention sites, one PHC was randomly selected from each of the five districts as a control site. The control PHCs were geographically at a distance from the intervention sites to preclude ‘contamination’. The current age of the respondents was somewhat higher in the intervention sites as compared to the control sites. For most other socio demographic variables the intervention sites were broadly similar to the control sites. (refer Part 2 of the report)

The sample size was calculated in order to detect an increase of 10 percent in self-reported current contraceptive utilization, assuming an alpha of 0.05 and using a two-sided test to achieve 80 percent power. It was determined that a sample size of 160 would be needed at each NGO site to enable analysis of inter-site variation. (Fleiss et al, 2003). A sample size of 800 was finalized for all the five sites. A cross sectional sample of married adolescent girls was selected at both base-line and end-line surveys. Since there was no interest in measuring inter-site variation in the control sites a smaller cross sectional sample of 100 married adolescent girls from each site (500 for all 5 control sites was finalized).

The project was evaluated in April 2010, by the Gokhale Institute of Politics and Economics, Pune. The evaluation was conducted after the intervention had been implemented at the project sites for 18 months.

The objective of the evaluation was to examine whether the intervention activities succeeded in fulfilling the project objectives.

Data Collection and Processing

The team for data collection included thirteen investigators, three supervisors and two data quality assurance coordinators. This team was trained for 5 days. After the initial orientation for 2 days, each investigator was asked to collect data from at least 9 married adolescent girls. Field training continued till data collection was accurate and consistent.

Supervision of data collection was instituted at three levels. At the first level, investigators re-checked each completed interview schedule before handing it over to their supervisor. The supervisors checked each interview schedule for completeness and consistency, while the data collection was still in progress. If there were missing or inconsistent values, the supervisors asked the investigators to go back and re-validate the information. At the end of each day, investigators sat with their supervisor and checked the interview schedules a second time and their validity was certified by the supervisors.

At the third level, a senior data quality assurance coordinator checked each interview schedule for completeness and consistency of data. If any inconsistency was detected, the investigator was sent back to the respondent the next day.

A software programme was prepared in 'Epi data' for data entry. A data entry clerk entered data from each questionnaire, and a second data entry cross clerk checked the entries. Data were transferred to 'SPSS' for analysis. Data from baseline and end-line studies were compared to study any change in reproductive health status and health utilization behaviours.

Salient Findings from the Evaluation

These findings are based on aggregate of study and control areas of 5 districts. It should be borne in mind that the differentials among the districts could affect the average results. District wise findings re presented in the report.

Socio-demographic Findings

In the study area, the mean current age of the respondents for the end-line sample (18.2 years) is slightly more than that of the baseline sample (17.8 years), whereas, the mean current age of the respondents in the control area is similar for the baseline and end-line samples. In the study area, in the end-line evaluation sample the median current age is a little higher than that of the baseline sample. There is no difference between the end-line and baseline samples in the level of educational attainment (educated \geq Class 8) for both study and control samples. Likewise, the occupational pattern of the respondents for the end-line and baseline samples for the study and control areas is similar. The intervention sites were broadly similar to the control for most socio demographic indicators.

Age at Marriage

The mean age at marriage at the intervention site has not changed (15.4 years) between the baseline and end-line studies. The mean age at marriage at the control site also remained unchanged at 15.5 years. However, among the girls (35) that got married in 2009 - 2010 at the intervention site there is a delay in age at marriage by one and half years indicating a trend in the positive direction.

Age at First Birth

Out of 759 respondents interviewed during the end-line evaluation, 509 reported a birth outcome. Out of the 509 married adolescent girls reporting a birth outcome, 111 delivered in 2008 and their mean age at first delivery was 16.9 years. Out of 509 respondents, 160 delivered in 2009 and their mean age at first birth was 17.5 years. A total of 61 MAGs delivered in 2010 and the mean age at first birth was 18.1 years.

In comparison, in the control area, out of a sample of 516 girls, 267 girls reported a birth outcome. Out of 267 married adolescent girls that had delivered, 72 girls delivered in 2008 and their mean age at first birth was 16.6 years. Out of 267 MAGs, 97 delivered in 2009 and their mean age at first birth was 16.9 years. In 2010, 41 MAGs delivered and their mean age at first birth was 17.6 years.

This indicates that in comparison with MAGS in the control area, MAGS in the study area are delaying their first birth marginally.

Contraceptive Use

Current contraceptive use was analyzed after standardization by marital duration. However, the standardized prevalence did not differ much from the unstandardized prevalence (33.7 percent and 31.5 percent). The current use of spacing methods has significantly increased in the study area. The prevalence of current contraceptive use has gone up from 6.6 percent at baseline to 33.7 percent at end-line in the study area. The increase in prevalence of use of spacing methods method-wise was: **1) Oral pills - 1.9 percent to 7.9 percent; 2) Condoms - 4.5 percent to 26.5 percent; and 3) IUD - 0.4 percent to 0.6 percent.** However, in the control area, there was no change in contraceptive use.

Proportion of Respondents reporting sustained contraceptive use (>= 6mths.) by parity

Parity	Percent using contraceptives for >=6 months – end-line data	
	Study area (%)	Control area (%)
0	0.39	0.19
1	6.8	0.96
2	4.5	0.58
3 +	1.4	00.0
Total	759	516

During the evaluation, the proportion of respondents reporting sustained contraceptive use, for more than 6 months, was significantly higher for each parity group, in the study area as compared to the control area.

In study area, 256 out of 759 MAGs (33.7 percent) reported contraceptive use. Out of these 41 percent reported sustained use for 6 months or more. On the other hand in the control area, merely 33 out of 516 MAGs (6.4 percent) reported current contraceptive use of which only 27.3 had used contraceptives for more than 6 months.

At the time of the evaluation, the program had been implemented for a period of 18 months only. This project duration would be insufficient to capture the impact of contraceptive use on fertility. What is evident, however, is that consistent use of contraception has increased in the study area as compared to the control area.

Maternal and Neonatal Health

In the SATHI project, registration with an ANM, for antenatal care, before 12 weeks of gestation was defined as early antenatal registration. Early antenatal registration increased in the study area from **60** percent at baseline to **78** percent at end-line. However, in the control area there was no significant change between baseline and end-line (**55** percent and **54** percent respectively).

A significant increase has occurred in the proportion of married adolescent girls availing of the minimum antenatal care package (early registration, 3 ANC check-ups, 2 TT injections and 90+ IFA tablets) from **8.1** percent at baseline to **56.1** percent at end-line in study area. In the control area, the increase is from **7.1** percent at baseline to **24.3** percent at end-line. The increase in coverage with minimum standard antenatal care in both the study and control areas may be partially attributed to NRHM but the substantially higher increase in the 5 intervention sites is attributed to the SATHI intervention.

The SATHI project had altogether 9 key activities. The reported exposure of the respondents to these activities was measured. About 33 percent respondents reported low exposure (Exposure to less than 3 activities); 36 percent reported medium exposure (exposure to 4 to 5 activities) and 31 percent reported high exposure (exposure to 6 or more activities) Exposure to SATHI intervention is associated with utilization of minimum standard antenatal care package. 67 percent MAGs with high exposure to the SATHI inputs had availed of the minimum standard of antenatal care as compared to 43 percent MAGs with low exposure to SATHI inputs.

The prevalence of any one self-reported antenatal complication decreased from **55** percent at baseline to **44** percent at end-line in the study area. Conversely the prevalence of any one self-reported antenatal complication increased from 37.7 percent at baseline to 50.7 percent at end-line in the control area, which may be due to better reporting.

Treatment seeking behaviour for antenatal complications in the study area increased from **75** percent to **88** percent, whereas in the control area it increased from **63** percent to **77** percent.

The proportion of institutional deliveries increased from **60** percent to **73** percent at end-line in the study area, whereas that in the control area the increase was from **49.9** percent to **69.2** percent. Large scale studies in India indicate that the increase in the proportion of institutional deliveries in both intervention and control sites is attributable to NRHM and JSY. In the control sites where the level was lower at baseline the change has been more rapid.

The number of postnatal visits by the govt. ANM increased significantly from **18** percent at baseline to **31.6** percent at end-line in the study area, whereas in the control area it increased from **14.12** percent to **20.8** percent. Additionally, in the study area at end-line **33.4** percent of the MAGs reported that they were also visited by the SATHI project ANMs.

There was a significant increase in the proportion of MAGs seeking treatment for postnatal complications from **56.0** percent at baseline to **78.8** percent at end-line, in the study area. However, no change was observed in the treatment seeking behaviour for postnatal complications between baseline and end-line, in the control area.

The proportion of respondents that reported early treatment seeking for neonatal complications increased from **40.2** percent to **58.2** percent in the study area, whereas in the control area, it increased from **45.0** percent to **51.6** percent.

Reproductive Health

Findings indicate a reduction in the proportion of self-reported menstrual problems from **78.5** percent to **64.6** percent at the intervention site. Even though the reported prevalence was lower at the control site, no change was observed between the baseline and end-line surveys (64.9 percent at baseline and 63.1 percent at end-line).

The proportion of MAGs that reported treatment seeking behaviour for urinary tract infection (UTI) symptoms increased from **26.3** percent to **46.4** percent in the study area, whereas no change was observed in the control area.

Treatment seeking behaviour for reproductive tract infections among those who reported the symptoms increased significantly from **28.1** percent to **60.4** percent in the study area. There was a significant reduction in the proportion of self-reported symptoms of reproductive tract infection from **34.8** percent to **27.3** percent in the study area. In the control area, no significant change occurred in the proportion of self-reported symptoms of reproductive tract infections (29.6 percent to 28.8 percent), or in the treatment seeking behaviour for reproductive tract infections (30.8 percent to 28.9 percent).

The proportion of self-reported symptoms of sexually transmitted infections in both the study and control areas was about 5 percent. The proportion of treatment seeking behaviour for self reported sexually transmitted infections increased from **21.2** percent at baseline to **65.0** percent at end-line in the study area; and from 12.5percent at baseline to **30.8** percent at end-line at the control area

Testing for HIV

Both the study and control areas reported a high level of awareness of the availability/existence of a test to detection of HIV. There was a significant increase in the proportion of awareness of ICTC services in the study area from **12.9** percent to **42.8** percent. In the control area, awareness increased from **5** percent to **13** percent.

The proportion of MAGs who reported ever having been tested for HIV significantly increased in the study area from **11.7** percent to **58.7** percent. In the control area, it increased from **1.8** percent to **15.9** percent. The increase in the control area can be attributed to the decentralization of ICTC services from the district level to rural hospitals. The significantly higher increase in the intervention sites is attributable to the SATHI intervention.

Conclusions

The SATHI project for married adolescent girls was implemented in five backward districts of Maharashtra with the aim to improve their reproductive health. The project was implemented through a network of 5 NGOs working in those districts.

The project was evaluated in April 2010. The data from the intervention sites compared to 5 control PHCs located in the districts where the SATHI intervention was implemented. The married adolescent girls at the intervention sites were slightly older. The intervention and control sites were similar for most other socio-demographic indicators.

At the time of the evaluation, even though the duration of the intervention was brief, it indicates some substantive impact. For couples that got married recently; delay in the age at marriage is noticeable. Similarly, the increase in age at first conception can be attributed to the intervention. In the control sites there is neither an increase in the age at first birth or in contraceptives use.

In the case of contraceptive use, the impact is remarkable. The evaluation indicates sustained use of contraceptives, condoms being the most preferred method. This reflects an attitudinal change brought out by the intervention, reflected through increased male participation in family planning. Contraceptive use appears to be mainly for spacing between the first and second child.

A significant increase is observed in the utilization of antenatal care services. The data indicate that this achievement was contributed by the increased supply of IFA tablets. The role of the intervention in increasing coverage with minimum standard antenatal care services cannot be denied.

Even though the change is significantly less than that seen at the intervention sites, there is an increase in utilization of maternal care services, particularly institutional delivery, and in health seeking behaviors for maternal morbidity in the control sites as well. The evaluators feel that this change can be attributed to the National Rural Health Mission.

Another significant outcome of the intervention is the increase in treatment seeking for antenatal, postnatal, post-abortion and neonatal morbidity. The reduction in maternal morbidity is attributable to the intervention.

There is a change in the health utilization behavior for UTI, RTI and STI. However, the prevalence of RTIs has not come down proportionately, in spite of the fact that a significant proportion of young women are opting for institutional deliveries.

In the context of HIV, there is significant increase in awareness of ICTC facilities and testing for HIV. The intervention appears to have influenced the service seeking behaviours among married adolescent girls and their spouses.

There was no change in the prevalence or in the health seeking behavior for RTIs and STIs in the control sites. However, there is an increase in the proportion of young women undergoing counseling and testing for HIV which may be attributable to the decentralization of HIV testing by NACO in 2009.

The collaboration between SATHI workers and the health providers from formal health sector seems to make an impact on RCH utilization behaviors which have the potential to reduce maternal and neonatal mortality and improve the health of married adolescent girls.

Recommendations and Implications for NRHM

It is recommended that the five components of a focused intervention on reproductive and sexual health for married adolescent girls, which was demonstrated by the SATHI project, be replicated on a larger scale as it has the potential of rapidly addressing two key MDG goals.

Surveillance of health needs by ASHA appeared to have played a significant role in this project. The process of ASHA visiting a few households every day and assessing the health and information needs of her community and ensuring that those at need access the services of the ANM, and PHC seems the most rational approach to improving the efficacy of RCH services.

Assessing health needs in the population under the ASHAs jurisdiction, ensuring that they have access to health services and supporting the VHSCs to monitor whether the needs of the community were addressed adequately or not seem the most rational responsibilities of an activist (ASHA) that represents her community.

With over 700,000 ASHAs trained in the country, replication of this strategy seems imminently feasible. The implications for NRHM are to include the skills for monthly surveillance, and linking the beneficiaries with health providers in the training curriculum for ASHAs. The system of surveillance developed for the SATHI project can be easily adapted for NRHM.

It is recommended that these functions are included in her roles and responsibilities and that she is reimbursed for carrying them out efficiently.

The need specific communication strategy based on behavioural diagnoses that was used in the SATHI project hails a paradigm shift in the way BCC is implemented in rural India. Its effectiveness is reflected in the dramatic change in behaviors related to HIV testing (a considerably difficult behaviour to influence). Since this BCC strategy was implemented by community based women with 7 to 8 years of schooling, its operationalisation through ASHAs in the NRHM should not be a challenge.

References:

Fleiss et al, 2003
NFHS – 3, 2006
Census of India, 2001
IHMP, 2003