Ashish Gram Rachna Trust, Pachod

Annual Report

2017 – 2018

Ashish Gram Rachna Trust, (Regn. No. E-249-Aurangabad) Pachod
P.O. Pachod (431 121), Taluka: Paithan
Dist. Aurangabad (Maharashtra)

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Preventing Child Marriage and Early Pregnancy in India
Activity Report for Ninth Quarter
April to June 2017

Introduction:

Institute of Health Management, Pachod has been implementing a project for "Preventing Child Marriage and Early Pregnancy in India" in the villages of two PHCs in Jalna District since April 2015. Details of activities undertaken during ninth quarter – April 2017 to June 2017 are given in this report.

Capacity Building of Facilitators (Female):

A 4-day training of trainers was organized for facilitators on Reproductive and Sexual Health (RSH) from 19th to 22nd April 2017. Objective of the training was to provide them with the skills of conducting Reproductive and Sexual Health workshops for adolescent girls. This training was attended by 16 facilitators. Average pre-test score was 20 and post-test score was 28 out of a total score of 30.

Married Adolescent Girls Component:

Monthly Surveillance Visits by ASHAs:
A total of 68 ASHAs are functioning, out of which, on an average monthly surveillance was done by 60 ASHAs (87.7%). Need specific BCC and counseling was also given by ASHAs during household visits. On an average 1254 (90.0%) married adolescent girls out of a total of 1393 married adolescent girls were visited during monthly surveillance visits. Based on their needs women were linked to health providers at the village level or higher levels of care. A total of 90 new married adolescent girls were registered during the quarter.

In this quarter, 113 new pregnant women were detected, out of which 76 (67.3%) were registered before 12 weeks of pregnancy and 37 (32.7%) were registered after 12 weeks of pregnancy. Out of the total pregnant women registered, on an average 200 (93.8%) pregnant women were examined every month. During the quarter, 109 women delivered, out of which 108 (99.1%) delivered in the hospital and one delivered at home. Out of the total women delivered, 108 women (99.1%) had five or more antenatal check-ups, 109 i.e. 100% women received two injections of Tetanus Toxoid and 108 (99.1%) women reported having consumed 100 Iron and Folic acid tablets in pregnancy. This indicates that universal coverage of women with the standard minimal antenatal care has been achieved.

During the reporting period, eight women reported danger signs during pregnancy, out of which four (50%) sought treatment. Two women reported complications during delivery. Out of the women delivered two months prior to the reporting month, 13 (81.3%) post-natal mothers were visited five times by ASHAs and 15 (93.8%) post-natal mothers were visited twice by ANMs. Post-natal complications were reported by one woman, who took

treatment for the complications. A total of 52 women reported symptoms of RTIs during the surveillance. Out of which 21 (40.4%) sought treatment.

During the reporting period, on an average 317 (31.7%) eligible couples, out of a total of 999 eligible couples were using any one temporary contraceptive method either to delay first pregnancy or increase the interval between two births. Most preferred method of contraception was condoms.

Supervision of Surveillance and Need Specific Behaviour Change Communication:
On an average 267 (77.3%) households out of a total of 346 planned households were visited in a month by the facilitators (female) for supervision of surveillance done by ASHAs. On an average 249 (72.3%) households out of a total 345 planned households were visited in a month by facilitators (female) to observe need specific BCC given by the ASHAs.

During this quarter, facilitators could not do supervisory visits during the month of May 2017 due to RSH workshops organized for the adolescent girls.

Behaviour Change Communication – Group Meetings Conducted by Facilitators:
Once a month Behaviour Change Communication (BCC) group meetings for married adolescent girls and mothers-in-law are conducted by facilitators (female). Due to RSH workshops for adolescent girls, facilitators (female) could conduct only 73 BCC group meetings out of a total planned 204 BCC group meetings in the quarter. On an average 245 married adolescent girls attended these BCC group meetings i.e. 67 percent of the expected number of married adolescent girls. Topics covered during BCC group meetings were – Importance of preventing child marriage & early pregnancy, and Care during pregnancy & Importance of antenatal checkups.

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Unmarried Adolescent Girls Component:

Reproductive and Sexual Health Workshops:
During the quarter, since the first batch of adolescent girls had completed "Life Skills Education" course of six–month duration, older girls 15-19 years were invited for a four-day workshop on Reproductive and Sexual Health

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 knowledge about Reproductive and Sexual Health.

- Adolescent girls would feel comfortable talking about Reproductive and Sexual Health issues.

From the last week of April 2017 to the second week of June 2017, a total of 13 Reproductive and Sexual Health workshops were organized for adolescent girls from Jamkhed PHC. These workshops were attended by 502 girls. Average pre-test score was 9 and post-test score was 25.1 out of a total score of 30. Average pre-test score of ASHAs from Jamkhed PHC was 14 and post-test score was 27 out of a total score of 30.

From the last week of April 2017 to third week of May 2017, a total of 340 adolescent girls were covered through seven workshops organized in Wadigodri PHC. Average pre-test score was 11.2 and post-test score was 23.8 out of a total score of 30. Average pre-test score of ASHAs from Wadigodari PHC was 13.5 and post-test score was 26 out of a total score of 30.

Life Skills Education Classes:
A total of 1478 adolescent girls were enrolled for the first batch, out of which 1213 (82.1 %) girls attended more than eighty percent of the classes.

During the reporting period, 267 Life Skills Education classes were conducted i.e. 57.7 percent of the planned Life Skills Education classes. It was not possible to conduct planned classes by ASHAs since they were accompanying adolescent girls for the workshops. On an average 21 girls per ASHA area attended Life Skills Education classes in 47 ASHA areas.

Kishori Mandals:
Kishori Mandal activities are organized once a week in the evening. During the quarter, 61 ASHAs in April, 61 ASHAs in May and 55 ASHAs in June facilitated Kishori Mandal activities. On average 20 adolescent girls enrolled by each ASHA participated in the Kishori Mandal activities every month. A list of activities organized through Kishori Mandals during the reporting period is given below:

- Quiz – general knowledge.
- Street play on importance of education for girls.
- Session on sun stroke.
- Craft – making door mats and pen holders.
- Rangoli.
- Mehandi.

Status of Kishori Mandals & Peer Leaders where ASHAs have discontinued work:
Facilitators (female) are mentoring and giving guidance to Kishori Mandals in 8 villages in which ASHAs have discontinued work due to personal reasons. Five activities out of a total of eight activities planned could be facilitated due to engagement of facilitators in the ongoing Reproductive and Sexual Health workshops. On an average 18 girls per village participated every month in the Kishori Mandal activities.

Facilitators also conducted Life Skills Education classes in these villages. On an average 19 girls per village attended these sessions.

Meetings with Parents:
During the quarter, forty-one out of the planned sixty-one meetings were conducted with the parents for seeking permission to send their daughters for the Reproductive and Sexual Health workshops. A total of 765 (83.2%) parents out of the expected number attended these meetings.

A second set of meetings were conducted with parents of eligible adolescent girls to motivate the parents to get their daughters enrolled for the second batch of Life Skills Education course. A total of fifty-nine meetings out of the planned sixty-one meetings with parents of adolescent girls were organized, which were attended by 917 (66.1%) parents out of the expected number to be attending the meetings.

Supervision of Life Skills Classes and Kishori Mandal Activities:
Facilitators (female) could undertake 108 supervisory visits to the classes during the quarter. It was observed that on an average 20 adolescent girls per village were present in the class conducted by the ASHAs. Facilitators could undertake 47 supervisory visits to Kishori Mandal activities facilitated by ASHAs. It was observed that on an average 19 girls participated in the Kishori Mandal activities.

Boys and Young Men Component:

Forty youth groups that are established have been functioning well in Jamkhed PHC.

BCC Group Meetings for Youth:
On an average 40 BCC group meetings were organized every month during the quarter. On an average 669 youth attended monthly BCC group meetings i.e. 83.6 percent of the number expected to attend the meetings. Topics discussed in these meetings were Domestic Violence, Addictions and how does conception occurs? On demand, a total of 12 youth were given individual counseling. Eighty peer leaders shared information with their peers. During the quarter 297 i.e. 74.3 percent youth were covered out of the total expected number to be covered by the peer leaders.

BCC Group Meetings for Spouses:
Once a month BCC group meetings are conducted with the spouses of married adolescent girls with the objective of increasing male responsibility. On an average 55 (82%) of the planned BCC group meetings were conducted every month with the spouses of married adolescent girls. On an average 581 spouses out of a total of 1085 spouses attended BCC group meetings i.e. 54 percent coverage. Topics covered were same as those covered in the BCC group meetings for married adolescent girls.

Community Based Monitoring:
On an average 20 (44%) out of the total planned meetings of Village Health Nutrition Water and Sanitation Committee members were organized every month for Community Based Monitoring. These meeting were attended by 128 (57 – female and 71 male) members i.e. 69 percent of the expected number. Topics discussed during these meetings

were, treatment and care to be taken and importance of safe drinking water, methods of storing drinking water & water borne diseases.

Advocacy

The process of preparation of the annual Programme Implementation Plan (PIP) by the health ministry in India is as follows:

1. Each district is asked to prepare their district health PIP.
2. All the districts send their PIPs to the State Ministry of Health and the state National Health Mission office,
3. Only the most impactful, feasible and replicable proposals are included in the State PIP.
4. The State sends the PIP to the National Ministry of Health.
5. The National Ministry of Health approves the funding for interventions and innovations, which it feels are relevant in the National context and sends the approved PIP back to the States by the month of May of a given year.

In order to the get IHMP's innovation included in the district PIP, the staff took district level officials to the two demonstration Primary Health Centres (PHCs) that are being supported by the DGC. The staff of the two PHCs wrote to the district officials and informed them how the interventions had made their work output much more effective. As a result of this advocacy at the PHC and district levels our innovations were included in the district PIP.

The next step was to convince the State Ministry of Health to include our scaling up proposal in the State PIP. IHMP made over a dozen trips to meet the state level officials in Pune and Mumbai to convince them to include our innovations in the State PIP. Here too we were very successful. IHMP's proposal and budget was accepted without any modification.

The next challenge was to advocate with the technical and bureaucratic decision makers at the Health department and Ministry of Health at the National level to approve funding for the scaling up of IHMP's model in 10 primary health centres in Jalna district. The director, IHMP made several trips to Delhi to meet with the concerned officials during the last quarter to secure approval and funding from the National Government.

Normally, the National approval of the State PIPs is received by May every year. This year the communication got delayed and was received by the State in the first week of July. IHMPs proposal was not approved by the National Government for two reasons.

1. The budget for each PHC in IHMP's proposal was Rs 9,48,940.00. The central Government found this budget to be too high and therefore its replicability was questioned.

2. IHMP's model is applicable only to States where there are literate ASHAs. Hence the Central Government felt that the model is not relevant for every State, particularly, the backward North Indian States.

Since then IHMP has been advocating its model for scaling up in Maharashtra and other States that have literate ASHAs.

IHMP has been advised to resubmit the proposal for inclusion in the supplementary PIP by reducing the intensity of the programme, reducing the budget and scaling it up to the entire District in order to demonstrate its relevance at the district level.

Accordingly, IHMP is preparing a proposal to cover 40 PHCs in the entire district of Jalna. The budget requested from the National Government has been reduced from Rs 9,48,940.00 to only Rs 4,14,750.00, per PHC, per year.

The Director IHMP is once again going to Delhi to meet with the concerned officials and get approval for the revised scaling up proposal and budget.

Preventing Child Marriage and Early Pregnancy in India
Activity Report for Tenth Quarter
July to September 2017

Introduction:
Institute of Health Management, Pachod has been implementing a project for 'Preventing Child Marriage and Early Pregnancy in India' in 53 villages of two PHCs in Jalna District since April 2015. Details of activities undertaken during tenth-quarter-July to September 2017 are given in this report.

Refresher Training of ASHAs:
First, 4-day refresher training of ASHAs was organized on LSE - Part 1, surveillance and BCC from 10th July to 13th July 2017 for ASHAs from Wadigodri PHC and from 17th July to 20th July 2017 for ASHAs from Jamkhed PHC. This refresher training was attended by a total of 49 ASHAs.

Second, 4-day refresher training was organized on LSE – Part 2 from 11th to 14th September 2017 for ASHAs from both the PHCs, which was attended by a total of 57 ASHAs.

Main objectives of the refresher trainings were:
- Importance of taking activities for making learning enjoyable
- How to prepare for taking the session in a participatory manner?
- ASHAs were asked to take session by using simple language and local lexicon in a participatory manner to make it easy to understand.

The other ASHAs and facilitators gave feedback to the ASHA taking the session. Every day best performing ASHA was selected by the panel of jury and given a prize.

Married Adolescent Girls Component:

Monthly Surveillance Visits by ASHAs:
A total of 68 ASHAs are functioning, out of which, on an average, monthly surveillance was done by 59 ASHAs (87.3%). Need specific BCC and counseling was also given by ASHAs during monthly household visits for the surveillance. On an average 1280 (90.2%) married adolescent girls out of a total 1419 married adolescent girls were visited during monthly surveillance visits. Based on their needs women were linked to the health provider at the village level or higher levels of care. A total of 43 new married adolescent girls were registered during the quarter.

In this quarter, 107 new pregnant married adolescent girls were detected, out of which 75 (70.1%) were registered before 12 weeks of pregnancy and 32 (29.9%) were registered after 12 weeks of pregnancy. On an average 200 (92.2%) pregnant women were examined every month out of a total of 217 registered pregnant women. During the quarter, 83 women delivered, out of which 82 (98.8%) delivered in the hospital and one delivered at home. Out of the total women delivered, 77 (93.8%) were examined five or

more times during pregnancy, all women received either two injections of Tetanus Toxoid or booster dose and 81 (97.6%) women reported having consumed 100 Iron & Folic Acid tablets. This indicates that almost universal coverage of women with the minimum standard antenatal care has been achieved.

In this quarter, 25 women reported danger signs during pregnancy, out of which 19 (76%) sought treatment. Only one woman reported complication during delivery. Out of the women delivered two months prior to the reporting month, 19 (95%) post natal mothers were visited five times by ASHAs and twice by ANMs during the post natal period. Coverage with post natal visits has improved tremendously. Two women reported post natal complications, out of which one sought treatment. A total of 95 women reported symptoms of RTIs during the surveillance. Out of which 52 (54.7%) took treatment. There is need to decentralize health services for the treatment of maternal morbidity and RTIs to improve treatment seeking behaviour.

During the reporting period, on an average 342 (33.9%), out of a total of 1007 eligible couples were using any one contraceptive method either to delay first pregnancy or increase the interval between two births. The most preferred method of contraception was condom.

Supervision of Surveillance and Need Specific Behavior Change Communication:
On an average 274 (78%) households out of a total of 354 planned households were visited in a month by the facilitators (female) for supervision of surveillance done by ASHAs. On an average 260 (73%) households out of a total of 354 planned households were visited every month by facilitators (female) to observe need specific BCC given by the ASHAs

Behavior Change Communication - Groups Meetings Conducted by Facilitators:
Once a month Behavior Change Communication (BCC) group meetings for married adolescent girls and mothers-in-law are conducted by facilitators (female). One hundred & sixty five (81%) BCC group meetings were conducted out of a total 204 planned BCC group meetings. On an average 543 married adolescent girls attended BCC group meetings every month i.e. 67 percent of the expected number of married adolescent girls. Topics covered during BCC group meetings were – abortion and post abortion care, temporary methods of contraception, birth preparedness, importance of having a delivery in a hospital and complications which can occur during delivery.

Unmarried Adolescent Girls Component:

Reproductive and Sexual Health Workshop:
A four day workshop on Reproductive and Sexual Health was organized from 24th to 27th July for the remaining 41 adolescent girls from four ASHA areas in Wadigodri PHC.

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 knowledge about Reproductive and Sexual Health.
- Adolescent girls would feel comfortable talking about Reproductive and Sexual Health issues.

Life Skills Education (LSE) Classes:
A total of 1332 adolescent girls have been enrolled for the second batch of LSE course. Eight adolescent girls were randomly selected from the girls enrolled with each ASHA for pre-test assessment. LSE classes for the second batch were initiated from July 2017 after conducting pre-test for 455 girls. During the quarter, on an average 57 ASHAs, conducted Life Skills Education classes at the village level and on an average 8 classes were conducted every month. On an average 20 adolescent girls attended the classes per ASHA area. During the quarter, 90.7 percent of the total adolescent girls enrolled attended more than 80 percent of the sessions conducted by the ASHAs and peer educators.

Kishori Mandals:
During the quarter, on an average 57 ASHAs facilitated Kishori Mandal activities once a week, each month. On an average 20 adolescent girls, in each ASHA area, participated in Kishori Mandal activities each month. During the quarter, 88.4 percent of the total adolescent girls enrolled participated in more than 80 percent of the activities facilitated by ASHAs and peer leaders. There are 114 peer leaders. A list of activities organized through Kishori Mandals during the reporting period is given below:

- Craft - making of door mats from old saris
- Preparing 'Rakhis' and doing henna.
- Actual filling up of forms for opening a savings account in the post-office and bank
- Competitions – debate, essay writing, memory games
- Organised 'Dandia' in Navaratri
- Visit to local institutions – Police station, ration shop.

Status of Kishori Mandals & Peer Leaders Where ASHAs Have Discontinued Work:
Facilitators (female) are mentoring and giving guidance to 16 peer leaders from 8 ASHA areas. Facilitators (female) undertook seven activities as per plan in these villages and average number of girls who participated in each activity was 16.

On an average 21 adolescent girls per village attended LSE sessions taken by facilitators (female)

Households Visits to Motivate Parents:
Facilitators (female) visited households of adolescent girls to motivate parents to get their daughters enrolled for the course and send their daughters regularly for the classes. On average facilitators visited 348 (83%) households out of a total of 419 planned households.

Supervision of Life Skills Education Classes and Kishori Mandal Activities:
During the quarter, Facilitators (female) undertook 177 supervisory visits to LSE classes conducted by ASHAs. It was observed that 20 adolescent girls were present in the classes.

During the quarter, Facilitators (female) undertook a total of 48 supervisory visits to Kishori Mandal activities facilitated by ASHAs. It was observed during each visit that 20 girls participated in the Kishori Mandal activities.

Boys and Young Men Component:

In Jamkhed PHC, 40 youth groups have been established and 956 youth are members of these groups.

Refresher Training:
3-day refresher training was organized for male facilitators from 31st August to 2nd September 2017. Main focus of the training was to improve their skills of facilitating sessions in a participatory manner. Each facilitator took the session in the classroom and all others gave him feedback on how it can be conducted in an effective manner.

BCC Groups Meetings for Youth:
On an average 40 BCC group meetings were organized every month in this quarter. On an average 703 youth attended monthly BCC group meetings i.e. 88 percent of the number expected to attend the meetings. Topics discussed during these BCC groups meetings were anatomy and physiology of male reproductive system, temporary family planning methods, and reproductive tract infections in men. A total of 52 youth were given individual counseling on demand. Eighty peer leaders shared information with their peers. In the quarter, on an average 317 youth were covered every month. i.e. 79 percent youth were covered out of the total expected number to be covered by the peer leaders.

Workshops for Peer Leaders:
Two one-day workshops were organized for the peer leaders, which were facilitated by external resource persons. The first workshop was facilitated by a resource person from Masum, Pune, which was attended by 48 peer leaders. Topics covered were gender, patriarchy, masculinity and violence against women.

The second workshop was facilitated by a resource person from Tathapi, Pune, which was attended by 48 peer leaders. Topics covered during this workshop were effect of addictions on the body, appropriate age of marriage for a boy and girl, freedom to choose a partner, new concept of masculinity and demonstration of how to use the website 'Let Us Talk Sexuality' for clarifying doubts and questions about sexual health.

Participation in the State Level Conference for Youth:
Two facilitators (male) working in Jamkhed PHC participated in a 3–day state level conference for youth. The main issues which were discussed during the conference were

freedom to express, right to equality, right to choose a partner, participation of youth in politics and the politics of identity based on religion and caste.

Behaviour Change Communication (BCC) Group Meetings for Spouses:
Once a month BCC group meetings are conducted with the spouses of married adolescent girls with the objective of increasing male responsibility. On an average 59 (88%) of the planned BCC group meetings were organized every month with the spouses of married adolescent girls. On an average 682 spouses out of a total of 1163 spouses attended BCC group meetings i.e. 59 percent coverage. Topics covered were same as those covered in the BCC group meetings for married adolescent girls.

Community Based Monitoring:
Every month review meetings were conducted with the members of the Village Health Nutrition Water Supply and Sanitation Committee to review needs identified by the ASHA and service provision by the sub-centre ANM. On an average 68 (74.7%) out of the total planned meetings were organized in July and August 20117. In the month of September VHNWSC meetings could not be conducted due to code of conduct enforced because of Gram Panchayat elections in October 2017. These meetings were attended by 205 (100 – female & 105 - male) members i.e. 69 percent of the expected number. Topics discussed during these meetings were importance of Village Health & Nutrition Day (VHND), what health services are provided on the day of VHND, environmental sanitation and importance of using latrine and review of project activities undertaken during the year and activities planned for the next year.

Workshops for Village Health Nutrition Water Supply & Sanitation Committee Members:
One-day workshops were organised for the committee members of Wadigodari PHC on 16th August 2017 and of Jamkhed PHC on 22nd August 2017. A total of 124 (46 - male & 78 - female) members attended the workshops. The agenda for the workshop was to discuss objectives of the project, review progress made, discuss how to increase participation of the committee members into various activities, who all can be taken as new members on the committee and what needs to be done to motivate ASHAs who have discontinued work. There was a lot of discussion on these issues and good suggestions were made like information about various government schemes to be given through monthly meetings. Committee members agreed to take the responsibility of suggesting names people who can contribute to project work and for resolving the problems faced by the ASHAs.

Advocacy
Several visits were made to the ministry of health and family welfare, Government of India in Delhi to understand why our scaling up proposal in Jalna district was not approved despite being highly recommended by the State Government. The response we received was that the IHMP model was too cost intensive for the Government of India to replicate in other districts in Maharashtra. It was communicated to us that if IHMP expects approval for scaling up its innovation the budget would have to be more or less similar to what the Government is allocating per district.

After coming back from Delhi we had a detailed meeting with the Director, Adolescent Reproductive and Sexual Health (ARSH). The proposal and budgets were revised and finalized under her guidance.

The revised proposal has been sent by the Director, ARSH to the Managing Director, National Rural Health Mission (NRHM) and to the finance department, GoM. Once their approval is obtained IHMP's proposal, which is now a part of the supplementary PIP of Mahashtra State, will be sent to the Government of India for funding.

Preventing Child Marriage and Early Pregnancy in India
Activity Report for Eleventh Quarter
October to December 2017

Introduction:

Since April 2015, Institute of Health Management, Pachod is implementing an innovative project in 53 villages of Jamkhed and Wadigodri PHCs, Jalna District with the aim of eliminating child marriage and reducing maternal morbidity and mortality. Interventions are targeted at unmarried and married adolescent girls and boys and young men. Details of activities undertaken during the eleventh quarter - October to December 2017 are presented in this report.

Married Adolescent Girls Component:

Monthly Surveillance Visits

A total of 68 ASHAs are functioning, out of which on an average monthly surveillance was done by 61 ASHAs (89.7%). Need specific BCC and counseling was given by the ASHAs during monthly household visits for health needs assessment and morbidity surveillance. On an average 1278 (86.5%) married adolescent girls out of a total 1477 married adolescent girls were visited for monthly health needs assessment and morbidity surveillance. Based on their needs married adolescent girls were linked to the health provider at the village level or higher levels of care. A total of 28 new married adolescent girls were registered during the quarter.

In this quarter, 125 new pregnant married adolescent girls were detected, out of which 92 (73.6%) were registered before 12 weeks of pregnancy and 33 (26.4%) were registered after 12 weeks of pregnancy for antenatal care. On an average 197 (92.1%) pregnant women were examined every month out of a total of 214 registered pregnant women. During the quarter, 123 women delivered, out of which 122 (99.2%) delivered in the hospital and only one delivered at home. Out of the total women delivered, 120 (97.6%) were examined five or more times during pregnancy, 121 (98.4%) received either two injections of Tetanus Toxoid or booster dose and 118 (95.9%) women reported having consumed 100 Iron and Folic Acid tablets. Coverage of women with minimum standard antenatal care is very high.

In this quarter, 18 women reported danger signs during pregnancy, out of which 16 (88.9%) sought treatment. Out of the women delivered, two women reported complications at the time of delivery and both took treatment.

Out of the women that delivered two months prior to the reporting month, 17 (85%) post-natal mothers were visited five times by the ASHAs and 14 (70%) were visited twice by ANMs during the post-natal period. Three women reported post-natal complications but none of them took treatment. A total of 64 married adolescent girls reported symptoms of RTIs during surveillance. Out of which 35 (54.7%) took treatment. There is need to

decentralize health services for the treatment of maternal morbidity and RTIs to improve treatment seeking behaviour.

During the quarter, on an average 357 (36.5%), out of a total of 979 eligible couples were using any one contraceptive method either to delay first pregnancy or increase the interval between two births. The most preferred method of contraception was condom.

Supervision of Surveillance and Need Specific Behaviour Change Communication:
On an average 994 (90%) households were visited every month by the facilitators (female) for supervision of health needs assessment and surveillance and to observe need specific BCC given by ASHAs.

It has been observed during supervisory visits that most of the ASHAs are able to record information in the surveillance register correctly during the monthly surveillance visit. Their communication skills for giving need specific BCC and counseling has improved.

Behaviour Change Communication – Group Meetings Conducted by Facilitators (female):
Once a month BCC group meetings were conducted by facilitators (female) with married adolescent girls. On an average 54 (79%) monthly BCC group meetings were conducted out of a total of 68 monthly meetings that were planned. These BCC group meetings were attended on an average by 578 married adolescent girls i.e. 71 percent of the expected number. Topics covered during monthly BCC group meetings were – post-natal care of mothers, care of newborn and care of a low birth weight baby.

Unmarried Adolescent Girls' Component:

Training of Peer Educators:
During this quarter, four training programmes of four days duration were organized for the training of peer educators. A total of 123 peer educators (two per ASHA) along with 59 ASHAs attended the training.

Main objective of the training were:
- To develop leadership skills among peer educators.
- To learn about what qualities are required to become a good peer educator.
- To learn about how to manage and coordinate activities of girls' collective (Kishori Mandal).
- To learn about the status of Adolescent Girls in rural Maharashtra.

Training methodologies used were participatory games, video films and discussion based on games and video films.

Life Skills Education Classes:
Sessions for the next three months of the LSE course were initiated after completing pre-test for 443 girls for sessions to be taken over the next three months. Post-test for the sessions of first three months was conducted for 435 girls. On an average 58 ASHAs

facilitated LSE classes at the village level and on an average 7 classes were facilitated every month. On an average 20 adolescent girls per ASHA area attended the classes. On an average 1201 (90%) girls out of a total of 1332 adolescent girls enrolled attended more than 80 percent of the sessions conducted by ASHAs.

Kishori Mandals:
During the quarter, on an average 58 ASHAs facilitated Kishori Mandal activities once a week, each month. On an average 19 girls per ASHA area participated in Kishori Mandal activities. During the quarter 92.4 percent of the total enrolled adolescent girls participated in more than 80 percent of the activities facilitated by ASHAs and peer educators. There are 116 active peer educators. A list of activities organized through Kishori Mandals during the reporting period is given below:

- Craft – Preparing paper lanterns, making flower vase, and painting.
- Cleanliness drive
- Rally – For preventing child marriage and promoting education of girls.
- Sports competitions – Khokho and Kabadi.
- Recipe competition for iron rich foods
- Street play – Emphasizing importance of education for girls.

Craft Workshops at Pachod:
During the quarter, two one-day workshops for preparing lanterns were organized at Pachod. One such workshop was organized in September 2017 for which two girls from each ASHA were invited and 80 girls and 38 ASHAs participated. A total of 75 lanterns were prepared in the workshop. After going back to their villages, these girls taught other girls how to prepare lanterns. Many adolescent girls prepared lanterns for their homes during Diwali. This was appreciated by parents and other people from the village.

Status of Kishori Mandals and peer educators where ASHAs have discontinued work:
Facilitators (female) are mentoring and giving guidance to 12 peer leaders from 6 ASHA areas. Facilitators conduct two sessions and one Kishori Mandal activity per month. On an average 15 adolescent girls per village attended LSE sessions taken by facilitators (female). On an average 14 girls who participated in each activity.

Household Visits to Motivate Parents:
Coverage of household visits was less in October 2017, because many facilitators had taken annual leave. Facilitators (female) visited households of adolescent girls to motivate parents to send girls regularly for classes and girls with low self-esteem were counseled. During November and December facilitators visited 399 households (95.1%) each month out of a total 419 planned households.

Supervision of Life Skills Education Classes and Kishori Mandal Activities:
During the quarter facilitators could undertake only 53 supervisory visits to LSE classes conducted by ASHAs. Number of supervisory visits was less due to ongoing peer leader

training. During supervisory visits it was observed that 20 adolescent girls were present for the LSE classes.

A total of 46 supervisory visits to support the Kishori Mandal activities were undertaken by the facilitators (female). It was observed during each visit that 18 girls participated in the Kishori Mandal activities.

Boys and Young Men Component:

In Jamkhed PHC, 40 youth groups are functioning well.

Refresher Training:
A 3-day refresher training was organized for the five male facilitators from 8th to 10th November 2017. Following topics were discussed during the training:

- BCC – How to provide Inter Personal Communication and Counseling.
- How to conduct BCC group meetings.
- Gender inequality and its effect on women.
- Introduction to Rashtriya Kishor Swasthya Karyakram.
- Counseling – How to undertake group counseling.
- Orientation on how to conduct a post-test for youth.

BCC Group Meetings for Youth:
On an average 39 BCC group meetings were organized each month in this quarter. On an average 687 youth attended monthly BCC group meetings i.e. 86 percent of the number expected to attend the meetings. Topics discussed during these BCC group meetings were counseling prior to marriage, HIV and AIDS, Anemia. Thirteen youth were given individual counseling on demand after the BCC group meetings.

A total of 80 peer leaders are active and they shared information with their peers. On an average 320 youth were covered every month i.e. 80 percent youth were covered out of the total expected number to be covered by the peer leaders.

Workshop for Peer Leaders:
A one-day workshop at Pachod was organized for peer leaders, which was facilitated by an external resource person from Men Against Violence & Abuse (MAVA), a Mumbai based organization. Sixty-six peer leaders participated in the workshop. Topics discussed during the workshop were – rights of youth, problems faced by youth, participation of youth in the politics and freedom to choose a partner.

Behaviour Change Communication (BCC) Group Meetings for Spouses:
Once a month BCC group meetings are conducted with the spouses of married adolescent girls with the objective of increasing male responsibility in the well being of his wife. On an average 56 (83%) of the planned 67 BCC group meetings were organized with the spouses of married adolescent girls. On an average 729 (67%) spouses out of a total of

1096 attended the BCC group meetings. Topics covered were same as those covered in the BCC group meetings for married adolescent girls.

Community Based Monitoring:
Every month review meetings were conducted with the members of the Village Health Nutrition Water Supply and Sanitation Committees to review needs identified by the ASHA and service provision by the sub-centre ANM. During the quarter, only 76 (55%) out of the total planned 138 committee meetings were held due to annual leave of facilitators and ongoing training for the peer educators. These meetings were attended by 167 (73- female and 94 – male) members i.e.70 percent of the expected number. Topics discussed during monthly review meetings were Prime Minister's Safe Motherhood Scheme, Rajiv Gandhi Health Insurance Scheme and review of project activities undertaken during the last one year.

Community Meetings:
Separate large community meetings for men and women were organized during the quarter. A total of 22 meetings with men and 37 meetings with women have been organized. These meetings were attended by 772 men and 717 women. The purpose of these meetings was to involve as many opinion leaders as possible and other stake holders into the dialogue for changing social norms such as child marriage and early pregnancy.

Issues discussed during these meetings were:

- Key objectives of the project
- Training inputs given to ASHAs.
- Roles and responsibilities of ASHAs regarding the project activities.
- Need for working with unmarried adolescent girls and strategy of the project.
- Vulnerability of married adolescent girls and strategy of the project.
- Importance of community monitoring and how this can be improved.

Challenges:
- Sustaining interest of ASHAs
- Retaining staff

Advocacy
The Director ARSH, Maharashtra deputed two colleagues from her department to modify the Integrated ASRH proposal submitted by IHMP. These two officials were asked by her to follow up the approval of the proposal by various departments.

At the State level, Director IHMP met the Principal Secretary, Finance, Technical expert NRHM and Director NRHM to expedite the approval of IHMP's proposal that has been included in the State supplementary PIP. Similar visits were made to meet the Deputy Commissioner, Adolescent Health, Ministry Of Health & Family Welfare and Health Secretary, Government of India to facilitate approval of the proposal at the level of the Central Government.

Preventing Child Marriage and Early Pregnancy in India
Activity Report for Twelfth Quarter
January to March 2018

Introduction:

Institute of Health Management, Pachod is implementing an innovative project in 53 villages of Jamkhed and Wadigodri PHCs, Jalna District with the aims of eliminating child marriage and reducing maternal morbidity and mortality since April 2015. Interventions are targeted at unmarried and married adolescent girls and boys and young men. Details of activities undertaken during 12th quarter –January to March 2018 are presented in this report.

Married Adolescent Girls Component:

Monthly Surveillance Visits

A total of 68 ASHAs are functioning, out of which on an average monthly surveillance was done by 62 ASHAs (91.2%). Need specific BCC and counseling was also given by the ASHAs during monthly household visits for the health needs assessment and morbidity surveillance. On an average 1252 (82%) married adolescent girls out of a total 1526 married adolescent girls were visited for monthly health needs assessment and morbidity surveillance. Based on their needs married adolescent girls were linked to the health provider at the village level or higher levels of care. A total of 22 new married adolescent girls were registered during the quarter.

Maternal Health:

In this quarter, 123 new pregnant married adolescent girls were detected. Out of which 88 (71.5%) were registered before 12 weeks of pregnancy and 35 (28.5%) were registered after 12 weeks of pregnancy for antenatal care. On an average 230 (94%) pregnant women were examined every month out of a total of 245 registered pregnant women. During the quarter, 88 women delivered, out of which 87 (99%) delivered in the hospital and one delivered at home. There was one twin birth. Therefore, outcome of total women delivered was 87 live births and 2 still births. Out of the total women delivered, 71 (80.7%) delivered at natal homes, which is a reflection of the cultural practice. Out of the total women delivered in the quarter, 85 (96.6%) were examined five or more times during pregnancy, 87 (98.9%) women received either two injections of Tetanus Toxoid or booster dose and 86 (97.7%) women reported having consumed 100 Iron and Folic Acid tablets. Coverage of women with minimum standard antenatal care is high.

In this quarter, 16 women reported danger signs during pregnancy, out of which only 8 (50%) sought treatment. Out of the 17 women delivered at ‘Sasari’ (husband’s village), one reported complications at the time of delivery and took treatment for the same.

Out of the women delivered two months prior to the reporting month, 26 (96%) post-natal mothers were visited five times by ASHAs and 25 (92.6%) were visited twice by ANMs during post-natal period. Seven women reported post-natal complications and only two women took treatment. There is need to decentralized health services for the treatment of maternal morbidity and RTIs to improve treatment seeking behavior.

During the quarter, on an average every month 365 (38.3%) out of a total of 953 eligible couples were using any one temporary contraceptive method. The most preferred method of contraception was condom.

Supervision of Surveillance and Need Specific Behaviour Change Communication:

On an average 1015 (91%) households were visited every month by the facilitators (female) for supervision of health needs assessment and to observe need specific BCC given by ASHAs.

It has been observed during supervision visits that majority of the ASHAs are able to correctly record information in the surveillance register during the surveillance visit. Their communication skills for giving need specific BCC and counseling needs to be further improved.

Behaviour Change Communication – Group Meetings Conducted by Facilitators (female):

On an average 64 (94%) monthly BCC group meetings were conducted out of a total of 68 monthly BCC group meetings that were planned. On an average 646 married adolescent girls attended these monthly meetings i.e. 67 percent of the expected number. Topics covered during monthly BCC group meetings were – Reproductive Tract Infections, HIV/AIDS and anemia.

Unmarried Adolescent Girls Component:

Life Skills Education Classes:

On an average 59 ASHAs facilitated LSE classes at the village level and on an average 8 classes were facilitated every month. On an average 19 girls per ASHA area attended the class. On an average 1230 (93%) girls out of a total of 1324 adolescent girls enrolled attended more than 80 percent of the sessions conducted by ASHAs. Second batch of adolescent girls completed the LSE course in February 2018. Third batch of adolescent girls was initiated from March 2018 in which 971 adolescent girls have been enrolled.

Kishori Mandals:

During the quarter, on an average 59 ASHAs facilitated Kishori Mandal activities once a week, each month. On an average 19 adolescent girls per ASHA area participated in Kishori Mandal activities. During the quarter, 92.6 percent of the total enrolled

adolescent girls participated in more than 80 percent of the activities facilitated by ASHAs and peer educators. There are 118 active peer educators. A list of activities organized through Kishori Mandals during the reporting period is given below:

- Competitions – drawing, debate, hand writing and fancy dress.
- Craft – Preparing flowers from the chart paper.
- Sports – Khokho, Memory game and lemon & spoon.
- Welcome of adolescent girls enrolled for the third batch and experience sharing by adolescent girls from the second batch.
- Organised function for 8th March – Adolescent girls gave a speech about their ideal role model woman personality in front of their peers, parents and other stakeholders from the community.

Since January 2018, peer educators and members of Kishori Mandals are encouraged to undertake activities independently. A total of 300 adolescent girls in their villages did 'rangoli' in school and in front of the Gram Panchayat office around the flag post for 26th January flag hoisting. Members of Kishori Mandals motivated their parents to attend flag hoisting at the Gram Panchyat office. This resulted in 262 women and 591 men attending flag hoisting in their villages.

In the month of February, it was planned to create awareness regarding disadvantages of child and early marriage through visiting households of unmarried adolescent girls. Pairs were formed of members who were willing to do household visits and each pair adopted 10 households on unmarried adolescent girls. A total of 131 pairs visited 748 households from their neighbourhoods. In the month of March, a total of 239 pairs of adolescent girls visited households of 1840 unmarried adolescent girls to create awareness regarding disadvantages of child and early marriage. In the monthly planning and review meeting of Kishori Mandals, it was decided to do a street play in the next month focusing on preventing child marriage and education of girls.

Status of Kishori Mandals and peer educators where ASHAs have discontinued work:

Facilitators (female) are mentoring and giving guidance to 10 peer educators from five ASHA areas. Facilitators conduct two sessions and one Kishori Mandal activities per month. On an average 19 adolescent girls attended each LSE session conducted by facilitators (female). On an average 16 girls participated in each Kishori Mandal activity conducted by the facilitator (female) and peer educators.

Household Visits to Motivate Parents:

Facilitators (female) visited households of adolescent girls to motivate parents to send their daughters regularly for classes and to get the girls enrolled for the third batch of the LSE course. During the quarter facilitators visited on an average 368 households (88.7%) each month out of a total of 415 planned households.

Supervision of Life Skills Education Classes and Kishori Mandal Activities:

During the quarter, facilitators (female) could undertake 35 supervision visits to LSE classes conducted by ASHAs. From January 2018, supervision visits to the LSE classes have been reduced to one per month instead of two per month. It was observed during the supervision visits that 19 girls were present for the LSE classes. Facilitators use the second visit for planning and taking review of activities undertaken by the girls' collectives.

A total of 52 supervision visits to support the Kishori Mandal activities were undertaken by the facilitators (female). It was observed during each visit that 19 girls participated in the Kishori Mandal activities.

Boys and Young Men Component:

Interventions for boys and young men are only being implemented in the villages of Jamkhed PHC. Forty youth groups which were established are functioning well.

BCC Group Meetings for Youth:

On an average 40 BCC group meetings were organized each month in this quarter. On an average 723 (90%) youth out of a total of 800 youth attended monthly BCC group meetings. Topics discussed during these BCC group meetings were temporary contraceptive methods, masculinity and domestic violence. On an average 11 youth were given individual counseling each month on demand.

A total of 80 peer leaders are active and they shared information with their peers. On an average 350 youth were covered every month i.e. 87 percent youth were covered out of the total expected number to be covered by the peer leaders.

Workshop for Peer Leaders:

A one-day workshop at Pachod was organized on 23rd March 2018 for peer leaders, which was facilitated by an external resource person from 'Samyak', a Pune based organization. Sixty-five peer leaders participated in the workshop. Topics discussed during the workshop were – gender, masculinity, gender discrimination, patriarchal system in our society, gender stereo types, gender based violence and economic empowerment of women.

Behaviour Change Communication (BCC) Group Meetings for Spouses:

Once a month BCC group meetings are conducted with the spouses of married adolescent girls with the objective of increasing male responsibility in the well being of his wife. On an average 63 (96%) of the planned 67 BCC group meetings were organized with the spouses of married adolescent girls. On an average 833 (67%) spouses out of a total of

1246 attended the BCC group meetings. Topics covered were same as those covered in the BCC group meetings for married adolescent girls.

Community Based Monitoring:

Every month review meetings were conducted with the members of the Village Health Nutrition Water Supply and Sanitation Committees to review needs identified by the ASHA and service provision by the sub-centre ANM. During the quarter, 114 (83%) out of the total planned 138 committee meetings were held. These meetings were attended by 242 (107- female and 135 – male) members i.e.71 percent of the expected number. Topics discussed during monthly review meetings were Rugna Kalyan Samiti and Roles & Responsibilities of the committee, services provided under Manav Vikas Mission, disadvantages of early marriage and adverse consequences of early pregnancy.

Challenges Faced:

- Retaining staff
- Sustaining motivation of ASHAs
- Harsh environmental/ weather conditions specially in summer when there is water shortage affect timeline of the activities

Integrated Project for the Empowerment of Adolescent Girls and Protecting them from the Consequences of Early Marriage, Early Conception, Sexual and Domestic Violence

1st April 2017 to 31st October 2017

1. Funded Activities Summary (8000 character limit up to two pages)

Integrated project for the empowerment of adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence was implemented from 1st Jan. 2013 to 30th Sept. 2017 by Institute of Health Management, Pachod (IHMP). This project was implemented in 30 villages of Adul PHC. The project included empowerment of adolescent girls through Life Skills Education and improving their educational and social status, protection of married adolescent girls from the adverse consequences of early motherhood and preventing sexual and domestic violence against young women by engaging young men.

Monthly Review Meetings & Capacity Building of ASHAs:

- Monthly review and planning meetings were organized at the PHC head quarter. On an average monthly review meetings were attended by 18 ASHAs.

- 3-day training on care of children less than five years of age was organized, which was attended by 17 ASHAs.

Unmarried Adolescent Girls:

- For the fifth batch of adolescent girls the Life Skills Education classes were conducted by peer educators.

- Twenty-one ASHAs continued to provide guidance and mentorship to 42 peer educators.

- A Total of 401 adolescent girls completed Life Skills Education course in the fifth batch.

- Mothers meetings were organized in 12 ASHA areas to get consent from the parents to send their daughters for the Reproductive and Sexual Health Workshops. These meetings were attended by 200 mothers.

- A total of 276 adolescent girls attended the workshop on Reproductive and Sexual Health in batches from the 5th batch of the Life Skills Education course.

- The field coordinators made 16 supervisory visits to observe Life Skills Education sessions conducted by peer educators. It was found during supervisory visits that on an average 20 girls were attending the classes.
- A total of 2017 girls participated in 42 rallies organized by Kishori Mandals. The main messages given were about consequences of child marriage.

- Kishori Mandals organized art and craft sessions, competitions (for essay writing, debate, drawing, etc.) and games.

- ASHAs facilitated 15 sessions on care of children under the age of five years, which were attended on an average by 33 girls per session.

- The field coordinators conducted 75 Life Skills Education sessions in non-ASHA areas. On an average 25 adolescent girls attended each session.

Married Adolescent Girls:

- A total of 18 ASHAs attended a one-day workshop to transfer information from old to new surveillance registers. ASHAs identify health needs, morbidity and information needs during monthly surveillance visit to households.

- 20 ASHAs did monthly surveillance during household visits. On an average 674 (87.4%) married adolescent girls were visited during the surveillance visit.

- Need specific BCC during household visits was given by 20 ASHAs to 87 percent of the registered married adolescent girls each month.

- On an average 41 i.e. 95 percent of the planned BCC group meetings were conducted with married adolescent girls and mothers-in-law by the Auxiliary Nurse Midwives ANMs). The average attendance for these BCC group meetings was 69 percent of the expected number.

- On an average 49 antenatal clinics were held jointly with the Government ANMs every month. On an average 199 (72.4%) pregnant women were examined every month.

- All Village Health Nutrition Water and Sanitation Committee meetings were held as per the planned schedule for community based monitoring.

Unmarried and Married Young Men:

- 24 youth groups established have continued to function during this reporting period.

- All planned BCC group meetings with youth were conducted every month.

- Two one-day workshops were organized for peer leaders at Pachod. Twenty peer leaders attended these workshops.
- On an average 205 (86%) of the expected number of youth were covered by the peer leaders.
- The period 1st July 2017 to 31st October 2017 was spent in evaluating the project. The control area got highly contaminated. While the Adul project was going on the Government of Maharashtra decided to scale up the IHMP model in Jalna district. This resulted in contamination of the control site and hence we are presenting the base-line end-line evaluation results of the intervention site.

2. Results (4000 character limit per question – up to one page each):
a. What have been the outputs of your funded activities to date?

Unmarried Adolescent Girls:

- 27 ASHAs from villages in Adul PHC have been trained and demonstrated skills in conducting 'Life Skills Education' classes.

- IHMP was able to sustain interest of 22 ASHAs till the end of the project and remaining five had to leave due to personal problems.

- 42 peer leaders took all the sessions for the 5th batch of adolescent girls and on an average 20 girls per peer leader attended the session.

- Twenty Kishori Mandals (Girls Collectives) were active during this period.

Married Adolescent Girls:

- 27 ASHAs trained in doing monthly surveillance and providing needs specific BCC. Out of which 20 ASHAs continued surveillance during the reporting period.

- Coverage of monthly surveillance for Married Adolescent Girls (MAGs) was maintained at 87 percent.

- Proportion of pregnant MAGs registered before 12 weeks of pregnancy for antenatal care increased to 82 percent which is impressive.

- During this period the proportion of MAGSs delivered in hospitals was 99 percent, which indicates that delivery in the hospital has become a norm. Only one woman that delivered at home was mostly because of inability to reach a hospital on time.

- The proportion of MAGs that received two injections of TT or booster during pregnancy was 97 percent.

- Prevalence of current use of any temporary family planning methods has increased from 18.1 percent in 2013-2014 to 29 percent in April to September 2017 either to delay first birth or increase interval between two births.

Unmarried and Married Young Men:

- More than 90 percent of youth groups established continued functioning during this period.

- On an average 398 i.e. 83 percent of the expected number of youths attended these BCC group meetings.

- On an average 205 i.e. 86 percent of the expected number of youths was reached by peer leaders.

b. What have been the outcomes of these funded activities to date?

- The proportion of girls completing 10^{th} or 12^{th} standard has increased. Also number of girls' continuing education beyond 12^{th} standard has increased.

- There has been a significant increase in the proportion of girls with improved self-esteem and self efficacy as measured with IHMP's scale.

- There has been a significant increase in cognitive skills.

- The proportion of girls getting married before 18 has reduced.

Married Adolescent Girls:

- Proportion of MAGs having first child birth after 18 years has increased.

- The proportion of low birth weight babies has reduced from 21.2 percent to 9 percent (based on monitoring data).

Unmarried and Young Married Men:

- Analysis of pre and post-test data showed encouraging results.

- Self esteem and self efficacy of young men has improved.

- The proportion of young men with gender equitable attitudes has increased.

- The proportion of young men marrying girls less than 18 years has reduced.

c. What were the unanticipated results (positive or negative) of these funded activities (if any)?

IHMP made several presentations of the Integrated Adolescent Reproductive & Sexual Health project being implemented in Adul PHC to the Health Secretary, Government of Maharashtra and other officials, which has led to the Rashtriya Kishor Swasthya Karyakram (RKSK i.e. National Adolescent Health Programme) cell of Government of Maharashtra inviting IHMP to scale up this project in 10 PHCs and thereafter in one district followed by 9 high prevalence districts of Maharashtra.

IHMP's Integrated ARSH project in Adul PHC has become an effective demonstration site for the RKSK in this State.

d. What have been the policy implications (if any) of these funded activities to date?

Government of India launched RKSK programme in 2014 and it was initiated in Maharashtra in 2016. Government of India is using peer educator strategy for the RKSK programme. Peer educators very often have to leave their villages either for further education or for jobs and girl peer educators leave their villages after marriage, which results in large scale attrition of trained peer educators.

Based on the experience of the Integrated project in Adul PHC, IHMP has been advocating the government that capacities of ASHAs should be built as trainer of peer educators and ASHAs should be given skills to mentor peer educators at the community level. IHMP with this opportunity to scale up in 10 PHCs, will be able to demonstrate that within the system ASHAs can become good trainers and mentors for peer educators. This would help in effective implementation of RKSK in the State.

e. How did you evaluate the results of these funded activities?

ASHAs updated the lists of married adolescent girls and unmarried adolescent girls from their villages. These were used as sampling frames for taking the sample. End-line data has been collected by using the same questionnaires, which were used for collecting baseline data.

Unmarried Adolescent Girls:

- Baseline data for the intervention PHC and one control PHC was collected in 2013. The end-line data has been collected during the period July – September 2017.
  The following indicators have been measured:
  - Changes in the cognitive and practical skills.
  - Improvement in self-esteem and self-efficacy has been measured using culturally appropriate scale developed by IHMP.
  - Increase in the proportion of girls getting married after 18 years of age
  - Increase in median age at marriage
  - Increase in the proportion of girls getting secondary and higher secondary school education.

- For each batch of adolescent girls under going 'Life Skills Education' pre and post - test was conducted to measure increase in cognitive and practical skills. Also self-esteem and self-efficacy was measured before and after each batch of life skills education.

Married Adolescent Girls:

- Monitoring data was collected every month to observe trends in:
  - Registration for antenatal care services before 12 weeks of pregnancy.
  - MAGs receiving minimal antenatal and post-natal care.
  - Current use of temporary family planning methods.

- Baseline data was collected from 400 MAGs. End-line data has also been collected from a similar number of MAGs. Change in the following indicators has been measured:
  - Age at first birth
  - Prevalence of contraceptive use
  - Prevalence of maternal morbidity – ante, intra and post natal complications
  - Prevalence of reproductive tract and sexually transmitted infections
  - Treatment seeking behavior for maternal and reproductive morbidity
  - Prevalence of Low Birth Weight babies.

Unmarried and Young Married Men:

- Pre-test has been conducted with 486 young men. After completing a series of sessions, post-test has been conducted with youth to measure:
  - Proportion of young men getting married to girls less than 18 years
  - Proportion of young men with gender equitable attitudes
  - Prevalence of domestic violence.

(Refer attached paper -**Life Skills Education Program for Young Men** for details.)

3. Adaptation

Policy environment

The "Integrated project for empowering adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence" supported by the MacArthur Foundation found a policy fit when the Government of India announced the Rashtriya Kishor Swasthya Karyakram (RKSK) (National Adolescent Health Program). The strategy for the National program was essentially peer led, life skills education for unmarried adolescent girls and boys and special clinics for married adolescent girls and their spouses. The strategy envisaged training of 5.4 million peer educators in the country.

Landscape

In Maharashtra, training of peer educators began in January 2016. The Government soon realized that sustaining the interest and motivation of such a large number of peer

educators was a herculean task. The Government did not have enough trainers, facilitators and supervisors to be able to implement the RKSK program after the peer educators had been trained. Besides it was discovered that the attrition of peer educators was intolerably high.

In light of the experience over the last 18 months the Government of India has decided to revise the RKSK strategy.

IHMP Innovation

While this initiative was going on in the formal health sector, Institute of Health Management, Pachod was demonstrating a Life Skills Education strategy that is implemented jointly by Accredited Social Health Activists (ASHAs) and peer educators.

Simultaneously, ASHAs undertake monthly surveillance of health needs of married adolescent girls and their spouses through home visits. The ASHAs counsel the couple and their family members and actively link them to health providers making sure that their health needs are addressed every month.

Boys and young men have been covered primarily through male staff and peer educators.

All the three component of IHMP's integrated project have indicated very encouraging results.

Advocacy

IHMP made a presentation of the innovative model to the Principal Secretary, Public Health, Maharashtra in June 2015. The principal secretary directed the Director, Adolescent Reproductive and Sexual Health (ARSH), in Maharashtra, to scale up the IHMP model in at least 10 PHCs in one of the districts with the highest prevalence of child marriages finally leading to scaling up in the entire district.

With support from Dasra, IHMP was able to scale up the programme in 2 Primary Health Centre (PHC) areas in 2015.

In January 2016, the Director ARSH passed an order for the scaling up of IHMP's model in 10 PHCs of Jalna District.

The next major challenge for IHMP was to mobilize sufficient funds for scaling up in another 8 PHC areas. Funds could be mobilized for scaling up only in November 2016. As soon as IHMP was confident that funds for scaling up could be mobilized, IHMP's model was presented to Government officials at the Central Government level in November 2016.

Coordinating Government approvals with fund raising for scaling up was a challenge. Finally, the scaling up in Jalna district could be initiated only in April 2017.

In August, 2016 a high profile delegation from USAID, Washington and the India office visited IHMP and studied the innovative model demonstrated by the Institute over a

period of 3 days. The USAID team decided to replicate some of the systems and processes demonstrated by the Institute in the States where they are leading the RMNCH +A program.

Program Environment

Early marriage, early conception and the consequent burden of morbidity among adolescent girls continue to be a problem in 9 high prevalence districts of Maharashtra. The RKSK program provides an opportunity to implement an Integrated approach. It also presents an opportunity for scaling up the program in the high prevalence districts of Maharashtra.

The integrated strategy adopted by IHMP in one primary health centre area is being evaluated by external evaluators. The results of this evaluation will be further used for advocacy for scaling up the innovations in Maharashtra.

4. learning

Rigorous methods adopted during demonstration projects for ensuring robust data collection for census, listing of target populations and baseline survey take a long time to complete, especially if the data collection is from both intervention and control areas.

Since the randomly selected sample of participants were not available during scheduled village visits, several rounds of data collection were required to be able to cover all the respondents.

Whereas, it was easier to interview participants in the intervention area by telling them about the benefits that would accrue to them and their community, it was more difficult to convince participants in the control villages to be interviewed.

The data collection for census, listing of target populations and baseline survey from the intervention and control villages took more than 6 months. This is a worthwhile investment.

The baseline data was used effectively for convincing decision makers regarding the need for the interventions being demonstrated by IHMP. We have found that policy makers are open to taking decisions based on research findings.

More than 75% of the ASHAs continued to be functional through the life of the project. However, because of their personal, family commitments and situations the number of functional ASHAs keeps varying. This has an effect on outputs, coverage and outcomes.

A series of training sessions for ASHAs are required in order to impart practical skills that are required for implementing the different components of the program. All the ASHAs could never be present for the scheduled training sessions, covering different components of the program. The result was that each training session had to be repeated

for a small number of ASHAs who were not able to attend the scheduled training. This needs to be kept in mind when scaling up innovations in the formal sector.

Following induction training, it is essential to do handholding of ASHAs in the field for developing skills for monthly surveillance and need specific behavior change communication with married adolescent girls and for conducting life skills education classes and Kishori Mandal activities for unmarried adolescent girls. Handholding is what makes IHMP's training more effective. This needs to be made a part of the Government training strategy.

Motivational activities need to be planned for maintaining the quality of work done by ASHAs and Government Auxiliary Nurse Midwives.

Monthly work plans of ASHAs and facilitators need to be prepared to give them clarity about their work and if prepared in a participatory manner it creates a sense of ownership.

The project villages suffered a severe drought over a period of 3 years from 2014 to 2016. In 2016, the paucity of drinking water forced several families to migrate. There were newspaper reports that adolescent girls were being married off in order to deal with the consequences of the drought. Even the best program planning is not able to foresee and overcome the consequences of such natural calamities.

The response of spouses of married adolescent girls to BCC group meetings conducted by ASHAs was poor. IHMP had to plan a different strategy for conducting BCC group meetings with young married men by involving male staff.

Health needs assessment through monthly surveillance and need specific behavior change communication continue to be the most effective interventions designed by IHMP. They assess health needs of the target population on a regular basis, generate demand for health services and promote healthy behaviors. These two interventions have the potential for achieving universal health coverage.

Three outputs namely - married adolescent girls registered before 12 weeks of pregnancy and the percentage that received minimum standard antenatal care can be attributed to surveillance and need based behavior change communication provided by the ASHAs on a monthly basis.

In order to activate Village Health, Nutrition and Sanitation Committee (VHNSC) members it is necessary to spend a substantial amount of time motivating them and orienting them about their roles and responsibilities before they become functional. However, it is a good investment as the participation of the community increases measurably after the VHNSC become active.

There is a reduction in maternal morbidity as well as reproductive tract infections and sexually transmitted infections. The proportion seeking treatment has increased. There is a significant increase in the use of contraceptives. The outcome of these interventions has

been measured at end-line. These outputs can be attributed to the monthly surveillance, monthly need specific behavior change communication and active linkage of married adolescent girls with health providers by the ASHAs.

Kishori Mandals are effective in providing a space for adolescent girls to meet, interact and take collective action. They provide a distinct identity for adolescent girls in their villages.

Life Skills Education (LSE) through peer educators has a great potential for empowering adolescent girls. However, it requires intensive inputs such as participatory selection of peer educators, leadership training and skills development for conducting LSE classes. The assumption by the Government that 6 days of training would produce skilled peer educators has been negated. The Government is planning a totally different strategy based on the presentations made by IHMP to the decision makers at the Central and State Government level.

Changing highly entrenched social norms like age at marriage and age at first birth, use of temporary contraceptives to delay first birth and son preference are perhaps the most difficult aspect of this program. The involvement of adolescent girls in bringing about this change through street plays and rallies has been a successful intervention in this programme.

Boys and young men are willing to undertake the role of peer educators. The selection of peer educators requires intensive mobilization and participation of the target population to identify and select their own peer educators.

An integrated approach with a well defined component for boys and young men has the potential for yielding rich dividends. Providing a space for boys and young men to meet and discuss issues is important for a program that is addressing empowerment and reproductive and sexual health issues among adolescent girls.

Pre-post data indicate that outcome of the peer educator intervention for boys and young men is very encouraging. The scales used by IHMP provide effective tools for measuring change among this target population.

Participatory management of a program for adolescent girls and boys and their parents and stakeholders has a longer incubation period but at the end it produces results more efficaciously.

Program interventions need to be minimized and simplified to facilitate scaling up. For this it is necessary to identify the interventions that have the greatest potential. In this program, life skills education by ASHAs and peer educators, participation of Kishori Mandals in influencing social norms, monthly surveillance, monthly need specific BCC, and active linkage with health providers seem to be the most effective interventions that can be scaled up.

Scaling up by its very definition means working with a rigid and bureaucratic government system. To get it activated and motivated takes time. Simultaneous advocacy efforts are required at the District, State and Central Government levels.

During scaling up, dilution of outputs and outcomes is to be expected. The outputs and outcomes achieved through pilot and demonstration projects simply cannot be expected while scaling up. This is the trade off when scaling up an innovation.

5. Sustainability

The "Integrated project for empowering adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence" has been implemented with support for MacArthur Foundation, in 22 villages under the jurisdiction of Adul PHC, since 2013.

The interventions will be sustained even after the project is over because the program was implemented through the ASHAs recruited by the Government and the Adul PHC staff. Informal interaction with the PHC staff indicated that their work became more effective because of the systems, processes and protocols introduced by IHMP.

This project site has played a remarkable role of demonstrating IHMP's innovations to various decision makers.

The Adul project has been & will be used for training of ASHAs and ANMs during the process of scaling up.

The reports from the Adul PHC staff encouraged the policy makers in Maharashtra to issue orders for the scaling up of the innovative RKSK strategy in 10 Primary Health Centers (PHCs) of the adjoining Jalna District.

Most recently the district authorities have requested IHMP to scale up the project in the entire Jalna District, which has a total of 40 primary health centers. The proposal for scaling up in the entire district has been sent by the State to the Government of India for funding.

With the existing level of interest of the local Government it is apparent that the program will not only be sustained but also scaled up in this region

The external evaluation of the Adul project was completed by 31st October 2017. The findings will be used for further advocacy to replicate the model in the 9 high prevalence districts of Maharashtra.

6. Comments

In our experience with funding agencies over the last 40 years, we can say without any hesitation that the partnership with MacArthur Foundation has been the most reliable and satisfying.

Many funding agencies only talk about equal partnership with their grantees. We feel that our partnership with MacArthur Foundation was the epitome of equality, trust and mutual respect.

For the sustained financial, moral and technical support we have received from The Foundation we shall be ever grateful.

Our partnership with MacArthur Foundation stands as a cornerstone in the evolution of Institute of Health Management, Pachod.

Champions of Bramhangaon:

This is a story of the three friends – Saima, Rojina and Salia who live in Bramhangaon village in Aurangabad District, Maharashtra.

Institute of Health Management, Pachod started a project in 2013 in this village and other villages under Adul PHC for adolescent girls to prevent early marriage. Getting their daughters married soon after they reach menarche was a norm in these villages. IHMP trained ASHAs to conduct classes for six-month Life Skills Education (LSE) course and establish Kishori Mandals (Girl's collectives) in their villages.

Saima attended the LSE course in the first batch (2013-2014) in her village. Salia had just come back to village after completing 7th standard in Aurangabad because her high school was far away from her aunt's house with whom she used to stay. Salia's parents live in Bramhangaon. Salia attended few sessions of the LSE course with her friend Saima. Since she became interested in participating in the LSE course, she enrolled for the next batch of LSE in 2014-2015. She took admission for 8th standard in her village. She met Rojina in school and both have become good friends.

One day Salia's aunt from Aurangabad came to visit her brother (Salia's father) when Salia was studying in 8th standard. After dinner, aunt told Salia's father and mother that she had come with a marriage proposal for Salia. She wanted her son to marry Salia. She was trying to convince her brother and his wife by telling them that Salia will be looked after like a daughter and will be very happy after the marriage. They will not have to worry about their only daughter. Salia has four brothers and she is the youngest. Salia who was in the next room when she heard this, she was very disturbed and could not sleep at night. Next day morning, she shared this information with her two friends –

Rojina and Saima. They both assured her that they would speak to her parents. Rojina and Saima went to her house in the evening and told her parents that we have learnt in our LSE course that it is illegal to marry a girl before the age of 18 years and risks associated with early marriage. Don't you remember that street play, we did four months ago, in which that girl who was married at 16 and soon after marriage she conceived, who died in the child birth.

Salia was upset and disturbed, when all this was going on. She could not concentrate on her studies and sleep at night. She went on a hunger strike and told her parents that she wants to study at least upto 12th standard and does not want to get married now. Aunt's son is much older than me and not a suitable match for me. Next day, again Rojina and Saima came with ASHA and spoke with Salia's parents and grand parents.

Finally Salia's parents were convinced and her father told his sister that Salia is young and we would like her to continue her studies. Just now we are not interested in getting her married. Her aunt was very angry and returned to Aurangabad. Since that day she has not come back to village or spoken with her brother. Her son has married another girl and they live in Aurangabad. After few days, Salia bounced back to her normal routine.

Since then Salia has completed LSE course in 2015. Rojina and Salia were chosen by their peers as per educators for the group. They attended training for the peer educators in 2016. After that both conducted six-month LSE course for other adolescent girls in their village. Each one had about 20 girls attending the classes regularly. Their parents were very proud that they were teaching other girls. Rojina also did mono act play about Savitribai Phule on 26th January in her school, which was appreciated by the teachers and other people from the village. Savitribai Phule more than 200 years ago started the school for girls and opened the doors for education of girls.

IHMP has collaboration with the Corporate Social Responsibility of USHA machines company, which organises training in sewing for women and girls. When one such training was organized at Pachod, Saima attended this Shilai School training. Now Saima does stitching of blouses and salwar & kamij in her village. She earns about Rs. 2000/- per month. She uses this money towards her educational expenses and gives remaining to her parents.

Now Rojina and Salia are 16 years old and will be sitting for their 10th standard board exams in March 2018. Saima is 18 years old and will be giving her 12th standard exam in February 2018. All three of them want to continue their education beyond 12th standard Now Rojina and Salia are aspiring to become teachers and Saima wants to be a doctor.

Programme for unmarried adolescent girls has transformed the lives of these three girls. They say that they will continue to prevent early marriage and promote education for girls in their village. Like the three girls in Bramhangaon, 'Life Skills Education' course and Kishori Mandal activities have touched and transformed lives of hundreds of adolescent girls in the villages in Adul PHC. This would not have been possible without the financial support of the MacArthur Foundation.

Scaling Up Project in Jalna

Integrated Project for Empowering Adolescent Girls and Protecting them from the Consequences of Early Marriage, Early Conception, Sexual and Domestic Violence

Annual Report - April 2017 – March 2018

Jalna Scale Up:

- Project office in Jalna established by July 2017.
- Full complement of the project team was in place by mid July 2017 i.e. Project Manager – 1, MIS Officer-1, PHC Coordinators – 5, Sub-centre facilitators – 21, Accountant -1 and Driver – 1.
- Village profiles of 112 villages were completed by 30th June 2017.
- Numbering of households and village mapping was initiated in July 2017 and was completed by end of August 2017.
- In August 2017, ASHAs and project staff were trained in collecting information for the listing of Unmarried Adolescent Girls (UAGs), listing of Married Adolescent Girls (MAGs) and marriages in the last five years.
- Listing of UAGs and MAGs was initiated from the last week of August 2017. Listing was completed by end of October 2017.

Baseline Survey:

- Research Director was engaged in Mid-July.
- Digital baseline survey format using Kobo tool box for the married adolescent girls was prepared with the help of Soft Corner, Pune.
- Big challenge was to train local investigators in collecting data using tablets.
- Data collection for married adolescent girls was completed in one month - 24th November 2017 to 23rd December 2017. Data from 470 married adolescent girls was collected.
- Digital format for collecting baseline data for unmarried adolescent girls was prepared by IHMP's Research Director.
- Data collection for unmarried adolescent girls was done from 12th January to 7th February 2018. Data from 494 unmarried adolescent girls was collected.

Capacity Building of Senior Management Staff:

- In the month of April 2017, seven senior staff of IHMP including Project Manager, Jalna attended six-day training on management skills at IHMP. These seven staff members were sent to CMC Vellore for the training on analytical skills.
- A team of seven staff members visited Seva Rural, Zagadia to learn about the mobile app being used by ASHAs.
- IHMP has been in contact with Armaan and other agencies to learn about mobile apps being used by these organizations. Ultimately IHMP wants to have the mobile app for the monthly surveillance done by ASHAs.
- IHMP has initiated the process of shifting from the current DOS based financial management system to Tally based financial management system. The entire finance team is undergoing capacity building to establish the Tally based financial management system.

Capacity Building of ASHAs and Project Staff:

- In July 2017, two-day training for the project staff was organized on mapping and numbering of the households at IHMP, Pachod.
- In August 2017, one-day training at the PHC head quarters was organized for ASHAs on collecting information in the listing formats for married adolescent girls, unmarried adolescent girls and marriages in the last five years.
- Six-day training on the technical aspects, surveillance, micro-planning and BCC was organized for ASHAs in five batches in February and March 2018.
- A total of 99 ASHAs have been trained and a separate batch will have to be organized for the remaining 64 ASHAs. Average pre-test score of ASHAs was 24 and average post-test score was 34 out of a total score of 50.
- Six-day training on the technical aspects, surveillance, micro-planning and BCC was also attended by sub-centre facilitators and PHC coordinators of four PHCs along with the ASHAs form their PHCs.

Community Mobilization:

- Initial community meetings focused on introduction of AGRT, objectives of the project and activities to be implemented under the project.
- Meetings with the members of Village Health Nutrition Water Supply and Sanitation Committee members regarding their roles and responsibilities in this project.
- Information about Village Health and Nutrition Day (VHND) and services provided at the VHND.
- Information regarding baseline data to be collected from married adolescent girls and unmarried adolescent girls.

Advocacy:

- Orientation of the project was given to the District Health Officer, District Training Team and Medical Officers of PHCs.
- Orientation of the Collector, Jalna regarding the project to be implemented in ten PHCs of Jalna District.
- Several meetings and discussions were held at the State level to get necessary permissions and orders for ASHAs to work in this project.
- In March 2018, Director, National Health Mission advised IHMP's Director to meet with the Collector and Chief Executive Officer of Zilla Parishad and District Health Officer of Jalna and submit a proposal for financial support for scaling up in the district from the District Innovation Fund. There has been a major transfer of IAS officers in Maharashtra. Both the Collector and Chief Executive Officer have been transferred. The Director IHMP is expected to meet with the new incumbents in the second week of May 2018

Integrated Reproductive and Sexual Health and Family Planning Project for Adolescent Girls and Young Married Women in Urban Slums

Activity Report - April 2017 to March 2018

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

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

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

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

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

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

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

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

Objective 1: To demonstrate a measurable increase in cognitive and practical skills in unmarried adolescent girls.

Objective 2: To validate a scale for self esteem and self efficacy and demonstrate a measurable improvement in the self esteem and self efficacy of unmarried adolescent girls.

Objective 3: To increase the duration of formal school education for unmarried adolescent girls.

Objective 4: To delay age at marriage among unmarried adolescent girls.

Activities Carried Out During 2017-18

Following key activities were carried out in the 12 slums under the Annasaheb Magar Hospital, Hadpsar, in Pune city during April 2017 to March 2018. Current report is compilation of activities for three quarters from April 2017 to Dec 2017, as the implementation activities were stopped during last quarter Jan to March, 18and the end line evaluation survey conducted.

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

1. Capacity building of Community Health Workers (CHWs): Twelve CHWs in the project slums were 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.For newly appointed CHWs IHMP provided **c**apacity building through induction training and regular field based hand holding through supportive supervision. For effective programme implementation by providing them with technical, management and BCC (Behaviour Change Communication skills). Following training programmes were organized for CHWs during reporting period.

Table1.1 –Training programs conducted for CHWs during April 2017 to March 2018

Sr.	Training subject	Month	Duration – days	No. of CHWs attended	Knowledge & skills provided
1.	Induction training for newly appointed CHWs	Sept 2017	06 days (includes 3 days in field training)	3	Cognitive skills – maternal health, neonatal health, child health, reproductive health, family planning. Practical skills on implementation of 6 IHMP RSH innovations
2.	In-service trainings of CHWs on Life Monthly surveillance and Life Skills Education	Apr 2017, to March 18	02 daysin each month	9	Cognitive technical and practical skills related to monthly needs assessment and conducting sessions of LSE.

2. In-service training: Monthly in-service training for CHWs was conducted every month except during last quarter Jan-March 2018 when end line survey conducted.9 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 conducts 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.

Table1.2: No of household visits provided by CHWs for needs specific BCC at household level

Period	Reporting for Number of CHW areas	Surveillance visits planned for registered MAG+YMWs	Surveillance visits actually conducted for MAG+YMWs	Percent MAG+YMWs visited
April to June 17	12	4078	3622	88.83
July to Sept 17	12	3652	3362	92.0
Oct to Dec 17	11	3888	3515	90.57

The average percentage of YMWs who had been covered by monthly surveillance was 90.47 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.

105 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. A total of 1162 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.	April to June 2017	36	350	Symptoms of Sexually transmitted infections, prevention and treatment of sexually transmitted infections, Importance of timely treatment of sexually transmitted infections.
2.	July to September 2017	36	378	Post natal care Abortion Routine antenatal care, and STI/RTI
3.	October to December 2017	33	434	Contraception Reproductive tract and sexually transmitted infections
	Total	105	1162	

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

5. Outreach clinics conducted by project ANM: The CHWs prepare a micro-planner every month which provides details of women and children with health needs along with details of the services they require. Based on the micro-planner, the CHWs actively link their clients to the Vasti level clinics conducted by ANMs. A total of 995 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 120 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 120mothers, conducted counseling sessions to 346 YMW that were detected with symptoms of RTIs and provided IPC to 295YMW on the use of temporary contraceptives.

Table 1.4: Outreach services provided by Project ANM during April 17 to March 18

Sr.	Details	Period				
		April to June 17	July to Sept 17	Oct to Dec 17	Jan to March 18	Total
1.	Number of clinics planned	72	72	72		216
2.	Number of clinics conducted	72	68	72		212
4.	Number of antenatal examinations done	321	332	342		995
5.	Number of postnatal mothers examined	42	45	33		120
6.	Counseling to YMW on use of temporary family planning methods	132	119	95		346
7.	Counseling to YMW with RTI symptoms	109	81	105		295
	Total	748	717	719		2184

6. Specialist OB Gynae clinic at PUHC:

Clinics for obstetric and gynecological services were conducted at the Annasaheb Magar Hospital, Hadapsar. A total of 11 clinics were conducted in the reporting period. 41 patients receivedtreatment 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 17	July to Sept 17	Oct to Dec 17	Jan to March 18	Total
Symptoms suggestive of RTI/STI	3	11	4		18
Antenatal Complications	1	0	0		1
Menstrual problems	11	3	1		15
Infertility	0	1	0		1
Number of patients with general complaints	1	3	0		4
Other complaints	0	1	0		1
Total	16	19	5		40

7. Slum Health and Development Committees (SHDCs): During reporting period,12 Slum Health and Development Committees were functioning in the all 12CHW areas. SHDC meeting was planned once in a month for each slum area. Out of the 100 SHDC meetings that were planned 99 were actually conducted in the last year. A total of 629 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 17	36	36	229	Community based monitoring
2.	July to Sept 17	36	35	215	New batch of LSE for unmarried adolescent girls
3.	Oct to Dec 17	28	28	185	Information on Govt. schemes on health, development, and livelihood.
	Total	100	99	629	

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.

9. On job training by Supervisors during field visits: Four CHW areas were allotted to each field cordinator. Monthly supervisory visits to assess the skills of the CHW and provide in-service training through demonstrations were planned and initiated in each CHW.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 2017-18

Table 2.1: Reported Symptoms of Reproductive Tract Infections.

Month	Reporting for Number of CHW Areas	Number of MAG + YMWs visited	Number of YMWs with symptoms of RTIs	Percent YMWs with symptoms of RTIs
April to June 17	12	3622	146	4.3
July to Sept 17	12	3622	127	3.7
Oct to Dec 17	11	3515	139	3.9

The average proportion of women detected with RTI symptoms was 3.91%.

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 17	12	146	92	63.0
July to Sept 17	12	127	63	49.6
Oct to Dec 17	11	139	67	48.2

The average proportion of women with RTIs who had sought treatment was 53.6 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 17	12	388	363	93.5
July to Sept 17	12	399	356	89
Oct to Dec 17	11	424	388	91.3
Total	12	1211	1107	91.27

The proportion of pregnant mothers who received antenatal care was 91.27%.

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 17	12	388	100	26
July to Sept 17	12	399	75	19
Oct to Dec 17	11	424	63	15

The proportion of pregnant mothers reporting any one antenatal complication was 19%.

Table 2.6: Treatment taken for Antenatal Complications.

Month	Reporting for Number of CHW areas	Number of pregnant mothers with antennal complications	No. pregnant mothers sought treatment for antennal complications	% pregnant mothers sought treatment for antenatal complications
April to June 17	12	100	81	81
July to Sept 17	12	75	62	82
Oct to Dec 17	11	63	47	79

The average proportion of pregnant mothers with symptoms of antenatal complications who sought treatment was 80.6%.

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 17	12	42	42	4
July to Sept 17	12	45	45	5
Oct to Dec 17	11	33	33	4
Total	**12**	**120**	**120**	**13**

Table 2.8: Reported Use of Family Planning Methods.

Quarter	Reporting for Number of CHW areas	Average Number of MAG &YMWs visited	Average Number of YMWs using any temporary FP method	Percent YMWs using any temporary FP method
April to June 17	12	1207	362	29.9
July to Sept 17	12	1120	328	29.2
Oct to Dec 17	11	1172	322	27.4

The average proportion of YMWs using any form of temporary contraception/family planning was 28.9 percent.

Case studies:

Case study –1

ANC complication

Usha (name Changed), young lady aged 21 years attended IHMP's monthly meetings in her slum. She was married 7 years back. One day she told the CHW of her slum that she

had missed her last menstrual period following which the CHW suggested to do a Urine pregnancy test, which turned out to be positive. Her family was very happy, after a long time she was pregnant. Usha registered for ante-natal care (ANC) and got her ANC examinations done regularly.

When she was in the 9th month of her pregnancy, Usha complained of watery discharge from her vagina. Usha then with her Mother in law went for an obstetric checkup to Sane Guruji Hospital. The doctor at Sane Guruji Hospital advised her to get admitted for a treatment. The doctor said that if she is not willing for admission then he will prescribe medicines that Usha can take at home. Usha was willing to get admitted for treatment but her mother in law insisted that Usha returns home and takes the prescribed medicine. Usha was taking medication but the watery discharge continued. Usha met IHMP's ANM and CHW during their home visit and told them that the watery vaginal discharge has not yet stopped. IHMP's ANM and CHW examined Usha and found the fetus was distressed so they counseled her mother in law and convinced her to take Usha to the hospital immediately.

At the hospital the doctors told Usha that they would have to perform an emergency caesarian section operation to deliver the baby otherwise there was a risk of the baby dying inside the uterus. The operation was successful and the baby and mother are fine. Usha's mother in law thanked IHMP staff and said it is because of their advice the baby was delivered without any complications.

Case study -2
Family planning and son preference

Savita (name changed) saw herself as an utter failure. A good wife ought to provide a son to perpetuate family name, how would she face her neighbor who had recently delivered a son. How would she cope with her own family she wondered? It was apparent that she had lost weight and was crying frequently. Every time she looked at her three daughters, she felt her husband was abusing her.

Institute of Health Management Pachod (IHMP) nurse working in her slum was explaining to a group of women about family planning and proper spacing between children. Savita fled from that meeting. But it did not escape the attention of our nurse. When the nurse entered Savita's home she saw Savita holding her three daughters and weeping. After much cajoling, Savita told the nurse about the physical abuse by her husband, of her unwanted pregnancy just to get a son, of her husband's refusal to use a condom and the shame she would bring on the family if she does not give birth to a son.

IHMP's nurse first explained to Savita how a husband is responsible for the birth of a son. She was obsessed with this task of making Savita's husband to realize his misconceptions. She could not talk to the husband directly, so she involved a Male worker of IHMP. He explained patiently and in 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.

IHMP's nurse was a happy lady on the day she went for her group meeting and saw Savita's smile. "I cannot thank you and your male colleague 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 condoms now!"

IHMP has been able to increase the use of contraceptives from 8 to 29 percent. Married adolescent girls like Savita have benefited from our family planning drive. Our health program does not merely delay first birth and increase spacing between two births, it also supports girls like Savita in coping with the dire implications of the social norm of "Son Preference".

Case study-3

Ankita (name changed), 19 years woman lives with her husband in a joint family at one of the slum where IHMP implements sexual and reproductive health project. She has recently delivered a baby and her brother in law's wife was looking after Ankita& her baby.

One day during a surveillance visit, a CHW visited Ankita's home and came to know about Ankita's delivery. As the CHW entered, Ankita's brother in laws wife showed disrespect and said not to discuss anything with Ankita as she had delivered a baby. However, CHW explained that the visit was for Ankita's and her baby's benefit; she showed Ankita BCC flash card and provided important information on post natal care as well as family planning. With this information, Ankita get convinced for taking up post natal checkup, however for family planning she was not clear.

On subsequent visits CHW took help from ANM, both of them visited Ankita's home and provided BCC to Ankita& her brother in law's wife on the importance of spacing. ANM explained what are the potential health risk to Ankita and future baby if she immediately got pregnant, she also presented benefits of delaying next child birth at least for three years. At this time Ankita seemed convinced with what ANM had explained, she asked queries like - what methods are available for spacing and can her husband also take active part in spacing; upon this ANM & CHW described everything to her including the four tools i.e. OC pills, Condoms, Cu-T, Injection to Ankita. That day Ankita realized importance of spacing between two children, she showed her desire to use contraceptives. Ankita convinced her husband as well, now he uses condom and both of them have decided to continue using it for next two years.

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

Certificate distribution for LSE batch III (May 17 to Dec17)Third batch of LSE:

187 UAGs out of total 240 attended LSE who had completed sessions on life skills education on 24and 25th April 2018 at Cluster wise in vasti Hadapsar received certificates. About 370 UAGs and their parents and SHDC members attended thiscertificate distribution ceremony.

Third Life Skill Education batch (May 17 to Dec 17):
The third batch of Life skills education (LSE) for unmarried adolescent girls was initiated in 12vastis during month of May 2017. At the beginning of batch a total of 240 girls were participated in pre-test to assess their levels of cognitive skills along with self-esteem and self-efficacy among the enrolled girls for LSE was conducted.

All 50 session were completed for this batch in Mar, posttest for four vasties could be completed by the end of December 2017. A total of 187 girls have been covered in this test, for posttest for knowledge and self esteem – efficacy will be conducted in Dec-Jan 2018.

Supervision of LSE classes: Supervision of the LSE classes was carried out through the IHMP field coordinator. 108 Supervisory visits were planned during the reporting period out of which 100 (93 percent) visits were conducted. 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

Workshops on Sexual and Reproductive Health: Total 8 workshops on Sexual and Reproductive Health were conducted for unmarried adolescent girls belonging to the slums of Hadapsar, Pune in April 2017, October 2017. Total 72 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. 72 participated in both the pre and posttests. Only the subjects that were present for the pre-test as well as the post-test were considered in this study.
Combine total number of girls from workshop mode and LSE classes mode who attended SRH sessions is 112.

SRH module conducted in LSE class mode:
Modules on Sexual and Reproductive Health were conducted for unmarried adolescent girls of the slums in Hadapsar, Pune from December, 17 to January 2018 period. During this quarter a new strategy was adopted of integrating the SRH modules in to the LSE mode of teaching and was piloted in the three slums of Hadapsar. All 16 modules of SRH where conducted in LSE class mode soon after completion of LSE modules. Classes were organized twice in a week on Saturdays and Sundays. Each day 2-3 modules were

conducted by Supervisors/ANM along with CHW. First 8 modules were conducted for 11-14yr and 15-19yr age group together while next 8 modules having content on family planning and contraception were conducted only for 15-19 age group in the month of January2018.

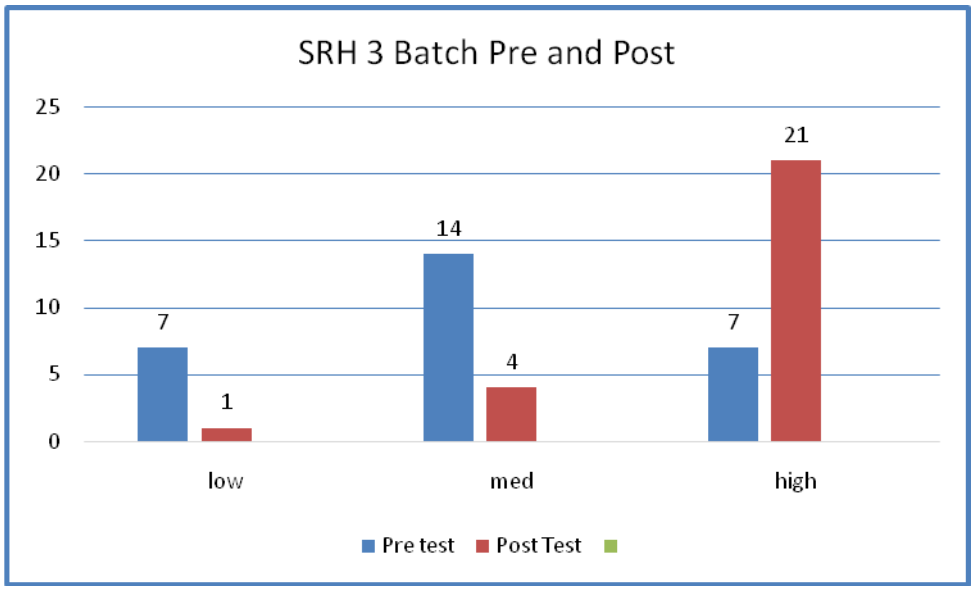
A total of 33 girls appeared for pre-test which was to assess levels of knowledge among the enrolled girls aged 11-14 years on last week of December.14 girls participated in pre-test to assess levels of knowledge among the enrolled girls aged 15-19 years for the workshop on last week of December. Overall 45 girl's attended the pre-test from both age groups. After completion of 16 sessions, a post-test was conducted on 12 February and a total of 33girls participated in the post-test. Girls present for both the pre-test and 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 7 in the pre-test to only 1 in the post-test. Also, a significant increase was seen in girls with high knowledge, from 7 in pre-test to 21 in post-test.

A tabular as well as graphical analysis of the data can be demonstrated as follows:

Percentage of scores	Pre-test (n=28)	Post-test (n=28)
Low knowledge (0-33%)	25	4
Moderate knowledge (34-66%)	50	14
High knowledge (67-100%)	25	75

Graph of analysis of level in knowledge before and after the SRH Workshop



Case study for LSE

Nita (name changed) attends Life skill education classes conducted by IHMP's community health worker (CHW) Asha (name changed). One day Asha noticed that Nita suddenly became very quiet during class, she did not talk at all. Once the class finished, she did not even stop to chat with her friends. Asha found her behavior very strange. Usually Nita used to talk so much that Asha had to ask Nita to stop. Asha asked Nita's friends what had happened to her. Her friends told Asha that her parents have found a boy who is well settled and earns very well and so they have decided to marry her off as soon as possible.

IHMP's CHW, Asha was shocked. Nita who is 17 years old is a student of class 12th. Asha knew that Nita wanted to study further and have a career as a Chartered Accountant (CA). Asha wondered, if Nita is married off so early, how is she ever going to become a CA? Asha decided to confront her parents. Along with her friends in her peer group she visited Nita's parents one evening. Asha asked Nita to express her desires and feelings to her parents effectively with the skills she had learnt during life skill education.

During their discussion with Nita's parents Asha and Nita's friends realized that the boy with whom her marriage was being arranged had a well-paid job in the metropolitan city of Mumbai and was very well settled. However, the boy and his parents had made it clear that they would not allow Nita to study any further after her marriage. They said they won't even allow her to work and have a career after her marriage. Nita told her parents that she is very keen to complete her education. She said that she aspires to become a chartered accountant one day. She said that if her dream is taken away from her she will never be happy in her life.

Nita's parents were convinced that they should allow Nita to continue her education and realize her dream of becoming a chartered accountant. They told the parents of the boy who Nita was supposed to marry that they had decided against her marriage to their son because of their decision not to allow her study or work after marriage.
Nita felt ecstatic that she got such timely support from Asha and her peers from Life Skills education.

Nita has completed 12th class now with a very good score. She has started studying a commerce course in a leading college in the city. She is pursuing her education as per her dreams. Her parents said that they can't thank Asha enough for supporting their daughter and restoring her happiness and the twinkle in her eyes.

Usually when a girl's marriage is broken, people in her community tend to stigmatize her. In Nita's case the outcome was very different. Asha talked to the neighbors and community leaders and told them that Nita had the courage to stand up for her rights and was able to convince her parents about her aspirations. People in her community started looking at Nita with respect and talked about her with pride. Asha is certain that Nita's experience will touch the lives of many more adolescent girls in her slum.

Integrated Project for Empowering Adolescent Girls and Rotecting them from the Consequences of Early Marriage, Early Conception, Sexual and Domestic Violence in the Villages under Karanjvihire PHC, Pune District

Annual activity report- April 2017 to March 2018

Introduction:

Over the last 40 years, Institute of Health Management Pachod (IHMP) – a non-profit organization – has been addressing the most pressing public health concerns of marginalized and disadvantaged groups and has created a lasting impact on the lives and health of over a million people. IHMP's major focus during the last 20 years has been on safeguarding and transforming the lives of vulnerable adolescent girls living in rural and urban slum communities.

Institute of Health Management Pachod is working in 19 villages (24 ASHA areas) under the Karanjvihire PHC, Khed block to provide reproductive health services for reducing maternal morbidity due to early pregnancy, and prevent low birth weight among babies. Additionally, IHMP provides life skills education to unmarried adolescent girls, which will be implemented in coming year to empower them to make independent life choices, and prevent child marriage. The targeted area is geographically challenging and has a mixed population i.e. tribal, non-tribal and a migrant population.

Forbes Marshall Pvt. Ltd. has approved a grant for 3 years for the SATH (Safe Adolescent Transition and Health) project in Karanjvihire PHC area to demonstrate an integrated reproductive sexual health project to empower unmarried adolescent girls aged 11-19 years and protect married adolescent girls and young married women of age <=24 years from the adverse consequences of early motherhood. This project has been implemented since May 2017.

The specific objectives of the integrated SRH project are:

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

Specific Objectives

1. To increase the proportion of women having 1st child birth after 18 years.
2. To increase the proportion of women receiving standard, antenatal & postnatal care.
3. To increase the proportion of women taking treatment for maternal complications.
4. To demonstrate a measurable reduction in maternal complications (antenatal, intra-natal and postnatal morbidity) in married adolescent girls.
5. To reduce the proportion of LBW babies.

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

Specific Objectives

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

Part 3: Attitudinal change in unmarried and young married men thereby demonstrating a measurable change in the prevalence of sexual and domestic violence and gender inequitable behavior.

Specific Objectives

1. To demonstrate a measurable change in the attitude of unmarried and young married men towards women as measured by the GEM scale.
2. To reduce the proportion of young men getting married to girls less than 18 years of age.
3. To reduce the proportion of young men involved in perpetrating sexual and domestic violence.

List of activities undertaken by IHMP for the integrated reproductive and sexual health and family planning project for young married women in Karanjvihire PHC, Khed block, supported by Forbes Marshall, during the financial year 2017-18:

A. Preparatory Phase

Recruitment and capacity building of project staff:
One project coordinator and one MIS coordinator were selected in the month of Feb 2017 and three field supervisors were selected in June 2017 by the IHMP selection committee

Training of Project Staff:
A six-days training program for the project senior staff was organised from 3rd to 8th April 2017 at IHMP Pachod. SRHR technical skills and management skills were imparted during the training program. As an outcome of the training program, project staff prepared a Logical Framework Analysis for the project. The LFA is being effectively used for planning, implementation, supervision and monitoring of the program. Project field coordinators and project manager attended the training.

Project middle level and senior management staff attended the training on Biostatistics and Epidemiology at Christian Medical College, Vellore from 16th April to 29th 2017.

A three-days training program for the project staff was organised from 6th to 8th July 2017 at IHMP Pachod. In this training skills for undertaking house numbering, census, and modified social mapping were imparted. Project field coordinators, field facilitators and project manager attended the training.

Visit to the PHC, project area and observations:
The IHMP project team along with the Forbes Marshall team visited PHC, Karanjvihire, Varale Sub-centre and nearby villages in mid March 2017. During the PHC visit following information was gathered:

Karanjvihire is a 24/7 PHC having medicines and lab tests as per IPHS standards but it does not have infrastructure and equipments as per IPHS standards. PHC is a new building constructed and equipped with the help of CSR funds. Well-equipped meeting /training hall of PHC has a projector for the training of staff and ASHAs. The PHC has a labour room, laboratory, separate wards for male and female, clean toilets, ample amount of charts, drinking water. Nurses are available for night duty. The PHC has a charter of services that is exhibited at the entrance where patients can read, but the list of medicines available is not displayed at the entrance.

There are 32 villages under the PHC with a total population of nearly 100000. The PHC has 12 sub-centres with approximatley 24 staff.

Information on Sub-centres under PHC:

Karnajvihire PHC has 12 sub-centres, 9 out of 12 sub-centres have infrastructure and equipment prescribed under IPHS standards and rest 3 don't have a building for the sub-centre. There are 10 ANMs in 12 Sub-centres, 2 sub-centres are vacant. 3 ANMs reside at the sub-centre while 9 sub-centres have residential quarters for the ANMs. ANMs maintain the MCTS register, R15, R3, R4, R16, RCH register and ANC register. During meetings, focus is mainly on Family planning, Immunization indicators and RCH programme.

ASHAs under PHC:

The number of functional ASHAs are 66 out of 74 expected. All 66 ASHA's have undergone the first 4 modules of training. 60 ASHAs have received HBNC training recently. ASHAs have not received training for RKSK. They maintain the following records- Family planning register, Survey register, Immunization register and 5A and 5B registers.

Selection of project Villages and ASHA:
In the month of April 2017, IHMP project team visited PHC, Karanjvihire for project orientation for the MO, PHC staff and ASHAs. During the visit, IHMP team finalised potential villages for project implementation in consultation with Dr Dhekle, MO PHC and PHC staff.

Following information was collected:

1. List of potential sub-centres and their geographical locations
2. List of PHC staff (ANM, MPW and other staff) and their contact details
3. List of ASHA, ASHA supervisor and their contact details

In the meeting, Dr Dhekle, MO PHC & PHC staff and IHMP team selected 6 sub-centres out of 12 sub-centres and 24 ASHA areas were finalised for project implementation.

Table: Name of the potential villages and ASHA in the project

Sr. N.	Village Name	ASHA Name
1	Ambhu	Usha Kamble
2	Gadad	Kamal Dangle
3	Velhavale	Shaila Lote
4	Deshmukhwadi	Nita Deshmukh
5	Wahagaon	Rasika Navale
6	Koliye	Nanda Kavde
7	KaranjVihire -II	Kavita Shivekar
8	KaranjVihire -I	Shobha Kolekar
9	Shive – II	Rupali Salunke
10	Shive – I	Vandana Gaikwad
11	Koregaon – I	Ujjwala Gogawale
12	Koregaon – II	Anita Galav
13	Shelu	Kalpana Gade
14	Askhed	Shanta Limbhore
15	Shinde gaon	Aruna Panmand
16	Sawardari	Vaishali Dhumal
17	Shinde thakarwadi	Subhadra Matale
18	Bhamboli	Nirmala Raut
19	Varale	Sonali Londhe
20	Wasuli	Sunita Kavre
21	Birdawadi	Chaya Retawade
22	Bordara	Rupali Padwal
23	Ambethan Vasti	Sanghamitra Naiknavre
24	Ambethan Gaon	Rekha Davane

B. Community Mobilisation

1. Meetings with key stakeholders:
During the preparatory phase of the project, project staff visited ASHA's, Sarpanch, Gramsevak, Gram panchayat members, Aaganwadi workers and key stakeholders in the project villages. The key objective of theses visits was to orient the community about the project and create a conducive environment. During these visits the IHMP team had discussions with following key stakeholders from the villages:

There were a total of 18 Gram panchayats in our selected project area with 24 ASHAs. One introductory meeting with gram panchayat members was conducted in each village, and vasti level pocket meetings were carried out in the month of April, May and June 2107.

Following topics/issues were discussed with the key stakeholders:

- Broad objectives and interventions to be implemented under the program.
- Oral consent to start the program and research activities in the villages.
- Information was shared with the members on house-listing, village mapping, census and baseline activity to be conducted in the villages.
- Participation of the community in planning and implementation of the program.

Pamphlet distribution:
A pamphlet was designed and printed which consisted of a brief description of the implementing organisation IHMP, funding agency Forbes Marshall and project objectives, interventions (SRH and LSE) and project target groups. Pamphlets were distributed during the house numbering, listing and at community meetings. Around 10,000 pamphlets were distributed in all 24 ASHA areas in the project villages.

Table: Community meetings conducted in April and May 2017

Sr.	Name of the Villages	Number of meetings conducted
1.	Ambhu	1
2.	Velhavale	
3.	Gadad	1
4.	Deshmukhwadi	1
5.	Wahagaon	1
6.	Koliye	1
7.	KaranjVihire	1
8.	Shive	1
9.	Koregaon	1
10.	Shelu	1
11.	Askhed	1
12.	Shinde	1
13.	Sawardari	1
14.	Bhamboli	1
15.	Varale	1
16.	Wasuli	1
17.	Birdawadi	1
18.	Bordara	1
19.	Ambethan	1
Note: Total 18 Gram Panchayat meetings were conducted approximately 30-40 people attended meetings including Sarpanch, Gramsevak, Gram panchayat members, AWW, ASHA and other village key stakeholders.		

C. Household numbering, mapping and census:

Design of formats for the census, house listing and listing of target populations:
The formats to be used for the initial survey of the selected villages were designed and pre-tested. The pretesting was done in an urban slum project area.

Training for house numbering, listing of target populations and mapping:
A one-day training program for the project staff and ASHA's was organised on 16th May 2017 at Karanjvihire PHC. Cognitive and practical skills regarding house numbering, mapping and listing of target populations was provided during the training. 21 ASHA, 1 ASHA supervisor, 3 field facilitators, project field coordinators, and project manager attended the training.

For the remaining three ASHA's training was conducted by the project coordinator. Simultaneously skills development for field work and and handholding of 24 ASHA's was undertaken by field facilitators.

House numbering and mapping:
House numbering, listing and mapping was initiated in the month of May 2017. During the house listing process each house was numbered. The numbers were written on the doors of each house.

A map of each village was prepared on which important landmarks of the village were shown, along with roads, school, temples, water resources and numbered houses. During the reporting period, house numbering and modified social mapping were carried out for all the villages under the project area. A total of 8687 structures were numbered in the 24 ASHA areas.

Listing of target population:
After the house numbering and mapping, listing of households and target population was carried out by the ASHA for her particular village. Pre-tested formats were used for listing the target population. Data collection was undertaken by ASHAs in all the project villages and data verification, validation and reliability checks were conducted by field supervisors in all the project villages during the reporting period. House listing, numbering, village mapping and data collection was initiated on 25th May 2017 and completed on 15th August, 2017.

Inclusion criterion for listing target beneficiary: 1) Permanent resident of village 2) Migrants living more than six months in the village

The key reasons for families that could not be covered were: 1) Temporary migration – family is out of village for one or two weeks. 2) Household with permanent migration

During the data collection, villagers were very cooperative and the only challenges faced by ASHA during listing were topography and distance between houses within the village.

The data collection operation was supervised by 3 IHMP field facilitators and field coordinators.

Data entry of census:
Data entry of census information i.e. details of unmarried adolescent girls, young married women, marriage data of last five years both boys and girls and young men was carried out in August 2017. A structure in Excel sheet was designed; information of 1209 unmarried adolescent girls, 682 young married women (20-24), 174 married adolescent girls (<=19), and 1727 youth (15-24) was entered. Lists of unmarried adolescent girls ≤ 19 years and young married women of age ≤ 24 were prepared for all the project villages.

Table: Distribution of villages, household and population in the project area.

Sr.	Name of Sub Center	Name of Village	Total house holds	Total popul ation	UAG 11-19 years	MAG <=19 years	YMW 20-24 years	Young men
1	Gadad	Ambhu	109	289	18	2	12	45
2		Gadad	192	429	20	3	15	54
3		Velhavale	78	241	21	1	10	29
4	Wahagaon	Deshmukhwadi	148	646	22	6	12	55
5		Wahagaon	188	839	34	6	18	41
6		Koliye	355	623	31	4	16	60
7	Shive	KaranjVihire - II	445	705	60	3	26	50
8		KaranjVihire -I		969	53	12	46	77
9		Shive - II	84	827	56	12	23	79
10		Shive - I	404	777	53	5	30	76
11	Koregaon	Koregaon - I	618	1375	45	15	38	42
12		Koregaon - II		464	21	5	17	29
13		Shelu	184	1580	117	23	37	161
14		Askhed	178	837	42	5	19	68
15	Varale	Shinde gaon	317	846	47	5	33	90
16		Sawardari	278	1169	73	9	46	98
17		Shinde thakarwadi	192	962	42	8	29	58
18		Bhamboli	714	858	67	5	28	70
19		Varale	323	775	34	2	21	55
20		Wasuli	444	961	37	3	51	71

21	Waki Br	Birdawadi	1192	1443	105	16	55	149
22		Bordara	215	969	53	6	30	77
23		Ambethan Vasti	1242	1066	78	8	30	125
24		Ambethan Gaon	787	1241	80	10	40	68
		Total	**8687**	**20891**	**1209**	**174**	**682**	**1727**
UAG: Unmarried adolescent girls, **MAG:** Married Adolescent Girls; **YMW:** Young Married Women								

D. Baseline survey:
The broad objective of the baseline study was to obtain information on the prevalence and predictors of certain parameters within the project area. The baseline information was used for planning, management and evaluation of the intervention, and to find out the unexplored research areas.

Data collection: A team of 10 external female investigators and 3 supervisors were recruited and appointed solely for data collection. A five days training for research team was conducted at Forbes Marshall training centre before actual data collection. Training of the research team for survey on young married women was conducted from 30th August to 2nd September. Training of research team for baseline survey on unmarried adolescent girls was conducted between 21st & 22nd September 2017.

Baseline data collection for young married women was carried out between 4th to 18th September 2017. A total of 329 young married women (120 married girls <=19 years & 209 women aged 20-24 years) were interviewed from 22 ASHA areas.

Baseline data collection for unmarried adolescent girls was carried out between 23rd September to 26th October 2017. A total of 385 unmarried adolescent girls (200 girls aged 11-14 years & 185 girls aged 15-19 years) were interviewed for the baseline survey from 22 ASHA areas.

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

A data entry program in EPI data was designed and pre-tested for data entry. In the reporting period, data entry of all 385 filled questionnaires for unmarried adolescent girls and 329 filled questionnaires for young married women was completed. Data analysis was conducted in the software STATA and carried out in the month January 2018.

Conclusions form baseline data:
Baseline survey findings indicate that there is a high drop-out rate from schools after age of 11 years. Very few girls can access higher education or vocational training. Dietary and nutrition knowledge and practices among unmarried girls are poor. Knowledge about reproductive health is abysmally low. Adolescent girls have poor mobility, decision making skills and participation in community activities.

A substantially high proportion of women living in the villages were married before the legal age of 18 years. Utilisation of SRH services is poor and dependent mostly on the private sector. A significantly high proportion of young married women reported maternal and neonatal morbidity, low birth weight babies, reproductive morbidity including domestic violence. The proportion using contraceptives is very low.

Utilisation of baseline data
The meticulously collected baseline data is being used for:

- Training of frontline workers in community diagnosis
- Technical, communication and management skills are being planned on basis of the community diagnosis
- Project planning is being undertaken on basis or this live data from the community where the project is going to be implemented
- The data will be used as a benchmark for evaluating change

E. Implementation MAG and YMW components:

Capacity building of ASHA's:

Induction training program for ASHAs to provide SRHR technical skills:
Induction training of ASHAs on Sexual and Reproductive Health (SRH) technical skills was planned and organized at the Karanjvihire PHC from 1st to 4th September 2017. A total of 24 ASHAs participated in the technical training. Following topics were covered during the training;

1. Menstrual cycle, How to identify pregnancy
2. Antenatal care, Postnatal care, Neonatal care
3. Maternal and neonatal morbidity
4. Abortion and RTI/STI
5. Family planning methods

Assignment on reproductive and sexual health:
After the technical training on SRHR, all the ASHAs were given assignments based on the topics covered during the training. ASHAs were asked to write answers of the assignment questions by referring the manual that was provided during the training. The key objective of this assignment was to reinforce technical skills. All the ASHAs that attended the training completed the assignments. IHMP team evaluated all the assignments and provided feedback to the ASHAs.

Induction training program for ASHAs for training on surveillance and BCC:

Training on Surveillance:
Protocols for monthly surveillance and monitoring were finalized in the month of Nov 2017. Training of ASHA workers on monthly surveillance was conducted from 13th to 16th November 2017 at Karanjvihire PHC. A total of 23 ASHAs attended the training. Following topics were covered during the training:

- VHND guidelines – roles of ASHA & ANM
- Importance of home visits
- Importance of surveillance & monitoring – for health needs assessment, morbidity detection & referral
- How to undertake monthly surveillance
- How to fill up surveillance forms

- How to use information collected from monthly surveillance for preparing micro-plans
- Linking clients to service providers
- Behaviour change communication
- Referral

Participatory methods were used during training. Role plays, mock interviews were conducted to provide practical skills for the above subjects.

Training on Need Based Behaviour Change Communication:
On 14th and 15th November 2017, training on behavior change communication was conducted along with monthly surveillance training from 13th to 16th Nov 2017. Resource persons demonstrated the use of flash cards for counselling on RSH services and family planning. The participants were asked to demonstrate counselling techniques through role plays. After the training each ASHA was given a set of two flash cards, and guides, one for MNH services and the other for family planning. The ASHAs were also given a surveillance register. They were provided with a bag to keep all the surveillance and BCC material.

On the job training was provided by IHMP staff after the training to all the ASHA workers to start home visits for surveillance and need based BCC. IHMP staff visited the ASHAs to strengthen their skills in surveillance and BCC. IHMP staff provided demonstrations on how to fill up the surveillance formats and use the BCC cards to provide need based BCC. A total of 24 ASHAs got support and hand holding during supervisory visits.

Table: Training programs conducted for ASHAs during April 2017 to March 2018

Sr.	Training	Month	Duration – days	No. of ASHAs attended	Knowledge & skills provided
1.	Induction training for ASHAs on technical Skills	September 2017	03 days	24	Cognitive skills – maternal health, neonatal health, child health, reproductive health, family planning.

Sr.	Training	Month	Duration – days	No. of ASHAs attended	Knowledge & skills provided
2.	Induction training of ASHAs on Surveillance and BCC	November 2017	04 days	23	Practical skills on implementation of IHMP RSH innovations-Morbidity surveillance-through history and examination, Surveillance and monitoring system, Need assessment for SRH and family planning, Preparation of micro plans for RH and family planning based on needs assessment, Need based BCC through flash cards, Reporting skills, Functioning of VHND and VHSNC.

Surveillance and Monitoring System:
Protocols for the surveillance & monitoring system for 24 ASHA areas were designed and printed. After the induction training; in order to develop practical skills for recording in surveillance registers, field facilitators provided on the job training to the ASHAs. ASHAs initiated home visits for monthly needs assessment, morbidity surveillance, and for the provision of needs specific BCC in their villages from December 2017.

The surveillance system covers following broad areas:

- Maternal health- Antenatal, Postnatal care and Antenatal, postnatal complication
- Neonatal health
- Reproductive health – Reproductive tract infections
- Family planning- Current user, permanent sterilization, Desire to use FP

In-service training:
Monthly in-service training for ASHAs was initiated in the month of December 2017. Four in-service training sessions of one day duration for each group were conducted during the reporting period. The ASHAs and project staff participated in these training sessions. One day was spent on planning and review of SRH services. Technical inputs were provided for the sessions planned for the month. Project inputs, outputs and coverage were reviewed and participatory planning was undertaken during the meetings. Practical skills were provided to the ASHAs.

Monthly needs assessment and morbidity surveillance by the ASHAs:
ASHAs initiated home visits for monthly needs assessment, morbidity surveillance, and for the provision of needs specific BCC in their villages from December 2017. Needs assessment through monthly surveillance was carried out by 21 ASHAs in the month December, 23 ASHAs in the month January, 22 ASHAs in February and by 22 ASHAs in March 2018.

One ASHA has diagnosed with Cancer and is under treatment whereas another ASHA was not working as she has found another job. The ASHA from village Ambethan Gaothan joined the project in the month of March 2018.

About 94.3 percent young married women (YMW), age ≤ 24 years were covered during the reporting period through monthly needs assessment. During these visits, ASHAs assessed health service and information needs of young married women, age ≤ 24 years, and provided need based BCC and counselling with the aim of generating demand. Needs of young married women aged ≤ 24 years that were assessed by the ASHAs during home visits in the reporting period is described in Table. 5

Table 5: Summary of monthly needs assessment & morbidity surveillance

Indicator	Category	December 2017	January 2018	February 2018	March 2018
Home visits to YMW for surveillance & need specific BCC by ASHAs	Actual	678	756	735	717
	Planned	703	786	785	789
	Percent	96.44	96.18	93.63	90.87
Currently pregnant mothers	Actual	90	94	79	85
	Expected	131	131	131	131
	Percent	68.7	71.8	60.3	64.8
Currently pregnant mothers received antenatal care	Actual	78	83	72	73
	Planned	90	94	79	85
	Percent	86.7	88.3	91.1	85.9
Currently pregnant mothers detected with symptoms of antenatal complications (prevalence rate)	No. detected	18	16	14	24
	Percent	20.0	17.0	17.7	28.2
Treatment taken by YMW for antenatal complications	Actual	9	11	8	22
	Planned	18	16	14	24
	Percent	50.0	68.8	57.1	91.7
Young married women detected with symptoms of reproductive tract infections (prevalence rate)	No. detected	39	50	37	36
	Percent	5.5	6.4	4.7	4.6

Indicator	Category	December 2017	January 2018	February 2018	March 2018
Treatment taken by YMW for symptoms of reproductive tract infections	Actual	14	23	26	19
	Planned	39	50	37	36
	Percent	35.9	46.0	70.3	52.8
Young married couples reported desire to use temporary FP methods (Excluding ANC, Permanent sterilized and currently using family planning beneficiaries)	Actual	54	51	39	43
	Total exposed for Desire to use FP Methods	412	427	404	387
	No Excluding ANC, Permanent sterilized and currently using family planning beneficiaries	291	329	331	330
	Percent	13.1	11.9	9.7	11.1
Young married couples using temporary FP methods	Actual users of temporary family planning methods	130	157	182	176

The average percentage of young married women who had been covered by monthly surveillance was 94.3 percent. On an average 66.4 percent pregnancies were detected as compared to expected. Around 88.0 percent pregnant mothers have undergone antenatal examination. The proportion of pregnant mothers reporting any one antenatal complication was 20.7 percent. A substantial increase in the proportion of young married women that took treatment for antenatal complications is observed in the month of March 2018 as compared to December 2017, January & February 2018. The average proportion of pregnant mothers with symptoms of antenatal complications who had sought treatment was 66.9 percent.

Average 5.3 percent women are detected with RTI. The average proportion of those women with RTIs who sought treatment was 51.2 percent.

There is substantial increase observed in the use of temporary contraceptives.46 young married women have started using contraceptives since December 2017.

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.

Needs specific behavior change communication:
During monthly household visits the ASHA 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, 1490 household visits were undertaken by ASHAs during which they provided need specific BCC.

Table: Needs specific BCC provided by the ASHA at household level

Sr.	Topic	Number of clients received needs specific IPC & counseling from ASHAs at household level			
		Dec-2017	Jan-2018	Feb-2018	Mar-2018
1.	Maternal care	90	94	79	85
2.	Treatment for symptoms of maternal morbidity	18	16	14	24
3.	Use of family planning methods	130	157	182	176
4.	Desire to use family planning methods	54	51	39	43
5.	Treatment for reproductive tract infections	39	50	37	36
6.	Postnatal care	11	17	19	29
	Total	342	385	370	393

Summary:

Capacity building of ASHAs for effective implementation of the IHMP innovations was achieved through hand-holding and mentoring in the field. The outcome of the IHMP innovations has been an increased trend in utilization of maternal and neonatal care services by the community, substantial increase in treatment seeking for reproductive health problems, increasing trend in contraceptive use.

Several challenges were faced during the first year of implementation. Getting trained investigators and staff for the preparatory phase was a challenge and could be overcome only through meticulous in house training. There was greater resistance in the initial period of the project from PHC & Sub centre staff, meetings and orienting them about the goals and importance of the project has resulted in creating a conducive environment.

Other challenges that we have faced are topography, mixed population i.e. project villages have migrants, tribal and rural population, weak transportation facilities, and attrition among staff.