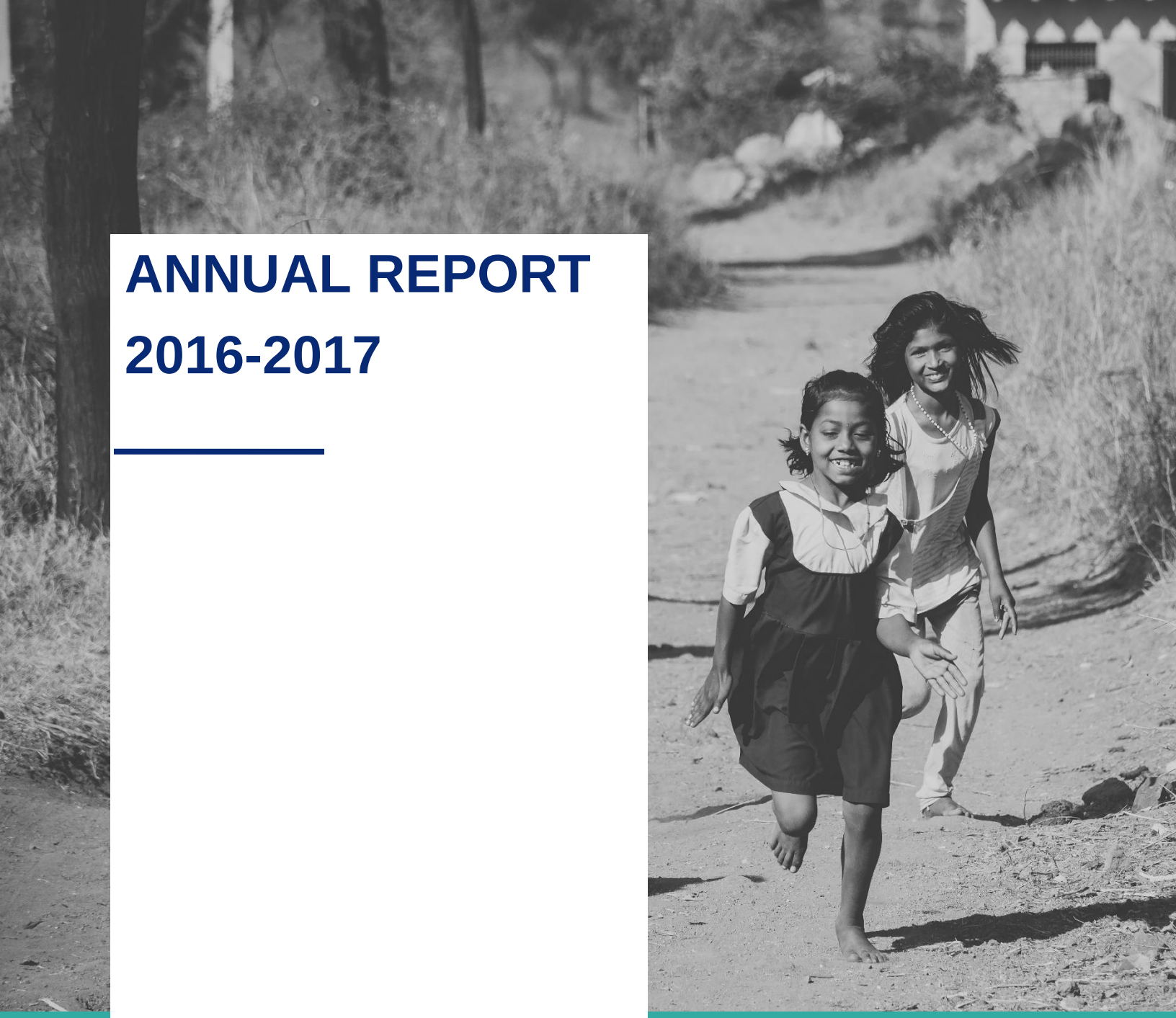


ANNUAL REPORT 2016-2017

IHMP
PIONEERS IN PUBLIC HEALTH

ASHISH GRAM RACHNA TRUST

INSTITUTE OF HEALTH MANAGEMENT PACHOD

Ashish Gram Rachna Trust, (Regn. No. E-249-Aurangabad) Pachod P.O. Pachod (431121), Taluka: Paithan Dist. Aurangabad (Maharashtra)

Content

About Ashish Gram Rachna Trust, Pachod

Ashish Gram Rachna Trust, Institute of Health Management, Pachod (AGRT/IHMP) undertakes programmes with the aim of innovating concepts, strategies and methodologies for implementing health and development programmes in rural areas and urban slums. AGRT/IHMP has been working in the underdeveloped Marathwada region of Maharashtra for the past 40 years. During this period, it has implemented innovations in the field of community health, Behavior Change Communication (BCC), water and sanitation, child development and nutrition, empowerment of adolescent girls and women. These innovations have provided policy options at the state and national levels. AGRT/IHMP's innovations are disseminated to the NGO sector through training programmes and to the government sector through policy analysis, research and advocacy.

Mission and Goal

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

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

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

Relationship between AGRT and IHMP

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

AGRT/IHMP headquarters are located in Pachod, District Aurangabad. Facilities consist of two conference halls, hostel for 32 trainees, mess, residential facilities for external faculty, computer

laboratory, library, documentation centre with photocopying facilities & audio - visual library. The Pune centre constitutes the AGRT/IHMP's urban branch.

Organizational Profile	
Legal Status	Registered Trust
Registration No.	E-249 (Aurangabad)
Income Tax Registration No. (Under Section 12A)	No. Nsk/Tech/12A (a)/79-80-81/4854
Income Tax Exemption (Under Section 80G)	ABD/CIT/TECH/80G/AGRT//144/38/2008-2009
FCRA Registration No.	083750005
Permanent Account No.	AAATA 3276G
Registered Office Address	Ashish Gram Rachna Trust Institute of Health Management, Pachod P.O. Pachod – 431 121 Tal. Paithan, Dist. Aurangabad, Maharashtra
Head Office Address	Ashish Gram Rachna Trust Institute of Health Management, Pachod P.O. Pachod – 431 121 Tal. Paithan, Dist. Aurangabad Maharashtra
Auditors	Mr. C. B. Kshirsagar, Chartered Accountant Partner, C G A S & Co. Flat No. 2, Plot No. 19, Adwait Apartment Vasant Baug Society, Bibdewadi, Pune - 411037
Bankers	Bank of Maharashtra, Pachod Branch P.O. Pachod – 431 121 Tal. Paithan Dist. Aurangabad

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

1. Integrated project for adolescent health and development
2. Innovations in National Rural Health Mission with a focus on Maternal & Child Health
3. Reproductive and Child Health – in rural and urban slums settings
4. Mainstreaming HIV AIDS into Reproductive and Child Health
5. Capacity building of Non-Government Organisations (NGOs) working in urban slum setting
6. Capacity building of NGOs working in rural setting
7. Research in community health with a focus on maternal and neonatal health
8. Scaling up maternal and neonatal health with a focus on married adolescent girls
9. Maternal and neonatal health with a focus on married adolescent girls
10. Life Skills education for unmarried adolescent girls
11. Relief and disaster management following Latur earthquake in 11 villages
12. Complete reconstruction of one village following Latur earthquake
13. Behaviour change communication
14. Child centered development through Bal Panchayats
15. Safe drinking water and sanitation – Beed and Aurangabad District
16. Prevention of Malnutrition in children below 5 years
17. Maternal and neonatal health care through Traditional Birth Attendants

Training Institute

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

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

Projects / Activities implemented during the period 1st April 2016 to 31st March 2017

1. Integrated project for the empowerment of adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence.

Activity Report - 1st April 2016 to 31st March 2017

Introduction:
This project was initiated from April 2014 in the villages of Adul PHC in Aurangabad District of Maharashtra. The project has three components – empowerment of unmarried adolescent girls and delaying age at marriage, protecting married adolescent girls from the adverse outcomes of early pregnancy and violence and gender sensitization of youth to reduce sexual and domestic violence.

This report describes activities undertaken for the three components during 1st April 2016 to 31st March 2017.

Part 1: Empowerment of unmarried adolescent girls through life skills education

Introduction:

During the reporting period, a total of 472 adolescent girls were enrolled for the 5th batch of 'Life Skills Education' course by ASHAs during household visits. A decision was taken to enroll married adolescent girls for 'Life Skills Education' course in those hamlets in which number of unmarried adolescent girls to be covered was less than 15.

It was decided to use peer led strategy for the 5th batch of 'Life Skills Education' course. Peer leaders would facilitate session of the six-month 'Life Skills Education' course and ASHAs would provide mentorship at the community level.

Specific Objectives of this intervention were:

1. To demonstrate a measurable increase in cognitive and practical skills.
2. To demonstrate a measurable improvement in the self-esteem and self-efficacy of adolescent girls.
3. To increase the duration of formal school education.
4. To delay age at marriage.

Activities implemented during the period 1st April 2016 to 31st March 2017:

No. of villages in which ASHAs are functioning - 18
No. of ASHAs functioning - 22
No. of Kishori Mandals - 22

Peer leaders took additional sessions for the adolescent girls from 4th batch during April to July 2016, while enrollment for the 5th batch was being done and Reproductive and Sexual Health workshops for the girls of 4th batch were being conducted. During supervision visit of field coordinators, it was observed that on an average 30 girls were attending the session conducted by peer leaders.

Reproductive and Sexual Health Workshops:

After the batch has completed six months 'Life Skills Education' course, older girls in the age group of 15-19 years were invited at Pachod for a 4 - day workshop on Reproductive and Sexual Health (RSH). A total of 323 adolescent girls were covered through seven workshops organized during May and June 2016.

Objectives of the Reproductive and Sexual Health Workshop:

- Adolescent girls would be able to describe the physical, mental and emotional changes taking place in their body.
- Adolescent girls would acquire correct scientific knowledge about Reproductive and Sexual Health.
- Adolescent girls would feel comfortable talking about Reproductive and Sexual Health issues.

Selection of Peer Leaders:

There are 23 Kishori Mandals (Girl's Collectives) established i.e. one Kishori Mandal per ASHA area. One ASHA discontinued after August 2016 due to personal reasons. Members of the Kishori Mandal democratically selected two peer leaders from each collective as their peer leaders. Peer leaders selected were older, intelligent and having good interpersonal skills.

Parents of peer leaders were contacted to get their consent to send their daughters every fortnight for training at Pachod. Capacity building on 'Life Skills Education' sessions was conducted for peer leaders with ASHAs once a fortnight on Sunday. This enabled peer leaders to take classes for the adolescent girls at the village level. A total of 16 one-day training sessions was conducted during eight-month duration. For each training session, on an average 28 peer leaders and 16 ASHAs were present.

'Life Skills Education' Classes Facilitated by Peer Leaders:
Peer Leaders took two sessions of the LSE course per week and once a week facilitated activities of the Kishori Mandal for the fifth batch of adolescent girls. On an average 18 girls were present both for the classes as well as Kishori Mandal activities.

Supervision of 'Life Skills Education' Classes Facilitated by Peer Leaders:
A total of 90 supervision visits were done during the six-month course. It was observed during supervision visit that on an average 18 girls were present for the classes conducted by the peer leaders.

'Life Skills Education' Classes Facilitated by Field Coordinators:
In 12 villages without ASHAs 'Life Skills Education' course was initiated because of demand from the community. Field Coordinators used to conduct once a week 'Life Skills Education' classes for the adolescent girls. On an average 21 girls were present for each session.

Activities undertaken by Kishori Mandals:
Kishori Mandals organized street plays and rallies. The key messages given through the street play and rally were – 'Marry your daughter only after she is 18 years old and continue education of your daughter beyond 12th standard'.

Street Play:

No. of street plays organized	- 28
No. of villagers who were present for the street play	- 6425

Rally:

No. of rallies organized	- 46
No. of girls participated	- 2429

Visit to Local Institutions:
Peer leaders with the help of ASHAs organized a visit to local institutions like police station, post-office, bank, Gram Panchayat, etc. A total of 2089 adolescent girl from the area of 22 ASHAs visited these local institutions i.e. 95 adolescent girls per ASHA.

Training on Use of Tablets:
Forty trained peer leaders conducted training on the use of tablets. Each peer educator trained five girls in their own village. Objectives of training on use of tablets were that girls would learn to access information related to further education through internet, see results of board exams and read newspapers. Peer educators covered 200 girls during the period April to December 2016. After that field coordinators conducted training of girls during the period January to March 2017 and covered 342 girls.

Preparing Lantern:
Twenty Peer leaders and twelve ASHAs attended the workshop on preparing lanterns at IHMP, Pachod which was organized just prior to Diwali. These peer leaders trained other girls at the village level. Many girls prepared lanterns and hung these in front of their houses during Diwali. This was appreciated by their families and communities.

Cultural Festival for Married Women:
In the month of January Kishori Mandals organized Haldi-Kumkum for their mothers and other married women from their village. A total of 545 mothers and other women from 16 villages attended the Haldi-Kumkum event.

Competitions Organised by Kishori Mandals:
During the reporting period, Kishori Mandals organized four competitions for adolescent girls. Women members of Gram Panchayat and Village Health Committee were invited as judges for the competitions. Two prizes were given for each competition. Details of the competitions that were organized and the number of girls that participated are given in Table: 1 below.

Table: 1. Details of Competitions Organised by Kishori Mandals – 1st April 2016 to 31st March 2017

Sr. No.	Competition	Organised by No. of Kishori Mandals	No. of Adolescent Girls Participated	No. of Adolescent Girls attended
1	Henna	22 + 13*	893	-
2	Skipping	22 + 13*	816	-
3	Debate (Importance of Teacher's Day)	22	270	440
4	Recipe – for iron rich foods	22	395	-

* - *Village without ASHAs*

Craft Workshops Organised at Kishori Mandals:
Field coordinators took four craft workshops at the Kishori Mandals. Through these workshops, demonstration was given on how to prepare these items. Many girls prepared these items at home after learning at the workshop, which was appreciated by their families. Details of the craft workshops are given below in Table: 2.

Table: 2 Details of Craft Workshops Organised at Kishori Mandals – 1st April 2016 to 31st March 2017

Sr. No.	Items	Organised at No. of Kishori Mandals	No. of Adolescent Girls attended
1	Flower vase using ice-cream sticks	22 + 13*	754
2	Paper flowers	16 + 10*	533
3	Pen stand from old news papers	22 + 13*	672
4	Doll from the socks	8 + 1*	45

* - *Village areas without ASHAs*

Behaviour Change Communication (BCC) Meetings:
During the reporting period, two BCC group meetings were organized for adolescent girls and their mothers on dietary requirements for adolescent girls and adult women and what you can do to prevent anemia at home. A total of 33 BCC group meetings were conducted. These were attended by 451 mothers and 605 adolescent girls.

International Women's Day:
Kishori Mandals organized a programme for the International Women's Day in their villages. Girls dressed up as leading women personalities/ role models like Savitribai Phule, Sunita Williams, etc. and spoke about their work. This was organized in 15 villages and was attended by 285 adolescent girls and 1060 villagers.

Skit:
On the occasion of the birth anniversary of Savitribai Phule on 3rd January, girls performed a skit and gave a speech about Savitribai Phule, who had started the first school for girls on 1st January 1848. This was attended by 190 parents and 433 adolescent girls. In the high schools, teachers asked these girls to do this skit again on 26th January – Republic Day.

Monthly Review Meetings of ASHAs at the PHC:
Monthly review meetings of ASHAs were organized on the second Monday of every month. On an average 18 ASHAs attended review meetings every month in which review of activities undertaken during the previous month and planning for the next month was done. ASHAs were also given necessary materials for the LSE classes and Kishori Mandal activities to be conducted.

Counseling for Adolescent Girls with Low Self Esteem:
Counseling was provided to the girls with low self-esteem and their parents during household visits. A total of 79 adolescent girls were counseled during the year.

Distribution of Cycles to Girls from the Needy Family:

Bank of Maharashtra, Pachod gave a donation for the purchase of 25 cycles to be distributed to adolescent girls who walk to a high-school in a nearby village. These cycles were distributed to girls from 11 villages with the aim of encouraging these girls to attend high-school regularly and to prevent their drop out. An agreement was signed with parents on stamp paper before handing over the cycle to ensure that the cycles are used only by the girls.

Personal Beauty Parlour Course:

Seven-day training on the personal beauty parlour was organized with the help of "Shramik Vidyapeeth", Aurangabad. A total of 40 girls participated in the workshop and each girl paid Rs. 100/- towards registration fees. Certificates were given by "Shramik Vidyapeeth" to the girls completing the course.

Visit to Ellora Caves:

A one-day trip was organized for peer leaders and ASHAs to visit Ellora caves. A total of 68 adolescent girls, ASHAs and IHMP staff visited the caves. This trip was organized to show our appreciation for the six-month Life Skills Education course taken by the peer leaders at the community level.

Pre-test and Post-test for the Life Skills Course:

Pre-test for cognitive skills based on the first 25 sessions of the LSE and self-esteem is conducted when a new batch is enrolled. After three months, post-test for cognitive skills based on the first 25 sessions of the LSE course and pre-test for cognitive skills based on the next 25 sessions of the LSE course is conducted. After the six-month course, post-test for cognitive skills based on the next 25 sessions of the LSE course and self-esteem is conducted. Details of the pre and post-test conducted during the reporting period are given below in Table: 3.

Table: 3 Pre-tests and Post-tests Conducted During April 2016 to March 2017

Sr. No.	Batch No.	Pre-test/ Post-test	No. of girls covered		Remark
			Cognitive Skills	Self Esteem	
1	4th	Post-test	LSE- II 407	407	-
2	5th	Pre-test	LSE – I 472	472	
3	5th	Post-test	LSE- I 432	-	-
4	5th	Pre-test	LSE - II 432	-	-
5	5th	Post-test	√	√	Was initiated in March 2017
6	1st (In villages without ASHAs)	Pre-test	done *	366	* Reported in last Annual Report
7	1st	Post-test	LSE – I 131*	-	Only from 8 villages
8	1st	Pre-test	LSE – II 131	-	Only from 8 villages

Case Studies:

Case Study: 1 – Anita the brave peer leader

Anita lives in Ektuni and she comes from a small farmer's family. Both the parents work on their fields. She is studying in 1st year of the graduation course in arts (B.A.). She has two sisters and one brother. Both the sisters are married. Her brother is studying in 9th standard. She completed 'Life Skills Education' in 2014-2015.

Anita said that I learnt many useful skills from the LSE course. I learnt about how to cope with the problems you face in life. I also learnt about how to communicate with others in the family and in the village. I also learnt about importance of stating your opinion. All these skills improved my courage and self-esteem.

I was selected as a peer leader from my group and I started coming to Pachod for the peer leader training, it also helped me in further improving my self-esteem. I was very happy when I was selected as a peer leader to facilitate Life Skills Education course since I like teaching other girls.

In front of my house, a group of boys used to sit and harass girls passing by. Earlier I used to be scared of these boys. But after the peer leader training with my improved self-esteem and courage, one day when I was going to temple, one of the boys came and pushed me. I stopped and abused him loudly to make him feel embarrassed in front of others. After reaching home, I told my parents what had happened. Since then none of these boys dare to trouble me. Peer Leader training has given me courage and skills to cope with any situations. I will able to use information learnt in future for myself and others.

One day, I overheard one woman telling other woman in my village that her daughter-in-law after nine years of marriage has not yet conceived. So, we are planning to get our son married again. After hearing this I could not keep quiet. I told that lady instead of blaming your daughter-in-law please send both of them to the hospital for checkup. My ASHA-tai also supported me. Now the family has decided to send them for the checkup.

Her dream is to complete her graduation and start working.

Case Study: 2 Rojina the ideal peer leader

Rojina lives in Bramhangaon, which is at a distance of 10 km. from the Adul PHC headquarter. In this village, there are many Muslim families. Her parents are both illiterate. Her mother works as agricultural labourer and father is mason.

Rojina enrolled for the 'Life Skills Education' course in 2014. Initially she hardly spoke in the class and was shy. Other girls in the class selected her as peer leader since she is intelligent. She learnt about roles and responsibilities and qualities of a good peer leader during the peer leader training. This motivated her to do something for her group. She talked to her friends about importance of personal hygiene during menstruation.

I was also trained to take sessions of LSE course. In the training, I learnt about how to prepare to take the sessions. I also learnt how to use tablet to access information from the internet. I also organized visit to police station and bank for girls from my Kishori Mandal, which also gave me confidence that I can take the responsibility and do the task assigned to me. Because of the LSE course, my communication skills and my stage daring improved. I started taking part in the debate competitions in the school. I did skit – "I am Savitribai Phule speaking" in the school. My teachers appreciated my performance and said well done. I also organized a program for the International Women's Day in my village with the help of my friends from Kishori Mandal.

My mother, grandmother and other women from my neighbourhood also used to sit in LSE classes taken by me. They are very proud of me. I also took art and craft sessions for the adolescent girls, which also motivated girls to attend the LSE classes regularly. Savitribai Phule is my role model and I would like to become a teacher in future.

Case Study: 3 Self-reliant Puja

Puja lives in Georai Budruk. Her village is at a distance of 3 km. from Adul PHC headquarter. She has studied up to 11th standard. Her both the parents are illiterate and work as agricultural labourers. She is from a poor family.

She attends 12th standard in a nearly village, which is about 5 km. from her village. She cycles to the school. She completed 'Life Skills Education' course in 2013-2014. She was chosen as a peer leader by other girls in Kishori Mandal. She organized with the help of ASHA visit to Police Station, Bank, etc. for girls from her village. She also took initiative for organizing street plays in the village. She encouraged other girls to take part in the street play and also got permission from their parents to allow them to take part in the street play.

Puja learnt how to do 'mehandi' (henna design) and 'rangoli' during the 'Life Skills Education' course. Now she is requested to do rangoli near flag post in school and at Gram Panchayat office on 15th August. She learnt how to do threading in the personal beauty parlour course organized by the Institute in her village. Now she does threading for other girls and women in her village and earns money to support her education.

After learning how to use tablet at Institute of Health Management, Pachod, she enrolled for the MSCIT course and completed the course with above 90 percent marks. She is able to access information through internet and send e-mails.

Puja said that because of the 'Life Skills Education' course, now I can speak in front of others and express my opinion without getting embarrassed. I have told my parents that I want to become engineer and start working. Only after that I will think about getting married.

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

Introduction:
Institute of Health Management, Pachod initiated work with unmarried and young married men in the age group of 15 to 25 years in the villages under Adul, Primary Health Centre (PHC) from 2014.

Specific Objectives

1. To adapt the Gender Equitable Men (GEM) scale, developed by the RISHTA project for rural youth, and demonstrate a measurable change in the attitude and behavior of unmarried and young married men towards women as measured by the GEM scale.
2. To reduce gender inequitable behavior in young men like eve teasing, molestation of girls and risky sexual behavior.
3. To reduce the proportion of young men getting married to girls less than 18 years of age.
4. To reduce the proportion of young men involved in perpetrate sexual and domestic violence.

Activities implemented during the period 1st April 2016 to 31st March 2017:

BCC Group Meetings with Unmarried and Young Married Men:

In each area under an ASHA i.e. about covering 200 households, one youth group has been established. There is a total of 24 youth groups in Adul PHC. Two BCC group meetings were organized every month with each youth group. Objectives of conducting these BCC group meetings were to improve knowledge, change attitudes and practices related to reproductive and sexual health and gender issues.

Table: 1 No. of BCC Group Meetings Conducted with Youth – April 2016 to March 2017:

Sr. No.	Month	Topics	Actual Meetings	Expected Meetings	%	Actual Attendance	Expected Attendance	%
1	Apr 16	Male Reproductive System and its functions	48	48	100	811	960	84
2	May 16	Diseases associated with Reproductive System and Sexually transmitted diseases	48	48	100	805	960	83
3	June 16	Use of family planning methods / contraceptives	48	48	100	883	960	92
4	July 16	Course of pregnancy	48	48	100	832	960	87
5	Aug 16	HIV/ AIDS	48	48	100	809	960	84
6	Sept 16	Ideal age of marriage in boys and girls. Ideal age for first conception	48	48	100	814	960	85
7	Oct 16	Domestic violence	48	48	100	822	960	86
8	Nov 16	Addictions.	48	48	100	804	960	84
9	Dec 16	Difference between sex & gender and gender discrimination	48	48	100	800	960	83
10	Jan 17	Masculinity	24	24*	100	418	480	87
11	Feb 17	Anemia	48	48	100	862	960	90
12	Mar 17	Effects of patriarchal system on women in the society	48	48	100	882	960	92
Total			552	552	100	9542	11040	86
Average			46	46	-	795	920	-

- In the month of January 2017, only one BCC group meeting was conducted with each group.

Table: 1 indicates that except in the month of January 2017, BCC group meetings were conducted with each youth group twice a month. On an average 86 percent of the expected number of youth attended the BCC group meetings every month.

Meetings Conducted by Peer Leaders with Unmarried and Young Married Men:
Two youth from every group have been selected as peer leaders. These peer leaders are expected to share new information learnt from the BCC group meetings conducted in the village and workshops

conducted at Pachod with their five friends. These five friends should be different from the regular attendees of BCC group meetings.

A one-day workshop was organized for 48 peer leaders at Pachod. Peer leaders have shared information on the topics mentioned above in Table: 1 with their five adopted friends during the period April 2016 to March 2017. Number of youths covered by peer educators during the year is given below in Table: 2.

Table: 2 No. of Youth Covered by Peer Educators:

Sr. No.	Month	Total no. of Peer Leader	Actual no. of youths covered by Peer Leader	Expected no. of youths to be covered by Peer Leader	Percentage
1	April 16	48	202	240	84
2	May 16	48	200	240	83
3	June 16	48	207	240	87
4	July 16	48	197	240	82
5	Aug 16	48	205	240	86
6	Sept 16	48	204	240	85
7	Oct 16	48	202	240	84
8	Nov 16	48	206	240	86
9	Dec 16	48	206	240	86
10	Jan 17	48	196	240	82
11	Feb 17	48	198	240	82
12	March 17	48	202	240	84
Total		576	2425	2880	84
Average		48	202	240	-

Table: 2 indicates that a total of 2425 youth were covered through a peer led strategy. On an average 202 youth (84% of the expected number of youth) were reached every month through peer educators.

Part 3: Protection of young married women from the adverse consequences of early conception and sexual and domestic violence.

Introduction:
Institute of Health Management, Pachod initiated activities and interventions for protection of young married women from the adverse consequences of early conception and sexual and domestic violence after completing census and baseline survey in the villages of Adul PHC in 2013.

Specific Objectives

1. To demonstrate an increase in the proportion of women having 1st child birth after 18 years of age
2. To increase the proportion of women registering for ANC before 12 weeks of pregnancy
3. To increase the proportion of women receiving minimal, standard, antenatal and postnatal care
4. To increase the proportion of women taking treatment for maternal complications
5. To demonstrate a measurable reduction in maternal complications (ante, intra and post-natal morbidity) in married adolescent girls.
6. To reduce the proportion of LBW babies

In April 2013, twenty-four ASHAs from Adul PHC started doing monthly surveillance after their induction training in surveillance and needs specific Behaviour Change Communication (BCC) was completed. In the first year, four ASHAs discontinued the work due to personal reasons. Five processes given below were established with the objective of achieving universal coverage and improving quality of coverage.

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

Activities implemented during 1st April 2016 to 31st March 2017:

ASHAs were called for one-day in April 2016 to transfer the information about Married Adolescent Girls (MAGs) from old to new surveillance registers.

Surveillance Coverage:

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

Table 1: Monthly Surveillance Coverage by ASHAs, April 2016 to March 2017

Month of Reporting	Reporting for No. of CO areas	Number of registered MAGs	Number of MAGs visited	Percent MAGs Visited
April 2016	20	715	650	90.9
May 2016	19	692	619	89.5
June 2016	20	743	666	89.6
July 2016	20	746	670	89.8
August 2016	20	746	676	90.6
September 2016	22	830	735	88.6
October 2016	22	831	746	89.9
November 2016	21	778	621	79.8
December 2016	22	840	659	78.5
January 2017	22	847	730	86.2
February 2017	21	795	685	86.2
March 2017	21	817	702	89.0
Total	250	9380	8159	87.0
Average	20.8	781.7	679.9	-

Table 1 indicates that on an average 21 ASHAs did monthly surveillance during household visits. During the reporting period, on an average 87 percent MAGs were visited during monthly surveillance visits by the ASHAs.

Group Meetings for Behaviour Change Communication Conducted by ANMs:

The project area has been divided into 43 geographical units. In each area, group meetings for BCC were conducted for MAGs every month. Topics for BCC were finalized in consultation with the MAGs. A session plan was prepared for each topic and in the session plan; participatory techniques were included for conducting BCC group meetings. Every month during in-service training ANMs were asked to demonstrate how they would conduct BCC group meetings at the village level.

Table 2: BCC Group Meetings of MAGs, Conducted by ANMs

Subject(s) Discussed	Month	Group meetings			Attendance in the meetings		
		Planned	Held	%	Expected	Atten-ded	%
Adverse consequences of child marriage and early pregnancy	Apr. 16	43	43	100	645	389	60.3
Care during pregnancy and importance of antenatal care	May 16	43	42	93.4	630	503	79.8
Danger signs during pregnancy and importance of HIV testing during pregnancy	June 16	43	43	100	645	437	67.8
Abortion and Post abortion care	July 16	43	43	100	645	495	76.7
Temporary methods of contraception	Aug. 16	43	42	93.4	630	472	74.9
Birth preparedness, danger signs during delivery and importance of why a delivery should be conducted in the hospital	Sept. 16	43	43	100	645	446	69.1
Postnatal care of mother	Oct. 16	43	43	100	645	425	65.9
Care of newborn	Nov. 16	43	43	100	645	405	62.8
Special care of low birth weight baby and vaccination	Dec. 16	43	42	97.7	630	392	62.2
Reproductive Tract Infection	Jan. 17	43	43	100	645	424	65.7
HIV/ AIDs	Feb. 17	43	43	100	645	437	67.8
Anaemia	Mar. 17	43	41	95.3	615	445	72.4
Total		516	511	99.0	7665	5270	68.8
Average		43	42.6	-	638.8	439.2	-

Table 2 indicates that 99 percent of the planned BCC group meetings were held. On an average 439 married adolescent girls attended BCC group meetings every month. Actual number of MAGs that attended the BCC group meeting was 69 percent of expected number.

This section of the report is for the area of 22 ASHAs in 18 villages.

Table 3: New Registrations during last one - year - April 2016 to March 2017:

Sr. No.	Month	No. of MAGs Registered for Antenatal Care		
		<12 weeks of pregnancy	>=12 weeks of pregnancy	Total
1	Apr. 16	09	02	11
2	May 16	08	01	09
3	Jun. 16	15	03	18
4	Jul. 16	08	14	22
5	Aug. 16	17	03	20
6	Sep. 16	20	14	34
7	Oct. 16	23	04	27
8	Nov. 16	17	01	18
9	Dec. 16	11	04	15
10	Jan. 17	27	02	29
11	Feb. 17	14	03	17
12	Mar. 17	18	04	22
	Total	187	55	242

Table 3 indicates that during the reporting period, 187 MAGs (77.3%) out of a total of 242 new pregnant MAGs detected were registered within 12 weeks of pregnancy for antenatal services.

Table 4: Reported abortion rate among MAGs

Month	No. of MAGs visited	No. of MAGs with pregnancy outcome	No. of MAGs who had abortion	Percent MAGs who had abortion
April 2016	650	14	0	0.0
May 2016	619	26	0	0.0
June 2016	666	14	3	21.4
July 2016	670	20	3	15.0
August 2016	676	22	1	4.5
September 2016	735	10	4	40.0
October 2016	746	26	0	0.0
November 2016	621	14	2	14.3
December 2016	659	26	2	7.7
January 2017	730	18	0	0.0
February 2017	685	22	1	4.5
March 2017	702	21	0	0.0
Total	8159	233	16	6.9

Table 4 indicates that a total of 16 women reported abortion as the outcome of pregnancy i.e. miscarriage rate of 6.9. There was not a single woman who reported complications after miscarriage.

Table 5: Reported use of family planning methods

Month	No. of MAGs visited	Non-pregnant MAGs	MAGs using FP method	% MAGs using FP method	MAGs using spacing method	% MAGs using spacing method
April 2016	650	498	136	27.3	133	26.7
May 2016	619	472	122	25.8	120	25.4
June 2016	666	508	165	32.5	162	31.9
July 2016	670	516	145	28.2	145	28.2
August 2016	676	512	164	32.0	162	31.6
September 2016	735	554	176	31.8	176	31.8
October 2016	746	564	171	30.9	171	30.9
November 2016	621	472	145	30.7	145	30.7
December 2016	659	505	154	30.5	154	30.5
January 2017	730	539	165	30.6	163	30.2
February 20157	685	512	159	31.1	159	31.1
March 2017	702	520	176	33.8	175	33.6
Total	8159	6172	1878	30.4	1865	30.2
Average	679.9	514.3	156.5	-	155.4	-

Table 5 indicates that on an average there were 514 non-pregnant MAGs every month. Out of these, on an average 155 couples used any one temporary family planning method. Prevalence of current use of any temporary family planning method was 30.2 percent.

Table 6: 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					
			Condoms	%	Pills	%	Cu T	%
April 2016	498	133	81	16.3	33	6.6	19	3.8
May 2016	472	120	63	13.3	37	7.8	20	4.2
June 2016	508	162	98	19.3	40	7.9	24	4.7
July 2016	516	145	90	17.4	33	6.4	22	4.3
August 2016	512	162	95	18.6	39	7.6	28	5.5
September 2016	554	176	107	19.3	45	8.1	24	4.3
October 2016	564	171	103	18.3	42	7.4	26	4.6
November 2016	472	145	95	20.1	29	6.1	21	4.4
December 2016	505	154	97	19.2	34	6.7	23	4.6
January 2017	539	163	103	19.1	35	6.5	25	4.6
February 2017	512	159	105	20.5	38	7.4	16	3.1
March 2017	520	175	120	23.1	37	7.1	18	3.5
Total	6172	1865	1157	18.7	442	7.2	266	4.3
Average	514.3	155.4	96.4	-	36.8	-	22.2	-

Table 6 indicates that 18.7 percent spouses of MAGs used condoms, 7.2 percent MAGs used oral pills and 4.3 percent were using Copper T.

Table 7: Outcome and Place of Delivery

Month	No. of MAGs* visited	No. of MAGs delivered	No. of Live Birth	No. of Still Birth	Delivered at 'Sasari'		Delivered at Maheri	
					Live Birth	Still Birth	Live Birth	Still Birth
April 2016	650	14	14	00	06	00	08	00
May 2016	619	26	25	01	04	00	21	01
June 2016	666	14	14	00	05	00	09	00
July 2016	670	20	20	00	03	00	17	00
August 2016	676	22	22	00	07	00	15	00
September 2016	735	10	10	00	01	00	09	00
October 2016	746	26	26	00	13	00	13	00
November 2016	621	14	14	00	05	00	09	00
December 2016	659	26	26	00	05	00	21	00
January 2017	730	18	18	00	07	00	11	00
February 2017	685	20	20	00	04	00	16	00
March 2017	702	21	21	00	06	00	15	00
Total	8159	231	230	01	66	00	164	01

**Number of MAGs delivered from the area of 22 ASHAs in 18 villages*

Table 7 indicates that 231 MAGs delivered during the reporting period, out of which 230 were live births and 1 was a still birth. Out of the 231 women delivered, sixty-six women (28.6%) delivered at husband's village ('Sasari') and 164 (71%) delivered at natal home, which reflects the cultural norm.

Table 8A: Number of newborns weighed at birth

Month	No. of MAGs delivered	No. of Live Birth	Delivered at 'Sasari'		Delivered at Maheri	
			Live Birth	No. weighed at birth	Live Birth	No. weighed at birth
April 2016	14	14	06	06	08	08
May 2016	26	25	04	04	21	21
June 2016	14	14	05	05	09	09
July 2016	20	20	03	03	17	17
August 2016	22	22	07	07	15	15
September 2016	10	10	01	01	09	09
October 2016	26	26	13	13	13	13
November 2016	14	14	05	05	09	09
December 2016	26	26	05	05	21	21
January 2017	18	18	07	07	11	11
February 2017	20	20	04	04	16	16
March 2017	21	21	06	06	15	15
Total	231	230	66	66	164	164

Table 8A indicates that all the newborns were weighed at birth.

Table 8B: Reported proportion of Low Birth Weight Babies

Month	No. of Live Birth	Delivered at 'Sasari'		Delivered at Maheri	
		No. weighed at birth	Low Birth Weight	No. weighed at birth	Low Birth Weight
April 2016	14	06	01	08	00
May 2016	25	04	01	21	00
June 2016	14	05	00	09	01
July 2016	20	03	02	17	00
August 2016	22	07	02	15	00
September 2016	10	01	00	09	00
October 2016	26	13	01	13	00
November 2016	14	05	00	09	00
December 2016	26	05	03	21	01
January 2017	18	07	02	11	02
February 2017	20	04	00	16	01
March 2017	21	06	00	15	00
Total	230	66	12	164	05

Only 17 (7.4%) out of the total newborns weighed were with low birth weight i.e. weight less than 2.5 Kg.

Table 9: Detection of Reproductive Tract Infections (RTIs)

Month	No. of MAGs visited	No. of MAGs with symptoms of RTIs	Percent MAGs with symptoms of RTIs
April 2016	650	10	1.5
May 2016	619	13	2.1
June 2016	666	17	2.6
July 2016	670	18	2.7
August 2016	676	19	2.8
September 2016	735	13	1.8
October 2016	746	15	2.0
November 2016	621	10	1.6
December 2016	659	21	3.2
January 2017	730	14	1.9
February 2017	685	13	1.9
March 2017	702	7	2.8
Total	8159	170	2.8
Average	679.9	14.2	-

Table 9 indicates that on an average 14 MAGs (2.8%) reported any one symptom of RTIs during surveillance every month.

Table 10: 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 2016	650	10	07	70.0
May 2016	619	13	09	69.2
June 2016	666	17	10	58.8
July 2016	670	18	15	83.3
August 2016	676	19	12	63.2
September 2016	735	13	08	61.5
October 2016	746	15	13	87.0
November 2016	621	10	09	90.0
December 2016	659	21	18	85.7
January 2017	730	14	11	78.6
February 2017	685	13	11	84.6
March 2017	702	7	05	71.4
Total	8159	170	128	75.3

Table 10 indicates that during the reporting period 128 (75.3%) out of a total of 170 detected cases of RTIs sought treatment.

Table 11A: 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 2016	650	02	00	00.0
May 2016	619	04	01	25.0
June 2016	666	06	00	00.0
July 2016	670	04	01	25.0
August 2016	676	05	00	00.0
September 2016	735	03	01	33.3
October 2016	746	07	04	57.1
November 2016	621	01	00	00.0
December 2016	659	13	00	00.0
January 2017	730	05	01	20.0
February 2017	685	05	00	00.0
March 2017	702	07	00	00.0
Total	8159	62	08	12.9

** MAGs-delivered two months prior to the reporting month at in law's place*

Table 11B: Reported treatment seeking for post-natal complications

Month	No. of post-natal MAGs*	No. of post-natal MAGs reported complications	No. of post-natal MAGs sought treatment for complications	% post-natal MAGs sought treatment for complications
April 2016	02	00	00	00.0
May 2016	04	01	01	100.0
June 2016	06	00	00	00.0
July 2016	04	01	00	00.0
August 2016	05	00	00	00.0
September 2016	03	01	00	00.0
October 2016	07	04	02	50.0
November 2016	01	00	00	00.0
December 2016	13	00	00	00.0
January 2017	05	01	01	100.0
February 2017	05	00	00	00.0
March 2017	07	00	00	00.0
Total	62	08	04	50.0

** MAGs-delivered two months prior to the reporting month at in law's place*

Table 11B indicates that 8 MAGs reported post-natal complications out of a total of 62 post-natal MAGs delivered at in-law's house. Out of which only 4 MAGs sought treatment for the post-natal complication.

Maternal Health Care:

ANMs from IHMP conduct antenatal clinic every month in each village and hamlet. On the day of Village Health and Nutrition Day (VHND), ANMs from the sub-centre are expected to visit the village and provide primary level health care. ANMs from IHMP also visited each village on the day of VHND for conducting antenatal clinic, which makes it easier to coordinate with the government ANM for provision of services. This section of the report is for the services provided by the ANMs.

Provision of antenatal and postnatal services:

These services are provided at the 'Anganwadi' centre in every village on the day of VHND by Government ANMs from the sub-centre and ANMs from IHMP. The ASHA of that village identifies the pregnant women during household visits and brings them for a check up to the 'Anganwadi' centre where the antenatal clinic is conducted.

During these clinics the ANM from IHMP conducts a systematic head to toe examination and records all necessary information of each pregnant woman. If she detects any high-risk cases she refers them to appropriate hospital. Government ANMs provide iron folic acid tablets and TT injections.

Table 12: New antenatal registration during April 2016 – March 2017:

Sr. No.	Month	MAG			General		
		<12	>12	Total	<12	>12	Total
1	April 2016	13	8	21	07	04	11
2	May 2016	27	17	44	12	13	25
3	June 2016	25	13	38	06	12	18
4	July 2016	27	17	44	12	13	25
5	August 2016	23	09	32	06	08	14
6	September 2016	24	13	37	04	06	10
7	October 2016	20	07	27	04	06	10
8	November 2016	23	09	32	06	08	14
9	December 2016	25	15	40	08	07	15
10	January 2017	26	13	39	10	14	24
11	February 2017	14	16	30	06	05	11
12	March 2017	18	12	30	09	08	17
	Total	265	149	414	90	104	194

Table 12 indicates that during the reporting period, a total of 414 new pregnant MAGs were registered, out of which 265 (64.0 %) were registered ≤ 12 weeks of pregnancy and 149 (36.0 %) were registered >12 weeks of pregnancy.

Similarly, a total of 194 new General pregnant women were registered, out of which 90 (46.4 %) were registered ≤ 12 weeks of pregnancy and 104 (53.6 %) were registered >12 weeks of pregnancy.

Table 13: Antenatal Clinic:

Month	Planned clinics	Actual clinics held	% clinics held	Expected no. of pregnant women to be examined	Actual no. of pregnant women examined	% pregnant women examined
Apr. 2016	37	32	86.5	240	158	65.8
May 2016	59	50	84.7	456	289	63.4
June 2016	55	52	94.5	519	340	65.5
July 2016	55	50	90.9	493	316	64.1
Aug. 2016	61	55	90.2	445	307	69.0
Sept. 2016	59	53	89.8	415	282	68.0
Oct. 2016	52	48	92.3	385	267	69.4
Nov. 2016	61	55	90.2	445	307	69.0
Dec. 2016	53	47	88.7	361	222	61.5
Jan. 2017	56	53	94.6	450	301	66.9
Feb. 2017	52	46	88.5	372	254	68.3
Mar. 2017	52	50	96.2	402	306	76.1
Total	652	591	90.6	4983	3349	67.2
Average	54	49.3	-	415.3	279.1	-

Table 13 indicates that on an average 49 antenatal clinics i.e. 91 percent were conducted and 279 (67.2 %) pregnant women were examined every month.

Table 14: Deliveries and Post-natal visits during the period April 2016 to March 2017

Beneficiaries	Deliveries			Abortions	PNC visit			
	Total	Maheri	Sasari		1st	2nd	3rd	Total
MAG	304	241	63	19	67	63	49	179
General	172	136	36	11	46	35	27	108
Total	476	377	99	30	113	98	76	287

Table 14 indicates that during the reporting period 304 MAGs delivered and 19 abortions were recorded. Out of a total of 304 post-natal mothers, 67 mothers received one post-natal visit, 63 mothers received two post-natal visits, and 49 mothers received three or more post-natal visits.

Similarly, 172 General pregnant women delivered and 11 abortions were recorded. Out of a total of 172 post-natal mothers, 46 mothers received one post-natal visit, 35 mothers received two post-natal visits, and 27 mothers received three or more post-natal visits.

Table 15: Maternal health services utilized during the period April 2016 to March 2017

Beneficiaries	Total deliveries	Antenatal check up				T.T. injection			Place of delivery		Who conducted delivery		
		0	1	2	3+	0	1	2 and B	Hospital	Home	TD	Hospital	Other
MAG	304	0	0	27	277	0	3	301	299	5	0	299	5
General	172	0	0	25	147	0	0	172	166	6	0	166	6
Total	476	0	0	52	424	0	3	473	465	11	0	465	11

Table 15 indicates that during the reporting period out of 304 MAGs that delivered, 277 (91.0 %) women were examined three or more times during pregnancy and 301 (99.0%) women received two T.T. injections or a booster dose. Out of 304 MAGs that delivered, 299 (98.4 %) were delivered in a hospital.

General pregnant women that delivered, 147 (85.5 %) women were examined three or more times during pregnancy and all women received two T.T. injections or a booster dose. Out of 172 General pregnant women that delivered, 166 (96.5 %) were delivered in a hospital.

Table 16: Outcome of delivery during the period April 2016 to March 2017

Beneficiaries	Total deliveries	Delivery out come		Birth weight	
		Live birth	Still birth	Normal	Low birth weight
MAG*	304	306	0	293	13
General*	172	173	0	164	09
Total	476	479	0	457	22

**Two twin deliveries in MAGs and one twin delivery in General pregnant women in the reporting period.*

Table 16 indicates that out of 304 MAGs that delivered, 306 were live births and no stillbirths. Out of 306 new born babies weighed, 13 (4.3%) were low birth weight babies. Similarly, out of 172 general pregnant women that delivered, 173 were live births and no stillbirths. Out of 173 new born babies weighed, 9 (5.2 %) were low birth weight babies.

Case Study: 1

Ambika is 21 years old. After completing10th standard, she got married when she was 16 years old. She lives in Hirapur with her husband who is 23 years old, studied up to 12th standard and a farmer. Ambika conceived after four months of marriage. She delivered a baby girl at natal home.

IHMP nurse is visiting this village for the last three years. Nurse said that whenever I visited Hirapur, Ambika used to meet me. In this village, I conducted BCC group meetings for married adolescent girls every month. In one such BCC group meeting, I was explaining about use of temporary methods of contraception – oral pills, condoms, Copper-T, etc. for delaying first pregnancy and increasing interval between two births. Ambika also was attending this BCC group meeting and after the meeting she told me that she would like to use Copper-T since her baby is only five months old. I advised her to go to Adul PHC for getting Copper-T inserted. In the next month, when I visited the village, Ambika told me that she had gone to Adul PHC and has got Copper-T inserted.

After her daughter became two years old, she and her husband decided to have another child so she went to PHC and removed Copper-T. Now she is pregnant again and by the time she delivers, birth interval between her two children will be little over three years, which is ideal. She has registered herself with the ANM for the antenatal care.

Case Study: 2

Meera is 18 years old, studied up to 8th standard and lives in the village – Ekatuni. She got married when she was 15 years old. Her husband has studied up to 6th standard. He is marginalized farmer. They both work on their fields as well as her husband has to work on daily wage to support the family.

ASHA of Ekatuni village detected her pregnancy during monthly surveillance visit and brought her for the check-up to village health and nutrition day. Nurse confirmed her pregnancy after doing UPT. IHMP nurse identified her as high risk after taking history on the basis of history of three abortions and her age being less than 19 years. IHMP nurse visited her home after the clinic and explained to her mother-in-law and husband that her pregnancy is high risk. Nurse told both of them to not allow her to do heavy work, bring her for the monthly antenatal check-ups and get her sonography done.

During the next monthly check-up at the village level, Meera told IHMP nurse that she had gone for the sonography and she has been told that she has twin pregnancy. Nurse explained to her that she must come for regular monthly check-ups, which she did during her entire pregnancy. She also consumed 100 iron-folic acid tablets. Her mother-in-law ensured that she consumed sufficient amount of sprouted pulses, green leafy vegetables, etc. during the pregnancy.

As per the advice, her husband took her to the hospital for delivery. She delivered after completing nine months twin baby girls, both weighing 2 kg. Mother and both the girls are doing well. Mother-in-law and husband are grateful that they got timely guidance.

Case Study: 3

Suvarna is 17 years old. She got married just after competing 10th standard when she was 16 years old. Her husband is 21 years old and studied up to 12th standard. Both work as agriculture labourers.

Suvarna had told ASHA during monthly surveillance visit that she was having foul smelling white discharge. Therefore, ASHA brought Suvarna to village level RTI clinic conducted by IHMP. Nurse asked her since how long you have these complaints? Suvarna said soon after marriage, she started having these problems and she had not shown to anyone. Suvarna also mentioned that she had missed her periods. Nurse did UPT and confirmed her pregnancy. Nurse explained to her mother-in-law and husband what complications can occur if as soon as possible doctor is not consulted for the discharge.

Nurse advised the couple to come to RTI clinics organized by the IHMP in their village. Suvarna and her husband both came to the RTI clinics in their village and both got treated at the same time. Suvarna's infection was cured and she continued with her pregnancy. She took minimum antenatal care during her pregnancy. After completing nine months, she delivered in the hospital a baby boy weighing 3 kg. Both mother and baby are doing well. Both Suvarna and her husband are grateful to the visiting IHMP nurse.

Monthly Community Based Monitoring By Village Health Nutrition Water Supply and Sanitation Committee (VHNWSC):

Sixteen Village Health Nutrition Water Supply and Sanitation Committees have been established and functioning well in the villages under Adul Primary Health Center. Committees comprise of 40 percent male members and 60 percent female members. During the reporting period 1st April 2016 to 31st March 2017, monthly meetings of VHNWSCs for community-based monitoring were organized at the village level. These committees have undertaken following activities in their respective villages:

- To monitor and review work of ASHA every month,
- To motivate those who required health services for service utilization,
- To ensure services are provided or not by government and AGRT
- To resolve obstacles/barriers for project implementation

Table 17: Details of Monthly VHNWSC Meeting – April 2016 to March 2017:

Month	Actual Meetings Conducted	Total No. of VHNWSC	%	No. of VHNWSC members attended meeting			Total No. of VHNWSC members			%	Individual visit to VHNWSC members
				Male	Female	Total	Male	Female	Total		
Apr. 16	16	16	100	36	55	91	52	74	126	72	-
May 16	16	16	100	38	52	90	52	74	126	71	-
June 16	16	16	100	41	59	100	52	74	126	79	-
July 16	16	16	100	40	63	103	52	74	126	82	-
Aug. 16	16	16	100	35	54	89	52	74	126	71	-
Sept. 16	15	16	94	35	58	93	52	74	126	74	2
Oct. 16	16	16	100	40	63	103	52	74	126	82	-
Nov. 16	16	16	100	35	54	89	52	74	126	71	-
Dec. 16	16	16	100	41	59	100	52	74	126	79	-
Jan. 17	16	16	100	42	67	109	52	74	126	87	-
Feb. 17	16	16	100	48	75	123	52	74	126	98	-
Mar. 17	16	16	100	41	76	123	52	74	126	98	-
Total	191	192	100	472	735	1213	624	888	1512	80	2
Average	16	16	-	39	61	100	52	74	126	-	-

Table 17 indicates that all 16 planned meetings of VHNWSC were conducted every month. On an average 80 percent of the committee members were present for the monthly meeting. On an average 76 percent of the male committee members and on an average 83 percent of the female committee members attended the monthly review meetings of VHNWSC.

2. Preventing Child Marriage and Early Pregnancy in India, Jalna District

Activity Report - April 2016 to March 2017

Introduction:

Institute of Health Management, Pachod initiated an innovative project in 53 villages of Jamkhed and Wadigodri PHCs in Jalna District since April 2015.

Main objectives of the project are:

- To prevent child marriage
- To reduce maternal morbidity and mortality

Interventions are targeted at unmarried and married adolescent girls, boys and young men.

Activities implemented during the period 1st April 2016 to 31st March 2017:

Capacity Building of ASHAs and Staff:

Capacity Building of ASHAs for Life Skills Education – Part 1:

Training for the first 24 sessions of the 'Life Skills' course was organized from 23rd to 28th May 2016 for ASHAs who could not attend earlier training due to personal reasons. This training was attended by three ASHAs from Jamkhed PHC and one ASHA from Wadigodri PHC.

The focus of the training was on the content and methodology for conducting the sessions of the first three months of the 'Life Skills' course. A pre and post-test of the ASHAs were conducted during the training. The average pre-test score was 31.6 out of 50 and the post-test score was 41.5 out of 50.

Modules Covered in the training were:

Module 1: Healthy Life Styles
Module 2: Home Management
Module 3: Local Institutions
Module 4: Team Building
Module 5: Legal Awareness
Module 6: Panchayati Raj System

Orientation of the New Staff:

In August 2016, orientation regarding the organization and project was organized for the staff that was recruited (Female Facilitators – 4, Male Facilitators - 4). They were explained the Theory of Change and strategy for various activities being adopted.

Capacity Building of New Staff and ASHAs for Technical aspects, Surveillance and Need specific BCC:

A six-day training on Technical aspects, Surveillance and Need specific BCC was organized to impart conceptual and practical skills. This training was attended by eight ASHAs (Four from Wadigodri and Four from Jamkhed PHC) who could not attend training organized earlier. Four facilitators (male) and four facilitators (female) who had joined recently also attended the training on Technical aspects, Surveillance and Need specific BCC.

Average pre-test score for the ASHAs was 27 out of 50 and post-test score was 40 out of 50. The average pre-test score for facilitators was 35 out of 50 and post-test score was 47 out of 50.

Capacity Building of ASHAs & Facilitators for Life Skills Education – Part 2:

Training was organized on the next 25 sessions of 'Life Skills' course, which includes modules on:

1. Communication and negotiations
2. Self-esteem
3. First Aid
4. Gender

ASHAs from Jamkhed PHC attended 6-day training from 28th November 2016 to 3rd December 2016 and ASHAs from Wadigodri PHC attended the training from 5th December to 10th December 2016. A total of 31 ASHAs from Jamkhed PHC and 22 ASHAs from Wadigodari PHC completed training. Remaining eight ASHAs who could not attend the training will be covered in January 2017. Average pre-test score for the ASHAs was 30 and post-test score was 40 out of a total score of 50.

Seventeen facilitators also attended the training on 'Life Skills' Part -2. Average pre-test score for the facilitators was 39 and post-test score was 45 out of a total score of 50.

Capacity Building of ASHAs and Facilitators for Life Skills Education – Part 2:

Training on Life Skills Education - Part 2 (next 25 sessions), of 6 days duration, was organized from 16th to 21st January 2017 for those ASHAs who could not attend the training organized in December 2016 due to personal reasons. This training was attended by seven ASHAs. Average pre-test score for ASHAs was 21.6 and post-test score was 39.4 out of a total score of 50.

Two new facilitators were recruited in January 2017, in place of two facilitators who left during the previous quarter. Average pre-test score for the facilitators was 31.3 and post-test score was 45 out of a total score of 50.

Training for Counseling:

Training of 4 days duration on counseling of girls with low self-esteem was organized for facilitators (16 female facilitators & 4 male facilitators) from 22nd February to 25th February 2017, which was conducted by a child psychologist.

Married Adolescent Girls (MAGs):

Monthly Surveillance Visits by ASHAs:

Table 1: Surveillance Coverage by ASHAs - April 2016 to March 2017

Quarter	No. of ASHAs	Reporting for No. of ASHAs	Number of registered MAGs	Number of MAGs visited	Percent MAGs visited
April to June 2016	210	193	4370	3759	86.0
July to Sept. 2016	212	194	4562	3862	84.7
Oct. to Dec. 2016	204	181	4242	3494	82.4
Jan. to Mar. 2017	204	183	4326	3636	84.0
Total	830	751	17500	14751	84.3
Monthly Average	69.2	62.6	1458.3	1229.3	84.3

Table 1 indicates that a total of 69 ASHAs are functioning, out of which monthly surveillance was done on an average by 63 ASHAs (91.3%). ASHAs identify health & information needs and detect morbidity during monthly household visits for the surveillance. Based on their needs women are linked to health providers at the village level or higher levels of care. ASHAs also provide need specific BCC and counseling during household visits. On an average 1229 married adolescent girls (84.3%), out of a total 1458 married adolescent girls were visited during the monthly surveillance visit.

Behaviour Change Communication (BCC) Group Meetings of MAGs:

Behaviour Change Communication (BCC) group meetings were conducted once a month in each ASHA area by the facilitators (female). Table 2, given below indicates that on an average 58 (85.3%) BCC group meetings were conducted out of a total of 68 BCC group meetings planned every month. On an average 558 married adolescent girls i.e. 64.1 percent of the expected number attended these BCC group meetings.

Table 2: BCC Group Meetings of MAGs, Conducted by Female Facilitators

Quarter	Topics covered	Group meetings			Attendance in the meetings		
		Planned	Held	%	Expected	Attended	%
April to June 2016	• Age of marriage, age of first conception and adverse consequences of early pregnancy	68	37	54.4	555	387	69.7
July to Sept. 2016	• Importance of antenatal care and care during pregnancy • Danger signs during pregnancy & importance of HIV testing during pregnancy • Post abortion care	204	165	80.9	2475	1565	63.2
Oct. to Dec. 2016	• Temporary methods of contraception • Birth preparedness, danger signs during delivery, importance of why a delivery should be conducted in the hospital • Post-natal care of mother	204	181	88.7	2715	1576	58.0
Jan. to Mar. 2017	• Care of newborn • Anemia • Reproductive Tract Infections	204	197	96.6	2955	2053	69.5
Total		680	580	85.3	8700	5581	64.1
Monthly Average		68	58	85.3	870	558.1	64.1

- BCC group meetings for MAGs were initiated from June 2016.

Maternal Health:

A total of 413 new pregnant MAGs were registered during the year, out of which 294 (71.2%) were registered before 12 weeks of pregnancy and 119 pregnant MAGs (29.8%) were registered after 12 weeks of pregnancy. This is higher than the proportion of early registrations reported by the NFHS 4 for Jalna District. On an average 224 pregnant MAGs (91.4%) were examined every month out of a total 245 pregnant MAGs.

A total of 494 married adolescent girls delivered during the year, 488 were live births and six were still births. There were 29 miscarriages during the year, which is 5.9 percent abortion rate.
A total of 494 MAGs delivered during the year out of which 485 (98.2%) MAGs delivered in the hospital and nine delivered at home. One of the home deliveries was attended by a nurse. Out of the total women delivered, 451 (91.3%) MAGs were examined five or more times during pregnancy, 490 (99.2%) received two doses or booster dose of Tetanus Toxoid injection and 463 (93.7%) MAGs reported having consumed 100 IFA during pregnancy. This indicates that almost universal coverage of MAGs with the minimum standard antenatal care has been achieved.

During the year, a total of 109 pregnant MAGs reported danger signs, out of which 66 pregnant MAGs (61.1%) sought treatment. Out of the MAGs delivered at their husband's village, 14 MAGs reported complications at the time of delivery. Out of which 12 MAGs (85.7%) took treatment. Out of the 120 MAGs delivered at husband's village two months prior to the reporting period, 114 (95%) MAGs were visited twice by the ANMs and 115 (95.8%) MAGs were visited five times by ASHAs. Fourteen MAGs reported postnatal complications and only four sought treatment for the complications. A total of 344 MAGs reported symptoms of RTIs during the monthly surveillance, out of which 178 (51%) sought treatment. There is need to decentralize health services for treatment of maternal morbidity and RTIs to improve treatment utilization.

It has been reported that birth weight of all 488 live births was taken, out of which 41 (8.4%) newborns were low birth weight i.e. weight less than 2.5 kg.

Family Planning:

Table 3: Reported Use of Family Planning Methods

Quarter	No. of MAGs visited	No. of Currently non-pregnant MAGs	No. of MAGs using any FP method	Percent MAGs using any FP method	No. of MAGs using any spacing method	Percent MAGs using any spacing method
April to June 2016	3759	2810	866	30.8	864	30.7
July to Sept. 2016	3862	3039	885	29.1	885	29.1
Oct. to Dec. 2016	3494	2776	901	32.5	898	32.3
Jan. to Mar. 2017	3636	2919	985	33.7	980	33.6
Total	14751	11544	3637	31.5	3627	31.4
Monthly Average	1229.3	962	303.1	31.5	302.3	31.4

Table 3 indicates that on an average 31.5 percent married adolescent girls reported using any family planning method and on an average 31.4 percent married adolescent girls reported using contraceptives every month either to delay first pregnancy or to increase interval between two births. The most preferred method of spacing was condoms with on an average monthly reported current use of 27.3 percent.

Supervision of Surveillance and Need Specific Behavior Change Communication:

Supervision visits for surveillance and need specific BCC done by ASHAs were initiated from July 2016. On an average 119 (95%) out of a total of 125 planned monthly supervision visits to ASHAs were done by the facilitators (female).

On an average 323 (89%) households out of a total of 361 planned households were visited in a month by the facilitators (female) for supervision of surveillance done by ASHAs. On an average 326 (90%) households out of a total of 361 planned households were visited every month by facilitators (female) to observe need specific BCC given by the ASHAs.

Unmarried Adolescent Girls

Life Skills Education Classes:

Classes for Life Skills Education were initiated from August 2016 after completing self-administered pre-test for knowledge and self-esteem for 1448 adolescent girls. ASHAs were conducting two sessions per week of Life Skills Education and organizing once a week Kishori Mandal activities. A total of 1580 adolescent girl were enrolled for the first batch. Classes are conducted in the evening at a place provided by the community. Life Skills course for the first batch was conducted from August 2016 to March 2017.

On an average 60 ASHAs conducted Life Skills Education classes every month. During the year, 97 percent of the total expected number of LSE classes were conducted every month. On an average twenty-one adolescent girls per ASHA area attended LSE classes every month. During the year, 86.2 percent of the total adolescent girls enrolled attended more than 80 percent of the sessions conducted by the ASHAs.

Kishori Mandal:

During the year, a total of 62 Kishori Mandals and 124 peer educators were functional. On an average 60 ASHAs facilitated Kishori Mandal activities every month. Activities like sports & debate competitions, art & craft workshops, street plays, rallies and visits to local institutions were organized by ASHAs with the help of peer educators. During the year, ASHAs had facilitated 73.4 percent of the total planned activities every month. On an average nineteen adolescent girls per ASHA area participated in the Kishori Mandal activities each month.

Household Visits to Engage Parents:

Household visits to engage parents of adolescent girls were done by the facilitators (female) during the morning field visits. Once in three-months parents of all the adolescent girls were visited to motivate them to get their daughters enrolled for the life skills course or to send them regularly for the classes. On average 421 household visits i.e., 64 percent of the planned household visits to engage parents were undertaken each month.

Supervision of Life Skills Classes and Kishori Mandal Activities:

During the evening field visits, facilitators (female) were supervising twice in a month Life Skills classes conducted by ASHAs and once in a month Kishori Mandal activities. On an average 75 out of a total of 123 planned supervision visits to the life skills classes were done each month. It was observed during supervision visits that on an average 21 adolescent girls were present in each class.

On an average 49 out of a total 60 planned supervision visits to Kishori Mandal activities were done by the female facilitators. It was observed during supervision visits that on an average 20 adolescent girls participated in activities conducted by each Kishori Mandal.

Boys and Young Men Component:

This component is being implemented only in the villages of Jamkhed PHC. In August 2016, lists of youth prepared from the census data were up dated and 40 community meetings for youth were held. In these meetings, objectives and strategy of the youth component were discussed. Each meeting was attended by 40-45 youth.

Formation of Youth Groups and Selection of Peer Leaders:

Forty youth groups have been established and 80 peer leaders have been selected (One unmarried & one married youth). Peer leaders were selected by members of youth groups. While selecting peer leaders they selected youth who has good interpersonal skills and would able to guide them. A self-administered pre-test was conducted for 843 youth before starting the interventions to measure their attitudes and behaviours towards girls and women.

Peer Leader Training:

Sixty-three (78.8%) peer leaders out of a total of 80 peer leaders attended one-day workshop at Pachod. A list of topics discussed during the workshop is given below:

- Objectives and strategy of the integrated programme implemented in their village
- Objectives and activities being implemented for unmarried and married youth
- Strategy for implementing the youth programme
- Roles and responsibilities of peer leaders
- A list of topics to be discussed at the community level was generated.
- A case study on ‘Saidapurchi Jadu’ was discussed.

BCC Group Meeting for Youth:

BCC group meetings have been initiated from December 2016. Forty BCC group meetings were conducted each month since December 2016. On an average 661 youth attended each BCC group meeting, which was 83 percent of the expected number. Since December 2016, on an average 14 youth were given individual counseling each month. Topics discussed during these meetings were:

- Gender
- Methods of Family Planning
- Domestic Violence
- Masculinity

One facilitator (male) and peer leader attended the state level youth conference in Pune.

Peer led BCC:

Peer led BCC strategy was initiated from January 2017 in which peer leaders adopt their five friends who are not members of youth group and share with them new information learnt in the workshop. In the reporting period, 817 youths (68% of the expected numbers) were covered by the peer leaders.

BCC Group Meetings for Spouses:

Since, there was a poor response to BCC group meetings for spouses conducted by facilitator (female). It was decided that facilitators (male) would conduct meetings for spouses. From September 2016 in Wadigodri PHC and from October 2016 in Jamkhed PHC, these meetings were conducted by facilitators (male). The main focus of these meetings was to increase awareness and participation of husbands in taking care of their spouses.

On an average 40 (66%) monthly BCC group meetings were conducted for spouses. On an average 419 (52%) out of the total expected number of spouses attended these meetings. Topics covered were same as those covered for married adolescent girls.

Community Based Monitoring:

On an average 36 (72%) out of the total planned meetings of Village Health Nutrition Water & Sanitation Committees were organized every month for community-based monitoring. These meetings were attended on an average by 190 members (82 – female and 108 male) i.e. 61 percent of the expected number. Topics discussed during these meetings were:

- Objectives and activities of the IHMP project for Adolescent Girls
- Roles & responsibilities of committee members in the IHMP project for adolescent girls
- Importance of safe drinking water and methods of water storage at the household level
- Age of marriage and age at first conception
- Importance of Gramsabha in democracy (Panchayati Raj system),
- Beti Bacho, Beti Padhao campaign
- What is meant by empowerment of women and how can it be achieved?
- Importance of conducting a delivery in the hospital and birth preparedness,
- Environmental sanitation part - 1
- Environmental sanitation part - 2.

Advocacy

Four officials from the Ministry of Health that are associated with policy making at the Central Government level were contacted individually. IHMP was requested to make a presentation on the difference between the Peer led formal Government Adolescent Health and Development programme and the ASHA led IHMP model.

Following the presentation, the policy makers observed that the ASHAs in Maharashtra have an average of 12 years of formal schooling which is why the ASHAs in this State are capable of leading this programme. However, in Northern States the ASHAs are not so literate and will not be able to undertake this responsibility. The Policy makers felt that they need a uniform policy for the entire country and the IHMP model would not be applicable in several backward States.

As a result of this development our advocacy initiatives were focused on the policy makers and implementers in Maharashtra State. There are 5 officials who needed to be convinced about the efficacy of the innovations developed by IHMP. Meetings were held with 3 out of the 5 Ministry of Health officials at the State level. Based on the experience, IHMP took a decision that in future to approach the policy makers at the Central Government level through the State level officials instead of reaching out to them directly.

The Pachod IHMP team held two meetings with the District Health Officer at Jalna and several meetings were held with the medical officers of the two PHCs.

IHMP's team in Pune met with the State Director, Adolescent Reproductive & Sexual Health (ARSH) to follow up on the Programme Implementation Plan for 2017 - 2018. The State has not heard from the Central Government as yet. Further the Director, ARSH was apprised of the developments in Jalna District where the project is being scaled up in another 4 PHCs. The Director was very particular that IHMP should undertake scaling up in all the 10 PHCs as decided in January 2015.

3. Integrated reproductive and sexual health and family planning project for adolescent girls and young married women in urban slums

Activity Report - April 2016 to March 2017

Introduction:

Institute of Health Management Pachod is working in the slums of Pune city since 1998. In October 2014, Yardi Software India Ltd. approved a grant for three years to demonstrate an integrated reproductive sexual health project to empower unmarried adolescent girls of age 11-19 years and protect married adolescent girls and young married women of age <=24 years from the adverse consequences of early motherhood. The project is being implemented in one Primary Urban Health Centre sanctioned by the Pune Municipal Corporation from 01st October 2014.

The specific objectives of the integrated RSH project are:

Part 1: Protection of young married women from adverse consequences of early motherhood

Objectives

1: To increase the proportion of young married women having 1st child birth after 19 years

2: To increase the proportion of young women using contraceptives for spacing (CPR)

3: To increase proportion of young married women receiving minimal, standard, antenatal and postnatal care

4: To increase the proportion of young married women taking treatment for maternal morbidity

5: To demonstrate a measurable reduction in maternal morbidity (ante, intra and post-natal morbidity) and RTIs / STIs in married adolescent girls.

6: To reduce the prevalence of LBW babies among married adolescent girls

Part 2: Empowerment of unmarried adolescent girls through life skills education

Objectives

1: To demonstrate a measurable increase in cognitive and practical skills in unmarried adolescent girls.
2: To demonstrate a measurable improvement in self-esteem / self-efficacy of unmarried adolescent girls.
3: To increase the duration of formal school education for unmarried adolescent girls.
4: To delay age at marriage among unmarried adolescent girls.

Activities Carried Out During 2016-17

Activities were carried out in 10 slums in Hadapsar, in Pune during April 2016 to March 2017.

Part 1: Protection of young married women from adverse consequences of early motherhood

1. **Selection and capacity building of Community Health Workers (CHWs):**

Twelve CHWs in the project slums are active and do provide community-based services with ANMs. Few CHWs due to family reason left the work, while in subsequent months IHMP recruited new CHWs in respective areas. During April – June 16 there were 10 CHWs who were providing services, in subsequent quarters to till date there are 12 CHWs who are working in respective slums. For newly appointed CHWs, IHMP did capacity building through induction training for technical, management and BCC (Behaviour Change Communication) skills and regular field-based hand holding through supportive supervision. Following training programmes were organized for CHWs during reporting period.

Table 1.1 –Training programs conducted for CHWs during April 2016 to March 2017

Sr.	Training subject	Month	Duration – days	No. of CHWs attended	Knowledge & skills provided
1.	Exposure visit cum orientation training at Sasoon General Hospital, Pune.	Apr 2016	1	7	Cognitive skills on ANC registration process at tertiary care hospital.
2.	Induction training for newly appointed CHWs	June 2016	07 days (includes 3 days of field training)	2	Cognitive skills – maternal health, neonatal health, reproductive health, family planning. Practical skills on implementation of 6 IHMP RSH innovations
3.	In-service trainings of CHWs on Monthly surveillance and Life Skills Education	Apr 2016, to March 17	02 days in each month	11	Technical cognitive and practical skills related to monthly needs assessment and conducting sessions of LSE.
4.	Orientation training on community-based projects by Kishori Mandal	Oct 16	1 day	12	Demonstration on presenting demonstrations on nutritious recipe, paper work.
5.	Orientation on ANC and USG. At PUHC, by PMC medical officer.	Mar 2017	01 day	11	Cognitive skills – maternal and reproductive health. Practical skills – conducting needs assessment, needs specific BCC

2. **In-service training:**

12 in-service training sessions of two days each were conducted. CHWs and project staff participated in these training sessions. These were for two days; one day was spent on planning and review of RSH services while the second day was for planning and review of Life Skills Education. Technical inputs were provided for the sessions planned for the month. Project inputs, outputs and coverage were reviewed and participatory planning was done during the meetings. Cognitive and practical skills were provided to the CHWs.

3. **Surveillance and Monitoring System:**

CHWs regularly conduct daily home visits for monthly needs assessment, morbidity surveillance, and for the provision of needs specific BCC in their slums. The surveillance system covers following broad areas:

- Maternal health
- Neonatal health
- Reproductive health – Reproductive tract infections
- Family planning

4. **Behavior Change Communication (BCC):**

IHMP has developed an innovative strategy for behavior change communication which signifies a paradigm shift in dissemination of information and influencing health behaviors.

Two distinct approaches are being implemented in the project area.

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

Needs specific behavior change communication:

During monthly household visits, the CHWs identify the information needs of the individual. Based on the behavioral diagnosis they provide information and counseling specific to the needs of the individual and family. This need specific BCC approach has brought about a measurable change in health-related behaviors. During the reporting period, household visits were undertaken by CHWs during which they provided need specific BCC.

Table 1.2: No. of households visited by CHWs for needs specific BCC at household level

Period	Reporting for Number of CHW areas	Surveillance visits planned for registered MAGs+YMW	Surveillance visits actually conducted for MAGs+YMW	Percent MAGs+YMW visited
April to June 16	10	3520	3194	90.7
July to Sept 16	12	4271	3849	90
Oct to Dec 16	12	4253	3740	88
Jan to March 17	12	4230	3724	88

Average percentage of YMW who had been covered by monthly surveillance was 89.1 percent.

Behavior change communication through a social norms approach:

Group BCC sessions were conducted to influence social norms like age at first conception, birth interval, promotion of contraceptives, early registration for antenatal services, utilization of minimum standard antenatal care, etc.

136 group BCC sessions for young married women aged <=24 years were conducted at the slum level, by the project ANM. They conducted these meetings using participatory methods. Total of 2672 women from the 10 project slums attended the meetings. (Refer Table 1.3).

Table 1.3: Group BCC sessions conducted at slum during April 16 to March 17

Sr.	Period	Group BCC sessions conducted	Young married women 15-24 attended	Topics discussed during group BCC sessions
1.	Apr to Jun 2016	32	599	Care of low birth weight babies. Female reproductive system. Menstruation and menstrual problems
2.	Jul to Sep 2016	35	695	Post-natal care, Abortion, Routine antenatal care
3.	Oct to Dec 2016	36	724	Contraception. Reproductive tract and sexually transmitted infections
4.	Jan to Mar 2017	33	654	Reproductive tract infections
	Total	136	2672	

5. Outreach clinics conducted by project ANM:

The CHWs prepare a micro-planner every month which provides details of women and neonates with health needs along with details of the services they require. Based on the micro-planner, the CHWs actively link their clients to the slum level clinics conducted by ANMs. A total of 266 clinics in the project area were conducted in the reporting period in the project area. Primary level care services for maternal health, child health and family planning were provided at the clinics. The ANM cross-checks whether all the clients listed in the micro-planner availed services or not.

Project ANMs provided home based care to post-natal mothers, counseling to young married women who were detected with symptoms of RTIs, and couples who expressed a desire to use temporary family planning methods. In the reporting period, ANMs provided postnatal care to 199 mothers, conducted counseling sessions to 587 YMW that were detected with symptoms of RTIs and provided IPC to 646 YMW on the use of temporary contraceptives.

Table 1.4: Outreach services provided by Project ANMs during April 16 to March 17

Sr.	Details	Period				
		April to June 16	July to Sept 16	Oct to Dec 16	Jan to March 17	Total
1.	No. of clinics planned	72	70	66	66	274
2.	No. of clinics conducted	66	68	66	66	266
4.	No. of AN examinations	286	311	268	278	1143
5.	No. of postnatal mothers examined	57	40	62	40	199
6.	Counseling to YMW on use of contraceptives	128	203	165	150	646
7.	Counseling to YMW with RTI symptoms	134	167	164	122	587

6. Specialist OB Gynae clinic at PUHC:

Clinics for obstetric and gynecological services were conducted at the Annasaheb Magar Hospital, Hadapsar. A total of 39 clinics were conducted in the reporting period. 203 patients received treatment at the clinics. The treatment was provided by IHMP's consulting gynecologist. The clinics were jointly organized by the PUHC and IHMP staff. Most of the patients were treated for RTI/STIs at the clinic.

Table 1.5: Patients treated at the clinics by symptoms

Symptoms		No. of patients			
	Apr to Jun 16	July to Sept 16	Oct to Dec 16	Jan to March 17	Total
Symptoms suggestive of RTI/STI	12	36	15	10	73
Consultation for contraceptive use	10	6	3	6	25
Antenatal Complications	4	0	0	0	4
Menstrual problems	14	26	12	14	66
Infertility	0	0	3	1	4
Anaemia	1	0	0	0	1
Other complaints	4	14	8	4	30
Total	45	82	41	35	203

7 Slum Health and Development Committees (SHDCs):

During reporting period, 12 Slum Health and Development Committees were functioning in the all 12 CHW areas. SHDC meeting was planned once in a month for each slum area. A total of 141 meetings were planned and conducted in the reporting period. A total of 852 SHDC members were present at the monthly SHDC meetings.

Table 1.7: SHDC meetings conducted during April 15 to March 16

Sr.	Period	SHDC meetings planned	SHDC meetings conducted	Attendance at SHDC meetings	Topics discussed during meetings
1.	April to June 16	33	33	196	Community based monitoring
2.	July to Sept 16	36	36	203	New batch of LSE for unmarried adolescent girls
3.	Oct to Dec 16	36	36	214	Information on Govt. schemes on health, development, and livelihood.
3.	Jan to March 17	36	36	239	Community involvement in family planning campaign.
	Total	141	141	852	

SHDC members monitored the work of CHWs and ANMs. SHDC members visited households to cross check and certify the needs assessed by the CHWs. SHDC members motivated the community to utilize services offered at the PUHC.

8. On job training by Supervisors during field visits:

Four CHW areas were allotted to each field coordinator. Monthly supervisory visits to assess the skills of the CHW and provide in-service training through demonstrations were planned and initiated in each CHW area. Using supervisory check lists, supervisors assess skills of the CHW and provide practical skills to strengthen the processes – i.e. surveillance for needs assessment, needs specific BCC, referral system, linking clients to providers, preparation of micro-plans and MPRs. 122 of 122 planned supervisory visits (100%) were conducted.

2. Service Provision and Coverage during 2016-17

Table 2.1: Reported Symptoms of Reproductive Tract Infections.

Month	Reporting for Number of CHW Areas	Number of MAGs + YMW visited	Number of YMW with symptoms of RTIs	Percent YMW with symptoms of RTIs
April to June 16	10	3194	138	4.3
July to Sept 16	12	3849	233	6
Oct to Dec 16	12	3740	141	3.7
Jan to March 17	12	3724	169	4.5

The average proportion of women detected with RTI symptoms was 4.6%.

Table 2.3: Reported treatment seeking for Reproductive Tract Infections.

Month	Reporting for Number of CHW areas	Number of MAG & YMWs with symptoms of RTIs	Number of ECs sought treatment on RTIs	Percent ECs sought treatment on RTIs
April to June 16	10	138	72	52
July to Sept 16	12	233	101	43
Oct to Dec 16	12	141	69	49
Jan to March 17	12	169	93	55

The average proportion of women with RTIs who had sought treatment was 50 percent.

Table 2.4: Coverage of Antenatal Care.

Month	Reporting for Number of CHW areas	Number of Antenatal examinations planned	Number of antennal examinations carried out	Percent received antenatal care
April to June 16	10	321	285	88.7
July to Sept 16	12	391	339	86.7
Oct to Dec 16	12	335	304	90.7
Jan to March 17	12	365	327	89.5
Total	12	1412	1255	-

The proportion of pregnant mothers who received antenatal care was 88.9%.

Table 2.5: Reported Symptoms of Antenatal Complications.

Month	Reporting for Number of CHW areas	Number of Currently pregnant mothers	Number of pregnant mothers with antennal complications	Percent pregnant mothers with antenatal complications
April to June 16	10	321	65	20.2
July to Sept 16	12	391	93	23.8
Oct to Dec 16	12	335	70	20.8
Jan to March 17	12	365	85	23.3

The proportion of pregnant mothers reporting any one antenatal complication was 20%.

Table 2.6: Treatment taken for Antenatal Complications.

Month	Reporting for Number of CHW areas	Number of pregnant mothers with antennal complications	No. of pregnant mothers sought treatment for antennal complications	% pregnant mothers sought treatment for antenatal complications
April to June 16	10	65	47	72.3
July to Sept 16	12	93	76	81.7
Oct to Dec 16	12	70	52	74.2
Jan to March 17	12	85	61	71.7

The average proportion of pregnant mothers with symptoms of antenatal complications who sought treatment was 75 percent.

Table 2.7: Coverage for Postnatal Care.

Month	Reporting for Number of CHW areas	No. of postnatal mothers identified	Home based post-natal care by CHW	Post-natal mothers with post-natal complications
April to June 16	10	60	57	5
July to Sept 16	12	45	40	5
Oct to Dec 16	12	65	62	8
Jan to March 17	12	41	40	2
Total	46	211	199	20

During the reporting period, 20 post-natal mothers reported complications.

Table 2.8: Reported Use of Family Planning Methods.

Quarter	Reporting for Number of CHW areas	Average Number of MAGs & YMW visited	Average Number of YMW using any temporary FP method	Percent YMW using any temporary FP method
April to June 16	10	1064	285	26.7
July to Sept 16	12	1283	355	27.7
Oct to Dec 16	12	1246	365	29.2
Jan to March 17	12	1241	348	28.0

The average proportion of YMW using any form of temporary contraception/family planning method was 28 percent. The increase in using temporary family planning method from 26 percent in (Apr-Jun 16) to 28 percent (Jan-Mar 17) has been reported.

Case Study -1

Savita (name changed) couldn't bear the burden of her worries. She saw herself as an utter failure. A good wife ought to provide a son to perpetuate family name, how would she face the family and neighbors who had recently delivered a son. Anybody could see that she had lost weight and was crying frequently. Every time she looked at her three daughters, she felt the husband's abuse. She could no longer hold her tears back when she saw the IHMP staff nurse working in her slum. To make the matters worse, the staff nurse was explaining in the group meeting about family planning and lack of proper spacing between the children. Savita fled from that meeting. It did not escape the attention of our staff nurse. She was determined to get to the root of all this. When the staff nurse entered Savita's home, to her horror she saw Savita holding her three daughters and weeping her heart out. After much cajoling, Savita told her story haltingly. She told the nurse about the abuse by her husband, of her terror of unwanted pregnancy to get a son, of her husband's refusal to use a condom and the eventually shame she would bring on the family if she does not produce a son.

The staff nurse was speechless releasing the gravity of the situation. She had come across cases of husbands blaming the wife for not producing sons but did not consider that it can happen in the slum she visits regularly! The nurse first explained to Savita how the husband's Y chromosomes are responsible for the birth of a son. She now was obsessed with this task of getting Savita's husband to realize his misconceptions and mistakes. She also realized that she could not talk to the husband directly, so she involved the Male supervisor of IHMP. The supervisor had to go out of his way to meet the husband, who would be available only on weekends. He explained very patiently and in a very simple language, how a husband's Y chromosome is responsible for the birth of a son. The husband was surprised, how come nobody had ever told him about this simple fact. He did love Savita deeply and felt ashamed of his

behavior towards her. He promised the field supervisor that he would share this knowledge with his other male friends. It is a crime to blame the wife for the birth of daughters, the husband said.

IHMP nurse was a happy lady on the day she went for her group meeting and met Savita. She saw Savita's smile and walked towards her with outstretched arms. "I cannot thank you and the supervisor enough she said. My husband treats me with respect and we are very happy now". And with a twinkle in her eye she whispered, let me tell you a secret, "my husband uses condom now!"

Case study -2

Sudha (ANM working at IHMP) went for a routine antenatal clinic to Sita's vasti and saw her crying and very upset at her home. Sita said to Sudha as soon as she entered the house, "Sister, I don't want to live anymore, I have lost all hopes. There is no future for me and my kids." Sudha was shocked due to her words. Sudha asked her what has happened that she is so devastated. Sita was not ready to speak at first but she told her story when Sudha assured her that she would help her no matter what her problem is.

Sita said, "Sister you told me many times to get myself registered early for my routine pregnancy checkup but I did not listen to you. I regret that I kept myself busy in household chores. I did not give importance to see a doctor. I went very late for my first checkup. Doctor found out after blood tests that I am HIV positive. Doctor said that it is possible that my other children and my husband may have the same disease. I wish if I had gone sooner to the doctor, I would have known earlier. I may die very soon; my children may also die very soon. I feel very helpless. I do not know what to do. I blame my husband for all of this. I desire that he should go to hell when he dies."

Sudha assured her that she will never tell anyone that she is HIV positive. Sudha told her she should not fear as there is free treatment available for HIV in government hospitals. Sudha explained to her that treatment for HIV is prolonged. Sita should get her husband and children tested for HIV as per doctor's directions as soon as possible. Sudha cleared her doubts regarding her unborn child. Chances that her unborn child will get HIV in future are less if she gets proper treatment. Sudha explained her that the doctor will decide when to start the medications depending on the severity of her condition. Sudha also explained her not to fight with her husband and both of them should solve this problem together.

When Sudha went for her next visit to Sita's vasti, she found out that Sita had got her husband and her children tested. She was happy that her children were not HIV positive. Sudha explained her husband about the importance of timely treatment. He promised Sudha that he would take care of himself and his wife also. Sudha visited her regularly before her delivery. Sudha provided her routine antenatal care that she usually provides to all pregnant mothers. Sita delivered her child normally at a government hospital. Her husband and her mother thanked Sudha for her timely guidance.

Case study-3

Smita (IHMP supervisor) visited a vasti for supervising a community health worker. Little did she know before going to the vasti that her work plan for the day is going to be disrupted? She started her

routine of following the health worker wherever she goes, evaluating her skills. Both of them decided to work in a particular part of the vasti and started covering the area. When they came out of the first house the community worker stopped a man who was driving a motorcycle. His name was Sanjay.

Community worker started telling Smita about Sanjay. Sanjay worked from early in the morning till very late the night. He also avoided seeing the worker as he did not like to listen to her advice. "He is like a son to me. But he does not listen to me. I have told him so many times to use contraceptives but he does not listen.", she said. When Smita asked both husband and wife, she found out that they have a son who is 8 months old. Sanjay's wife wanted to use contraceptives after the birth of the son but he did not allow her. She got pregnant four months back. She went to her natal family and had to undergo an abortion. When Sanjay and her mother in law found out what she did, they were very angry. Sanjay did not want any type of contraception even after the abortion. His wife had tried to convince him many times before. But he would not listen to her.

Smita and community health worker explained to him the importance of spacing between children. He was still not ready to accept it. He kept saying, "I earn so much for my family, I want more children. Once we have two or three children she can undergo a family planning operation. Her own mother does not want her to use any of such things." But Smita did not want to leave without telling him about the adverse effects on his wife's health due to repeated pregnancies. Smita assured him his choice will also be considered about which method is suitable for the couple. He promised Smita and the worker that he will attend the special clinic with his wife and then he will decide what to do. Both the health worker and Smita were happy that they could convince Sanjay to stop avoiding the worker and go to the special clinic.

Next week, Sanjay and his wife came to IHMP's outreach clinic. They were explained the ill effect of frequent pregnancies without any spacing on a woman and her new born baby. Sanjay heard about the problem of low birth weight and its implications and finally decided to use a contraceptive to ensure a gap of 3 years between two births.

Part 2: Empowerment of unmarried adolescent girls through life skills education

Certificate distribution for LSE batch I (Aug 15 to Mar 16) and initiating second batch of LSE:

On 14 August 2016, a total of 239 UAGs who have completed sessions on life skills education received certificates at Narmadabai Kisan Prashala, Gosavi slum Hadapsar. About 400 UAGs and their parents and 70 SHDC members attended this certificate distribution ceremony.

Second Life Skill Education batch (Aug 16 to Mar 17):

The second batch of Life Skills Education (LSE) for unmarried adolescent girls was initiated in 9 slums during month of July 2016 and in rest 3 slums during month of September 2016. At the beginning of

batch, pre-test was conducted for a total of 231 girls enrolled for LSE to assess their levels of cognitive skills along with self-esteem and self-efficacy.

All 48 sessions were completed for this batch in March. Post-test for four vastis could be completed by the end of March 2017. A total of 55 girls have been covered in the post-test, for remaining slums post-test for knowledge and self-esteem & self–efficacy will be conducted in April 2017.

Supervision of LSE classes:

Supervision of the LSE classes was carried out through the IHMP field coordinator. 314 Supervisory visits were planned during the reporting period out of which 308 (95 percent) visits were done. During these visits the IHMP field coordinator performed the following functions:

- Checking of UAG attendance register maintained by CHW for LSE classes
- Methodology adopted by the CHW while taking LSE
- Use of participatory methods
- Reasons for irregular attendance

Peer leader selection and training:

Two girls each from the LSE class were selected as peer leaders. A total of 24 girls were selected as peer leaders from 12 LSE classes. Three days training of peer leaders was planned and organised at Shri. Annasaheb Magar Hospital, Hadpsar Pune; between 8th to 10th November 2016. A total of 23 peer leaders, 11 CHWs and IHMP field coordinators participated in the training. Participatory methods were used to generate discussions among girls.

Workshops on Sexual and Reproductive Health:

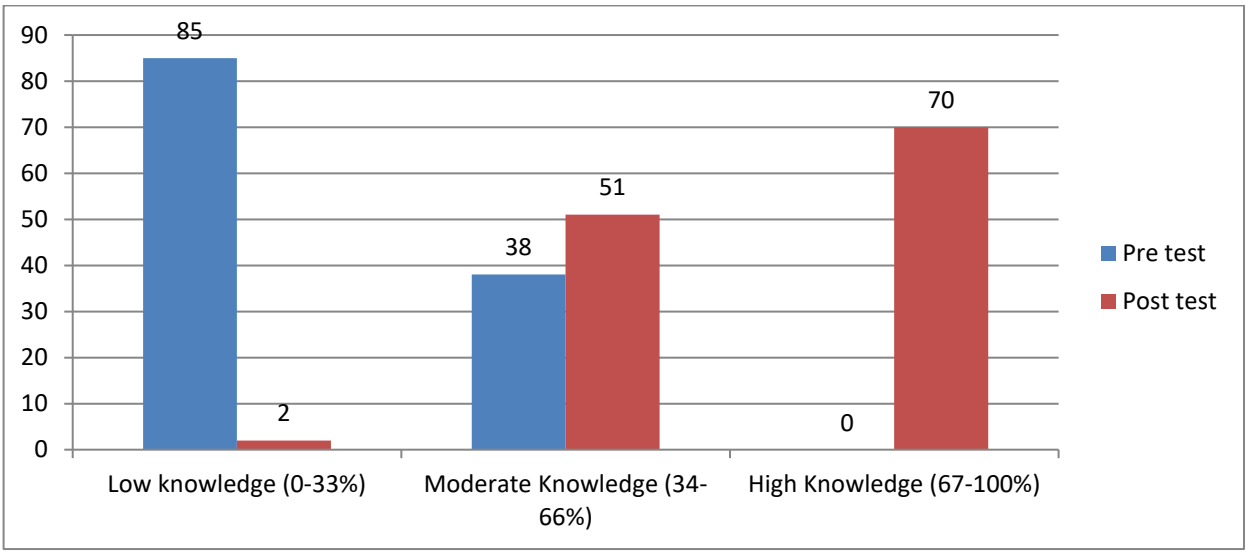
Total 4 workshops on Sexual and Reproductive Health were conducted for unmarried adolescent girls belonging to the slums of Hadapsar, Pune in June 2016, August 2016, February 2017 and March 2017. Total 158 girls attended the workshops. A pre-test was conducted to assess levels of knowledge among the enrolled girls aged 11-19 years for the workshops. 123 girls participated in both the pre and posttests. Only girls that were present for the pre-test as well as the post-test were considered in this study.

A significant increase in knowledge of sexual and reproductive health, among unmarried adolescent girls was observed in the post-test compared to pre-test. Number of girls with low knowledge significantly reduced from 85 in the pre-test to only 2 in the post-test. Also, a significant increase was seen in girls with high knowledge, from 0 in pre-test to 70 in post-test.

A tabular as well as graphical analysis of the data has been given below:

Percentage of scores	Pre-test (n=123)	Post-test (n=123)
Low knowledge (0-33%)	85	2
Moderate knowledge (34-66%)	38	51
High knowledge (67-100%)	0	70

Impact of RSH workshop on girls RSH knowledge



LSE Case Study:

Sima *(name changed)*, is a 17 years old girl who lives in one of the slums in project area. Before she was selected as peer leader, Sima had never participated in any kind of group activities. Sima sincerely attended LSE sessions, she got encouragement from her peers in LSE classes, and entire class chose her as their peer leader. IHMP provided Sima training on leadership, team building and community mobilization. IHMP has conducted several group activities with UAGs in her slum, where Sima took active role and mobilized girls and their parents; with the help from her friends she also arranged food items for nutritious recipe competition at her slum. For next LSE batch, the CHW was on maternal leave. It cannot be possible to conduct LSE sessions without a CHW. Sima came forward and expressed her will to teach new batch, she mobilized girls and conducted 20 LSE sessions under guidance from the IHMP supervisor. There are many things more to tell about her leadership, she herself visited households for convincing parents to send their girls to IHMP's sexual and reproductive health workshop. Very often Sima has voluntarily worked as substitute for CHW; she mobilizes and takes & brings back girls from SRH workshop. For enrolling needy girls in current new LSE batch, Sima has visited many households in her slum and encouraged more and more girls to get enrolled for LSE. Thanks to her efforts, CHW could manage to start LSE sessions in surprisingly short duration of time. At present Sima happily continues her voluntary work as a peer leader, she visits household of girls who are drop outs from school and negotiates with their parents to delay girl's marriage and enroll her into formal education. Sima is happy with her role at her slum, she always expresses her gratitude towards IHMP for providing exposure to leadership skills.

Key Organizational Initiatives

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

Governance

Organization Structure

Board of Trustees

▼

Managing Trustee

▼

Director / Addl. Director

▼

Management Committee

▼

Coordination Committee (All programme coordinators)

▼

Individual Programme Committees

▼

Field Supervisors and Field Workers

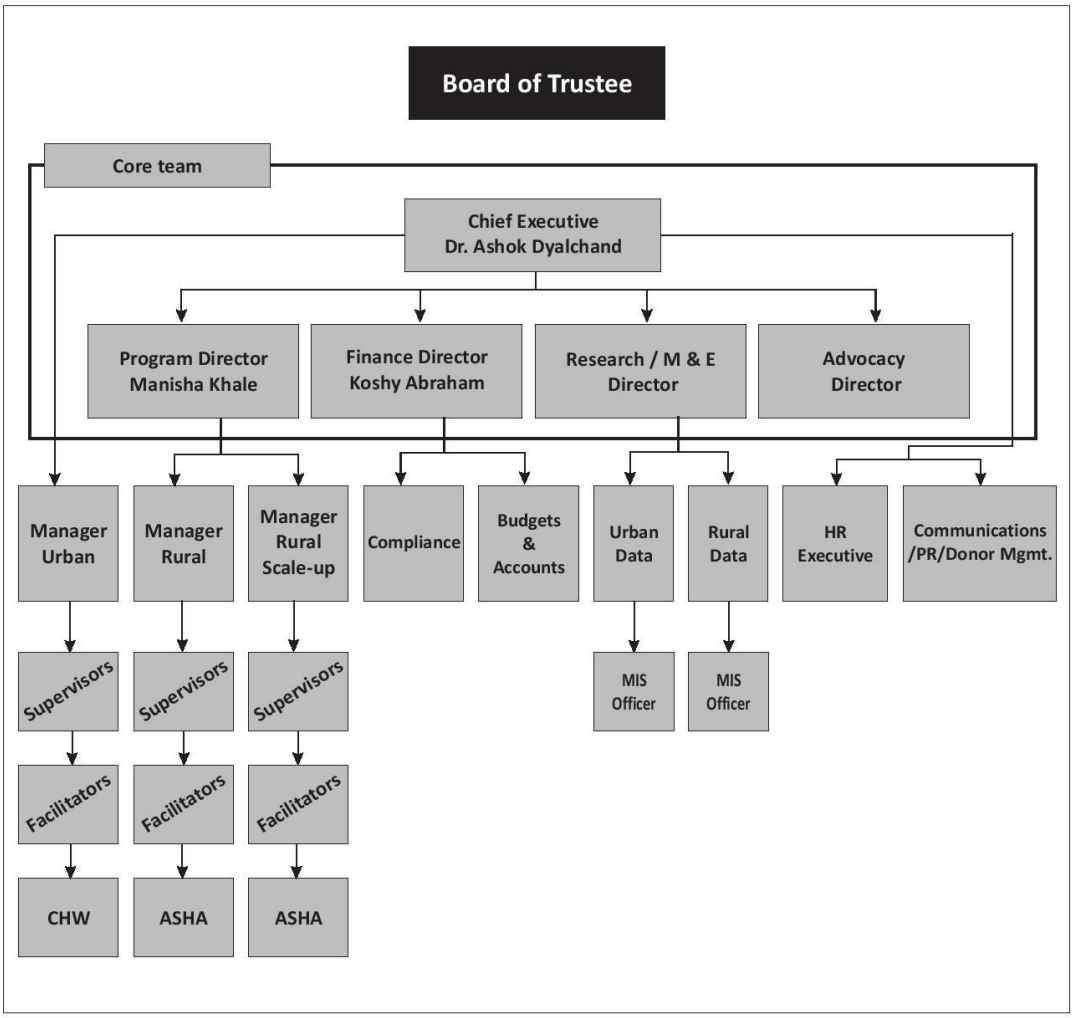
▼

Community Health Workers /ASHAs

▼

Village / Slum Health & Development Committees

Organization Structure



Board of Trustees

Sr. No.	Name	Age	Gender	Occupation	Position in the Board
1	Dr. C. A. K. Yesudian	67	Male	Retd. Dean, School of Health Systems, Studies, TISS, Mumbai	Chairperson
2	Ms. Manisha Khale	64	Female	Additional Director, IHMP	Managing Trustee
3	Prof. (Mrs.) Kalindi Mazumdar	85	Female	Retd. Prof. Nirmala Niketan, Mumbai	Trustee
4	Mr. David Gandhi	53	Male	Development Consultant, Pune	Trustee
5	Dr. A. Dyalchand	69	Male	Director, IHMP	Trustee
6	Dr. Nandita Kapadia Kundu	54	Female	Sr. Researcher at Centre for Communication, Johns Hopkins Bloomberg School of Public Health, Pune	Trustee

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

Board of Trustees Meetings

The Board of Trustees meetings were held during the period 2016-2017 as follows:

Sr. No.	Date
1	16.07.2016
2	28.12.2016
3	20.02.2017
4	31.03.2017

Audited statements of accounts and balance sheet for the financial year 1st April 2016 to 31st March 2017 were accepted and approved in the Board of Trustees meeting held on 18th November 2017.

The budget for the period 1st April 2016 to 31st March 2017 was reviewed and approved on 26th February 2016.

Transparency Disclosures

- No remuneration, sitting fees or any other compensation is paid to any Board of Trustees
- The Director and Additional Director who are also trustees are paid consolidated salaries.
- Travel reimbursements were made to Board of Trustees attending Board meetings
- Total costs of travels incurred by Board of Trustees during the year amounted to Rs. 15,00/-

Legal Compliances

Ashish Gram Rachna Trust, Pachod complies with statutory requirements of Income tax Act. 1961, BPT Act 1950 and Foreign Contribution Regulation Act. 1976. AGRT has received renewal of registration under the Foreign Contribution (Regulation) Act, 2010.

All donor requirements were duly complied with.

Ashish Gram Rachna Trust, Pachod followed a rigorous audit process. The statutory auditor was appointed during the Board of Trustees meeting held on 8th July 2016.

Audited statements of accounts and balance sheet for the financial year 1st April 2016 to 31st March 2017 were accepted and approved in the Board of Trustees meeting held on 18th November 2017.

Information on distribution of staff by Gender and Salary

Salary Distribution by Gender as on March 31, 2017			
Monthly Salary of Staff Members (in Rs.)	Men	Women	Total
≤5,000	0	0	0
5,001 – 10,000	40	10	50
10,001 – 25,000	17	25	42
25,001 – 50,000	3	2	5
≥50,001	3	0	3
Total	63	37	100

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

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

Sr. No.	Name	Designation	Experience	Education	Specialization
1	Dr. A. Dyalchand	Director	AGRT/IHMP 43 years	MBBS MD CMC Vellore MPH, Johns Hopkins, Baltimore, USA	Health Management Epidemiology HIV AIDS
2	Ms. M. Khale	Additional Director	AGRT/IHMP 40 years	M.Sc. Biochemistry, M.Sc. RCH London School of Hygiene & Tropical Medicine, UK.	PHC / RCH HIV AIDS
3	Mr. K. Abraham	Financial Mgmt / Cost analysis	AGRT/IHMP 34 years	B.Com, DBA, DHA, CCO	Financial Mgmt. and Admin.
4	Dr. N. Kapadia-Kundu	Consultant	AGRT/IHMP 22 years + 10 years as consultant	MA, PhD JHU, Baltimore, USA	Behavioral Sciences
5	Mr. S. M. Shinde	Coordinator, Integrated ARSH	AGRT/IHMP 31 years	MSW	Rural drinking water supply & sanitation,
6	Mr. H. B. Pawar	Coordinator, Child health	AGRT/IHMP 28 years	MSW	Child nutrition & development
8	Mr. J. J. Rupekar	Integrated Counselor	AGRT/IHMP 27 years	MSW / HIV Counseling	Integrated counseling
9	Mr. G. R. Kulkarni	Research Coordinator,	AGRT/IHMP 18 years	M.Sc. Statistics; Training in	Biostatistics / research

		Biostatistician		Epidemiology at Johns Hopkins.	
10	Ms. Kalpana Sanas	In-charge Desk Top Publishing (DTP)	AGRT/IHMP 20 years	DTP & website designing	Designing and production of BCC material
12	Ms. Rupa Takale	Field coordinator Life skills Education	AGRT/IHMP 18 years	MSW; Training in ARSH	Life skills Education for Adolescent girls
13	Ms. Pushpa Kharat	Integrated Counselor	AGRT/IHMP 14 years	MSW/ HIV Counseling	Integrated counseling
14	Dr. K. Bharucha	Consultant	Retd. Prof. Ob. Gynae. BJMC, Pune	MBBS, MD	Ob. Gynae. RTI / STI / HIV AIDS

Finance

Responsibility Statement by the Management

AGRT/ IHMP confirms:

1. The Annual Accounts have been prepared on the basis of the accounting policies adopted by the organization with compliance to Accounting Standards wherever necessary.
2. Sufficient care has been taken for the maintenance of accounts as per the applicable legal statutes of India.
3. The Statutory Auditors have performed their task in an independent manner and the management letter submitted by the Statutory Auditors has been considered by the management.
4. During day to day operations of the organization, ethical accountability, value of money and environmental concerns has been given highest priority.

No part of the income during the previous year has been applied and used directly for the benefit of:
a. The author or founder of the organization
b. Any person who has made a substantial contribution to the organization
c. Any relative of the Board of Trustees
d. Any concerns in which the above-mentioned category of persons has substantial interest. (As required under Sec. 13(3) of Income Tax Act, 1961)

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

FINANCIAL STATEMENTS

(Please find them attached on the next page)

FUTURE FOCUS

The Institute shall continue the implementation of the "Integrated project for the empowerment of adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence in the villages under Adul PHC in Aurangabad district.

IHMP will initiate an "Integrated project for the empowerment of adolescent girls and protecting them from the consequences of early marriage, early conception sexual and domestic violence" in Pune rural district through CSR support.

IHMP shall continue to scale up for the Project on Preventing Child Marriage and Early Pregnancy in India, in villages under two PHCs in Jalna District.

IHMP shall send a proposal to the State Government to scale up the project on Preventing Child Marriage and Early Pregnancy in the whole of Jalna district.

IHMP will continue to implement the Integrated reproductive and sexual health and family planning project for young married women in urban slums of Pune City.

ACKNOWLEDGEMENTS

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

- MacArthur Foundation, USA
- Dasra Impact Foundation, Mumbai
- Yardi Software Pvt. Ltd, Pune
- Forbes Marshall Steam Systems Pvt.

During this period AGRT received donations from:

- A large number of individual donors through GlobalGiving, UK

SUPPORT OUR WORK

You can empower a rural adolescent girl with Life Skills Education through a donation of Rs. 7500.00.

You can provide a rural adolescent girl a bicycle worth Rs. 4000.00 so that she can continue her education till at least 10th or 12th grade.

Sixty percent girls get married before 18 years and suffer the adverse consequences of early motherhood. You can ensure primary health care for a child mother through a donation of Rs 9000.00.

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

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

All donations to Ashish Gram Rachna Trust are eligible for tax exemption under Section 80G of the Income Tax Act, 1961.
For more information, please write to us at admin@ihmp.org OR adminpachod@ihmp.org

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