

**Ashish Gram Rachna Trust, Pachod**

# **Annual Report**

**2014 - 2015**

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

## Table of Contents

		Page No.
<b>1</b>	<b>Integrated project for the empowerment of adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence</b>	<b>01-01</b>
	<b>Part 1:</b> Empowerment of unmarried adolescent girls through life skills education	<b>01-09</b>
	<b>Part 2:</b> Attitudinal change in unmarried and young married men, thereby demonstrating a measurable change in the prevalence of sexual and domestic violence and gender inequitable behaviors	<b>10-13</b>
	<b>Part 3:</b> Protection of young married women from the adverse consequences of early conception and sexual and domestic violence.	<b>14-28</b>
<b>2</b>	<b>Primary Health Care in a Rural Setting</b>	<b>29-29</b>
<b>3</b>	<b>Delaying Age of Marriage in Marathwada Region of Maharashtra</b>	<b>30-37</b>
<b>4</b>	<b>Scaling up for the Project on Preventing Child Marriage and Early Pregnancy, in Jalna District</b>	<b>38-40</b>
<b>5</b>	<b>Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city</b>	<b>41-61</b>
<b>6</b>	<b>Integrated reproductive and sexual health and family planning project for young married women in urban slums of Pune City Integrated reproductive and sexual health and family planning project for young married women in urban slums of Pune City</b>	<b>62-67</b>
<b>7</b>	<b>Training Report</b>	<b>68-68</b>

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

### **Introduction:**

This project was initiated from 1<sup>st</sup> April 2014 as a continuation of the Integrated Project for the empowerment of adolescent girls and protecting them from the consequences of early marriage, early conception, sexual and domestic violence initiated in Adul PHC in January 2013 as a no cost extension of the previous project funded by the MacArthur Foundation. The justification for continuation of the Integrated Project was to have the activities of three components fully in place in Adul PHC and to be able to demonstrate the synergistic impact of all three components after a period of three years.

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

#### **Introduction:**

Empowerment of Unmarried Adolescent Girls through Life Skills Education (LSE) course was initiated in August 2013 in Adul PHC after completing the baseline survey and induction training of 24 ASHAs as 'Life Skills' teachers. Each ASHA conducted Life Skills Education for two batches of unmarried adolescent girls. In the first cycle of the LSE course 797 adolescent girls were enrolled in August 2013. They completed the LSE course of six month duration in February 2014.

#### **Specific objectives of this intervention were:**

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



**Activities implemented during the period 1<sup>st</sup> April 2014 to 31<sup>st</sup> March 2015:**

No. of villages: 17

No. of ASHAs: 20

No. of Kishori Mandals: 20

Four ASHAs dropped out because of personal reasons. In consultation with the ASHAs it was decided that they would take one batch of adolescent girls instead of two batches for the second cycle of the Life Skills Education course.

**Reproductive and Sexual Health Workshops:**

A series of 3-day workshops on reproductive and sexual health were organized for the adolescent girls who had completed the LSE course.

Prior to starting workshops with the adolescent girls mothers meetings were conducted at the village level in April 2014, which were attended by 330 mothers. Mothers were explained the objective of the workshop and verbal consent from mothers was obtained in the meeting. This was followed up with an individual consent letter for the workshop sent for each girl. Each girl was requested to bring the consent letter signed by her parents while coming for the workshop.

**Objectives of the Reproductive and Sexual Health Workshop:**

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

Starting from mid-May 2014 a total of 210 adolescent girls were covered in 9 batches.

**Mothers Meeting:**

In the month of July 2014, 20 meetings were organized (one meeting per ASHA area) to encourage mothers to enroll their daughters for the 'Life Skills' course. These meetings were attended by a total of 321 mothers. During the meetings, course content and how the

course helps to improve self esteem of the girls was explained. Pamphlets describing the objectives of the course and course content were distributed during these meetings.

#### **Refresher Training:**

Three-day refresher training was organized for ASHAs, which was attended by all 20 ASHAs. Focus of the training was on those sessions, which the ASHAs found difficult to conduct. Sessions on communication and self-esteem were simplified and the methodology for conducting these sessions were demonstrated to and practiced by the ASHAs in the class room.

#### **Life Skills Course:**

It was decided to enroll only one batch for the second cycle of the Life Skills course. In the second batch, a total of 412 adolescent girls were enrolled. Classes for the second batch were initiated in August 2014. Each ASHA conducted two sessions on Life Skills and one activity for the Kishori Mandal per week as per the planner.

#### **Kishori Mandals:**

Twenty 'Kishori Mandals' were established i.e. one 'Kishori Mandal' in each ASHA area. While Kishori Mandals were in the process of being established, field coordinators took two sessions with each group of adolescent girls. The objective of these two sessions was to focus on leadership skills and importance of working as a team. A total of 355 adolescent girls attended these two sessions.

Kishori Mandals organized visits to local institutions like Gram Panchayat, Bank, Post-office, Ration Shop, Anganwadi and Primary health sub-center as part of the course for Kishori Mandal members. A total of 382 adolescent girls visited these local institutions.

In the month of October 2014, all the Kishori Mandals organized a street play – "The Undesired Girl has become the Wanted One" – 'Nakoshi Zali Havishi' in their villages, focusing on the issue of sex selection and sex determined abortion. The street play also highlighted that if a girl is given an equal opportunity for education she is also able to reach great heights. These street plays were attended by almost 10,400 villagers.

#### **Supervision of the Life Skills Classes:**

Each field co-coordinator visited the LSE conducted by the ASHAs, twice a month, to observe how the sessions were being conducted. After the session field coordinators used to give feedback on the session taken and if necessary demonstrate how to conduct sessions in a participatory manner. Field coordinators resolved problems like lack of place for conducting classes and light connection, regular attendance, etc. by involving village committees and parents.

On an average 20 adolescent girls were present in each class for the 'Life Skills' classes and Kishori Mandal activities every month.

**Training of Peer Educators:**

When IHMP came across an opportunity for mobilizing extra resources from the Canadian Fund for Local Initiatives, a proposal was sent for value addition to the existing program for adolescent girls in Adul PHC. Funds received under the CFLI have been used for the training of peer educators and developing computer and internet skills among adolescent girls.

A total of 176 peer educators (12 per ASHA area) were trained in leadership skills from 7<sup>th</sup> January 2015 to 8<sup>th</sup> February 2015. The main objective of training peer educators was to give them skills to continue functioning as a group in their own village and undertake various activities to improve the social status of adolescent girls in their own village.

Between 9<sup>th</sup> and 28<sup>th</sup> February 2015 peer educators were invited for three-day training on use of tablets, which was attended by 182 adolescent girls. Two peer educators from each ASHA area that acquired skills for using tablets have been given the responsibility for training other girls in their village.

**Various Workshops for Skills Development:**

Workshops for various skills developments were organized based on the demand from the adolescent girls.

**a. Beauty Parlor Course:**

This 8-day course was organized with the assistance of Shramik Vidyapeeth, Aurangabad. Thirty girls from four villages attended the course and have been given certificate of completion by Shramik Vidyapeeth.

**b. Rangoli Workshop:**

A workshop for 'Rangoli' was organized in July 2014. A total of 51 adolescent girls from the area of 6 ASHAs participated in the workshop. Many girls after going back did 'Rangoli' in their schools during Independence Day. These girls are also invited in their own village to do 'Rangoli' for social functions/ events.

**c. Making Lanterns:**

Deepavali is a festival of lamps and people hang lanterns outside their homes on this day. Since there was a demand from adolescent girls a training workshop was organized just before Deepavali to teach them how to make lanterns. A total of 81 adolescent girls attended the workshop. Several adolescent girls made lanterns and sold them in their villages.



### **Sports Competitions:**

Sports were organized at the village level by Kishori Mandals. A total of 360 girls participated in the games. Musical chair was organized at the village level by the Kishori Mandals. A total of 355 girls took part in the musical chair. Three prizes were given for the event in each village.

### **Quiz:**

A quiz was conducted at the village level for the winners from two Kishori Mandals. After that winner group from each ASHA area was invited to Pachod for an inter village competition. There was a tough competition for the final position. Three groups with the highest score were given prizes.

### **Additional Inputs for Adolescent Girls with Low Self-esteem:**

During the reporting period two group sessions were conducted by the field coordinators for additional inputs for girls with low self-esteem. These two sessions were conducted in 11 villages. The first session was attended by 197 girls and second session was attended by 184 girls. Out of these girls, 45 girls were with low self-esteem. The first session covered - "What is my identity and second session covered - Who I am? Participatory games were used and girls with low self-esteem were given the chance to speak first and the other girls were allowed to speak after them.

### **International Women's Day:**

A one-day program was organized on international women's day. Peer educators, ASHAs and women members of the Village Health Nutrition Water and Sanitation Committee were invited. About 200 girls and women participated in various events. The day ended with Ms. Mangal Khinvasara, a social activist speaking about women rights and giving examples from her own experiences about how they can be achieved.

### **Launch event:**

The integrated project to prevent child marriage and early pregnancy and address the adverse consequences of early motherhood is being scaled up in the adjoining 53 villages in Jalna district with support from the Dasra Giving Circle. It was decided to organize a launch event for the scaling up by showcasing the achievements in the existing project villages of Adul PHC that is being supported by MacArthur Foundation.





### **Certificate Distribution:**

It was decided that on the same day as the launch event was organized, certificates would also be distributed to 797 adolescent girls who have completed the 'Life Skills' course. The event was organized on 14<sup>th</sup> February 2015 and the adolescent girls were given certificates by Mr. Richard Bale, Consul General for Canada. The program was attended by about 1500 people, which included ASHAs, adolescent girls and their parents, villagers, leaders, health providers and government officials from Jalna district.

### **Higher Education of Adolescent Girls:**

The Canadian Government approved funds for the integrated project through the Canada Fund for Local Initiatives (CFLI). Bicycles have been purchased from this fund and have been distributed to adolescent girls groups (Kishori Mandals) so that the girls can learn how to ride. Girls who wish to continue higher education in neighboring villages were identified and have been provided with bicycles. The bicycles were distributed on the day the scaling up project was launched.

It was decided to provide adolescent girls with twenty first century skills such as use of computers, tablets and internet. This initiative has been a game changer as it has expanded the horizon for the girls by increasing access to information exponentially. On the day of the launch event, tablets and bicycles were distributed to peer-educators and ASHAs. Funds for the purchase of cycles and tablets and for organizing the launch event were mobilized from Canada Fund for Local Initiatives (CFLI) and GlobalGiving, UK.





## **Pre and Post Tests for the Life Skills Course:**

### **Post test for the girls in the first round of life skills education:**

Post-test was conducted for 765 adolescent girls after completion of the 'Life Skills' course. Similarly after the Life Skills course, 721 adolescent girls were assessed for their self-esteem and self efficacy.

### **Pre test for the girls in the second round of life skills education:**

Pre-test for cognitive skills, self-esteem and self efficacy was conducted after adolescent girls that were enrolled for the second round of the Life Skills course after obtaining consent of the parents. A total of 412 adolescent girls underwent the pre-test and assessment of self-esteem and self efficacy.

### **Case Study 1:**

Kalpana is a resident of Georai (BK). She is 16 years old and studying in 11<sup>th</sup> standard. She completed 'Life Skills' course from the first round of Life Skills Education in her village. She is a member of the Kishori Mandal. Her mother has studied up to 7<sup>th</sup> standard and works as the ASHA in her village. Her father has studied up to 9<sup>th</sup> standard and he works as an agriculture laborer.

Kalpana attended 'Life Skills' classes regularly. She learnt about the importance of education from the Life Skills classes. She could not afford to go to coaching classes or take tuition because of the poor economic condition of her family. She decided to do self studies in 10<sup>th</sup> standard. She got 67 percent marks in 10<sup>th</sup> Board exams because of sheer hard work. She also used to work as an agricultural laborer with her mother during her school holidays. She used the money she earned for buying books and stationary required for her schooling. She wants to do general nursing after 12<sup>th</sup> standard. She has decided to get married only after completing her education.

She was selected as a peer leader by her friends because she is always willing to help others in their studies. After attending peer leader training, she has started regularly writing reports for the Kishori Mandal activities in the minute's book given to them. She learnt how to draw 'mehandi' (Henna) designs in her Life Skills classes. Now if there is a wedding in the village, she is called to do 'mehandi' for the bride. She participates in the street play and encourages other girls also to take part in the street play.

Kalpana said "Because of the Life Skills course, my self-esteem has improved and I realized who I am? Now I do not hesitate to speak in front of anyone and I can express my opinion very well.

### **Case Study: 2**

Preeti is a resident of village Ektuni. She is studying in 9<sup>th</sup> standard. She has one brother who is in 11<sup>th</sup> standard and one sister who is married. Her mother has studied up to 7<sup>th</sup> standard and her father has studied up to 3<sup>rd</sup> standard. Both work on their agriculture fields.

Preeti was enrolled for the first batch of ‘Life Skills’ course. She attended classes regularly since she realized that she was learning new information outside her school curriculum. She ensured that a group of her friends attended the ‘Life Skills’ classes regularly. After completing the ‘Life Skills’ course, she has started taking part in various activities in her school. When Preeti was asked her opinion about the Life Skills course she said – “I have learnt new information and acquired new skills after attending the Life Skills course. Earlier I did not know how to handle a pressure cooker, now I use it with confidence. I also realized that you need four qualities to have self-esteem. I am trying to inculcate those four qualities in me. At present, I am finding information learnt in the class useful. But I am confident that this information and skills will be useful for me even in the future. We visited the bank, post office and police station and learnt how to use these facilities. Now I am learning to ride a bicycle. I have learnt how to use the tablet and internet and I am going to teach my friends how to use these to get new information, see results of the board examinations and details of higher education available in neighboring villages.

### **Designing a Culturally appropriate scale to measure Self Esteem and Self Efficacy among unmarried adolescent girls**

**Operational Definition of Self Esteem:** “A positive or a negative orientation toward oneself. An overall evaluation of one’s worth or value.”  
(Source: Rosenberg)

**Operational Definition of Self Efficacy:** Person’s belief in his or her ability to cope with daily hassles as well as adaptation after experiencing all kinds of stressful life events.

Beliefs are determinants of how people think, behave, and feel.  
(Source: Albert Bandura)

### **Designing the Scale – Factor analysis**

Details	Self Esteem scale	Self Efficacy scale
Items with factor loadings >0.40	12	16
Eigen value	6.708	11.65
Variance explained	39.4%	43.1%
Scale reliability coefficient – Cronbach’s alpha	0.895	0.94

### The Culturally Appropriate Scale

Scale	Factors with significant loading	Items adapted from international scales	Items from IHMP research
Self Esteem	12	6 items from Rosenberg Scale	6 items
Self Efficacy	16	10 items from Ralf & Mathais Scale	6 items

Pachod –*paisa* scale was used to measure attitudes. Respondents rated attitude statements on a scale of 0 - 100 *paisa*.

Low agreement - 0-50 *paisa* /High agreement - 51-100 *paisa*

### Measurement of Self Esteem

Self Esteem Scores	Before Life Skills Education 790 Girls tested	After Life Skills Education 721 Girls tested
Girls with Low Self Esteem	9 %	2 %
Girls with High Self Esteem	57 %	69 %

### Measurement of Self Efficacy

Self Efficacy Scores	Before Life skills Education 790 Girls tested	After Life Skills education 721 Girls tested
Girls with Low Self Efficacy	14 %	3 %
Girls with High Self Efficacy	48 %	60 %

### Application of Self Esteem & Self Efficacy Scale

- To identify girls with Low Self Esteem & Low Self Efficacy and provide special care
- To evaluate Life Skills Education or other empowerment programmes

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

### **Introduction:**

In the first year of the project, qualitative research was undertaken with boys and young men for designing and pre-testing the instrument for assessing self-esteem and adapting the GEM scale. Group counseling sessions and protocols for behavior tracking among youth were designed.

This component of the report is presented in two parts:

1. Activities undertaken for unmarried and married youth, 15-25 years of age
2. Reproductive & Sexual Health clinics organized for youth

**Activities undertaken for unmarried and married youth of 15 to 25 years of age during 1<sup>st</sup> April 2014 to 31<sup>st</sup> March 2015:**



### **1. Group Formation and Selection of Peer Educators:**

A list of youth was prepared from the updated census data and a meeting of youth was organized in each ASHA area. In the meeting with boys and young men the need for establishing a group was discussed. It was agreed that members will meet once a month to discuss issues on Reproductive and Sexual Health, Gender and Domestic Violence. It was also agreed that the concerns of youth will be given priority. One youth group was established per ASHA area in Adul PHC during August and September 2014. Each group was asked to select two peer educators. Now there are a total of 24 youth groups and 48 peer educators. During this process a total of 960 youths were involved.

### **2. Group Meetings with Youth:**

Group meetings for youth were initiated from October 2014. Details of group meetings conducted are given in **Table: 2**.

**Table: 2 Group Meetings with Youth:**

Sr. No.	Months	Expected Meetings	Actual Meetings	% Meetings Conducted	Expected Attendance	Actual Attendance	% Youth Attended
1	Oct. 2014	24	24	100	480	361	75
2	Nov. 2014	24	24	100	480	338	70
3	Dec. 2014	24	22	92	440	344	78
4	Jan. 2015	24	24	100	480	373	71
5	Feb. 2015	24	24	100	480	407	85
6	Mar. 2015	24	24	100	480	337	70
<b>Total:</b>		144	142	99	2840	2160	76
<b>Average:</b>		<b>24</b>	<b>23.7</b>	<b>99</b>	<b>473</b>	<b>360</b>	<b>76</b>

During the reporting period, a total of 142 group meetings were conducted and a total of 2160 youth attended these meetings i.e. on an average 23 group meetings were conducted every month and on an average 360 youth attended meetings every month. A list of topics discussed with the youth is presented below:

1. Use of mobile phone for pornography – disadvantages.
2. Male reproductive system – structure and function.
3. Reproductive tract infections and sexually transmitted infections.
4. Use of family planning methods.
5. How does conception take place?
6. HIV/AIDS
7. Age at marriage of a boy and girl and appropriate age at first conception for a girl.

### 3. Peer Led Education:

Two peer educators were selected from each group and were invited for one-day orientation. During the meeting the roles and responsibilities of peer educators was decided. It was decided that each peer leader was expected to adopt five friends and give them information learnt from the group counseling sessions. If anyone was in need of individual counseling, peer educators were to refer him to the visiting doctor and counselor from IHMP. Peer educators also discussed topics listed above with their peers. 240 youths were covered by the peer educators.





#### 4. Male Clinic:

Reproductive and sexual health and counseling services were provided every month through a male doctor at the village level. Details of the patients examined are given in Table: 3.

**Table: 3 Details of Patient Examined & Treated in the Clinics for Youth:**

Month	No. Of Clinic Conducted	No. of Patients Treated				
		Fungal Infection	Sexual Health Problems	RTI/STI	General	Total
April 2014	18	14	00	01	115	130
May 2014	10	07	02	01	77	87
June 2014	12	03	13	03	98	117
July 2014	14	12	12	04	119	147
Aug. 2014	14	12	06	04	103	125
Sept. 2014	14	05	08	00	87	100
Oct. 2014	12	03	06	00	58	67
Nov. 2014	15	11	24	00	62	97
Dec. 2014	14	03	36	00	74	113
Jan. 2015	21	16	66	9	230	321
Feb. 2015	13	10	24	9	96	139
March 2015	18	14	13	1	80	108
<b>Total:</b>	175	110	210	32	1199	1551
<b>Average:</b>	15	9	18	3	100	129

A total of 1551 patients were examined and treated, out of which 110 cases had fungal infection, 210 youth had sexual health problems, 32 cases had RTIs/ STIs and remaining 1199 had other general complaints.

#### Case Study 1:

##### Village: Ektuni

Prakash (name changed) is a resident of village Ektuni, 22 years old and studied up to 7<sup>th</sup> standard. In the month of February 2015, he had blisters, skin had peeled off and there was a wound near the urethral opening. When the peer leader learnt about his complaint, he advised him to get examined by the visiting male doctor from IHMP. Prakash refused to go to the doctor visiting his village because he was embarrassed that others in the village would get to know about his problem. Prakash asked the peer leader – “What will happen to my honor (Ijjat)”?

The peer leader shared this information with the counselor from IHMP. Both visited Prakash and counseled him that it was necessary for him to consult a doctor in Paithan or Aurangabad and get treatment immediately. The next day Prakash went to a doctor in Aurangabad and took treatment for a week. He was cured. He spent about Rs. 3000/- on his treatment.

## **Case Study 2:**

### **Village: Wadacha Tanda**

Satish (name changed) is a resident of village Wadacha Tanda. He has studied up to 12<sup>th</sup> standard. He learnt about the male clinic being organized in his village through his friend. He came to male clinic with the complaints of white discharge per urethra since 2-3 weeks, burning while passing urine and pain in abdomen since 4-5 days. Initially, he was hesitant to speak about his problem. During the counseling session, he revealed that he regularly visits a commercial sex worker in a nearby town. He also mentioned that he has failed 3 times in his board exam. He belongs to a farmer's family. But he does not like to work on the farm with his father nor does he want to do any other work for his livelihood. He said that he was constantly worried about his marriage and sex life.

After examination and counseling the doctor treated him for STI. He was told about the risk associated with unprotected sexual intercourse with a commercial sex worker. He was also referred to a surgeon in Aurangabad for his complaint of burning micturation and pain in abdomen to rule out urethral or bladder calculi.

During a follow up visit, it was found that his discharge per urethra had reduced. He was diagnosed with small calculi in his bladder for which he was taking treatment. He was also put on anti – anxiety medication by the psychiatrist.

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

#### **Introduction:**

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

#### **Specific Objectives**

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

In April 2014, twenty-four ASHAs from Adul PHC were oriented and trained in doing surveillance and giving needs specific Behaviour Change Communication. Thereafter, five processes were established with the objective of achieving universal coverage and improving quality of coverage.

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



### **Activities implemented during 1<sup>st</sup> April 2014 to 31<sup>st</sup> March 2015:**

#### **Refresher Training for ASHAs:**

ASHAs were called for one-day in April 2014 to transfer the information about Married Adolescent Girls (MAGs) from old to new surveillance registers. ASHAs were also called for three-day refresher training on surveillance and Inter Personal Communication (IPC) in June 2014. As an exercise, the ASHAs were given surveillance data to enter in to the surveillance format. After completing the exercise, each ASHA was given individual feedback by the trainers. Each pair of ASHA was given situations for demonstrating IPC done during household visits in the classroom. When each pair came forward and did the role play, all other ASHAs and trainers gave them feedback.

#### **Surveillance Coverage:**

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

**Table 1: Monthly Surveillance Coverage by ASHAs**

Month of Reporting	No. of reporting ASHAs	Number of registered MAGs	Number of MAGs visited	Percent MAGs Visited
April 2014	20	426	392	92.0
May 2014	20	484	436	90.1
June 2014	20	509	460	90.4
July 2014	21	551	504	91.5
August 2014	20	533	485	91.0
September 2014	20	534	484	90.6
October 2014	20	539	488	90.5
November 2014	20	540	471	87.2
December 2014	20	554	443	80.0
January 2015	20	558	434	77.8
February 2015	20	566	469	82.9
March 2015	20	574	477	83.1
<b>Average</b>	<b>20</b>	<b>531</b>	<b>462</b>	<b>87.0</b>

Table 1 indicates that 20 ASHAs did monthly surveillance during household visits. During the reporting period, on an average 87 percent MAGs were visited during monthly surveillance visits by the ASHAs.

**BCC Group Meetings Conducted by ANMs:**

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



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

Subject(s) Discussed	Month	Group meetings			Attendance in the meetings		
		Planned	Held	%	Expected	Attended	%
Adverse consequences of child marriage and early pregnancy	April 2014	43	42	97.7	630	323	51.3
Temporary methods of contraception – Modern methods	May 2014	43	40	93.0	600	299	49.8
Care during pregnancy & importance of antenatal care	June 2014	43	43	100	645	322	49.9
Danger signs during pregnancy & importance of HIV testing during pregnancy	July 2014	43	42	97.7	630	306	48.6
Birth preparedness, danger signs during delivery & importance of why a delivery should be conducted in the hospital	Aug. 2014	43	43	100	645	333	51.6
Temporary methods of contraception – Natural methods	Sept. 2014	43	42	97.7	630	363	57.6
Postnatal care of mother	Oct. 2014	43	43	100	645	287	45.7
Care of newborn	Nov. 2014	43	43	100	645	296	46.0
Special care of low birth weight baby & vaccination	Dec. 2014	43	43	100	645	302	46.8
Abortion	Jan. 2015	43	43	100	645	311	48.2
Post abortion care	Feb. 2015	43	43	100	645	326	50.5
Anemia	Mar. 2015	43	43	100	645	327	50.7
<b>Average</b>		<b>43</b>	<b>42.5</b>	<b>98.8</b>	<b>637.5</b>	<b>316.3</b>	<b>49.6</b>

Table 2 indicates that 99 percent of the planned BCC group meetings were held. On an average 316 married adolescent girls attended BCC group meetings every month. Actual number of MAGs that attended the BCC group meeting was 50 percent of the expected number.

This section of the report is for the area of 20 ASHAs in 17 villages.

**Table 3: Reported miscarriage rate among MAGs**

<b>Month</b>	<b>No. of MAGs visited</b>	<b>No. of MAGs with pregnancy outcome</b>	<b>No. of MAGs who had abortion</b>	<b>Percent of MAGs who had abortion</b>
April 2014	392	12	2	16.7
May 2014	436	18	0	00.0
June 2014	460	18*	0	00.0
July 2014	504	17	1	05.9
August 2014	485	13	1	07.7
September 2014	484	16	1	06.3
October 2014	488	13	1	07.7
November 2014	471	13	2	15.4
December 2014	443	16*	1	06.3
January 2015	434	08	2	25.0
February 2015	469	10	4	40.0
March 2015	477	22	2	09.9
<b>Total</b>	<b>5543</b>	<b>176</b>	<b>17</b>	<b>09.7</b>

\*One still birth in June 2014 and one in December 2014

Table 3 indicates that a total of 17 women reported miscarriage as the outcome of pregnancy i.e. miscarriage rate of 9.7. There was not a single woman who reported complications after miscarriage.

**Table 4: Reported use of family planning methods**

Month	No. of MAGs visited	Currently non pregnant MAGs	MAGs using any FP method	Percent MAGs using any FP method	MAGs using any spacing method	Percent MAGs using spacing method
April 2014	392	281	69	24.7	69	24.7
May 2014	436	325	60	18.5	57	17.5
June 2014	460	361	66	18.3	66	18.3
July 2014	504	400	89	22.1	86	21.5
August 2014	485	382	86	22.5	85	22.3
September 2014	484	382	90	23.6	90	23.6
October 2014	488	384	97	25.3	97	25.3
November 2014	471	368	93	25.0	93	25.3
December 2014	443	338	82	24.3	82	24.3
January 2015	434	322	86	26.7	86	26.7
February 2015	469	355	96	27.0	95	26.8
March 2015	477	361	102	28.3	101	28.0
<b>Average</b>	<b>462</b>	<b>355</b>	<b>85</b>	<b>23.9</b>	<b>83.9</b>	<b>23.7</b>

Table 4 indicates that on an average there were 355 non pregnant MAGs every month. Out of these, on an average 84 couples used any one temporary family planning method. Prevalence of current use of any temporary family planning method was 23.7 percent.

**Table 5: Reported use of any spacing methods by type of method**

Month	Currently non pregnant MAGs	MAGs using any spacing method	Number of MAGs currently using following type of spacing method					
			Condom	%	Pills	%	Cu T	%
April 2014	281	69	47	16.7	10	3.6	12	4.3
May 2014	325	60	40	12.3	06	1.9	11	3.4
June 2014	361	66	45	12.5	10	2.8	11	3.1
July 2014	400	89	59	14.8	13	3.3	14	3.5
August 2014	382	86	59	15.5	11	2.9	15	3.9
September 2014	382	90	59	15.5	14	3.7	17	4.5
October 2014	384	97	65	16.9	14	3.7	18	4.7
November 2014	368	93	66	17.9	16	4.4	11	3.0
December 2014	338	82	58	17.2	13	3.9	11	3.3
January 2015	322	86	58	18.0	14	4.4	14	4.4
February 2015	355	96	65	18.3	14	3.9	16	4.5
March 2015	361	102	70	19.4	17	4.7	14	3.9
<b>Average</b>	<b>355</b>	<b>85</b>	<b>58</b>	<b>16.2</b>	<b>13</b>	<b>3.6</b>	<b>14</b>	<b>3.9</b>

Table 5 indicates that 16.2 percent spouses of MAGs used condoms, 3.6 percent MAGs used oral pills and 3.9 percent were using Copper T.

**Table 6: Reported proportion of low birth weight babies**

<b>Month</b>	<b>No. of MAGs*</b> <b>visited</b>	<b>No. of</b> <b>Newborns</b> <b>weighed at</b> <b>birth</b>	<b>No. of</b> <b>newborns were</b> <b>LBW</b>	<b>Percent LBW</b> <b>newborns to</b> <b>MAGs</b>
April 2014	392	12	1	08.3
May 2014	436	18	4	22.2
June 2014	460	17	2	11.8
July 2014	504	17	1	05.9
August 2014	485	13	0	00.0
September 2014	484	16	3	18.6
October 2014	488	13	2	15.4
November 2014	471	13	0	00.0
December 2014	443	15	0	00.0
January 2015	434	08	0	00.0
February 2015	469	10	0	00.0
March 2015	477	22	3	13.6
<b>Total</b>	<b>-</b>	<b>174</b>	<b>16</b>	<b>09.2</b>

\*Number of MAGs delivered from the area of 20 ASHAs in 17 villages

During the reporting period 174 women delivered from the area of 20 ASHAs and all the newborns were weighed at birth. Only 16 (9.2 percent) out of the total newborns weighed were with low birth weight i.e. weight less than 2.5 Kg.

**Table 7: Detection of Reproductive Tract Infections (RTIs)**

Month	No. of MAGs visited	No. of MAGs with symptoms of RTIs	Percent MAGs with symptoms of RTIs
April 2014	392	08	2.0
May 2014	436	06	1.4
June 2014	460	10	2.2
July 2014	504	17	3.4
August 2014	485	13	2.7
September 2014	484	14	2.9
October 2014	488	12	2.5
November 2014	471	11	2.3
December 2014	443	07	1.6
January 2015	434	10	2.3
February 2015	469	09	1.9
March 2015	477	09	1.9
<b>Average</b>	<b>462</b>	<b>11</b>	<b>2.3</b>

Table 7 indicates that on an average 11 MAGs (2.3%) reported any one symptom of RTIs during surveillance every month.

**Table 8: Reported treatment seeking for RTIs**

Month	Number of MAGs visited	Number of MAGs with symptoms of RTIs	Number of MAGs sought treatment on RTIs	Percent MAGs sought treatment for RTIs
April 2014	392	08	07	87.5
May 2014	436	06	04	66.7
June 2014	460	10	07	70.0
July 2014	504	17	15	88.2
August 2014	485	13	09	69.2
September 2014	484	14	10	71.4
October 2014	488	12	06	50.0
November 2014	471	11	08	72.7
December 2014	443	07	04	57.1
January 2015	434	10	09	90.0
February 2015	469	09	06	66.7
March 2015	477	09	06	66.7
<b>Total</b>	<b>-</b>	<b>126</b>	<b>91</b>	<b>72.2</b>

Table 8 indicates that during the reporting period 91 (72.2%) out of a total of 126 detected cases of RTIs sought treatment.



**Table 9: Reported prevalence of post natal complications**

Month	No. of MAGs visited	No. of post natal MAGs*	No. of MAGs reported post natal complications	% MAGs with post natal complications
April 2014	392	2	0	00.0
May 2014	436	3	0	00.0
June 2014	460	7	3	42.9
July 2014	504	7	0	00.0
August 2014	485	6	0	00.0
September 2014	484	6	0	00.0
October 2014	488	4	0	00.0
November 2014	471	7	2	28.6
December 2014	443	3	2	66.7
January 2015	434	4	0	00.0
February 2015	469	2	0	00.0
March 2015	477	3	0	00.0
<b>Total</b>	-	54	7	13.0

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

Table 9 indicates that 7 MAGs reported post natal complications out of a total of 54 post natal MAGs delivered at in-law's house. None of the 7 MAGs sought treatment for the post natal complication.



### **Maternal Health Care:**

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

antenatal clinics, monthly RTI / STI clinics are also conducted for young women by a visiting mobile team from IHMP.

**Provision of antenatal and postnatal services:**

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

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

**Table 10: New antenatal registration during April 2014 – March 2015:**

Sr. No.	Month	MAG		
		= <12	>12	Total
1.	April 2014	05	13	18
2.	May 2014	12	19	31
3.	June 2014	12	14	16
4.	July 2014	13	16	29
5.	August 2014	28	12	40
6.	September 2014	26	27	53
7.	October 2014	27	12	39
8.	November 2014	22	12	34
9.	December 2014	16	17	33
10.	January 2015	24	22	46
11.	February 2015	07	11	18
12.	March 2015	06	19	25
	<b>Total</b>	<b>198</b>	<b>194</b>	<b>392</b>

Table 10 indicates that during the reporting period, a total of 392 new pregnant MAGs were registered, out of which 198 (50.5%) were registered  $\leq$  12 weeks of pregnancy and 194 (49.5%) were registered >12 weeks of pregnancy.

**Table No. 11: Antenatal Clinic:**

Month	Planned clinics	Actual clinics held	% clinics held	Expected no. of pregnant women to be examined	Actual no. of pregnant women examined	%
Apr. 2014	33	31	93.9	172	122	70.9
May 2014	48	48	100	232	184	79.3
June 2014	40	38	95.0	203	137	67.5
July 2014	47	46	97.9	258	163	63.2
Aug. 2014	44	44	100	240	157	65.4
Sept. 2014	52	48	92.3	230	225	97.8
Oct. 2014	38	38	100	276	190	68.8
Nov. 2014	52	49	94.2	318	205	64.5
Dec. 2014	50	47	94.0	282	196	69.5
Jan. 2015	45	44	97.8	455	318	69.9
Feb. 2015	43	38	88.4	320	233	72.8
Mar. 2015	45	44	97.8	344	242	70.3
<b>Average</b>	<b>44.8</b>	<b>42.9</b>	<b>95.8</b>	<b>277.5</b>	<b>197.7</b>	<b>71.2</b>

Table 11 indicates that on average 43 antenatal clinics were conducted and 198 (71.2%) pregnant women were examined every month.

**Table 12: Deliveries and Post natal visits**

Beneficiaries	Deliveries			Abortions	PNC visit			
	Total	Maheri Natal Home	Sasari In-laws Home		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Total
MAG	370	316	54	22	33	39	46	118

Table 12 indicates that during the reporting period 370 MAGs delivered and 22 abortions were recorded. Out of a total of 118 post natal mothers, 33 mothers received one post natal visit, 39 mothers received two post natal visits, and 46 mothers received three or more post natal visits.

**Table 13: Maternal health services utilized during the period April 2014 to March 2015**

Beneficiaries	Total deliveries	Antenatal checkup				T.T. injection			Place of delivery		Who conducted delivery		
		0	1	2	3+	0	1	2 and B	Hospital	Home	TD	Hospital	Other
<b>MAGs</b>	370	0	1	29	340	0	2	368	355	15	1	355	15

Table 13 indicates that during the reporting period out of 370 MAGs that delivered, 340 (91.9%) women were examined three or more times during pregnancy and 368 (99.5%) women received two T.T. injections or a booster dose. Out of 370 MAGs that delivered, 355 (95.9%) were delivered in a hospital.

**Table 14: Outcome of delivery during the period April 2014 to March 2015**

Beneficiaries	Total Deliveries	Outcome of Delivery		Birth Weight	
		Live birth	Still birth	Normal	Low birth
<b>MAG</b>	370	366	6*	351	15

\*Two twin deliveries

Table 14 indicates that there were 366 live births and 6 stillbirths. Out of 366 new born babies weighed, 15 (4.3%) were low birth weight babies.

#### **RTI /STI clinics for women:**

A doctor and nurse from IHMP visited every village once a month to conduct RTI /STI clinics for women.

**Table 15: RTI & STI Clinic for women – April 2014 to March 2015**

Sr. No.	Month	RTI/STI		Gynae.		Infertility		ANC		Other	Total Patients
		<24	>24	<24	>24	<24	>24	<19	>19		
1.	Apr. 2014	09	05	07	01	00	00	20	10	67	119
2.	May 2014	12	03	01	01	00	00	27	10	74	128
3.	June 2014	12	04	04	02	03	00	29	32	78	164
4.	July 2014	21	07	43	08	08	00	54	33	156	330
5.	Aug. 2014*	-	-	-	-	-	-	-	-	-	-
6.	Sept. 2014*	-	-	-	-	-	-	-	-	-	-
7.	Oct. 2014*	-	-	-	-	-	-	-	-	-	-
8.	Nov. 2014*	-	-	-	-	-	-	-	-	-	-
9.	Dec. 2014*	-	-	-	-	-	-	-	-	-	-
10.	Jan. 2015*	06	17	00	03	00	00	03	04	07	40
11.	Feb. 2015	06	10	00	03	00	00	11	36	24	90
12.	Mar. 2015	09	06	03	00	00	00	09	14	18	59
	<b>Total</b>	<b>75</b>	<b>52</b>	<b>58</b>	<b>18</b>	<b>11</b>	<b>00</b>	<b>153</b>	<b>139</b>	<b>424</b>	<b>930</b>

\*Did not have a lady doctor from Aug. 2014 to mid Jan. 2015

Table 15 indicates that a total of 930 women were examined and treated during the period April 2014 – March 2015, of which 127 women had RTIs /STIs, 76 women had gynecological problems, there were 11 cases of infertility and 424 had other problems. ASHAs referred 153 pregnant MAGs and 139 pregnant women over 20 years to the doctor.

#### **Case Study 1:**

Vaishali is a resident of village Ranjangaon. She was 16 years old when she got married. Now she is 17 years old.

When she came to the ‘Anganwadi’ centre on a Village Health and Nutrition Day for a check-up, she was three months pregnant. Her weight was 43.5 kg at the time of registration and height less than 145 cm. which is one of the risk factors. She was advised to come every month for antenatal check up. When she came for the next check up, she complained about vomiting and pain in the lower abdomen. The IHMP nurse advised her to consult an obstetrician at Pachod, which is very close to her village. She took treatment and felt better. After that she started eating well. During the next visit, the IHMP nurse advised her to eat sprouts, green leafy vegetables, peanuts and jaggery ladu and drink milk instead of tea. She was also advised to take iron folic acid and calcium tablets, which she took regularly. Her weight started increasing. In the second trimester the nurse advised her to have her delivery in the hospital. Vaishali had decided to go to her natal home for her delivery, which is in Pachod. She went to the government rural hospital at Pachod for delivery. She delivered after completing nine months, a healthy baby girl with birth weight of 2.5 kg. Both mother and baby are doing well.

#### **Case Study 2:**

Asha is a resident of village Anterwali. She has studied up to 8<sup>th</sup> standard. When she got married, she was 16 years old. After four months of marriage, she was vomiting so she came to the village clinic for a check-up. The IHMP nurse did a urine pregnancy test and found that she was pregnant. She registered her for antenatal care and advised her to come every month for a check-up. In the next month when the IHMP nurse visited the village, she learnt that Asha had a miscarriage. So she visited her home and advised her about what care she should take to prevent complications after the abortion.

She missed her periods again after three months. She came for a check-up at the village clinic and it was confirmed that she was pregnant. She was coming regularly for check-ups but this time also she ended up having a miscarriage. Thus she had two miscarriages in one year. The IHMP nurse advised her family to take her for an examination to the Medical College, Aurangabad. During her blood test it was diagnosed that she had RH negative blood group. She started taking treatment with the obstetrician at the Medical College. After few months, she became pregnant again. She used to go for a follow-up to the doctor. For antenatal check-ups she was coming regularly to the village clinic. After completing nine months of pregnancy, she delivered in the hospital a healthy baby boy. Both mother and baby are doing well. Asha said – “I have become a mother because of the critical advice given to me by the IHMP nurse for that I shall be eternally grateful.



**Case Study 3:**

Tai is a resident of Dabharul Tanda. Her husband is a marginal farmer. When she got married, she was 15 years old. She became pregnant after two months of marriage. She delivered a baby girl with a birth weight of 1.5 Kg. Tai had to take a lot of care of her daughter, since she was a low birth weight baby. Six months after her delivery, Tai was suffering from foul smelling discharge and itching. She could not tell anyone in the house about her problem. She used to feel weak, tired and irritable all the time.

One day, she shared her problem with the ASHA of her village. The ASHA told her not to get worried and advised her to come to the RTI clinic in the village conducted by IHMP. The doctor examined her and gave her treatment and the nurse from IHMP visited her and counseled her husband during follow up visits. She was completely cured.

Six months after completing her treatment, she became pregnant again. She came for routine antenatal care to the IHMP nurse on the Village Health & Nutrition Day. As per the advice of the nurse, she took 100 iron and folic acid tablets during pregnancy. After nine months, she delivered a baby girl on 15<sup>th</sup> September 2014, who weighed 2.5 Kg. at birth. Her first girl is now two years old. Both her daughters are doing well.

**Community based monitoring through monthly review meetings of Village Health, Nutrition, Water and Sanitation Committees (VHNWSCs):**

There are 16 VHNWS Committees in Adul PHC. Of the total members on the committees, 60 percent are women and 40 percent are male. Details of the monthly review meetings conducted have been presented in **Table: 16**. During the review meetings, committee members monitor performance of ASHA and monitor whether women with health needs identified by ASHA have received health services or not, motivate people to demand health services, ensure that government health services as well as AGRT services are reaching the most vulnerable households. The committees resolve problems which are barriers/ hurdles for the implementation of project activities. Committee members take responsibilities and actively participate in various activities implemented by IHMP.

**Table: 16 - Monthly Review Meetings of VHNWSC - April 2014 to March 2015**

Sr. No.	Month	Total No. of VHSC	Actual Meetings conducted	% of meetings conducted	Total No. of VHNWSC Members			No. of members Attended meeting			% of members attended meeting	Individual visit to VHNWSC members
					Male	Female	Total	Male	Female	Total		
1	April 14	16	15	94	41	64	105	25	39	64	61	3
2	May 14	16	14	88	43	61	104	21	32	53	51	2
3	June 14	16	10	63	28	37	65	24	27	51	78	0
4	July 14	16	13	81	39	56	95	21	31	52	55	1
5	Aug. 14	16	16	100	47	70	117	21	42	63	54	2
6	Sept 14	16	11	69	38	52	90	16	25	41	46	2
7	Oct. 14	16	16	100	47	70	117	25	37	62	53	0
8	Nov. 14	16	16	100	47	70	117	25	46	71	61	0
09	Dec. 14	16	14	88	43	61	104	16	34	50	48	0
10	Jan.15	16	14	88	43	61	104	18	45	63	61	0
11	Feb. 15	16	11	69	38	52	90	16	37	53	59	0
12	Mar. 15	16	15	94	41	64	105	20	39	59	56	0
<b>Average</b>		<b>16</b>	<b>14</b>	<b>88</b>	<b>41</b>	<b>60</b>	<b>101</b>	<b>21</b>	<b>36</b>	<b>57</b>	<b>56</b>	

Table: 16 indicate that on an average 14 out of 16 meetings were conducted every month. On an average 56 percent committee members attended the monthly review meetings.

### **Case Study:**

#### **Village – Georai BK**

Georai BK village is in Adul PHC. The village has a population of 1280. Vimal is the ASHA of the village. She also takes 'Life Skills' education classes for adolescent girls. She had 49 girls enrolled for the first batch. She used to take classes in the large open space available in Kumbharwada. Young boys from the village used to create a lot of noise and tease girls when the class was going on. The ASHA and AGRT staff decided to discuss this problem in the next meeting of Village Health, Nutrition, Water and Sanitation Committee. After the meeting, members called the father of one of the adolescent girls who has a large house and requested him to give one room for the LSE class. He agreed to give space and provide electricity for the class.

Committee members also called all the boys who used to create nuisance and told them not to do this and not go to that place when the class is being conducted. Since then these boys stopped giving trouble and after that 'Life Skills' sessions were conducted regularly without any interruption.

## **Reproductive & Child Health Care in a Rural Setting**

**Introduction:** The Institute of Health Management, Pachod (IHMP) implements Reproductive & Child Health Care (RCH) project in 30 villages of Adul PHC. Maternal health care is provided to women in the reproductive age group. RTI/ STI services are provided by the IHMP to both women and men through a mobile clinic.

### **Activities undertaken during 1<sup>st</sup> April 2013 to 31<sup>st</sup> March 2014:**

- 1. Maternal Health Care:** Every month 36 Village Health & Nutrition Day (VHND) were organized in Adul PHC by the sub-center ANM. On the same day, ANM from IHMP also visited the village and complemented health services provided by the government ANM. Pregnant women were examined from head to toe and screened for the risk factors. Pregnant women identified with the risk factors were either referred to PHC or to a visiting doctor from IHMP.

A total of 758 pregnant women were registered during the year. Out of which 615 (81%) were registered before 12 weeks of pregnancy and remaining 19 percent was registered after 12 weeks of pregnancy. A total of 486 women delivered during the year. Out of which 482 were live births and 4 were still births. Ten pregnant women reported abortion. Out of the total women delivered, 470 (96.7%) were hospital deliveries (444 delivered in the PHC & 26 delivered in the private hospitals) and 16 (3.3%) were home deliveries. Out of 482 newborns weighed at birth, 64 newborns weighed less than 2.5 kg., which is indicating prevalence of low birth weight as 13.3 percent.

- 2. RTI/ STI Services:** Every month, a lady doctor and nurse from the IHMP visited each village and examined women referred by ASHAs who were identified during surveillance visit with the symptoms of RTIs.

During the year, 50 cases of RTI/STI and 17 cases of gynecological problems in women above 19 years of age were examined and given treatment. A total of 425 other cases and 129 pregnant women referred by the ANMs were also examined by the IHMP doctor. Pregnant women requiring referral services were referred to the tertiary level care centers.

- 3. Preparation of Life Skills Manual:**

For a course of 6-month duration on Life Skills for adolescent girls, a manual with 50 sessions was prepared and 500 copies were printed. Also, teaching aids were prepared and printed.

## **Delaying Age of Marriage in Marathwada Region of Maharashtra**

**Project Location:** 32 villages & hamlets under Adul PHC, Paithan Taluka (30,000 population)

**District:** Aurangabad , Marathwada Region,

**State:** Maharashtra

### **Description of project:**

Through the CFLI project, IHMP will provide Life Skills Education for adolescent girls.

- A total of 160 adolescent girls with high self-esteem scores will be identified out of 1600 that are expected to undergo life skills education.
- These girls will be developed into peer educators by providing them with leadership and team building skills.
  - Each peer educator will adopt two girls with low self-esteem and mentor them.
  - The 160 peer educators will conduct participatory activities for 1600 adolescent girls with a special focus on 320 girls with low self-esteem and self-efficacy.
- IHMP will provide counselling to girls with low self-esteem, including parental counselling. This intervention will specifically empower girls with low self-esteem.
- Peer educators who complete their mentoring effectively will be given incentives in the form of scholarships for the Maharashtra-State-Certificate-In-Information-Technology (MSCIT) course.
- The peer educators will be assisted in establishing Girl's Groups (Kishori Mandals) in their villages. The Kishori Mandals will negotiate for continuation of education and a delay in the marriage of adolescent girls.

### **Project Implementation:**

The project was implemented as per the plan provided.

The problem in Maharashtra is that over 40 percent adolescent girls are married before they reach 18 years of age. A majority of these girls become mothers before 18 years as a result of which they suffer a huge burden of morbidity and mortality.

Our research indicates that 'Life Skills Education' results in improvement in knowledge, self esteem, self efficacy, and decision making, communication and negotiation skills. As a result of this empowerment they are able to negotiate with their parents to continue formal education and delay their marriage.

**Outcomes Achieved:**

A total of 176 adolescent girls underwent leadership training in 6 batches over a period of about 5 weeks. Soon after undergoing leadership training the peer educators were invited for training in the use of computers and internet. A total of 182 adolescent girls (peer educators) attended the training on computer and internet. The training was conducted for 6 batches of peer educators over a period of about 3 weeks.

Peer educators were trained in the basic skills in the use of computers. They were taught to create a new folder or add folders for contacts, connecting to a Wi-Fi network, Installing Applications, Youtube, facebook etc. were taught through theory and practical demonstration. They were taught to understand the use of a tablet & its accessories for participatory computer education.

Girls groups (Kishori Mandals) 24 groups have been given 1 bicycle each for learning how to ride. The remaining bicycles will be loaned to girls desirous of higher education accessible in neighboring villages.

Further the peer educators will conduct Life Skills Education (LSE) classes and participatory activities for adolescent girls in their villages with a focus on girls with low self esteem.

Each peer educator / adolescent girl has identified 5 girls in her village, with a focus on girls with low self esteem and self efficacy. The peer educators will mentor and impart life skills education and computer training to the girls that they have adopted.

Establishment of leadership and involvement of Girls Groups (Kishori Mandals) in

- negotiating for continuation of their education and a delay in their marriage

1216 adolescent girls have been organized into 48 Kishori Mandals (Adolescent Girls Clubs). The Kishori Mandals are undertaking several activities such as street plays, processions/rallies and home visits to negotiate continuation of education and a delay in marriage among adolescent girls. Another 400 girls will be mobilised into Kishori Mandals in the next 12 months.

- Positive trend in proportion of girls able to delay age at marriage
- Positive trend in proportion of girls continuing formal education

Qualitative research suggests that adolescent girls in the project area have been successful in negotiating a delay in their marriage thereby indicating a positive trend.

- Measurable improvement in self esteem and self efficacy of unmarried adolescent girls assessed by the culturally appropriate scale developed by IHMP

Pre post tests were conducted for each batch of adolescent girls enrolled. The self esteem and self efficacy of the girls was measured, using the scale designed by IHMP. The results indicate a measurable improvement in the self esteem and self efficacy of adolescent girls that have attended life skills education.

- Increase in proportion of girls with IT competencies

182 adolescent girls / peer educators have attended classes of 3 days duration, to improve their computer and internet skills. There was a measurable increase in their skills. (**Refer Annexure - 1**)

- Increase in cognitive skills (Knowledge)

Pre-post tests were conducted to measure changes in the adolescent girls attending life skills education.

- Which expected outcomes were not achieved during the delivery of this project?

Delay in age at marriage is a long term change which is dependent upon a change in social norms, perceived norms and individual household level behaviour. Whereas qualitative research indicates a positive trend a quantitative change will be measured during the end line survey in 2016.

- Were there any unanticipated benefits of the project?

Parental approval of safe spaces, increased mobility of adolescent girls and organisation into Kishori Mandals is an apparent change that has been achieved as a result of this project.

#### **Partners:**

Dasra and GlobalGiving are intimately involved with this project. Dasra is supporting the scaling up of this project. GlobalGiving is supporting IHMP in crowd funding of this project through their portal.

As communicated earlier the larger project on life skills education for unmarried adolescent girls, sexual and reproductive health services for married adolescent girls and gender sensitisation of young men is being supported by MacArthur Foundation.

#### **Communications:**

A local advocacy initiative was undertaken on 14<sup>th</sup> February 2015. It was attended by over 1500 adolescent girls and their mothers, 100 ASHAs and 150 local leaders and Government officials. The event was reported in local newspapers and radio spots.

**Cost Analysis:**

The project was completed within the approved budget

The broad goal of the project was to train peer educators who would conduct life skills education and computer and bicycle training for adolescent girls in their villages. The peer educators will be undertaking this as volunteers, thereby contributing to sustainability of the project.

**Describe any lessons learned:**

The adolescent girls have to take their final school examinations in the month of April. Despite the strain of preparing for their exams, the girls came for leadership and computer training in large numbers, indicative of the interest and commitment among the adolescent girls.

A peer led initiative for the empowerment of adolescent girls is feasible. The sustainability of this initiative and its effectiveness can only be measured in due course of time.

**Other comments or observations:**

Utilising the support provided under CFLI was possible and effective because of a long standing on-going project. IHMP was able to utilise the CFLI grant very effectively as an add-on to the on-going project.

## **Annexure – 1**

### **Training of Peer Educators**

Training of Peer Educators was organized in two parts during the period January and February 2015. Twelve Peer Educators were invited from the area of each ASHA volunteer.

The first training focused on leadership development and team building skills. Six sessions per day using participatory activities were organized. In consultation with the girls four topics were prioritized for community projects, which were:

1. Promoting education of adolescent girls up to 10<sup>th</sup> or 12<sup>th</sup> standard
2. Prevention of child marriage
3. Prevention of nutritional anemia in adolescent girls
4. Campaign for environmental sanitation (Cleanliness drive)

Each group decided to work on one of these topics for their community project. On the fourth day, adolescent girls worked in small groups to plan the strategy and activities of the community project which they would undertake in their villages.

#### **Objectives of the 4-day training were:**

- Develop leadership and team building skills in adolescent girls
- Finalize roles and responsibilities of Peer Educators.
- Acquire cognitive and practical skills for taking 20 life skills sessions with other adolescent girls.
- Selection of activities for the Community Project and prepare a plan of action for three months.

**Table: 1**

#### **4-day Training of Peer Educators on Life Skills & Community Project**

<b>Batch No.</b>	<b>Period</b>	<b>No. of Peer Educators Attended</b>
1.	7 <sup>th</sup> Jan. – 10 <sup>th</sup> Jan. 2015	28
2.	16 <sup>th</sup> Jan – 19 <sup>th</sup> Jan. 2015	29
3.	20 <sup>th</sup> Jan. – 23 <sup>rd</sup> Jan. 2015	28
4.	28 <sup>th</sup> Jan. – 31 <sup>st</sup> Jan. 2015	34
5.	2 <sup>nd</sup> Feb. – 5 <sup>th</sup> Feb. 2015	24
6.	6 <sup>th</sup> Feb. – 8 <sup>th</sup> Feb. 2015	33
<b>Total:</b>		<b>176</b>

#### **Second Training of Peer Educators was on the Use of Tablets**



The second training of peer educators was on the use of tablets

Training Period: 9<sup>th</sup> February 2015 to 28<sup>th</sup> February 2015

Total Number of Batches: 6

Training Duration Per batch: 3 days

Each day began with revision of the previous day's inputs. The training was divided into 15 sessions with 5 sessions per day, each of one hour duration.

Day\Sessions	1	2	3	4	5
<b>One</b>	Know your Device	Unlock screen, Turn on and off	Applications - Meaning & it's usage	Messaging Use of key pad	Calling, saving a number
<b>Two</b>	Revision	Settings, Changing wallpaper, date and time	Creating a document and saving	Camera operating and accessing gallery	Music, Volume
<b>Three</b>	Revision	Basic terms of Internet	Google Search	Access some websites	Access some websites

A Total of 182 girls and 18 ASHA volunteers from 16 villages received training. Please refer **Table: 2** for details.

**Table: 2**

**3-Day Training of Peer Educators on Use of Tablets**

Batch No.	Period	No. of Peer Educators attended
1	9 <sup>th</sup> Feb. – 11 <sup>th</sup> Feb. 2015	44
2	12 <sup>th</sup> , 13 <sup>th</sup> & 15 <sup>th</sup> Feb. 2015	30
3	16 <sup>th</sup> Feb. – 18 <sup>th</sup> Feb. 2015	27
4	19 <sup>th</sup> Feb. – 21 <sup>st</sup> Feb. 2015	33
5	23 <sup>rd</sup> Feb. – 25 <sup>th</sup> Feb. 2015	20
6	26 <sup>th</sup> Feb. – 28 <sup>th</sup> Feb. 2015	28
<b>Total</b>		<b>182</b>



Tablets have been distributed to the ASHAs. Hence they will be the custodians. Peer Educators after training are expected to adopt five adolescent girls from their villages who have completed Life Skills education and teach them skills required for the use of tablets and accessing the internet. The ASHAs have been asked to make the tablet available to the girls whenever they want to use it.

**Day one:** The whole of the first day was spent in making the girls comfortable with the device. They were explained about all the accessories provided in the box and how to use them. The basic operating system of the device was taught to them. Turning the screen on and off, locking and unlocking the screen, screen rotation and other functions were explained. They were taught how the tablet could be used as a phone.

**Day two:** During the training sessions the girls are provided with all the basic operating skills required to handle the tablet. Girls were taught to prepare a word document in an application named Polaris Office, save it and then open it from the folder. The purpose of creating a word document was that they should learn to make a document, get acquainted with the office functions, and those who find it interesting, could take it up to a higher level by opting for the Maharashtra State Certificate in Information Technology (MS-CIT) course. The basic settings of the tablet like changing date and time on the device; changing wallpaper were taught. The girls were taught to use the camera, video recording, flash light etc.

**Day three:** Last day of the training was completely dedicated to internet. These girls had very little knowledge about internet. The aim was to make them aware of internet, what to use it for, and finally how to access the required information.

The girls were provided with basic terminologies related to internet like browser, search engine, website etc. Then they were explained about Google search, and asked to find some information. Later they were provided with an opportunity to surf websites like Maharashtra Government, Maharashtra State Board of Secondary and Higher Secondary Education, Yashwantrao Chavan Maharashtra Open University, Aurangabad University, MPSC, Agricultural Department of Government of Maharashtra. The purpose of selecting these websites was to give the girl's skills to access their result; see the time table of the exams online. They can get information about government policies, scholarships, etc. Most of them come from families that make their living on agricultural activities and hence it is quite helpful for them to have access to the online market rates, subsidies and other related information.

**Observations:** During the training we observed that the girls from higher age groups, like the ones from 9<sup>th</sup> to 12<sup>th</sup> standard and higher, are the ones who want to learn more and are capable of explaining things to others. Girls were found particularly good when it came to basic operating, since most of them have a smart phone in their homes. Most of the girls prepared a document, and even saved it correctly. But the scenario was different when they were asked to do it individually, which implies that they need more practice. The girls enjoyed clicking photos and videos, which turned out to be one of the most entertaining parts of the whole training schedule. The younger girls found internet access more difficult since most of the websites were of no use to them. The older girls took interest in it and were happy to access the information through the tablet. Overall the performance of adolescent girls was good.

Most of the ASHA volunteers were reluctant to take up the training and had come with the mindset of simply accompanying the girls. Language was a big barrier for them; most of them could not read English at all. But even when it came to the websites, which were in Marathi, they did not seem to be very interested. But there were some exceptions. Few of the ASHAs performed extremely well. The ASHA volunteers need to be motivated to undergo further training.

Summing up, the training was a good experience. The crucial part is to see if the prime purpose of the training, making a difference in the adolescent girl's life is achieved or not. IHMP will assess this long term change in the future.



## **Scaling up for the Project on Preventing Child Marriage and Early Pregnancy, in Jalna District**

### **Introduction:**

Delay in age at marriage is a long term change which is dependent upon a change in social norms, perceived norms and individual household level behaviour. Whereas qualitative research indicates a positive trend a quantitative change will be measured during the end line survey in 2016.

The second objective is to protect married adolescent girls from the burden of morbidity as a consequence of early motherhood and gender based violence.

It is aimed to scale up the integrated approach of working with unmarried adolescent girls, married adolescent girls, boys and young men to address the issue in 53 villages of Jalna District from April 2015. The project was launched on February 14, 2015 with a local event for which adolescent girls, their mothers, ASHAs the frontline workers, local leaders and Government officials were invited. Over 1500 people attended the function which resulted in an increased awareness and demand for the project.

The integrated project for adolescent sexual and reproductive health required capacity building of the staff of Institute of Health Management, Pachod (IHMP). Visits were organized to various NGOs in Mumbai and Pune to expose the staff to innovations and methodologies being implemented by the NGOs that were visited. The exposure visits resulted in a new vision and improved conceptualization of how to address the problem for the IHMP staff.

### **Regional Launch:**

AGRT/IHMP organised a regional launch for the project on Preventing Child Marriage and Early Pregnancy in India on 14<sup>th</sup> February 2015, which is going to be initiated in the villages of two Primary Health Centres (PHCs) in Ambad Block, Jalna District. Medical officers, other staff members and ASHAs of two PHCs were invited for the launch. Each ASHA was requested to bring two adolescent girls and their parents from her village. District and block level officials were also invited for the launch.

### **Objectives of the Regional Launch:**

- ASHAs from two PHCs to learn about the objectives of project for the unmarried and married adolescent girls being undertaken in their villages and understand vulnerability of the adolescent girls.
- ASHAs from two PHCs to understand from ASHAs of Adul PHC about how Life Skills course for the unmarried adolescent girls was organised and what impact it has created in the lives of the adolescent girls.
- ASHAs from two PHCs to learn from ASHAs of Adul PHC about how focussed intervention to identify health and information needs of the married adolescent girls was operationalised. How linkages were established with the ANM to provide primary level care and referral.

- To facilitate acceptance to undertake additional interventions and activities by the ASHAs and PHC staff.

Regional launch was attended by about 1500 - ASHAs, adolescent girls and village, block & district level officials.

After the launch, ASHAs have been inspired and motivated to participate in the new project which is going to be initiated in their villages. Block and District authorities have promised that they will extend full cooperation and support for the implementation of this project.

### **Field Visit for the Capacity Building of the Staff**

A field visit for the capacity building of IHMP staff was organised from 21<sup>st</sup> to 27<sup>th</sup> February 2015 and from 1<sup>st</sup> to 3<sup>rd</sup> March 2015. A team of 12 members visited Naz Foundation, SNEHA & VACHA in Mumbai and SAMAYAK & Tathapi in Pune. Two-day training was also organised with the help of a resource person from SAMYAK to improve understanding of working with young men and how their perception of the masculinities can be changed.

### **Objectives of the Field Visit:**

- Learn from other organisations what interventions and strategies these organisations are using for working with adolescent girls and youth.
- Encourage staff members to adapt new innovative interventions and strategies learnt from the field visit into their own work to improve the quality of their work.
- Build capacities of the staff to do things differently, which will add value to the existing ongoing interventions.

After the visit a debriefing session was organised and each staff member was asked to list out at least three things learnt from each organisation. A list of activities/ interventions prepared by the staff members, which can be adapted into IHMP's project is given below.

1. Include more participatory games appropriate for the session in our Life Skills education course.
2. Adapt module on 'Being Financial Savvy' and include it in our Life Skills education course.
3. Prepare newsletter with the help of youth
4. Whether games can be used as entry points to work with youth and whether competitions for games can be organised to sustain interest of the youth
5. Sending video clips through mobile and using these video clips to initiate discussion on the various issues
6. Starting computer and life skills classes in the school for the children in 7<sup>th</sup> to 10<sup>th</sup> standard
7. Establish a committee for the prevention of child marriage at the community level
8. Organise workshop for youth on anti dowry and motivate youth for taking oath for not accepting dowry at the time of marriage.
9. Arrange visit to various vocational training institutes
10. Prepare individual profile of each girl with her dreams and aspirations

11. Initiate a study group in the organistaion, which will meet once a week. Each member of the group will read one article and then have discussion on that article
12. Establish small library at the village level to encourage reading habit in adolescent girls and youth.
13. Use unfinished story as a method for taking the session of the life skills education.
14. During school or board exam time, let the girls come to the centre and study for the exam
15. Initiate English speaking classes and coaching for maths through volunteers

## **Scaling up and advocacy of a model primary health care programme for the urban poor in the slums of Pune city**

### **1. Summary**

The efficacy of IHMP's key 6 innovations has been adequately demonstrated to the policy implementers and officials of the Municipal Corporation. There is sufficient evidence to indicate that the innovations improved the access and utilization of primary health services by the urban poor living in slums.

Outsourcing delivery of obstetric and gynecological services at the primary level increases the utilization of emergency obstetric care (EMOC) and treatment of RTIs and STIs.

There are services and entitlements that have been provided by the Municipal Corporations and State Governments. The poorest for whom these entitlements have been put in place are not aware of their existence nor do they make any attempt to access them. Empowering civil society for generating demand for services and ensuring accountability of health providers and facilities has ensured that the poorest in the community are assured of these services and entitlements. However, since IHMP was not able to federate the slum health committees up to the level of the Municipal Corporation the change was limited to its project area.

Capacity building of CHWs/ ANMs for effective implementation of the 6 IHMP innovations was achieved through hand-holding and mentoring in the field.

The outcome of the 6 innovations has been an increase in utilization of maternal and neonatal care services by the community, increase in treatment seeking for reproductive health problems, increase in contraceptive use, increase in the coverage of children with complete primary immunization, early detection and treatment for communicable and non-communicable diseases such as diabetes and hypertension.

### **2. Introduction, Goal and Outcomes**

Institute of Health Management Pachod is working in the slums of Pune city. Oxfam approved a grant for three years to demonstrate 6 IHMP innovations in a formal Primary Urban Health Centre (PUHC) established by the Pune Municipal Corporation and advocate for their adoption in NUHM.

Goal - To build evidence of the efficacy of 6 innovations developed by IHMP by demonstrating the innovations through a Pune Municipal Corporation's Primary Urban Health Centre (PUHC) and advocating their replication in the urban public health sector.

**The specific objectives of the urban health program are:**

- **Specific objective 1:** Build evidence regarding the efficacy of key innovations, such as monthly surveillance, micro-planning, outreach, need specific BCC and community based monitoring to improve access and utilization of primary health services by the urban poor living in slums.
- **Specific objective 2:** Demonstrate the efficacy of Obstetric and Gynecological services through a (per clinic) out-sourcing strategy at the primary level to ensure timely referral for emergency obstetric care (EMOC) and treatment of RTIs and STIs.
- **Specific objective 3:** Empowering Civil Society for generating demand for services and ensuring accountability of health providers and facilities
- **Specific objective 4:** Capacity building of CHWs/ ANMs for effective implementation of 6 IHMP innovations.
- **Specific objective 5:** Develop linkages for providing secondary and tertiary level health care services in collaboration with the tertiary level health care institutions.

**Expected outcomes of a model PUHC are:**

***At the community level - there will be a change in the health status of the community***

- Increase in utilization of maternal and neonatal care services by the community
- Increase in treatment seeking for reproductive health problems
- Increase in contraceptive use and reduction in the total fertility rate
- Increase in the coverage of children with complete primary immunization
- Early detection and treatment for childhood illness
- Early detection and treatment for communicable diseases – malaria and TB
- Early detection and treatment for non-communicable diseases – diabetes and hypertension

***At provider level - community and facility based health workers (PUHC) will be able to demonstrate the capacity / skills to implement the key innovations introduced by IHMP. The key innovations that will be introduced in the public health sector are:***

- Monthly surveillance of health needs
- Micro-planning and monitoring of health needs by Community Health Workers (CHWs)
- Outreach services to create effective linkage of health needs with primary, secondary and tertiary levels of health care.
- Early detection and treatment of women in need of EMOC and Gynaecological services through a per clinic, contractual strategy
- Need and situation specific BCC combined with a social norms approach.



- ‘Slum Health and Development Committees’ empowered to demand health rights and monitor identification of health needs and services provided at all levels.

**At Policy level:** IHMP will demonstrate an understanding of the innovations at a policy level and will advocate their large scale replication at a State and National level.

### 3. Changes in context

The implementation of NUHM was initiated in 2014. IHMP is collaborating with Pune Municipal Corporation (PMC) to roll out this programme in the urban slums of Pune city. The actual roll out has been initiated in 2015. PMC has requested IHMP to train its front line workers.

In March 2014, AGRT IHMP won the National DASRA award for the project “Intervention to delay age at first conception and avert the adverse consequences of early motherhood among Married Adolescent Girls”.

The Government of Maharashtra has requested IHMP to scale up this intervention in eight of the most backward districts of Maharashtra. Preparations for scaling up are underway.

In October 2014, AGRT / IHMP was offered Corporate Social Responsibility (CSR) support by a Pune based IT software company for scaling up the Reproductive and Child Health programme in the slums of Pune city. The IT Company has communicated to IHMP that it is committed to providing CSR funds over the next 3 years for mainstreaming this project in the NUHM in the urban slums of Pune city.

### 4. Progress with implementation of the Project\* (both quantitative and qualitative)

**Specific objective 1: Build evidence regarding the efficacy of key innovations, such as monthly surveillance, micro-planning, outreach, need specific BCC and community based monitoring to improve access and utilization of primary health services by the urban poor living in slums.**

**Surveillance and Monitoring System:** Protocols for the surveillance and monitoring system for urban slum areas were designed and printed. In order to develop practical skills for filling surveillance registers, IHMP staff provided on the job training to the CHWs. Monthly needs assessment through surveillance was carried out by the CHWs. The surveillance system covers the following broad areas:

- Maternal health
- Neonatal health
- Reproductive health – Reproductive tract infections
- Family planning
- Child immunization
- Child health – Diarrhoea, fever, and ARI

**Needs specific behaviour change communication:** During monthly household visits CHWs identify the information needs of each individual. Based on the behavioural diagnosis they provide information and counselling specific to the needs of the individual and family. This need specific BCC approach has brought about a measurable change in health related behaviours. During the reporting period, 6716 household visits were undertaken by CHWs during which they provided needs specific BCC. (Refer Table 1)

**Table 1: Needs specific BCC provided by the CHW at household level**

Sr.	Topic	Number of clients received needs specific IPC & counselling from CHWs at household level			
		Apr to Jun 2014	Jul to Sep 2014	Oct to Dec 2014	Jan to Mar 2015
1.	Maternal care	405	481	519	472
2.	Treatment for symptoms of maternal morbidity	54	86	80	87
3.	Use of family planning methods	1239	477	543	480
4.	Treatment for reproductive tract infections	177	353	295	167
5.	Management of child morbidity	264	193	184	160
	Total	2139	1590	1621	1366

**Behaviour change communication through a social norms approach:** Behaviour Change Communication (BCC) is also being implemented through a social norms approach. Group BCC sessions were conducted to influence social norms like age at first conception, birth interval, early registration for antenatal services, utilization of minimum standard antenatal care, utilization of minimum standard postnatal care, screening for non-communicable diseases, etc.

A total of 243 group BCC sessions for women aged 15-44 years and 17 group BCC sessions for all slum dwellers were conducted at the slum level, by the project staff. The group BCC sessions for reproductive and child health were conducted by the project ANMs and the group BCC sessions on NCDs were conducted by the project senior social workers.

They conducted these meetings using participatory methods through effective use of audio-visual material. A total of 3464 women from the 18 project slums attended the meetings. Group BCC to generate demand for PMCs “Shahari Garib Yojana” (Health Assurance Scheme for the Poor) was carried out in 15 slums and a total of 244 individuals attended the group BCC sessions. (Refer Table 2).

**Table 2: Group BCC sessions conducted at slum during April 2014 to March 2015**

Sr.	Period	Group BCC sessions conducted	Participants attended	Topics discussed during group BCC sessions
1.	April to June 2014	63	881 women 15-45 yr of age	<ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Reproductive tract infections</li> </ul>
		15	244 individuals from 18 slums	<ul style="list-style-type: none"> <li>• PMCs “Sahari Garib Yojana”.</li> </ul>
2.	July to September 2014	63	895 women 15-45 yr of age	<ul style="list-style-type: none"> <li>• Reproductive tract infections</li> <li>• Sexually transmitted infections</li> </ul>
		02 sessions in Yamuna Nagar slum	20 individuals of age 30 & above with diabetes & hypertension	<ul style="list-style-type: none"> <li>• Hypertension &amp; diabetes</li> <li>• Complications occurred due to diabetes and hypertension</li> <li>• Management of complications</li> <li>• Life style behaviours – diet, physical activity, addictions</li> </ul>
3.	October to December 2014	57	844 women 15-45 yr of age	<ul style="list-style-type: none"> <li>• Urinary tract infections</li> <li>• Female anatomy and physiology</li> <li>• Menstrual cycle and hygiene</li> </ul>
4.	January to March 2015	60	844 women 15-45 yr of age	<ul style="list-style-type: none"> <li>• Antenatal care</li> <li>• Post-natal care</li> <li>• Abortion</li> </ul>
	<b>Total</b>	<b>260</b>	<b>3728</b>	

**Outreach clinics conducted by project ANM:** The CHWs prepare a micro-planner every month which provides details of the health needs of women and children along with details of the services they require. Based on the micro-planner, the CHWs actively link their clients to Vasti level clinics conducted by ANMs. A total of 201 clinics were planned and organized during the reporting period in the project area. Primary level care services for maternal health, child health and family planning were provided at the clinics, 1613 antenatal examinations were conducted by ANMs. The ANM cross-checked whether all the clients listed in the micro-planner had availed services or not.

**Policy Implications:** Whereas, the NUHM policy has prescribed “Outreach” as one of the key strategies for urban health care there has been progress on this only since 2014. IHMP has contributed in terms of providing an operational definition and designing necessary processes, systems and protocols. This is a key contribution of IHMP and these innovations are in the public domain after collecting sufficient evidence of their efficacy.

**Care and support for individuals with Diabetes and Hypertension in Yamuna Nagar and Dalit slum:** In the last year screening camps for diabetes and hypertension were organized by the project in two slums namely Dalit slum and Yamuna Nagar slum. A total of 107 individuals were detected with any kind of hypertension and 74 individuals were detected with diabetes. During the reporting period, patients with diabetes and hypertension were followed up regularly by the CHW and project staff. During the follow up visits, special counselling on treatment, monitoring, and dietary & other life style behaviours was provided by the project staff. During the initial follow up visits the project staff pre-tested the content for needs specific BCC and MIS. The initial draft of the protocols for needs specific BCC and MIS for hypertension and diabetes have been designed and are being field tested. A total of 99 patients were actively linked to the secondary and tertiary care facilities for treatment of diabetes and hypertension. 64 patients are taking regular treatment for management of hypertension and 35 patients are taking regular treatment for management of diabetes.

**Monitoring of blood pressure and blood sugar levels in Yamuna Nagar slum:** Monitoring of blood pressure for hypertensive and blood sugar levels for diabetic patients was carried out for two month period in Yamuna Nagar slum. A total of 42 hypertensive patients and 44 diabetic patients were covered. The activity was carried out with the help of a student medical doctor, placed at IHMP from TISS Mumbai and two CHWs from Yamuna Nagar slum. Digital BP apparatus was used for taking blood pressure and glucometer was used for taking blood sugar levels. On an average BP was taken 8 times per patient and 2 times blood sugar levels were tested in the two month period. During the visits need based BCC was given by the medical doctor. BCC material (flash cards/pamphlets) were designed and pre-tested during these two months. Two CHWs were given on the job training on needs specific BCC to modify life style behaviours and measurement of blood pressure & blood sugar levels.

**Policy Implications:**

1. There is a high prevalence of diabetes and hypertension among the urban slum poor of Maharashtra.
2. Contrary to the prevailing perceptions, the prevalence of hypertension and diabetes is higher among socio economically marginalized households / individuals.
3. The public health sector does not have any system in place to deal with this developing epidemic.
4. Both these non communicable diseases require monitoring on a biweekly, or at least a weekly basis. The cost of merely monitoring blood pressure and blood glucose would cost slum dwellers more than what they can afford. Hence, neither do people living in slums get these illnesses monitored on a regular basis, nor can they afford regular treatment.

5. IHMP has testing technology and community based outreach strategies for developing an affordable system that can be replicated at the level of the Municipal Corporation. This includes providing BP apparatuses and Glucometers and skills development among CHWs to use this technology and provide monitoring services for a small fee.
6. IHMP is developing protocols for surveillance of high risk factors and hopes to design relevant preventive protocols and BCC material that can be put in the public domain.

**Specific objective 2: Demonstrate the efficacy of Obstetric and Gynecological services through a (per clinic) out-sourcing strategy at the primary level to ensure timely referral for emergency obstetric care (EMOC) and treatment of RTIs and STIs.**

Clinics for emergency obstetric and gynecological services were conducted at the Galande Patil dispensary. Treatment was provided to 308 patients by IHMP's consulting gynecologist once a week at the PUHC. In the reporting period, 37 obstetrics /gynecology clinics were planned, and of them 35 were conducted by the PUHC and IHMP project staff.

Specialized clinics at the PUHC have resulted in a substantial increase in referral and utilization of services by women with maternal and reproductive morbidities.

**Policy Implications:**

Cost effective specialist care in obstetrics and gynecology can be made accessible to the poorest living in slums by providing these services at the PUHC level through Gynecologists from the private sector appointed and paid on a per clinic basis.

**Specific objective 3: Empowering Civil Society for generating demand for services and ensuring accountability of health providers and facilities**

**Capacity building of Slum Health and Development Committee (SHDC):** 12 Slum Health and Development Committees (SHDCs) have been established. During the reporting period, one orientation meeting for SHDC members were planned and conducted.

SHDC members of all 12 SHDCs were oriented about Rajiv Gandhi Arogya Jivandai Yojana. Information on procedures to avail the scheme, benefits of the scheme, how to utilize the scheme by the urban poor etc. were discussed in length. As an outcome of this new initiative, SHDC members undertook a small campaign in their slums, around 150 households received information on the scheme. And out of these, 12 households had enrolled under the scheme, and 4 individuals received the benefit under the scheme.

**Slum Health and Development Committees (SHDCs):** During the reporting period, 12 Slum Health and Development Committees were functioning in the 18 slums. SHDC meetings were planned once in a month for each slum area. Out of the 143 SHDC meetings that were planned 119 were actually conducted in the last one year. A total of 547 SHDC members were present at the monthly SHDC meetings.

**Table 5: SHDC meetings conducted during the period - April 2014 to March 2015**

Sr. No.	Period	SHDC meetings planned	SHDC meetings conducted	Attendance at SHDC meetings	Topics discussed during meetings
1.	April to June 14	35	31	109	Review of CHWs work, outreach clinics conducted by ANM
2.	July to Sept 14	36	32	103	CHWs performance, work initiated by the PMC in their respective slum on water supply, sanitation, garbage disposal, Discussion on how to increase demand for PMCs “Shahari Garib Yojana”.
3.	Oct to Dec 14	36	26	158	CHWs performance, MPR, discussion about implementation of Rajiv Gandhi Yojana
4.	Jan to March 15	36	30	177	CHWs performance, MPR
	Total	143	119	547	

SHDC members monitored the work of CHWs and ANMs. They visited households to cross check and certify the needs assessed by the CHWs. SHDC members reviewed the work-plans prepared by CHWs to ensure completeness & accuracy and the MPR prepared by ANMs to ensure that those who required services actually received them. SHDC members motivated the community to utilize services offered at the PUHC.

**Campaign to increase awareness and generate demand of PMCs “Shahari Garib Yojana” – a right based approach through Slum Health and Development Committees (SHDC):**

In the reporting period, SHDC members conducted campaigns and cluster meetings to increase the awareness about the scheme among marginalized households and generate demand for PMC’s “Shahari Garib Yojana” in their slums. A total of 18 cluster meetings were planned, of this 15 were actually carried out during the reporting period. After the cluster meetings follow-up of SHDCs was carried by the project staff, during these follow ups the review of enrolment procedures, potential beneficiaries of the scheme, any barriers faced in completion of the procedure for applying to the scheme etc. were discussed and SHDCs were oriented on the problems/issues which they faced. A total of

51 follow up visits with the 12 SHDCs were carried out, as a result of this follow ups 49 households received the health assistance card under the scheme. Some of the SHDC members accompany the beneficiaries in submitting the application form at the PMC office.

**Policy Implications:** The Pune Municipal Corporation has budgeted a considerable amount of funds for this scheme. The funds are underutilized as slum communities are unaware of this scheme and even those who have heard about it do not know how to get enrolled. Civil society can play a crucial role in securing this entitlement for the poorest.

**Specific objective 4: Capacity building of CHWs/ ANMs for effective implementation of 6 IHMP innovations.**

Capacity building of Community Health Workers (CHWs): Capacity building of the CHWs is an important component of the project. The goal is to build capacity of CHWs 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.

**Table 6: Training programs conducted for CHWs during April 2014 to March 2015**

Sr. No.	Training subject	Month	Duration – days	No. of CHWs attended	Knowledge & skills provided
1.	Refresher training on Needs specific BCC	April 2014	01 day	12	How to provide needs specific BCC, how to make a behavioural analysis, use of BCC cards and checklists etc.
2.	Induction training for newly appointed CHWs	June 2014	07 days	04	Cognitive skills – maternal health, neonatal health, child health, reproductive health, family planning. Practical skills on implementation of 6 IHMP innovations
3.	Training on NCDs	Sept 2014	02 days	11	<b>Cognitive skills</b> – symptoms of high blood pressure / diabetes, complications occurred due to high BP/diabetes, monitoring of BP/ diabetes and management of complications. <b>Practical skills</b> – Measurement of blood pressure using digital BP apparatus, Measurement of blood sugar levels using glucometer, Provision of needs specific BCC / counselling to modify life style behaviours and regular monitoring and treatment

**In-service training:** During the reporting period, 12 in-service training sessions were conducted. CHWs and project staff participated in these training sessions. Project inputs, outputs and coverage were reviewed and participatory planning was done during the meetings. Cognitive and practical skills were provided to the CHWs.

**On the job training by Supervisors during field visits:** In the reporting period, attrition of staff has made an impact on coverage of supervisory visits, in some CHW area 1 visit per month were planned. Using supervisory check lists, supervisors assessed skills of the CHWs, and provided 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. A total of 312 Supervisory visits were planned during the reporting period out of which 213 (68 percent) visits were conducted.

**Specific objective 5: Develop linkages for providing secondary and tertiary level health care services in collaboration with the tertiary level health care institutions.**

**Meetings with PUHC:** During the reporting period several meetings with Medical Officer, PUHC were organized. Participatory planning of the gynaecologist clinic at PUHC, review of outreach activities, upgrading the services at the PUHC, MIS for referral tracking was discussed during these meetings.

**Meetings with PMC officials:** Several meetings with PMC officials were conducted during the reporting period. Impact of outreach on health service utilization for MNH & RH, Facilities for providing OB gynaecologist clinic at PUHC, NUHM implementation, implementation of PMCs health insurance scheme in the 18 project slums, and rolling out of NUHM in the city of Pune etc. were topics that were discussed during the meetings. Following key decisions were taken by the PMC officials:

- Involvement of IHMP in NUHM: The Pune Municipal Corporation (PMC) has received approval for the PIP submitted to the MOHFW, Government of India for implementing NUHM. PMC is now in the process of planning the activities under NUHM. PMC has invited IHMP to write a letter for involvement in the following activities under NUHM:
  - Capacity building of CHWs for Urban Slum
  - Establishment of management information system
  - Establishing a behaviour change communication strategy – for MCH and FP
  - Capacity building of ANMs located at PUHCs
  - Capacity building of PUHC Medical officers
  - Orientation of slum Health committees and community groups

A meeting with RCH officer, Health Dept. PMC was held in the fourth week of March 2015. In the Pune city, NUHM activities will be initiated from the April 2015.

- PMC is ready to appoint IHMP CHWs under NUHM as community link worker, so their work will be continued under NUHM



- PMC promised to take the SHDC members on Mahila Arogya Samity, which will be formulated under NUHM
- PMC will involve IHMP for training community link worker, ANMs, doctors and other NUHM staff under NUHM

i) **Outcome / Key Result**

**Table 1: Surveillance Coverage.**

Period	Reporting for Number of CHW areas	Surveillance visits planned for registered eligible couples	Surveillance visits actually conducted for eligible couples	Percent ECs visited
April to June 14	15	9200	7886	85.7
July to Sept 14	14	9914	8878	89.5
Oct to Dec 14	15	10474	9406	89.8
Jan to March 15	14	8666	7639	88.1

The average percentage of ECs who had been covered by monthly surveillance was 88.2%

**Table 2: Reported Symptoms of Reproductive Tract Infections.**

Month	Reporting for Number of CHW areas	Number of ECs visited	Number of ECs with symptoms of RTIs	Percent ECs with symptoms of RTIs
April to June 14	15	7886	177	02.2
July to Sept 14	14	8878	353	03.9
Oct to Dec 14	15	9406	295	03.1
Jan to March 15	14	7639	294	03.8

The proportion of ECs detected with RTI symptoms was 3.3 percent.

**Table 3: Reported treatment seeking for Reproductive Tract Infections.**

Month	Reporting for Number of CHW areas	Number of ECs with symptoms of RTIs	Number of ECs sought treatment on RTIs	Percent ECs sought treatment on RTIs
April to June 14	15	177	116	65.5
July to Sept 14	14	353	222	62.8
Oct to Dec 14	15	295	149	50.5
Jan to March 15	14	294	167	56.8

The average proportion of women with RTIs who had sought treatment was 58.9 percent.

**Table 4: Coverage of Antenatal Care.**

Month	Reporting for Number of CHW areas	Number of Antenatal examinations planned	Number of antenatal examinations carried out	Percent received antenatal care
April to June 14	15	405	347	85.7
July to Sept 14	14	481	393	81.7
Oct to Dec 14	15	527	438	83.1
Jan to March 15	14	472	389	82.4

The proportion of pregnant mothers who received antenatal care was 83.1 percent.

**Table 5: Reported Symptoms of Antenatal Complications.**

Month	Reporting for Number of CHW areas	Number of Currently pregnant mothers	Number of pregnant mothers with antenatal complications	Percent pregnant mothers with antenatal complications
April to June 14	15	347	54	15.6
July to Sept 14	14	393	86	21.9
Oct to Dec 14	15	438	80	18.2
Jan to March 15	14	389	87	22.3

The proportion of pregnant mothers reporting any one antenatal complication was 19.5%.

**Table 6: Reported Treatment Seeking for Antenatal Complications.**

Month	Reporting for Number of CHW areas	Number of pregnant mothers with antenatal complications	No. pregnant mothers sought treatment for antenatal complications	% pregnant mothers sought treatment for antenatal complications
April to June 14	15	54	48	88.9
July to Sept 14	14	86	78	90.7
Oct to Dec 14	15	80	72	90.0
Jan to March 15	14	87	73	83.9

The average proportion of pregnant mothers with symptoms of antenatal complications who sought treatment was 88.3 percent.

**Table 7: Institutional Deliveries.**

Month	Reporting for Number of CHW areas	Total deliveries	Institutional deliveries	Percent institutional deliveries
April to June 14	15	56	54	96.4
July to Sept 14	14	59	56	94.9
Oct to Dec 14	15	53	52	98.1
Jan to March 15	14	60	58	96.7

Almost all i.e. 96 percent mothers delivered in a hospital.

**Table 8: Coverage with Postnatal Care.**

Month	Reporting for Number of CHW areas	No. of postnatal mothers identified	Home based post-natal care by CHW	Post-natal visits by ANM	Postnatal mothers with postnatal complications
April to June 14	15	56	54	54	09
July to Sept 14	14	79	76	66	05
Oct to Dec 14	15	68	67	65	05
Jan to March 15	14	60	58	55	05
<b>Total</b>		<b>263</b>	<b>255</b>	<b>240</b>	<b>24</b>

263 postnatal mothers were identified, CHWs provided home based postnatal care to 255 mothers and 240 mothers were examined after delivery by the ANM, at home, within 42 days.

**Table 9: Reported Use of Family Planning Methods.**

Month	Reporting for Number of CHW areas	Non sterilized ECs	ECs using any temporary FP method	Percent ECs using any temporary FP method
April to June 14	15	1056	230	21.8
July to Sept 14	14	1279	325	25.4
Oct to Dec 14	15	1480	393	26.6
Jan to March 15	14	1310	349	26.6

The average proportion of non-sterilized ECs using any form of temporary contraception was 25.1 percent.

**Table 10: Reported Prevalence of Diarrhoea among Children Under Three Years of Age**

Month	Reporting for Number of CHW areas	No. of children under 3, visited by CHW	No. of children under 3 with symptoms of diarrhoea	Prevalence of diarrhoea among children under 3
April to June 14	15	1865	50	02.6
July to Sept 14	14	2185	166	07.6
Oct to Dec 14	15	2501	131	05.2
Jan to March 15	14	2519	128	05.1

The average reported prevalence of diarrhoea among children under three years of age was 5.1 percent. Children that were suffering from diarrhoeal episodes were referred and treated.

**Table 11: Reported Prevalence of ARI among Children Under Three Years of Age**

Quarter	Reporting for Number of CHW areas	Number of children under 3 years visited by the CHW	No. of children under 3, with symptoms of ARI	Prevalence of ARI among children under three
April to June 14	15	1865	167	08.9
July to Sept 14	14	2185	402	18.4
Oct to Dec 14	15	2501	426	17.0
Jan to March 15	14	2519	320	12.7

The average reported prevalence of ARI among children under three years of age was 14.3 percent. Children that were suffering from ARI episodes were referred and treated.

## 5. Beneficiary information

	Women		Men	
	Beneficiary Number	%	Beneficiary Number	%
<b>Dalit</b>	3791	44.0	4107	44.0
<b>Tribal</b>	560	06.5	607	06.5
<b>Muslims</b>	732	08.5	739	08.5
<b>Others<sup>1</sup></b>	3532	41.0	3826	41.0
<b>Total</b>	8616		9334	

<sup>1</sup> **Others:** Includes all other social groups besides tribals, dalits and muslims such as General, OBCs, etc

## **6. Lessons learned**

- Primary level care at the household and slum levels, which is constituted by monthly health needs assessment, morbidity surveillance, inter-personal communication and counseling is the most crucial element of urban health care. It effectively links the community with health care services at all levels and ensures that individuals are not denied their guarantees and entitlements. These are the processes, systems and protocols that need to be advocated under NUHM.
- There is evidence that the five components of the proposed strategy, for health of the urban poor, have the potential for universal coverage with RCH services. However the 5 interventions need to be separately evaluated to study the efficacy of the interventions as well as a process evaluation to understand pathways to bringing about change.
- Advocacy initiatives for mobilising support from the corporate sector under CSR can yield desirable results. The advocacy mechanism and content is very different from that required with Government policy makers and implementers. IHMP proposes to establish a model Public Private Partnership (PPP) programme that can be used as a demonstration for motivating other corporate bodies.
- On basis of its experience with the Pune Municipal Corporation, IHMP plans to respond to the call for feedback toward the National Health Policy.
- Two types of advocacy initiatives are required for bringing about a change in the formal health system. Some Civil Society Organisations (CSOs) need to undertake the role of activists to highlight gaps and deficiencies in the formal health system. This activist action often results in effective policy formulation and budgetary allocations.
- However, more often than not, the gap lies in the efficacious implementation of these policies by the State and local bodies. For fulfilling this gap between policy formulation and policy implementation a second set of CSOs need to demonstrate alternative processes, systems and strategies (often referred to as innovations) to the Government so that effective implementation is made possible. IHMP has traditionally taken on the role of an innovator and demonstrated alternative systems.
- Since IHMP was on the task force which undertook policy formulation for NUHM the Institute was successful in getting these innovations included in the policy document.
- Government officials are open to change if irrefutable evidence of the efficacy of innovations is provided to them.

- In the project supported by Oxfam the Institute has been successful in not merely demonstrating innovative interventions but also in advocating their adoption by the Pune Municipal Corporation. Now that NUHM is being rolled out the Pune Municipal Corporation is approaching IHMP to operationalise the said innovations in the slums of Pune city.

- Advocacy is required not merely for changing the functioning of the formal health infra-structure but also for influencing other key stakeholders. An estimated Rs.18,000 Crores are expected to be mobilised under CSR, as a result of the recent government bill. IHMP felt that this was a great opportunity to establish effective PPP engagements between NGOs, corporate sector and Government. The Oxfam supported project has initiated this exciting PPP journey for IHMP.

A

### **Case study I: Early detection of reproductive morbidity and effective referral**

Sidharath Nagar is one of the 18 slums under the urban health project, situated on Nagar road. Savita Jagtap is the community Health worker trained by Institute of Health Management, Pachod for providing outreach services in the Sidharath Nagar slum, Nagar road. She visits all the households in her slum once a month.

Anita (name changed) is a 42 years old sterilized woman residing in the slum. CHW regularly visits her and enquires about problems related to reproductive health. In spite of the fact that she is suffering from red discharge per vagina, she didn't share this information with the CHW during her home visits.

After few months, when Anita learned about reproductive health problems during group meetings and when she felt comfortable to speak with the CHW, she told her about the red discharge and irregular menstruation, which she is suffering from last two months.

The CHW referred Anita to the Ob & Gynae clinic conducted by IHMP at the PUHC. The gynaecologist at the PUHC examined her and referred her to the tertiary care hospital for further treatment. She visited the tertiary care hospital, where she underwent internal examination and was called for further examinations. The ANM and CHW counselled her regarding the importance of taking treatment for the disease following which she utilized the services at the tertiary care hospital for further investigations and treatment. After laboratory investigations, she was advised hysterectomy operation. Anita has undergone the operation, and she was told that it reduced the risk of cervical cancer.

## **Case study II: Pune Municipal Corporations “Shahari Garib Yojana”**

Yamuna Nagar is one of the slums under the jurisdiction of the Urban Health Project. It consists of 450 households with a total population of 2500. In the last few months, IHMP has initiated a project in the Yamuna Nagar slum to disseminate information concerning Non-Communicable Diseases (NCDs) and to conduct screening for NCDs.

Babu Shelar is a 46 year old resident of the Yamuna Nagar slum. He lives with his wife and two children. The following account was narrated to a Community Health Worker. Soon after an episode where Babu's son suddenly felt dizzy and fainted, Babu reported that his blood pressure rose and the left side began to tingle. As he worked to collect sufficient funds for a hospital visit, a significant period of time passed and he eventually reported losing all sensation in his left side. Babu was finally admitted to the Sahyadri Hospital where he was treated for paralysis on his left side. The cost of the treatment was 3 lakhs. Babu was forced to repay this amount by borrowing from his relatives and friends since he had no health insurance at the time.

When he was finally discharged, he was no longer able to work. Even after returning home, he still needed 3000 to 4000 rupees a month for his medication, and all of these financial responsibilities rested on his son. Finally, SHDC and IHMP staff members counselled Babu to avail of the PMC Shahri Garib Yojana (SGY) scheme. The SHDC & IHMP staff supported him to collect the paperwork required to apply for the scheme, and he ultimately received a membership card. Babu is now able to use his card at the Kamala Nehru Hospital of PMC to receive the medical services and resources that he needs free of cost.

PMC's SGY scheme was of great assistance to Babu. Like him, many slum dwellers are not making use of this scheme. One of the SHDC's initiatives is to generate demand for this scheme and to increase enrolment. It has the potential to significantly reduce out of pocket expenditure and improve the health seeking behaviour of slum community residents.

### **Challenges:**

- The greatest challenge has been the attrition of community health workers. The socio economic condition of slum dwellers and the job opportunities available to them have changed. As a result very few agree to work as CHWs on a long term basis.
- Attrition of the supervisory staff
- Inability to make commitments to Pune Municipal Corporation
- Slow roll out of NUHM due to change in Government

## 7. Monitoring and Evaluation

IHMP has a well established surveillance and monitoring system, including a Management Information System (MIS). Quantitative data presented to Oxfam on a quarterly basis is an outcome of this evolved MIS. In addition to the routine monitoring of the project, IHMP has endeavoured to evaluate some of the key innovations such as monthly surveillance of health needs, interpersonal communication specific to the needs of the individuals and households. The emphasis on process evaluation is to enable us to share these processes with other NGOs and the Government.

In addition to the routine monitoring undertaken by IHMP, three research studies were carried out during the reporting period to strengthen the processes.

### **Study I: Community based research to detect prevalence of diabetes and hypertension among urban poor population in the slums of Pune city**

Research to study the prevalence of diabetes and hypertension and risk factors associated with the NCDs among urban poor population residing in the slums was carried out in the reporting period. The objectives of the research are:

- To study the prevalence of diabetes and hypertension among urban poor population in the age group 15-65 living in the slums of Pune city
- To study the risk factors associated with the prevalence of diabetes and hypertension
- To study levels of knowledge and awareness regarding the symptoms of diabetes and hypertension
- To formulate an outreach strategy for prevention, care and support for NCDs
- To pre-test, design and develop protocols, systems and communication materials for the control of NCDs in urban slums

927 individuals were interviewed under the study, interviews were held in the last financial year. In the reporting year, data checking, data cleaning, data analysis was carried out. Following are the key results from the data analysis;

- A total of 927 individuals of age 15 and more with 385 males (41.5%) and 542 females (58.5%) from Yamuna Nagar slum, Nagar road Pune were interviewed. The mean reported age of the respondents was around 32.6 years.
- About two out three (64.4%) of the respondents were currently married, 26.7 percent were never married, and 8.8 percent widowed, divorced or separated.
- **Tobacco use:** 46.6 percent of respondents were either smoking or using smokeless tobacco whereas 3.9 percent of the respondents were using both



forms of tobacco, i.e. smoking and also smokeless tobacco. The mean age of initiation of smoking among the respondents was found to be 18.4 years.

- **Alcohol consumption:** About 14 percent of the respondents have consumed alcohol in past 30 days and 17.4 percent consumed in past 12 months. The mean age of initiation of alcohol consumption was found to be 22.5 years.
- **Fruits and Vegetables consumption:** A vast majority of the respondents (>than 95%) reported that they had less than three servings of fruits and vegetables per day on those days when they consumed it.
- **Physical activity:** 17.8 percent (17.4% for men and 18.1% for women) of the respondents were not meeting WHO recommendation on physical activity (total Physical Activity MET minutes per week is < 600).
- **Hypertension:** a little less than half of the respondents (47.4%) had never been checked for hypertension.
- **Prevalence of hypertension:** Prevalence of stage I hypertension is found to be 23.8%; and prevalence of stage II hypertension is found to be 14.6%.
- **Risk factors associated with prevalence of stage II hypertension:** Prevalence of stage II hypertension was found to be high among;
  - Individuals with age 55 and above
  - Individuals that are illiterate
  - Individuals who are engaged in service
  - Current daily users of tobacco
  - Individuals who consumed alcohol in the past 30 days
  - Individuals with BMI  $\geq 30.0 \text{ Kg/m}^2$
- **Prevalence of diabetes:** The prevalence of any type of diabetes is found to be 8.4 percent. No significant difference in prevalence of diabetes is found between men and women.
- **Risk factors associated with prevalence of diabetes:** Prevalence of diabetes was found to be high among;
  - Individuals with age 55 and above
  - Individuals that are illiterate
  - Individuals with BMI  $\geq 25.0 \text{ Kg/m}^2$
  - Among those who have IDRS score medium or high

### **Study 2: End-line survey:**

An end-line study to evaluate impact of IHMP interventions on output and outcome indicators was carried out in the month of March 2015. A detailed protocol was prepared for the end-line survey. A structured interview schedule was designed and pre-tested to

collect information from ever married women 15-45 years of age. After the end-line questionnaire was pre-tested and finalized, a guide for administering the questionnaire was prepared for the investigators. A Pune based NGO was appointed for data collection. Investigators appointed by the NGO were trained for 4 days at IHMP, Pune Centre from 10<sup>th</sup> to 13<sup>th</sup> March, 2015. Investigators were trained in the skills of interviewing, how to conduct oneself in the field and how to fill questionnaires. Explanation was also given about each question in the questionnaire. The main emphasis of the training was to impart practical skills for interviewing and filling the questionnaires. This was done with the help of dummy interviews, role plays and actual interviews in a slum not included in the Project.

After ensuring that each investigator could conduct interview and fill the questionnaires satisfactorily, the actual end-line data collection was initiated by the external agency on 14<sup>th</sup> March 2015. A team of six investigators, two supervisors, and one researcher for quality control was appointed by the external agency. In addition to this IHMP had appointed a senior research investigator for the data quality assurance.

#### **End-line Survey - Data Collection:**

The end-line data collection was completed on 27<sup>th</sup> March 2015. Out of 400 sampled women of age 15-44 years, a total of 379 women of age 15-44 years, from 15 CHW areas were interviewed, of them 208 women have a child under three years of age, and 171 women aged 15-44 were interviewed.

### **8. Financial Progress**

The financial report and utilisation certificate have been sent. Over 90 percent of the approved budget was utilised. The under expenditure was primarily because of attrition of CHWs, SHDC members and a few staff. This led to a request for reallocation of resources. Once the reallocation was approved there was no variance of over 10 percent for any line item.

### **9. Accountability**

Accountability to civil society through Slum Health and Development Committees (SHDCs) is a specific objective of this project. Every month CHWs report the needs assessed in the community and ANMs report the needs addressed / services provided through outreach and at the PUHC. This comparison undertaken by Slum Health and Development Committees forms the basis for community based monitoring by SHDCs.

## **10. Feedback**

Feedback is sought through community level meetings and on a routine basis

AGRT - IHMP has a long history of association with Oxfam since 1978. It has the project number MAH -1 in the archives of Oxfam GB. IHMP has an excellent relationship with Oxfam to this day.

## **11. Conclusion / General Comments**

IHMP has been successful in providing adequate evidence regarding the efficacy of key innovations, such as monthly surveillance, micro-planning, outreach, needs specific BCC and community based monitoring to improve access and utilization of primary health services by the urban poor living in slums.

There is sufficient evidence to indicate that decentralized Obstetric and Gynecological services through a (per clinic) out-sourcing strategy at the primary level significantly increases the utilization of emergency obstetric care (EMOC) and treatment of RTIs and STIs.

There are services and entitlements that have been provided by the Municipal Corporations and State Governments. The poorest for whom these entitlements have been put in place are not aware of their existence nor do they make any attempt to access them. Empowering civil society for generating demand for services and ensuring accountability of health providers and facilities has ensured that the poorest in the community are assured of these services and entitlements. However, since IHMP was not able to federate the slum health committees up to the level of the Municipal Corporation the change was limited to its project area.

Capacity building of CHWs/ ANMs for effective implementation of the 6 IHMP innovations was achieved through hand-holding and mentoring in the field.

Establishing primary level care and effective outreach was the first step to developing linkages for providing secondary and tertiary level health care services. Collaboration with the tertiary level health care institutions was achieved by frequent meetings and orientations and physically linking frontline workers with the secondary and tertiary care centres.

The outcome of the 6 innovations has been an increase in utilization of maternal and neonatal care services by the community, increase in treatment seeking for reproductive health problems, increase in contraceptive use, increase in the coverage of children with complete primary immunization, early detection and treatment for communicable and non-communicable diseases such as diabetes and hypertension

## **Integrated reproductive and sexual health and family planning project for young married women in urban slums of Pune City**

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### **Activity Report – October 2014 to March 2015**

#### **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 and sexual health project to empower unmarried adolescent girls of age 11-19 years and protect married adolescent girls and young married women of age  $\leq 24$  years from the adverse consequences of early motherhood. The project is being implemented in one Primary Urban Health Centre (PUHC) sanctioned by the Pune Municipal Corporation from 01<sup>st</sup> October 2014.

List of activities undertaken by IHMP for the **Integrated reproductive and sexual health and family planning project for young married women in urban slums**, supported by Yardi Software India, during the financial year 2014-15:

- a. Recruitment of project staff
- b. Community mobilization
- c. House listing, mapping and census
- d. Baseline survey in study area
- e. Selection of Community Health Worker (CHW)
- f. Capacity building of the project staff

#### **a. Recruitment of project staff:**

Various posts for this project were advertised in local newspapers and Devnetjobs in October 2014. About 75 applications were received. After short-listing, the selected candidates were invited for a personal interview. A selection committee was established, criteria for selection were finalised and suitable candidates were selected in the month of October 2014.

Two field coordinators joined their duties in the month of November 2014, and one field coordinator joined in the month of December 2014. A contractual agreement of one year duration is being signed for each appointee.

#### **b. Community mobilization:**

To create conducive environment following community mobilization activities were carried out by the project staff in the first quarter of the project.

1. **Visit to the project area:** IHMP team visited 8 slums in the month of October 2014, and two slums in the month of November 2014 under the project area. During the slum visits the following information was collected:

- Boundaries of the slums
- Community groups and other NGOs working in the slum
- Distance of slum from the PUHC

2. **Meetings with key stakeholders:** In the reporting period, ten visits to the project slums were planned and carried out to orient the community about the project and create an enabling environment. During these visits the IHMP team had discussions with following key stakeholders from the slums:

- Pune Municipal corporator, ward no. 43, Hadpsar, Pune
- Office bearers of the youth mandals, women group's, etc. – Twenty
- Key persons from the slums – Seventy
- ICDS, Anganwadi workers – Seven

Following topics/issues were discussed with the key stakeholders:

- Objectives and broad strategy of the program
- Oral consent to start the program and research activities in the slums
- Information on house-listing and census activity to be conducted in the slums

3. **Community meetings:** In November and December 2014, 14 community meetings were planned and carried out in 10 project slums to create an enabling environment. A total of 429 (average 30 individuals per meeting) individuals attended the meetings. Following topics were discussed during the meetings:

- Needs of unmarried girls and young married women
- Broad objectives of the program
- Planned interventions/activities for unmarried girls and young married women
- Participation of the community in planning and implementation of the program
- Oral consent to start the program and research activities in the slums
- House-listing, numbering and census activity to be conducted in the slums

4. **Pamphlet distribution:** A pamphlet consisting of a brief description of the Sexual & Reproductive Health and Family Planning project was designed and printed in the month of October 2014. Pamphlets were distributed during the house numbering, listing and at community meetings. Around 5000 pamphlets were distributed in all 10 project slums.

### **c. House listing, mapping and census:**

In the month of November 2014, three investigators with sufficient previous experience were recruited for the purpose of mapping, house numbering, census and listing of target populations. A one day training program for the project staff and three investigators was organized on 11<sup>th</sup> November 2014 at IHMP Pune. Cognitive and practical skills regarding house numbering, mapping and listing of target populations were provided during the training.

House numbering, listing and mapping was initiated in the month of November 2014. During the house listing operation each house has been numbered. The numbers were written on the doors of each house. A map of each slum was prepared on which important land marks of the slum along with roads, lanes and numbered houses were shown. A total of 5647 structures were numbered in the 10 slums.

**Listing of target population:** After the house numbering and mapping, listing of households and target population was carried out by trained external investigators. Pre-tested formats were used for listing the target population. House numbering, listing and data collection was initiated on 12<sup>th</sup> November 2014 and completed on 22<sup>nd</sup> December 2014.

A total of 5647 structures were numbered, of these 491 were found to be empty, and 97 were occupied by shops, temples, AWW centres, etc. A total of 5059 households were listed, out of these 4846 were covered (95.7%) under the listing of population and target groups. A total of 20,301 individuals were listed from these households.

- A total of 1469 unmarried girls of age 11-19 years (7.2% of total population) were identified in 4846 households. Of all the unmarried adolescent girls, 796 were found to be in the age group 11-14 years, and 673 were 15-19 years of age. A total of 420 girls (28.6%) in the age group 11-19 were found to be out of school. The proportion of non school going girls was significantly higher in the age group 15-19 (48.3%) as compared to the girls in the age group 11-14 years of age (11.9%) ( $p=0.000$ ).
- A total of 1235 young married women (6.1% of the total population) in the age group  $\leq 24$  years were listed from all the project slums. A total of 183 married adolescent girls were listed from 4846 households.

**Table: Summary of house listing, numbering and census of target population**

Sr.	Indicator	Actual	Percentage	
			Actual	Expected
1.	Number of slums to be mapped, numbered	10	100%	100%
1.	Number of households numbered and covered under census	4846	95.2%	80-100%
2.	Total population enumerated	20301	Average 4.18 persons per family	Average 4 to 4.9
3.	Number of unmarried adolescent girls of age 11-19 years listed out	1469	7.2% of total population	7-9 % of total population
4.	Number of young married women of age <=24 years listed out	1235	6.1% of total population	6% of total population

**House numbering and mapping in the control area:** In March 2015, control area for the project was decided. A total of 11 slums from ward 90, Ramtekdi were selected for the control area for the project. House numbering has been carried out in March 2015. During this operation each house has been numbered. The numbers were written on the doors of each house. House numbering and sketch mapping was carried out for all 11 slums under the control area. A total of 4,491 structures were numbered in the 11 slums.

#### **d. Baseline survey in study area:**

The broad objective of the baseline study is to obtain information on the prevalence and predictors of certain parameters for project area. The baseline information will be used for management and evaluation of the intervention, and to find out the unexplored research areas.

**Data collection:** A team of 10 external female investigators and 4 supervisors were selected and appointed for the data collection work. A five days training for research team was conducted at IHMP Pune centre before actual data collection.

Baseline data collection for unmarried adolescent girls was carried out from 16<sup>th</sup> to 26<sup>th</sup> January 2015. A total of 350 interviews of unmarried adolescent girls were conducted.

Baseline data collection for young married women was carried out from 5<sup>th</sup> to 19<sup>th</sup> February 2015. A total of 327 interviews of young married women of age <=24 years were conducted. Out of 327 young married women interviewed, 159 were married adolescent girls of age <=19 years and 168 were young married women of age 20-24 years.

During data collection at the slum level, supervisor observed at least one interview of each investigator every day. At IHMP Pune, office the filled-in questionnaires was 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 350 filled questionnaires for unmarried adolescent girls and 327 filled questionnaires for young married women is completed

**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 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 slums were married before the legal age of 18 years. Utilisation of Sexual & Reproductive Health services is poor and dependent mostly on the private sector. A negligible number reported utilisation of Pune Municipal Corporation health services. A 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:

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

#### **e. Selection of Community Health Worker (CHW):**

Community mobilization activities for getting the nominations for CHWs were planned and carried out during January to March 2015. Following activities have been carried out during the reporting period:

- Using the maps and census information, project area has been divided into 12 clusters each having an average of 400 households. In each cluster one CHW will be appointed.
- In each CHW area, 2 meetings were planned and organized. In the first meeting IHMP staff describe the process of getting nominations for CHW, roles and responsibilities of the CHW, and background required for CHW. In the second meeting IHMP staff received the nominations for CHWs from the community.



- **First mobilization meetings/contacts – orientation about project, CHWs roles and responsibilities:** In all 12 CHW areas, a total of 26 meetings and contacts were planned and carried out. A total of 464 individuals (Male - 148, Female - 316) were contacted during this exposure
- **Second meetings/contacts for receiving nominations for CHWs from community:** After conduction of first meeting, in each CHW area, a second meeting was planned and carried out. These meetings were carried out after 7 days of the first meeting in the respective CHW area. A total of 51 corner meetings were carried out and 1067 individuals (male – 190, women – 867) attended the meetings.
- **Nominations received for CHWs:** During the second contact/meeting with the community, nominations for CHWs and slum health and development committees were received. A total of 58 nominations for CHWs' post from 12 CHW areas were received.

#### **f. Capacity building of the project staff:**

For the capacity building of staff appointed by IHMP, an exposure visit to NGOs based in Mumbai and Pune was organized in the month of February 2015. Field coordinators participated in the exposure visit. IHMP staff visited Samyak Pune, SNEHA Mumbai, VACHA Mumbai, and NAZ foundation Mumbai. The objective of the exposure visit was to understand interventions implemented by other NGOs to address issues regarding gender equality, age at marriage and domestic violence. During the exposure visit the following functions and processes were observed;

- Design of interventions for unmarried adolescent girls and young married women
- Strategies used by NGOs to implement life skills education
- Strategies and process used by NGOs for community mobilization
- Interventions to address gender equality and violence against women
- How to involve men to address issues regarding age at marriage and violence
- Use of mobile technology for community needs assessment and monitoring
- Cognitive skills – gender, patriarchy and masculinity

#### **Challenges:**

Several challenges were faced during community mobilisation, primarily obstruction by local politicians and slum lords. It required patient and diplomatic negotiations to overcome these problems. However, once these problems were resolved the community response has been amazing, as reflected by the enthusiastic nominations by the community for the post of Community Health Workers.

Getting trained investigators and staff for the preparatory phase was a challenge and could be overcome only through meticulous in house training.

## **Training Report**

### **Training Course Conducted During the Period - April 2014 to March 2015**

The Institute of Health Management Pachod (IHMP) has been conducting health management courses for the field coordinators and program managers from voluntary sector as well as from the government since 1987.

EFICOR, Satana, Madhya Pradesh had approached IHMP to conduct a training for grassroots workers of the Satna team on maternal, child health, social mapping and Behaviour Change Communication (BCC). A 10-day course was designed to cover the learning objectives sent by the EFICOR and was conducted in Hindi from 16<sup>th</sup> to 26<sup>th</sup> September 2014.

Fifteen participants attended the course. Teaching methods used were lecture - discussions, group work, group exercises, field visits and presentations.

#### **Course Evaluation:**

Participants evaluated the course on the basis of content, facilitation & presentation by faculty and rating against the expectation listed by them on the first day.

#### **Rating Against Expectation:**

A total of 21 expectations were listed by the participants regarding topics/issues, which they wanted to be covered in the course. At the end of the course, 91 percent of the participants rated that the training had fulfilled their all expectations.

#### **Content Evaluation:**

82 percent of the participants expressed high level of satisfaction for the course content.

#### **Faculty Evaluation:**

Eleven IHMP faculty members were involved in the training, most of the participants rated the presentation and facilitation by faculty members as “excellent”.

#### **Feedback from the participants:**

Most of the participants liked the session on male & female reproductive system, first aid, social mapping, how to conduct BCC group meeting and National Rural Health Mission.