



Preventing Child Marriage and Early Pregnancy in India

*Dasra Giving Circle
September 2014*

*A comprehensive assessment report on Institute of Health Management Pachod (IHMP) for the
Dasra Giving Circle on preventing child marriage and early pregnancy in India*

Table of Contents	Pg.
I. Basic Facts	1
II. Executive Summary	1
A. The Organization – Institute of Health Management Pachod (IHMP)	1
B. Proposed Plan	2
C. Investment Highlights	2
III. Organization Overview	4
A. Key Milestones	4
B. IHMP's Current Programs	5
C. Rationale for working on Child Marriage	5
IV. Proposed Plan	6
A. IHMP's Strategic Plan	6
B. Approach under the Dasra Giving Circle	7
C. Program and Operating Model	8
D. Opportunity for the Sector	13
V. Operational Plan	13
A. Activity Roll Out	13
B. Financials	14
C. Management and Organization Structure	15
VI. Impact Assessment	17
A. Expected Outcomes	17
B. Historical Success	18
C. Process for Impact Monitoring and Evaluation	19
VII. Risk Mitigation and Key Areas of Dasra Support	19
A. Risks and Mitigants	19
B. Key Areas of Dasra Support	20

I. The Basic Facts

Name: Institute of Health Management Pachod (IHMP)

Address: Pachod, Aurangabad – 431 121, Maharashtra

Website: www.ihmp.org

Email: admin@ihmp.org

Telephone No.: +91 2431 221331

Presenter: Dr. Ashok Dyalchand, Executive Director

Legal status: Registered with the Charity Commissioner as Ashish Gram Rachna Trust

Year founded: 1975

Funders: MacArthur Foundation, Oxfam, Ford Foundation, Rockefeller Foundation

	Current Status: 2012-2013	Proposed 3-Year Plan: 2014-2017
Geography of impact	Maharashtra – Rural & Urban	Maharashtra - Rural
Total outreach	50,000 population across 32 villages and 18 urban slums, directly benefiting ~5,000 adolescent girls	60,000 population across 60 new villages, directly benefiting 6,000 adolescent girls and 1,500 boys & young men
Budget for CM	INR 0.8 crores	INR 3.3 crores*
Total org budget	INR 1.4 crores	INR 7.9 crores*

**Amount is cumulative for the three-year period*

II. Executive Summary

A. The Organization – Institute of Health Management Pachod (IHMP)

- IHMP was founded in 1975 with a vision of **eradicating maternal mortality and morbidity** – began with providing maternal and child health services through a hospital in rural Maharashtra.
- It presently delivers **focused interventions for at-risk adolescent girls** to enable long term impact through delaying the age of marriage, age at first conception and through a measurable improvement in sexual and reproductive health status.
- To protect adolescent girls from the dangers of early marriage, IHMP has undertaken an **integrated approach** which includes the following elements:
 - **Lifeskills education program for unmarried adolescent girls:** Initiated in 1999, the objective of this intervention is to improve the cognitive & practical skills, and the self-esteem & self-efficacy of unmarried adolescent girls through lifeskills education with the aim of delaying their age at marriage.
 - **Sexual & Reproductive Health program for married adolescent girls:** Initiated in 2003, the element is aimed at delaying the age of first conception, instilling a treatment-seeking behavior and reducing the prevalence of maternal morbidity.
 - **Gender Sensitization with boys & young men:** This is a newly introduced element, aimed at creating gender-equitable attitudes and behaviours in unmarried and young married men to reduce prevalence of sexual and domestic violence.

B. Proposed Plan

- The existing government programs (such as the *SABLA* scheme) targeting adolescent health and development have major **implementation gaps**, very low coverage and a **fragmented approach**. In January 2014, the Government of India has announced a **policy for an integrated program** for adolescent girls and boys.
- An opportunity has arisen with IHMP being asked to be on the state government task force responsible for the strategic and implementation plan of this program. While leveraging its presence in the task force, IHMP aims to **influence the Government of Maharashtra** to adopt the **organization's proven systems, protocols** and monitoring mechanisms for the delivery of the government's integrated program targeting adolescent girls. To achieve this objective, IHMP would use prospective funding from the Dasra Giving Circle (DGC) to:
 - **Demonstrate the intervention:** IHMP shall scale its intervention to **60 villages** in *Marathwada* – a region in rural Maharashtra with close to 70% prevalence of child marriage, impacting a direct target population of (i) 4,000 unmarried adolescent girls, (ii) 2,000 married adolescent girls and (iii) 1,500 boys and young men, through the implementation of all three elements of the integrated program.
 - **Advocate with the government:** IHMP shall engage in quarterly meetings and annual workshops with state and national level government functionaries to attain acknowledgement followed by adoption of the organization's systems and protocols.
- The proposal to the DGC of **INR 3.3 crores** shall therefore catalyze IHMP's objective of state-wide adoption of the integrated program.

C. Investment Highlights

- **Comprehensive approach – working with unmarried and married adolescent girls and boys**
 - IHMP has a **comprehensive approach** towards resolving the issue – it has structured interventions for unmarried and married adolescent girls and boys.
 - It is the only organization that Dasra came across in its due diligence that has a targeted intervention to protect married adolescent girls from the **dangers of early marriage**.
 - By focusing on gender equitable attitudes and behaviours in boys and young men, IHMP shall be able to have a comprehensive and **lasting impact** in the community.
- **Experienced and progressive management team**
 - IHMP's senior management team has piloted and improvised on several interventions over the past three decades, and continues to remain **open-minded to further improvisation** when their research suggests.
 - The management team has free and open discussions, both internally as well as externally, and ensures that **decision-making is democratic**.
 - Dr. Dyalchand, the Executive Director of IHMP, has presented over 300 research papers at various conferences, and has also been an awardee at the Dasra Girl Power Awards in 2014.
- **Strong research and evaluation capabilities**
 - IHMP has been working on a measurement scale suited to the Indian context to **effectively measure ambiguous traits** such as self-esteem and self-efficacy in adolescent girls. The scale developed after a number of iterations, allows IHMP to **identify the most vulnerable** girls in the community, **measure the impact** of their program and thereby also build evidence for the effectiveness of their intervention.

- **Ability to achieve scale and leverage government infrastructure**
 - IHMP leverages **existing community health workers** appointed by the government, for the last-mile delivery of their interventions. This provides opportunity for IHMP to smoothly mainstream their interventions with the government programs.
 - IHMP has been invited by the Maharashtra state government to be a **part of the task force** that shall design the strategic and implementation plan for the newly announced policy for adolescent health and development. IHMP is therefore in a position to strategically drive advocacy efforts with the government. This if successful, would lead to efficacious use of government funds in the district, followed by state-wide delivery of the integrated program, thereby having the potential to **benefit 4.5 million adolescent girls** across 44,000 villages of Maharashtra.

III. Organization Overview

The Institute of Health Management Pachod – registered as *Ashish Gram Rachna Trust*, was founded in 1975 with a vision of eradicating maternal mortality and morbidity. IHMP strives for the development of communities by conducting (i) grassroots programs for improving public health, (ii) training of NGOs in program delivery and (iii) policy advocacy. The organization has been dedicated to uplifting marginalized groups, with a specific focus on women, adolescent girls and children.

In the mid-90s, IHMP streamlined its programs to focus on its vision of eradicating maternal morbidity and mortality and in the process, the organization found the need to strengthen its interventions with adolescents to enable longer term impact. IHMP primarily works in the backward *Marathwada* region of rural Maharashtra and in the urban slums of Pune.

A. Key Milestones

IHMP's journey over 35 years and the evolution leading to its current programs are highlighted below:

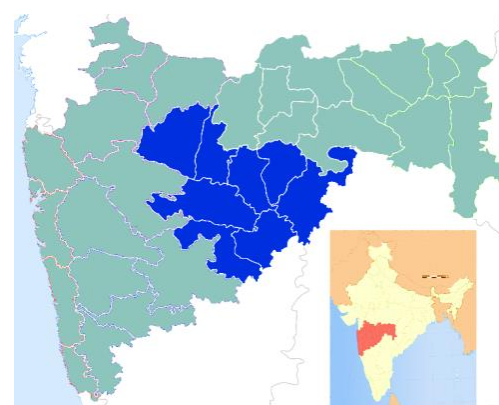
1975	Dr. Ashok Dyalchand (founding trustee) decided to provide maternal and child health services through a small hospital in Pachod village in Aurangabad, a district in Maharashtra badly hit during the 'famine of the century' in the region, which resulted in widespread malnutrition, morbidity and mortality.
1977	A team of health professionals got together to initiate a Comprehensive Health Project , i.e. the provision of maternal and child health services through Traditional Birth Attendants and Auxiliary Nurse Midwives.
1990	The trustees of IHMP decided that this experience should be shared with other NGOs through training. IHMP established itself as a reputed centre for imparting practical-oriented, hands on training in Community Health , and trained members of over 40 NGOs and community based organizations.
1995	The organization started working in urban areas with the establishment of the Pune centre. IHMP has engaged with 18 urban slum communities through this centre.
1999	IHMP identified the need to work more closely with adolescent girls, to achieve its objective of reducing maternal morbidity and mortality. The life-skills program for adolescent girls was conceptualized and begun during this year.
2003	Acknowledging that social norms take years to alter and that girls would continue to get married at a young age, the organization conceptualized its initiative to work with married adolescent girls and their spouses, through a health-based program.
2013	IHMP decided to take on an integrated approach – combining the interventions of lifeskills education programs for unmarried adolescent girls, reproductive health interventions for married adolescent girls, and a new element of gender sensitization for boys and young men. With support from the MacArthur Foundation, IHMP has been able to pilot the integrated model in 30 villages .

B. IHMP's Current Programs

	Lifeskills education	Sexual & Reproductive Health	Gender Sensitization
Objective	To help unmarried adolescent girls improve cognitive & practical skills, self-esteem & self-efficacy, increase the duration of formal school education and delay the age at marriage.	To help married adolescent girls delay the age of first conception, instill a treatment-seeking behavior, and reduce the levels of maternal morbidity.	To instill gender equitable attitudes and behaviours in boys and young men thereby reducing prevalence of sexual and domestic violence.
Model	Delivered at the community level by a field worker who forms groups, conducts sessions, identifies high-risk and high-potential individuals and links them with training opportunities provided by IHMP.	Delivered at household level by a field worker who makes monthly surveillance visits, provides health counseling, co-ordinates group counseling sessions and creates linkages with primary health providers.	Delivered by a male community health worker through group counseling with a behavior-change approach. Individual counseling provided to boys and young men on a need-basis.
Outreach	9,000 unmarried adolescent girls have already undergone the lifeskills training since 1999.	30,200 married adolescent girls have been provided sexual and reproductive health services since the program's initiation in 2003.	This is a new element of IHMP's model and the implementation of this component shall begin in September 2014.

C. Rationale for working on Child Marriage

IHMP's area of intervention is situated in the Aurangabad district of Maharashtra, which is where IHMP has undertaken community-based development and the provision of health care for over 35 years. Aurangabad is one of the eight districts that fall under the *Marathwada* region (highlighted in the map) – where the prevalence of child marriage is significantly higher, and this fact is hidden by the state-wide averages and therefore often ignored. As of 2007, while one in three women aged 20-24 reported marrying before age 18 across Maharashtra, **the prevalence of child marriage in Aurangabad District stood at 65.4%**



Early marriage produces child mothers and afflicts **inter-generational risks** of mortality, morbidity and malnutrition to young mothers and their newborns. Adolescent girls less than 15 years are five times more likely to experience maternal deaths than women 20-29 years¹.

While there are provisions in the government policies to address the issue of child marriage, IHMP has identified gaps in the system that are causing road-blocks to the same; these include:

- **Gap between policy formulation and implementation:** While policies for government interventions are formulated at the national level, adolescent health and development is a state subject and therefore, the responsibility of the implementation of the programs lies with the state. With an infrastructure of this nature, there is often a gap between the policies and the grassroot realities, leading to a host of challenges in the implementation of the programs.
- **Low coverage:** Adolescent health and development programs by the government are being implemented in parts of Maharashtra however the coverage remains low. For e.g. lifeskills education is to be delivered through the *SABLA*² program – however, only 2 out of 8 high risk districts of *Marathwada* are being covered under this program, that too as a part of a nutrition-focused intervention.
- **Fragmented Approach:** While the government has various different schemes that aim to impact adolescent development (such as the *Adolescent Reproductive & Sexual Health* program), there has been no integrated model that holistically targets unmarried and married adolescent girls and boys. IHMP has identified key factors beyond the policies that have led to fragmented and unsuccessful implementation; these include –
 - Inadequate training of field-level staff
 - Lack of guidelines and protocols for program implementation
 - Inefficient monitoring mechanisms

IV. Proposed Plan

A. IHMP's Strategic Plan

Opportunity

In January 2014, the Government of India introduced a **comprehensive policy** for adolescent health and development. Maharashtra is one of the first few states to initiate the implementation of this program. IHMP has been invited by the Maharashtra state government to be a **part of the task force** that shall design the strategic and implementation plan for the program.

IHMP's goal over the next 5-7 years is to influence the state government of Maharashtra to adopt the different components of the integrated program as a part of the National Rural Health Mission. IHMP's implementation mechanisms for the integrated program are presently filling the gap created by the unsuccessful implementation of the existing government schemes. Keeping this in mind, the advocacy efforts with the government would be

¹ Source: Website of 'United Nations Human Rights', <http://www.ohchr.org/>

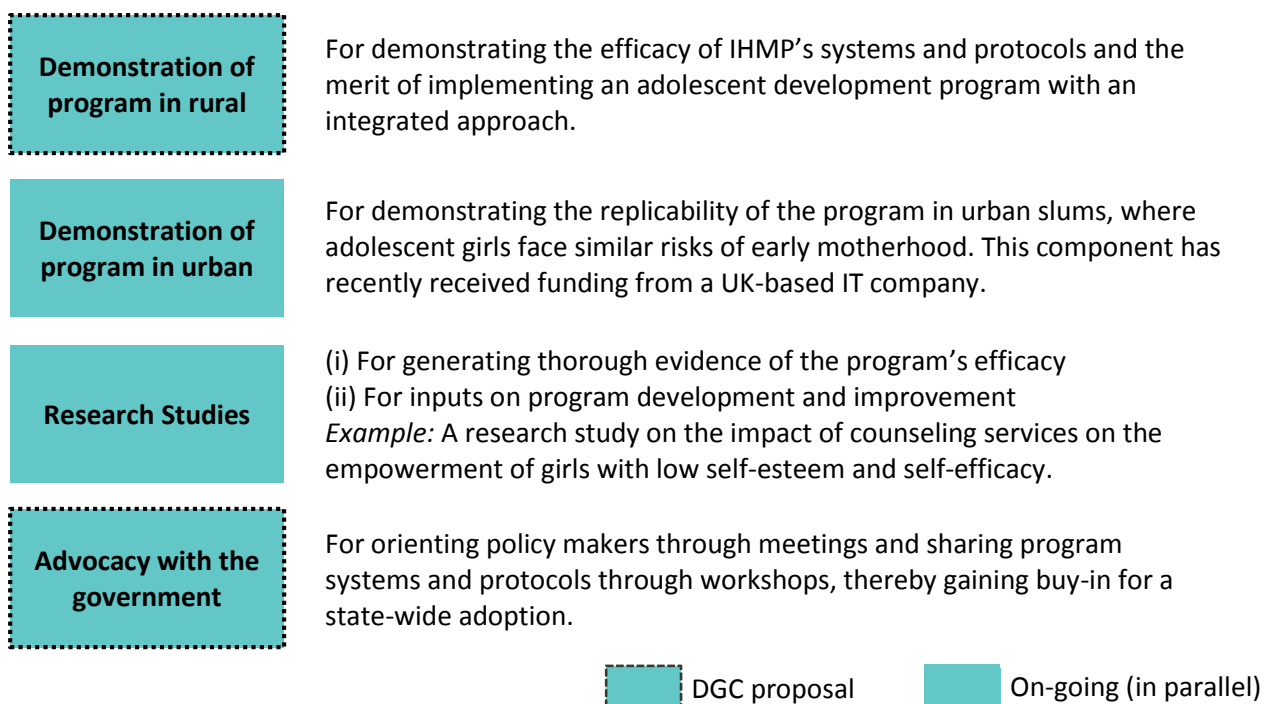
² *SABLA* is a scheme sponsored by the central government for the empowerment of adolescent girls under the Ministry of Women and Child Development and has a focus on nutrition and health of adolescent girls 11-18 years old.

not to introduce a brand new program but to adopt the organization's proven **methodology, protocols, modules and monitoring mechanisms**.

The various stages of buy-in from the government that IHMP would therefore target to achieve are:

- **Acknowledgement** of the efficacy of IHMP's intervention,
- **Adoption** of the requisite systems and protocols for the implementation of the program, and
- **Appointment** to build capacity of state level government functionaries for training of district/block level officials.

To progress towards the objective of state-wide adoption, IHMP plans to undertake the following holistic approach:



B. Approach under the Dasra Giving Circle

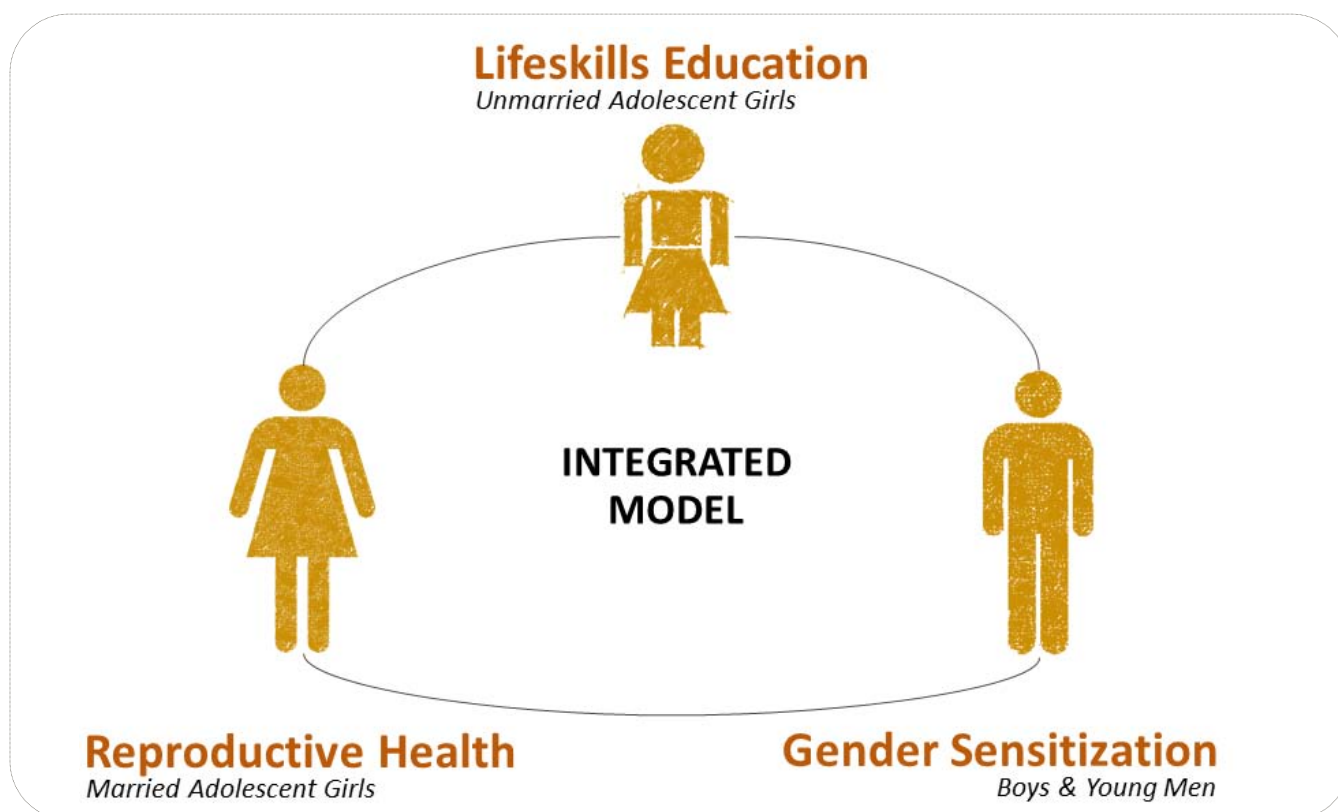
IHMP plans to use the DGC funds for the following components:

- 1. Demonstration of program in rural** – IHMP shall reach out to **60 new villages** in *Marathwada*, impacting a direct target population of **(i)** 4,000 unmarried adolescent girls, **(ii)** 2,000 married adolescent girls and **(iii)** 1,500 boys and young men, through the implementation of all three elements of the integrated program. So far, IHMP has already piloted the integrated program across 30 villages with support from the MacArthur Foundation, and the learnings from this pilot shall enable the organization to improvise while scaling the intervention to create the right demonstration site of 60 new villages.

2. Advocacy with the government – IHMP shall engage in quarterly meetings and annual workshops with state and national level government functionaries to advocate for the adoption of the organization's systems and protocols, and the efficacious use of government funds to implement the integrated program across Maharashtra.

C. Program and Operating Model

The next section shall go through the different components of the proposed program and highlight its impact on delaying the age of marriage and age at first conception.



Unique aspect of the proposed program:

- The lifeskills education and sexual & reproductive health components are both delivered by **Accredited Social Health Activists**, more commonly referred to as ASHAs. An ASHA is a government trained female health activist who belongs to the community and serves as an interface between the community and the public health system. Every ASHA reports into a **Primary Health Centre (PHC)**, which is typically responsible for approximately 30 villages in the vicinity. IHMP therefore **leverages the presence of a government functionary** in every village for the implementation of the integrated program, after receiving buy-in from the local PHC, providing them with holistic training and additional monthly remuneration.
- Before the role of the ASHA was formulated under the National Rural Health Mission (NRHM) in 2008, IHMP appointed its own field staff from within the community. It is note-worthy that all of IHMP's trained field personnel were absorbed by the NRHM to serve as ASHAs in their respective villages.

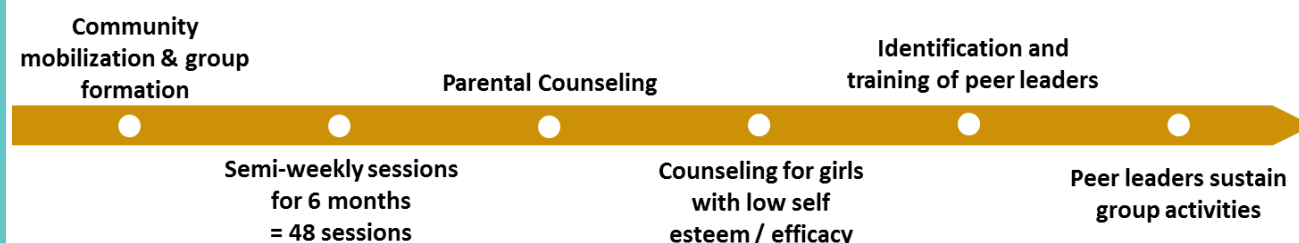
1. Lifeskills education Program for Unmarried Adolescent Girls

Objective

A needs-assessment survey conducted by IHMP in 1999, established that the girls in the *Marathwada* region especially lack self-confidence and self-efficacy, which deter their ability to delay their age of marriage. Lifeskills programs have a positive and significant net effect on their decision-making ability, mobility, sense of self-efficacy, access to resources and their gender role attitudes. Several studies³ have reached the conclusion that a well-structured life skills education program, is a promising approach for empowering adolescent girls in rural India and it can result in a delay in age at marriage.

Model

IHMP's Lifeskills Education program is delivered by the ASHA in the target villages through the following approach:



- IHMP shall provide a 21-day comprehensive training and modularized content to the ASHAs from the villages being considered under the program. The modules cover topics such as Communication skills, self-identity, local institutions, government schemes, sex education, etc.
- Every ASHA worker shall conduct semi-weekly sessions with 2 batches of 15-20 girls each over a 6 month period. In this manner, all the adolescent girls in the village are reached in about 1.5 - 2 years, depending on the size of the village. Additionally, a facilitator who is an IHMP staff member shall periodically accompany the ASHA worker to the sessions, to provide facilitation support and also undertake monitoring responsibilities.
- Peer leaders from within the girls group shall be identified to receive leadership training from IHMP, and would then be responsible to take charge of the group after 6 months, with lesser involvement from the ASHA worker.
- Through the period of the intervention, the organization will also work towards strengthening its mechanism to identify the most vulnerable girls in every village, to provide individual and professional counseling by IHMP-appointed counselors.

Outreach

Over the next three years, IHMP will deliver the lifeskills education program, reaching out to:

- **200 adolescent girl groups** comprising a total of **4,000 unmarried adolescent girls** in 60 villages,
- Parents of **4,000** unmarried adolescent girls through behaviour change communication sessions,
- **360 peer leaders**, who shall be identified and trained in leadership and facilitation skills.

³ Source: Population Council, 2009; CEDPA, 2001

Renuka organized the Girl's Group (Kishori Mandal) in her village and was its leader for two years. The Kishori Mandal in Renuka's village performed a street play about the importance of education for girls. Renuka motivated other girls from her group to participate in the street play. They have been performing the street play in the several parts of their village in addition to motivating parents through interpersonal communication. The number of girls going to high school in this village doubled over 2 years.

2. Sexual & Reproductive Health Intervention with Married Adolescent Girls (MAGs)

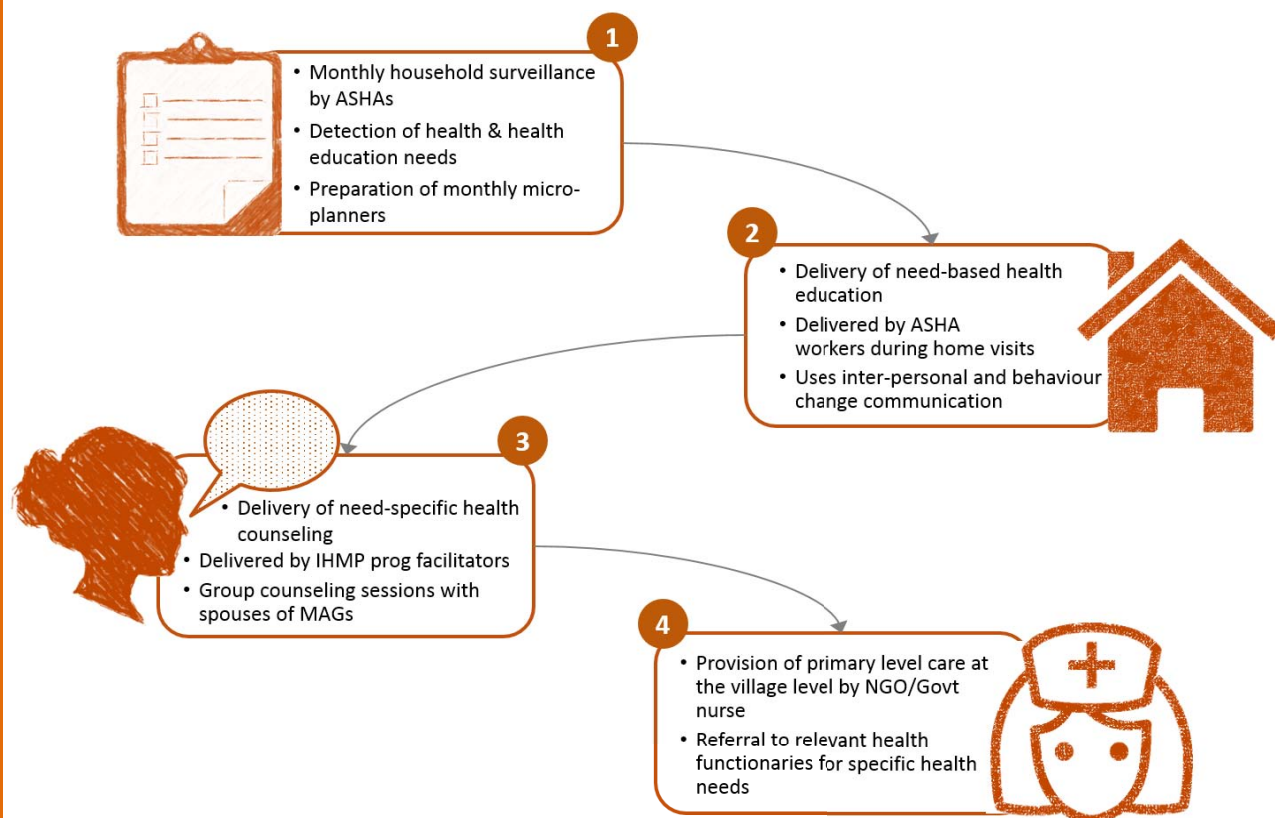
Objective

The reproductive health program with married adolescent girls aims to:

- Delay the age of first conception, and to increase the interval between births.
- Increase the proportion of MAGs using contraceptives
- Increase the proportion of MAGs seeking treatment for standard antenatal and postnatal care
- Increase treatment seeking for reproductive tract infections
- Reduce prevalence of maternal morbidity among married adolescent girls

The on-field intervention with the married adolescent girls has been represented below:

Model



- IHMP shall train the same ASHAs in the 60 villages and provide necessary protocols to build on their existing role under the National Rural Health Mission. As indicated in the above diagram, the ASHA workers have key responsibilities for the delivery of sexual and reproductive health program. They will conduct surveillance of health needs and morbidity levels, and provide 'need specific' inter-personal

Model

communication and counseling during their household visits. ASHAs shall actively link married adolescent girls to public health providers and ensure that they receive services at the monthly village clinics conducted by government nurses or by a visiting medical doctor.

- Every month, participatory behaviour change communication sessions will be organized for married adolescents, their spouses and other stakeholders in the community to influence norms like age at first birth, son preference and spacing between two births.
- IHMP plays a key role in liaising with Village Health Committees – also appointed under the National Rural Health Mission – in empowering them to undertake community based monitoring of the project, therefore enabling accountability to civil society.
- The handholding provided by IHMP through training and facilitation support at the village, is expected to build sufficient capacity in the ASHA to internalize the systems and sustain the practices even after IHMP phases out its presence in the project area.

Outreach

Through this component of the integrated program:

- **2,000 married adolescent girls** shall receive sexual & reproductive health care and counseling
- The **spouses** of 2,000 married adolescents shall receive counseling on a monthly basis
- **60 ASHAs** shall undergo holistic training in surveillance, micro-planning, primary level healthcare provision, and inter-personal and behaviour change communication.
- The intervention shall reach a total **population of 60,000** across 60 villages in *Marathwada*.

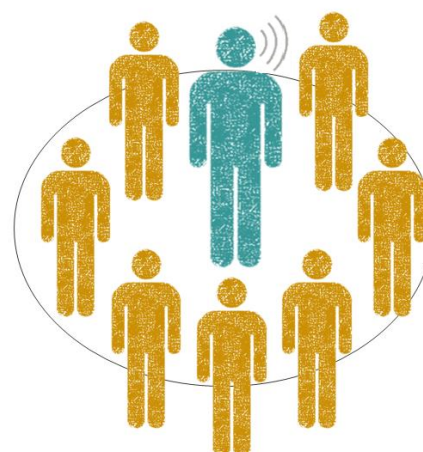
Kavita is a resident of village Kadethan. She got married when she was 15 years old and became pregnant at the age of 16 years. During her visit the IHMP nurse found that Kavita was at high risk as her weight during pregnancy was only 35 Kg. The nurse found out that her mother-in-law and husband were planning to have the baby delivered at home. After counseling by the nurse, Kavita's husband and mother-in-law agreed to take her to the hospital for delivery.

3. Gender Sensitization with boys and young men

Objective

The objective of this component is to create an attitudinal change in unmarried & young married men (age 15-25), specifically as below:

- To reduce the proportion of young men getting **married to girls less than 18 years**
- To reduce gender inequitable behavior like eve teasing, molestation of girls and risky sexual behaviours
- To reduce the proportion of young men perpetrating violence
- To demonstrate a measurable change in the attitude and behavior of unmarried and young married men towards women as measured by the *Gender Equitable Men (GEM)*⁴ scale.



⁴ GEM is a scale published by FHI360 to measure 24 significant indicators of gender equality in men.

Model

- IHMP aims to leverage community-based multi-purpose male health workers (MPHWs) appointed in every village by the National Rural Health mission, to deliver the program at the village-level.
- Through MPHWs, monthly group meetings and group counseling of married and unmarried boys will be organized at the village level. Some of the topics that shall be covered in the group sessions include – reproductive & sexual health of young men, government policies for youth development, family planning (safe sex, unwanted pregnancies), gender discrimination, etc.
- Group meetings will be conducted with young men using a behavior change approach. During these meetings, the unmarried and married young men will be invited for individual counseling for further information and guidance.
- Counseling services will be provided with a special focus on youth with poor self-esteem and self-efficacy.

Outreach

The gender sensitization component shall be implemented in **30 villages** under the plan proposed to the DGC in Year 2, after learning from the insights that emerge through the pilot integrated program under the interventions funded by MacArthur Foundation.

- **1,500 boys and young men** shall receive group and individual counseling
- **30 public health workers** shall receive training in facilitating individual and group sessions with a behavior change approach and in identifying individuals in need of counseling.

4. Advocacy with the Government

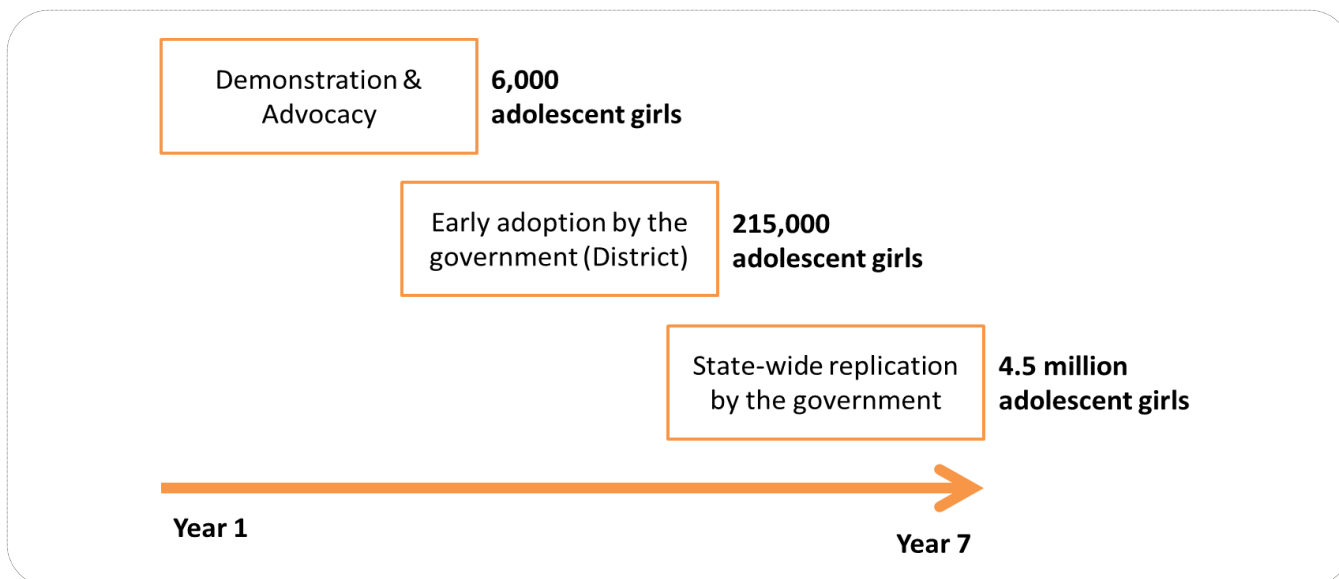
Objective & Model

- To present the effectiveness of the systems and protocols undertaken by IHMP in its program delivery, the organization shall engage in continuous advocacy efforts through meetings and workshops. These efforts shall encompass both, a top-down as well as a bottom-up approach, particularly when it comes to the **meetings** with government functionaries. In the process, IHMP shall engage with the Secretary of the Ministry of Health and Family Welfare, the Director of the National Rural Health Mission and then the state and block level administrators.
- The **workshops** shall bring together several other NGOs to collectively voice the need of a structured government program that helps delay the age of marriage, age at first birth and ensures good reproductive health indicators for the young mothers of the state. By conducting **three major workshops** across the 3 years and backing it with strong evidence from the field, IHMP aims to attain government buy-in, providing opportunity for replication across the state.

Past Success

By 2012, IHMP's intervention with married adolescent girls was **mainstreamed with the government Reproductive & Child Health program** in one administrative block consisting of **196 villages**. This was made possible through advocacy with the district and block level officers, as well as with the 7 Primary Health Centres in the block. This development provided IHMP with the confidence that their program protocols and **systems were replicable** in the public health sector.

D. Opportunity for the Sector



V. Operating Plan

A. Activity Roll Out

Following is a summary of the **activity roll out plan** for the various interventions highlighted above:

	Activity	Y1		Y2		Y3	
		H1	H2	H1	H2	H1	H2
Program - Rural	Recruitment of ASHA / Male Health Workers						
	Training of ASHA / Male Health Workers						
	Implementation of Lifeskills education						
	Implementation of Reproductive Health intervention (MAG)						
	Implementation of Gender Sensitization with boys						
Advocacy	Launch Workshop – sharing the vision						
	Dissemination Workshop – drawing attention to the work						
	Advocacy Workshop – presenting the findings, making proposals						
	Meetings with State level govt functionaries						
	Meeting with District & Block level govt functionaries						

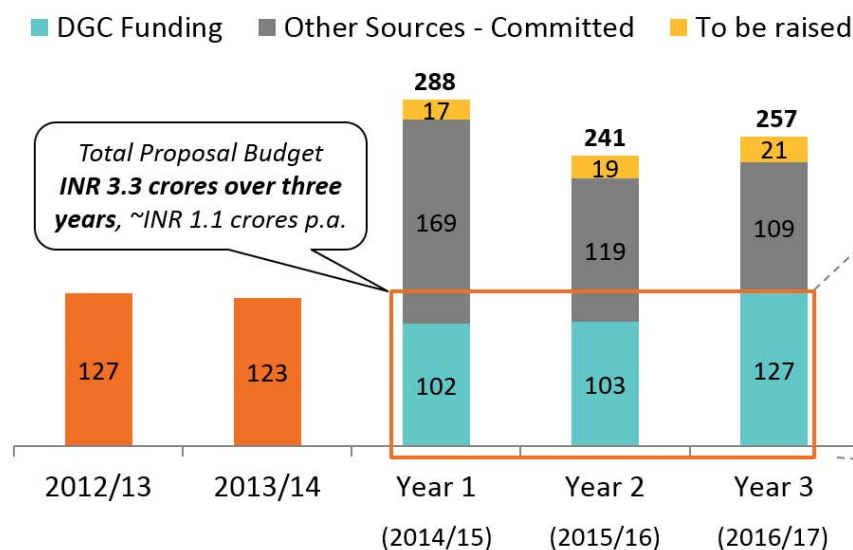
B. Financials

Following is the detailed budget for the DGC proposal for the next three years:

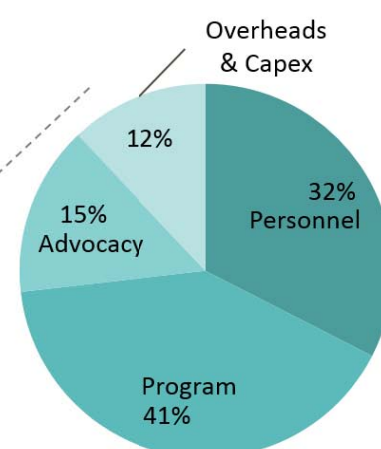
Budget Item	Amount (INR lakhs)			Total Project	
	Y1	Y2	Y3	Amount (Y1 – Y3)	% of total
Personnel	31	34	42	108	32%
Direct Program Cost	39	42	54	135	41%
Personnel	24	30	36	90	27%
Operations	6	6	6	18	6%
Local Travel	2	3	3	8	2%
Impact Assessment	6	3	9	18	6%
Advocacy	14	15	19	49	15%
Overheads	10	11	12	32	10%
Capital Costs	8	0	0	8	2%
Total	102	103	127	332	100%

- IHMP's proposal requires INR 3.3 crores, which comprises approximately 40% of the organization's overall budget for the next three years. This has been detailed below:

IHMP Year-on-Year Budget (INR lakhs)



Split of DGC Budget, %



Past and Current Funders

In the past, IHMP has received funding from reputed institutional agencies such as Rockefeller Foundation, Ford Foundation and Christian Aid UK.

MacArthur Foundation (funding IHMP since 2003) and Oxfam are presently IHMP's primary funders. Both of these grants come to an end in 2014/15 and 2015/16 respectively – hence the expected dip in the total budget of the organization in Year 2.

- To achieve its larger objectives, the organization aims to replicate the integrated program in 30 urban slums in Pune (Maharashtra) as well as undertake research and evidence-building initiatives. For this, a budget of INR 1.9 crores over three years has been included in the total budget. As of August 2014, IHMP has been able to secure INR 1.35 crores from *Yardi*, a UK-based IT company, to implement its urban pilot. The organization presently has proposals to UKaid and Sir Dorabji Tata Trust in the pipeline.
- IHMP has a corpus fund of INR 5 crores, the interest from which contributes ~INR 50 lakhs to the income of the organization per year, primarily utilized for senior management remuneration (approximately 50% of salaries) and research initiatives.
- IHMP has worked with budgets in the range of INR 7-8 crores in the past (2005), when the organization was managing several initiatives in parallel.

C. Management and Organization Structure

Following are the bios of the key senior management personnel at IHMP:

Dr. A. Dyalchand, Executive Director

- M.B.B.S, CMC, Vellore, India, Master of Public Health (MPH), Johns Hopkins University, Baltimore USA,
- Completed course work for Doctorate in Public Health, Johns Hopkins University, Baltimore.
- Has 36 years of experience in planning, monitoring and evaluation of public health programs. AGRT was the first NGO to implement maternal and neonatal health through traditional birth attendants (Dais), under his guidance.
- He evaluated the community-based monitoring component of NRHM in Rajasthan and Maharashtra for Government of India, and designed the BCC component of Reproductive Child Health 1, an instructive module, for World Bank.

Ms. Manisha Khale, Program Director Rural

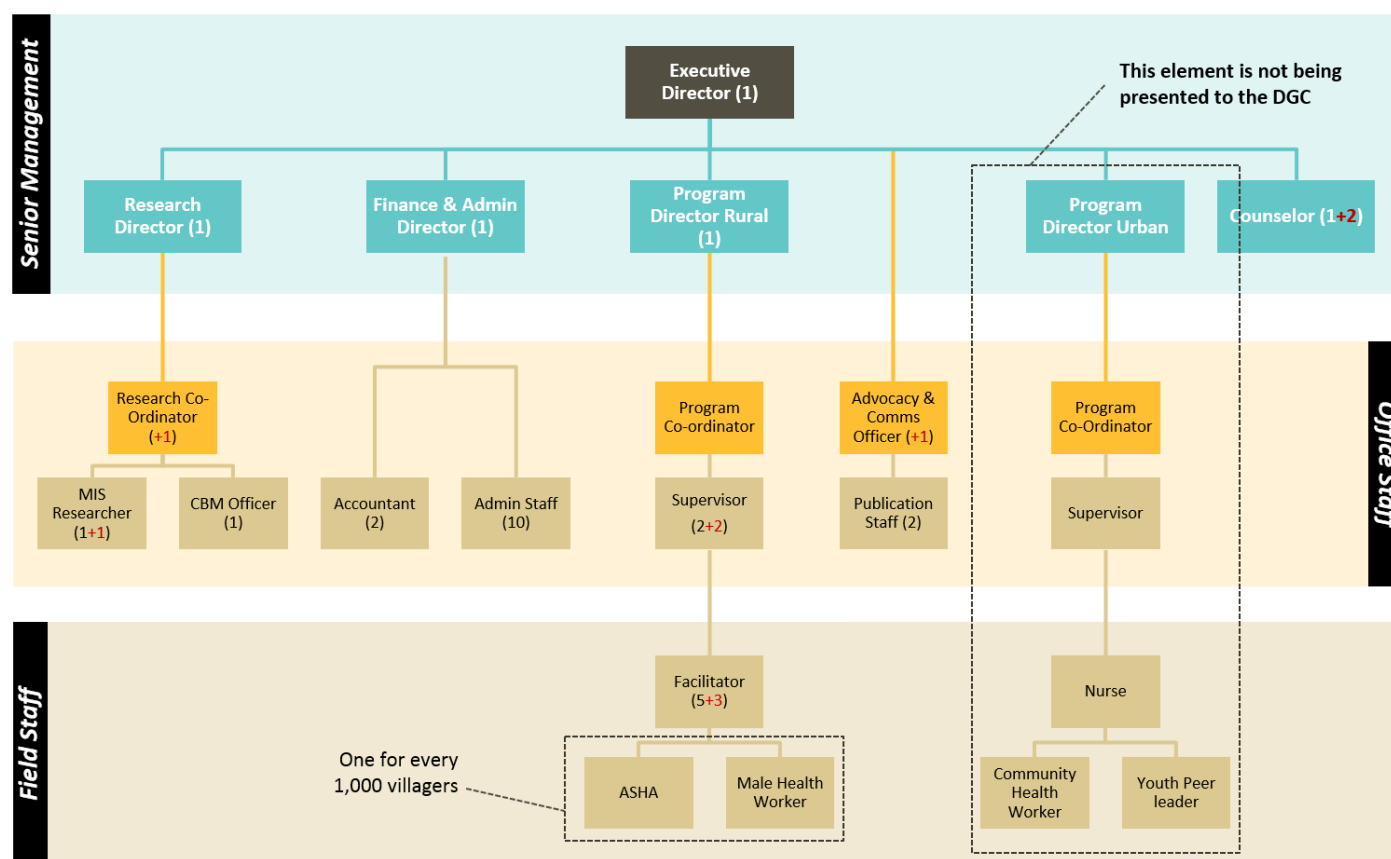
- M.Sc. (Biochemistry), M.S. University, Baroda, M.Sc. (Community Health for Developing Countries), London School of Hygiene & Tropical Medicine.
- She has 35 years of experience in Reproductive and Child Health, and 16 years of experience in Adolescent Reproductive and Sexual Health.
- She is an expert in child and adolescent nutrition and has conducted social assessment, and prepared an ICDS proposal for Maharashtra, in 1998 for World Bank.

Mr. Gopal Kulkarni, Research Director

- M.Sc (Statistics), Shivaji University Kolhapur. Training in “Biostatistics, Epidemiology, JHU Baltimore and “Advanced Biostatistics, Multiple Regression, Logistic Regression and Survival Analysis”, CMC, Vellore.
- He is an expert in designing surveillance and monitoring systems, MIS and research evaluation protocols.

IHMP's Organization Structure

- IHMP presently has a **team size of 42** members across their management, office and field staff.
- IHMP has a strong and experienced second-line management covering the functions of Program, Research and Finance & Admin.
- Over the next three years, IHMP shall add **17 new members** to the team, of which 10 shall have a direct role under the plan proposed to the DGC.
- As the organization strengthens its role as an influencer, a key hire for IHMP in the first year of the proposed plan is an Advocacy and Communications officer.



Numbers after the '+' represent new resources to be hired

Board Composition

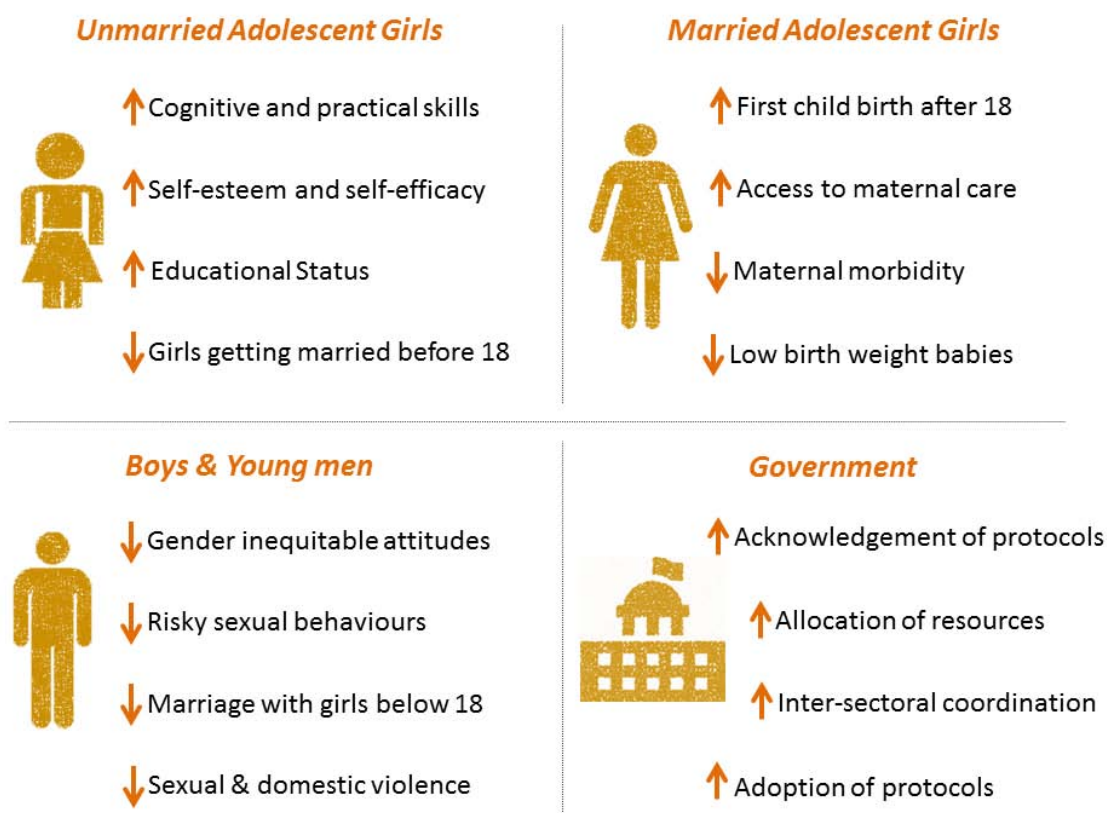
IHMP has an experienced five-member board that meets once every quarter and is fairly engaged in the direction of the organization. The members on the governing body include:

Name	Position on Governing Body	Other offices/positions held by the member outside your organization
Dr. C. A. K. Yesudian	Chairperson	Dean, School of Health Systems Studies, TISS, Mumbai
Ms. Manisha Khale	Managing Trustee	Program Director, IHMP
Mrs. Kalindi Muzumdar	Trustee	Retd. Prof. Nirmla Niketan, Mumbai
Dr. A. Dyalchand	Founder Trustee	Executive Director, IHMP
Mr. David Gandhi	Trustee	Development Consultant, Pune

VI. Impact Assessment

A. Expected Outcomes

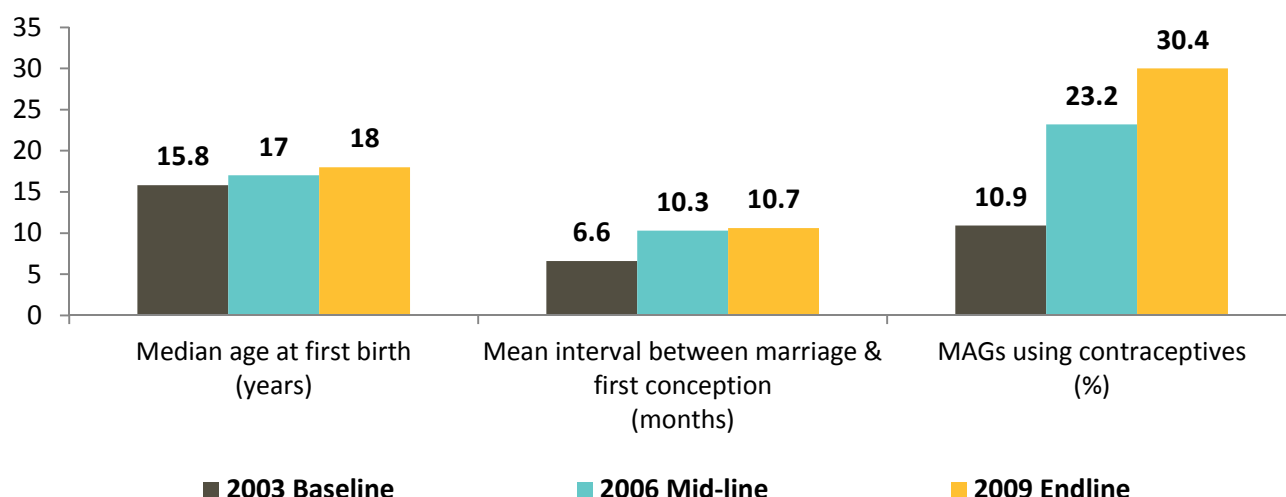
Over the next three years, IHMP aims to achieve the following outcomes with support from the DGC:



↑ denotes increase/improvement, ↓ denotes reduction

B. Historical Success

Following are some key highlights from the baseline, mid-line and end-line study facilitated by IHMP in its project site with a sample size of **~800 married adolescent girls**:



Between 1999 and 2006, the median age at marriage increased from **14.5 years to 17.5 years** in IHMP's project area for their lifeskills education program with unmarried adolescent girls.

Examples of past advocacy successes

- In 1998, IHMP was **commissioned by the World Bank** to develop 'behavior change communication' material targeted towards young women. This material was later adopted by the Ministry of Health and Family Welfare for the national reproductive and child health program.
- For the last several years IHMP has been advocating an integrated approach to adolescent health and development. In 2008, IHMP **organized a State level workshop** on adolescent health and development. The innovations developed by various NGOs in Maharashtra were showcased. After **several years of advocacy**, IHMP's contribution lead to the Government of India announcing an integrated policy for adolescent health and development this year.
- In 2011, IHMP was invited by the Ministry of Health & Family Welfare (MOHFW) on the Task Force for developing Indian Public Health Standards (IPHS) for National Urban Health Mission (NUHM). IHMP accepted the responsibility for developing job definitions of various functionaries in Primary Urban Health Centres and for **designing curricula for their training and capacity building**. In 2008, IHMP was invited by the Government of India on the **Task Force** for formulating the NUHM.

C. Process for Impact Monitoring & Evaluation

- The primary tool of evaluating impact of the integrated program is **through baseline and endline surveys**. The organization appoints external agencies for major studies conducted to exclude any bias.
- **For monitoring the lifeskills education program**, pre and post questionnaires are additionally conducted before and after the 6 month period during which the program is delivered. These questions help to assess the change in knowledge and skill of the adolescent girls. Part of the questions for the baseline and endline study for this program are derived from the indicators of a measurement scale internally developed by IHMP.
- IHMP has been working on **building a scale suited to the Indian context** to effectively measure ambiguous traits such as self-esteem and self-efficacy in adolescent girls. For this, it started with existing scales, such as the Rosenberg Scale and Ralph & Matthias scale, and added additional questions based on interviews with community members, which took the local context into account. The resulting set of questions was then administered for three different groups of 600-800 individuals and with the help of statistical analysis, IHMP has been able to identify 27 questions which are more indicative of the overall results.
- For monitoring the reproductive health program with married adolescents, ASHAs are asked to submit their report against necessary indicators to their respective **Village Health Committees** and/or **directly to the facilitators** (IHMP staff), who then provide the data for being entered into the system at the IHMP office.
- IHMP has a dedicated 3-member team for research and impact assessment, which is expected to grow to 5 members as a part of the proposed plan.

VII. Risk Mitigation and Key Areas of Dasra Support

A. Risks and Mitigants

The following risks have been identified, for which IHMP plans to incorporate certain mitigation strategies.

- **Risk:** Maharashtra is one of the first few states in the country to initiate the implementation for the new integrated policy on adolescent health and development. This serves as a great opportunity, however with the upcoming state elections later this year and the probable change in government, there is **uncertainty about the priority for the budgets** allocated to this program.
- **Mitigation:** IHMP shall undertake advocacy efforts with a top-down and bottom-up approach to ensure there is sufficient buy-in at various levels of the government – ranging from block and district level officials to the state and national level.
- **Risk:** IHMP leverages the existing community health workers appointed by the government for the last mile delivery of its various interventions, by providing additional remuneration for the supplementary work performed. When mainstreaming the interventions with the government program, there is a **risk that the health workers may not be paid the same additional remuneration** by the government.

- **Mitigation:** Since it is the adoption of program systems and protocols that IHMP is advocating for, the organization is simultaneously pushing the health ministry to pay the community workers not just for outputs, but also for processes. These efforts have already begun to bear fruit, whereby the state government has issued a regulation that the health workers can be paid upto an additional INR 1,000 on the basis of the efficacy of the processes they undertake. The regulation while passed in January 2014, is yet to be implemented in the state.
- **Risk:** The Dasra Giving Circle funds will enable IHMP to set-up a demonstration site of 60 villages for a period of three years. IHMP recognizes from its experience that advocating with the government for systematic changes is a lengthy and cumbersome process and could take up to 5-7 years to bear fruit. Keeping this in mind, **IHMP would need to raise additional funding beyond the three year period** to sustain and grow the demonstration site to prove the program's efficacy across geographies.
- **Mitigation:** In August 2014, one of IHMP's proposals to a UK-based IT company has already been approved for the replication of the integrated program in the urban slums of Pune. For raising additional funds, proposals to UKaid and Sir Dorabji Tata Trust are already in the pipeline and IHMP shall sustain its fundraising efforts through the years.
- **Risk:** The intervention of gender sensitization with boys and young men is a **new component** of the integrated program which may bring up **new challenges to the organization**, and may require further program development.
- **Mitigation:** To mitigate this, IHMP shall undertake a phased approach in the growth of this component. Starting September 2014, IHMP shall pilot the gender sensitization program in 30 villages with support from the MacArthur Foundation. Based on learnings from this pilot, IHMP shall then scale the program to 30 additional villages in May 2015 as a part of the plan proposed to the Dasra Giving Circle.

B. Key Areas of Dasra Support

- **Human Resources:** Dasra will help IHMP fill key positions such as the Advocacy and Communications officer. Over the long term, IHMP wishes to establish a dedicated fundraising/resources team for which Dasra shall provide assistance. Dasra will also help Dr. Ashok Dyalchand, the Executive Director, to think through his succession plan and the transition process for the same.
- **Communications Strategy:** As IHMP strengthens its role as an influencer in the adolescents space, what and how it puts out in the public domain becomes very important. For the same, Dasra will help IHMP with its communication strategy and also connect the organization with professional firms that will help them create quality collateral and material for dissemination.
- **Fundraising:** With funds permitting, IHMP would like to further expand its demonstration site, conduct strong research and evidence-building, and provide training to build the capacity of other organizations in the sector. Dasra shall therefore help IHMP raise funds for meeting these targets and growing the organization, while building fundraising capabilities within IHMP.