Promoting, Safe Behaviours, Sexual and Reproductive Health and Gender Equal Attitudes in Young Married Couples in Maharashtra

Report of the Evaluation conducted by Abrar Khan, UNFPA
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1. Profile of Implementing Agencies

Ashish Gram Rachna Trust established the Institute of Health Management at Pachod (IHMP) for implementing programs of health and development in rural areas and urban slums of Maharashtra. Few activities now extend to other states including Gujrat, Madhya Pradesh, Chattisgarh and Goa. IHMP's approach to programs is characterized by the importance it gives to intervention research, innovation, testing of pilots, large scale program implementation, training, policy advocacy combined with efforts put into organizing and mobilizing communities toward self-reliance and sustainability.

Primary health care is a major program with its focus on generating demand for quality health services for women and children IHMP has specialized in the provision of obstetric care through TBAs. Services at the government Sub-centers and PHC are strengthened by IHMP by providing additional services for women's health, gynaecological morbidity, STD/HIV prevention, neonatal care areas usually underserved. Experiments in work with adolescents were initiated in early nineties and IHMP has developed a life skills education curriculum for out of school adolescent girls. Over the course of one year information and skills are offered through well structured sessions covering issues like food and nutrition, anaemia prevention, improvement of the reproductive health and sexuality education. Work has also been initiated with married young men and women, in past, needs assessment studies on reproductive health morbidity and a qualitative study on high risk behaviours in men had been carried out. UNFPA youth friendly services pilot project has been planned on the basis of this information to focus on young married men, their sexuality and health risks in rural settings.

2. Setting and Context

Project activities were implemented in a cluster of 28 villages falling under the Vihamandwa PHC area of Paithan Block, covering an approximate population of 32,000 including 700 young married couples. Mostly small and marginal farmers or agricultural laborers some run small businesses and shops or pursue other occupations for making a living. About 23% of men in 15-24 age range are married and almost 75% reported being sexually active. The median age of young married men is 23 years and majority of them are sexually active. Almost half of the married adolescent girls completed middle school education with their husbands usually having educational levels of class 8^{th} or more. Mean age at marriage for girls is 15.9 years with husbands generally 4 years older. Mean age at first conception has been 16.3 years. High incidence of RH morbidity was observed in girls with 82.1% reporting problems during delivery, 64.5 % menstrual problems and 49% reporting symptoms of UTI/RTI/STI. While awareness of HIV/AIDS

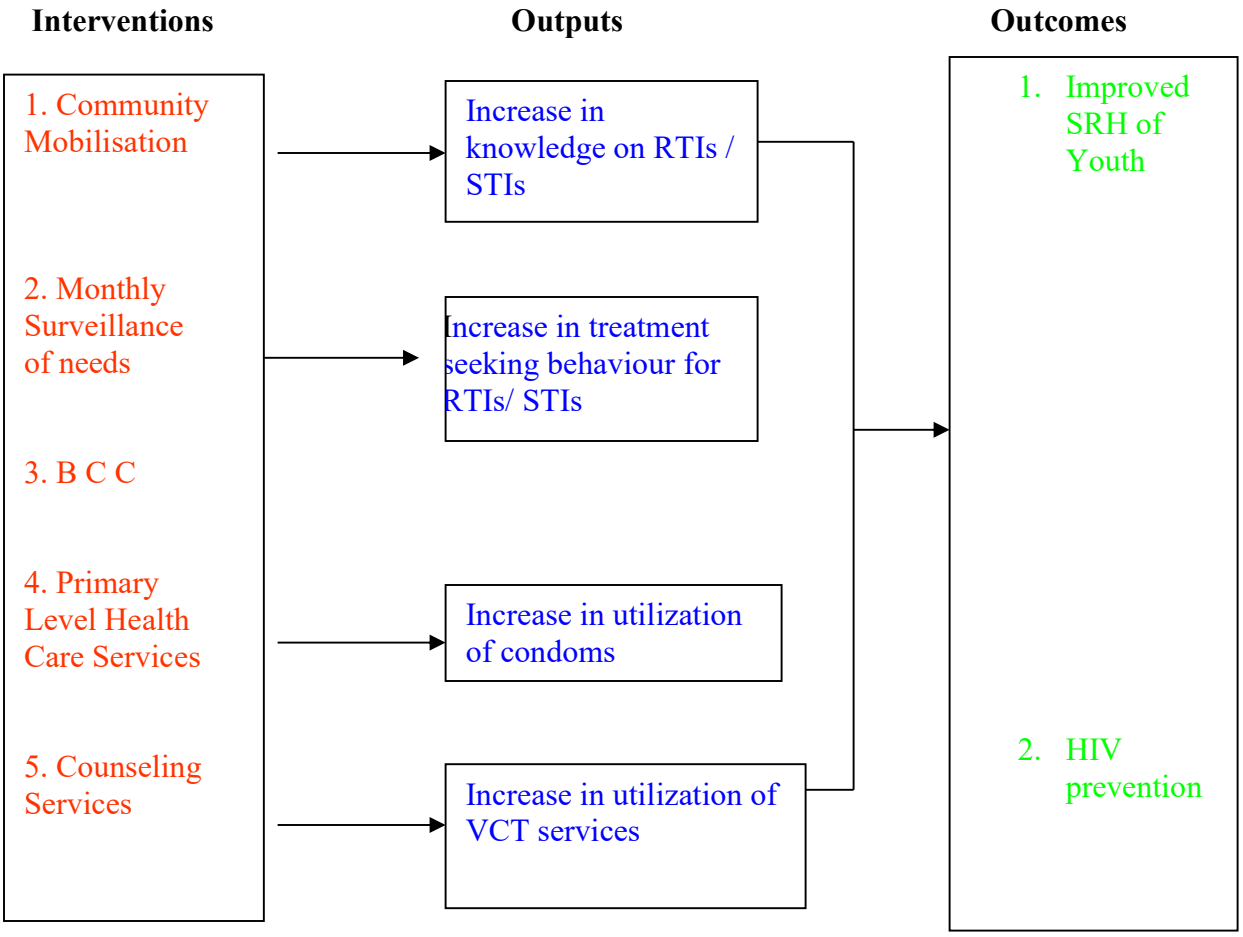
was there widespread misconceptions were found around modes of transmission that could possibly contribute to stigma and discrimination. Only 4% of married adolescent girls reported current usage of condoms by their husbands. Even though 89% husbands new of condoms only 21% reported using them currently. About 10% young men reported symptoms of STI and an equal number reported symptoms of UTI. Misconceptions related to sexuality abound.

3. Strategies

- Community Mobilization
    - Establishment of Village Health Development Committees (VDCs)
    - Selection and training of community health volunteers (CHVs)
    - Selection and training of peer couples SATHI Couples)
    - Selection and training of youth as depot holders
- **Monthly Surveillance (micro planning)**
    - Maternal health – menstrual, pregnancy
    - Reproductive health needs
    - Behaviour tracking
- **Behaviour Change Communication**
    - Interpersonal communication (IPC) through CHVs
    - Group meetings – field staff/ CHVs/ Peer couples
    - Couple workshops
    - Print media –pamphlets, calendar, newsletters etc.
    - Information centres (SATHI Kendra)
- **Primary Level Health Care Services**
    - Maternal health services
    - Clinical services for RTI/STIs
    - Sexual health services
    - VCTC
- **Counseling Services:**
    - Household level
    - Clinic & VCTC
- Referral services
    - From village level to FRUs
    - From FRUs to Medical college (MGIM) Aurangabad

4. Youth friendly Services Model

Conceptual Framework



The conceptual framework forms the basis of IHMP intervention model and can be characterized by its following distinctive features.

4.1 Village Development Committee (VDC)

Considered to be the focal point in this model the VDC is a local committee having 7-13 members consisting of elected Panchayat members, other opinion leaders, and women from community. It serves the dual purpose of providing social approval and support to the idea of youth friendly SRH services for adolescents/young people and at the same time it plans manages and controls activities of the project in the village. In all 21 VDCs have been initiated and are involved in the running of the project, IHMP has a formal MOU with the VDCs who select, appoint, track work performance and make payments to the village based Community workers(CW). Community Health Volunteers (CHVs)

Further more VDC workers also monitor the work of other local functionaries like AWWs and ANMs.

Change CW to CHV in the entire document.

4.2 Monthly Surveillance of Needs and Services

IHMP has for some years worked on evolving a comprehensive system of collecting information on needs and tracking utilization of services in the communities. This system was adapted for use in the project where each married adolescent couple in the village is identified and registered, is visited by the community worker each month and need for SRH service identified, referral for service is made, if the service was utilized and referral was effective is checked back and follow up is carried out as needed. Record is maintained in a register including a separate sheet for each family and information is cross checked by supervisors. Information from this surveillance system is shared every month at the meeting of the VDC. This is a very transparent and participatory process of micro-planning and reviewing performance at the village level. Information from this fits directly into the project MIS and reporting system.

4.3 Behaviour Change Communication (BCC)

A well designed and comprehensive behaviour change communication strategy is another key feature of this model. Aiming to create healthy social norms related to maternal health, sexual health, gender and sexuality a system for behaviour tracking has been introduced to determine BCC needs at the individual, household, group and community level. Well planned and properly executed BCC activities are carried out at individual level through IPC, at group level through group meetings and specialized workshops and at community level through events, poster displays and distribution of pamphlets, newsletters and print material in the local dialect.

A designated ‘Sathi Couple’ married adolescent/young man and his wife, both volunteers, is at the forefront of BCC activity in their village. They have received training, are provided with a ‘BCC kit’ and ‘Question box’ and manage a ‘Sathi kendra’ from a room in their house holding weekly sessions for men and women separately providing SRH information, referrals for services and supplies of condoms on request. 30 Sathi Couples’ function as peer educators and the ‘Sathi kendra’ functions as a youth information centre. In addition for unmarried girls community workers organize life skills education sessions.

There are several inputs described in this paragraph. We feel that a small description of the information centres, and the question box would be appropriate.

We recommend a separate para describing the Life skills education of unmarried girls by CHVs.

4.4 Primary Level Reproductive Health Care Services

Unique to this model is the collaboration with the government health system for strengthening maternal health, RTI/STI and HIV/AIDS counseling and testing services targeting young people. A formal arrangement has been made with State Aids Control Society (MSACS) and Health Department for making the Vihamandwa PHC as a VCTC at the tertiary level. Once a month clinics are supported by doctors from Aurangabad Medical College while IHMP through the project provides services of counselors and lab technicians who have completed the training required by SACS. IHMP also arranges through its team of ANMs, doctors and counselors for organizing once a month ANC clinics and separate RTI/STI clinics for women and men at the 6 sub-centers catering mainly to young people. A group of 30 tailors and shopkeepers in the area have been enrolled to function as depot holders for distribution of free condoms.

4.5. Referral to Secondary and tertiary care centres. Patients needing referral are referred to GMCH, MGIM, Govt. Hospital Paithan, Rural Hospital Pachod.

5. Staffing and Structure

- Position: Coordinator (1)

  Profile: Fulltime position held by a senior staff member at IHMP with a Masters in Social Work. Overall in charge of the project and responsible for planning, managing implementation with the project team, monitoring and reporting of project activities including coordination with UNFPA.

- Position: Supervisors 4 (2 Male and 2 Female)

  Profile: Full-time position holding Masters degree in Social work or other Social Sciences with responsibilities for organizing meetings and BCC activities along with CWs and Sathi Couples. Maintaining liaison with VDC members and reviewing monthly surveillance data provided by the CWs.

- Doctors (2) 1 Male and 1 Female

  Profile: Part-time positions linked to number of clinics conducted in a month. Run monthly RTI/STI clinics for young women and men. Work jointly with counselors and lab technicians.

- ANMs (2)

  Profile: Full-time positions holding a Diploma in Nursing (Auxiliary Nurse and Midwifery training) and responsible for managing ANC clinics at the 6 sub-centers. In addition provide health education during group meetings. These ANMs also conduct ANC clinics at the village level.

- Community Workers (29) Community Health Volunteers

  Profile: Married young woman from the village selected by the VDC, usually educated till class 8th and responsible for mapping young married couples and unmarried girls' areas. Complete surveillance records through home visits, accompany clients to sub-centre and generally ensure referrals, provide SRH information and counseling, distribute condoms to women and conduct LSE classes with unmarried adolescent girls. Usually work two shifts of few hours each day with follow up and referral work in morning and LSE sessions in afternoon (evening). Receive a small stipend through VDC and provided by the project. Written consent is taken from family for their agreement to undertaking SRH work.

- Sathi Couples (30) Volunteers

  Profile: Young married woman and her husband selected by the VDC to provide SRH information to other married women and men and unmarried girls and boys. (They provide info only to unmarried boys). Organize a Sathi Kendra at a room in their house for a few hours one day a week where books, pamphlets and posters on SRH topics are displayed and distributed. Written consent is taken from family for their agreement to undertaking SRH work.

- Depot Holders (30) Volunteers

  Profile: Residents of village with a tailor shop or a small provision shop willing to stock and distribute free condoms on request.

  IHMP supported services of 2 Lab Technicians provide laboratory testing support during the monthly STI clinics at the sub-centers and at the VCTC at the PHC. Services of 2 counselors are also available through IHMP for providing counseling support during the STI clinics and at the VCTC.

6. Project Implementation Process

6.1 Design and Development Stage: Call for submitting a proposal was received in June 2005 2004 and a proposal was submitted for UNFPA approval in June 2004, after a long period of negotiation (Gap of one year) a revised proposal and budget was requested by UNFPA in May 2005. quite a substantive and ambitious agenda was taken up in July 2005 that included full spectrum of activities including, reproductive health, sexual health, HIV/AIDS prevention, voluntary counseling and testing for HIV for married and unmarried adolescents in 12-24 age group in July 2005 . As the idea around the project approach evolved elements of peer educator involvement, setting up of youth information

centers, clinics for availing services and life skills education were added to the program mix.

6.2 Establishing Village Development Committees (VDC): Consultations were held with Gram Panchayats and others holding influence in the area regarding need and importance of SRH information and services for young people. Data collected during earlier studies was used to win over their support. The village was included only if such support was forthcoming from the community leaders. This committee was accountable to the people as well as the Gram Panchayat and consisted of 7-13 members represented by elected representatives of panchayat, women and others wielding influence in the community. One day orientation is provided to 162 members of the 21 VDCs and a formal MOU is signed with IHMP. VDCs select and appoint a community worker in their area and also nominate the 'sathi couple' using criteria of which one is written consent from parents. VDCs have monthly meetings to review performance and work progress, as needed support is also offered by members in solving any problems in carrying out information and service activities with young people.

6.3 Mapping, Listing of Married Couples and Baseline Survey: Data available from census was updated and a complete listing/registration was carried out for all the married young people in the project area. Members of the VDC played an important role in this activity facilitating buy in and support of local residents. A uniform pre coded questionnaire was used to collect baseline information from a sample of 13-19 year old married girls and their husbands. Questions included, background characteristics, age at menarche, marriage and first conception, and reproductive history(number of conceptions, still births, abortions, current pregnancy, and , maternal health, reproductive morbidity including menstrual and gynecological problems RTI/UTI and STI, contraception and condom use, knowledge of HIV/AIDS including prevention and treatment and knowledge of testing. Questions on family violence were also included. Any new additions to the list of married adolescents' girls in the village are updated on a regular basis.

6.4 Monthly Surveillance System: Integrated with the listing/registration of all married adolescent girls in the project area is a micro-planning tool used by the community workers. A page in a register is assigned to each couple and they are given an identification code, during the home visits a set of questions relating to maternal health, sexual health and reproductive morbidity, contraceptive/condom use are collected. Based on identified need referrals are made to the government health centers or special clinics run by IHMP in the area. Service utilized from the clinics are compiled by ANMs and the entries are made in the same register, easily cross-checking all referrals that were effective. In case of any person who was referred and did not take the service a follow up visit is made. Supervisors carry out a meticulous verification process to ensure that entries in the register are correct and complete. On a monthly basis during VDC meetings information from the surveillance system is presented to the group, if needed their support is enlisted to persuade the person/s to avail the service. The system was developed by IHMP for their MacArthur program and adapted for use in the YFS initiative.

6.5 Behavior Change Communication: FGDs and baseline survey helped identify behaviors that needed to be targeted for change. Appropriate content and messages were developed on ANC/PNC, RTI, STI, HIV/AIDS and VCT, menstrual problems, sexuality and condom use. Content and messages were separated depending on their usage in either group meetings or during IPC, home visits or in couple workshops or workshops for young married men. In a planned way a topic is taken up and reinforced through all levels of interactions individual, group and community and consistently followed by all staff members. BCC in the project is used in a holistic and comprehensive way addressing, knowledge, attitudes and beliefs, behaviors and kills in all adding up to create new social norms and positive values. Individual perceptions of risk for HIV infection are explored during workshops with young men along with issues of stigma and discrimination. Information and referrals for services is tied up closely with BCC activities to increase use of SRH services at the sub-centre and PHC.

6.5.1 'Sathi Couple' and 'Sathi Kendra': Closely integrated in the total BCC approach are the 'Sathi Couples' a team of husband and wife volunteers in the age range of 18 to 24 years selected by the VDC to impart SRH information to other young men and women, After being recruited they receive training during a workshop and are provided with a 'Communication Kit' in a attractive bag that also serves as a brand logo for the 'Sathi couples.' The kit has materials in Marathi on issues related to RH, Child health, RTI, STI and HIV/AIDS, including books, booklets, pamphlets, flyers for distribution, posters pasted on a string line for putting on view conveniently. On one day in every week for one hour a 'Sathi kendra' is set up in a room of the couples house at separate time slots for young married/unmarried girls and boys (only unmarried boys). Books, posters and materials are put on display, individually and in small groups young people come to the centre and receive information, condoms are also available for free distribution. The Kendra also has a tin 'question box', where individuals can put in anonymous questions relating to sexual and reproductive health issues. The questions if appropriate are discussed during group meetings; others are addressed in a newsletter distributed periodically. Some questions are taken up for discussion by doctors during discussion sessions. Simple record of persons visiting and topics discussed are being maintained.

6.5.2 Life Skills Education: Community workers in each village organize groups of 10-15 unmarried adolescent girls for a year long life skills education course. The curriculum6 is designed by IHMP and consists of 3 modules with structured sessions following a participatory methodology. In the final round the groups participate in a 3 day residential workshop on sexuality and reproductive health at IHMP where sessions are facilitated by IHMP staff.

6.6 Primary Level Sexual and Reproductive Health Services: IHMP has set up ties with the government PHC and 6 sub-centers in the block for providing accessible clinical services. The sub-centre space is utilized by the project ANMs to organize maternal health clinics exclusively for young women and provide comprehensive ANC services inclusive of early registration, weight record, BP, urine test, TT shots, IFA and screening/referrals for any obstetric complications. Community workers escort women

from their villages and ensure timely follow up visits. Government ANMs from the area work closely and offer a helping hand.

6.6.1 Once every month the sub-centre is also the venue for specialized RTI/STI clinics held on two consecutive days for men and women.

Maternal health (MH) clinics are held at the village level. Subcentres are utilized only when the MH clinics are held in the SC villages.

Where ever possible joint MH clinics are held with the Govt. ANMS

A male/female doctor assisted by the lab-technician and counselor the run the clinics mostly following the syndromic approach for management of STI, though some basic tests are also carried out at times. Effort is taken to persuade clients to get their spouses to visit the clinic, hence the arrangement of the male/female clinics on the following day.
(An important aspect of the Primary level sexual and reproductive health services is that full time doctors have not been appointed for this project) They are contracted on a per clinic basis which is what makes this a cost effective intervention)

(Mention is required of the separate RTI STI clinics started for males). The clinics for males and the couple workshops are primarily the forum for addressing the sexual health problems in young men.

6.6.2 A unique accomplishment for the project is the initiation of a VCTC at the area PHC, after obtaining all formal approvals from the Government of Maharashtra and the State Aids Control Society. Lab-technicians and counselors have been provided training and protocols as per the state norms and male and female doctors from Aurangabad Medical College run the centre once every month. Referrals are made at the STI clinics and through the BCC activities at the community. (Needs clarification)

6.6.3 To facilitate promotion and easy availability of condoms each village has an identified depot holder who may be a local tailor or a grocery shop owner. They stock and distribute free condoms and have received orientation for providing information on correct and consistent use of condoms. Records of distribution and inventory for stocks/supply are also maintained by them. Their involvement is completely voluntary and is nurtured by a desire to be of service to their communities and peers.

7. Involvement of Young Persons

Providing a leading edge to the project and its activities are the Community Workers, Sathi Couples and depot holders mostly in 18-24 years age range, married and residents of the village, they are deeply committed to work and make a difference to the life of young persons in their communities. Well equipped with SRH information and communication skills they aspire to be positive role and reach out to their peers individually and in small groups, engaging almost all the young people in the village.

8. Advocacy and Networking:

IHMP, with its profile and strong leadership has managed to get formal approvals from the state health department for using the sub-centre and PHC facilities for providing SRH services under this project. State Aids Control Society has also provided the endorsement for the VCTC at the PHC level. With policy advocacy as a major program area for IHMP the organization is well positioned amongst NGOs and state officials and often uses findings of its intervention research to inform and influence policy dialogue and program direction.

9. Staff Training and Capacity Building

In the course of the project extensive inputs have been provided towards training and capacity building of community leaders, staff and volunteers. VDC members received 2 days of initial orientation, Community workers (CHV) received training spread over several phases covering primary health care, maternal health, RTI/STI, basic medicine kit, communication and interpersonal counseling(10 days). This was followed by a surveillance system and probe questions (2 days) training for tracking information. Specialized RTI/STI and HIV/AIDS (3 days) training was arranged for all field and project staff. In addition coordinators, supervisors, ANMs, counselors and lab technicians also received appropriate training (4 days) for HIV/AIDS counseling, testing, record keeping, care and support at HFPTC organized by state AIDS control society. Orientation and training was also arranged for Sathi couples and depot holders. Medical officers(2), ANMs(7) LHVs and male/female supervisors at the government health services in the area were provided one day of orientation.

10. Management Structure

VDC at the village level functions as the first level of management structure engaged in micro-planning and review of progress, members deliberate on the monthly surveillance reports presented by the community workers. Supervisors provide the second level support holding weekly reviews with the community workers. Once every month coordinator holds group meetings to consolidate all information and reports, in addition to periodic prescheduled visits and onsite meetings are also carried out. Other professional units at IHMP provide technical inputs as needed under the over all guidance of the director and assistant (associate) director.

11. Key Indicators and Results

(To be added)

12. Issues in Sustainability

The project through its current activities and IHMP,s work from past has generated a strong sense of community ownership with VDC members, Community Workers, Sathi

Couples, depot holders are all local residents of the villages generally volunteering their services. The system of micro-planning and monthly surveillance is in place and helps to bind together individual activities of all these players. It is unlikely that such a rigorous and human resource intensive mechanism would be able to last without funding support from an alternate source. Strong motivation is in place to carry forward the activities for community mobilization and providing SRH information to young persons, since they have the training and no additional resources are needed. However there is a great concern that the availability of SRH services at the sub-centre and PHC (primary) may be difficult to sustain after the project duration. The limitations of continuing with SRH information and awareness in the absence of an accessible services network are very well understood. The realization to seek proper medical care for RTI/STI and other sexual health services has just got a move and it is too early to expect young men and women to travel to a PHC to avail these services. With IHMP having long-term program interests, more systematic planning to consider what may be sustainable and how is under consideration. (Not in the UNFPA project area, where all project activities have come to an end on 31 December 2006) One possibility under review is a dialogue with the government health department to tryout the successes of this model in reaching out to married young persons in 200 blocks. The Government has already agreed to scale up this project in 10 high risk districts of Maharashtra where median age and marriage and first conception is low, and simultaneously undertake a research study to determine the impact of YFSRHS in Government PHCs. However that still does not address the problem that the intervention in this PHC has come to an abrupt end 18 months after initiation.

Further more IHMP has alternate funding to continue with life skills education activities with un-married girls. (All project activities are being wound up from 1st January 2007, Only the present batch of girls receiving LSE will continue till their course is over)

13. Observation and Lessons Learnt

- Open dialogue with communities, sharing of factual data about current vulnerability and need for SRH information and services for young people could galvanize local leadership for action.
- Potential of young men and women to volunteer their services in an organized way could be tapped. Careful selection by community, proper orientation and training, support in terms of materials and communication kit, ongoing motivation and encouragement can create lasting avenues for peer to peer information sharing on a range of SRH issues.
- 'Sathi Couple' a husband and wife team holds a lot of promise in reaching out to newly married and young couples. A continuum of services including, maternal and child health, RTI,STI, HIV prevention and VCT is able to address all needs in a gradual and trusting manner.
- Differential activities to suit needs of married, unmarried, male and female could be addressed under the same program provided separate clinics with male and female doctors are available and separate forums are used to reach out messages to married men/women and unmarried boys and girls (life skills education)

- Easily accessibility to SRH services is absolutely essential to complement information and awareness activities. Even in a short period change could be notices in utilization of RTI and STI treatment services and use of condoms.
- A system of surveillance and micro-planning and tracking services though a bit resource intensive is essential to ensure that all married and unmarried young people are being reached and referrals made for services are being availed. Such rigorous tracking helps in identifying individuals and families in need of follow up to facilitate them avail services. (This is the corner stone of this project. We do not think it is resource intensive as the number of clients per link worker is so small. The link worker has to visit only 4 – 5 houses a day). This is the key lesson for replication wherever ASHA is being employed under NRHM).
- The surveillance and micro-planning is also the basis for the accountability of health providers to the community through the VDC. It is this system that ensures ownership, facilitates community monitoring and accountability. The system ensures control over resources by the community through their VDCs.
- The surveillance and micro-planning system provides the mechanism for focusing BCC and primary level services on young couples and thereby effectively operationalising YFSRH.
- Attitude change is a slow process, achieving partner compliance in cases of RTI/STI is still a very up-hill task
- An 18 month project implies only 12 months of effective intervention. It is too short a period for any measurable change in SRH status. Hence baseline and endline surveys are a waste of resources. What could have been planned is a more detailed process evaluation.
- If policy advocacy was the only broad objective of this project that should have been explicitly stated in the agreements with the partners.
- Parallel and stand alone services for providing SRH services to young persons are not viable and cost effective, RTI, STI and HIV/AIDS prevention and treatment services have to be integrated in the public health system alongside other RCH services.
- UNFPA should ensure mechanisms of sustainability through alternate funding or through the local Governments before undertaking short term projects that require such intensive mobilization and raise expectations of the target populations.
- If policy advocacy was the only brad objective of this project UNFPA should have involved all its partners in the advocacy process.

14. Costing of Activities

Sr. No.	**Programme Activity Cost**	**UNFPA Rs /-**	**IHMP Rs /-**
1	Creating enabling environment for young people	58,340:00	400:00

2	Building knowledge and skills in SRH for young people	5,26,325:00	11,250:00
3	Clinical service provision	1,84,671:00	----
4	Training and capacity building	24,672:00	37,600:00
5	Baseline, MIS, End line	1,71,592:00	----
6	Management	1,98,046:00	4400:00
7	Programme Material	43,626:00	…
8	Over Heads	5,55,846:00	7,98,150:00
Total		**17,63,118:00**	**8,51,800:00**

15. Genesis and Evolution of Major Project Events and Activities

- Request for proposal was received from UNFPA and a proposal was submitted almost one or one and half year earlier from the actual start, after a series of negotiations with UNFPA office and the original design evolved into its current form including components of RH, SH, HIV/AIDS, VCT and testing with a thrust on use of peer educators, life skills, information centers and clinics for men.
- As a first step consultations were held with Gram Panchayats and others holding influence in the area regarding need and importance of SRH information and services for young people. Data collected during earlier studies was used to win over their support. The village was included only if such support was forthcoming from the community leaders. (July 2005)
- The process of forming the VDC was completed with 7-13 members who elected their own chairperson. One day orientation was arranged for VDC members where purpose, working procedures and roles were further made clear along with a basic orientation on SRH for adolescents/young people. A formal MOU was also signed between the VDC and IHMP. VDC were to select a Community Worker and Sathi Peer Couple for their area.
- Census mapping and listing/registration was done for married adolescent couple in each area, a proper baseline was completed and the monthly surveillance system was put in place. (November/December 2005)
- ANC clinics at the government sub-centre (Village level) space were started for providing services to married young women through the ANMs for this project. (November 2005)
- Depot holders for different areas were identified and trained to initiate condom distribution services. (November 2005)
- Full scale BCC strategy was rolled out with complementary activities during inter-personal counseling and home visits, group meetings, workshops etc. (January 2006)
- RTI/STI clinics at the sub-centers were initiated in February 2006. In May the clinics were started separately for men and women on two consecutive days.

- Sathi couple workshops were conducted and Sathi kendras established.)August 2006)
- VCTC service was initiated once a month at the PHC level after completion of all the official communications with the government and getting the staff have the required training from SACS. (September 2006)
- End line survey (December 2006)