"Trends analysis and interpretation for recent past with regard to NGO's data under project SAMARTH in FHI (Family Health International)"

A dissertation submitted in partial fulfillment of the requirements
for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Kapil Dev Sharma
Roll No. PG/08/020



International Institute of Health Management Research
New Delhi -110075
May, 2010

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Under the guidance of

JYOTI JAGTAP
Technical Specialist
FHI(Family Health International)
New Delhi

Dr. NITISH DOGRA
Assistant Professor
IIHMR, New Delhi

Certificate of Internship Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Kapil Dev Sharma has successfully completed her 4 months internship in our organization from February 1, 2010 to May 31, 2010. During this intern she has worked as Intern and did the trends analysis and interpretation for recent past with regard to NGO data under project SAMARTH in FHI, under the guidance of me and my team at FHI(Family Health International) NewDelhi.

We wish her good luck for her future assignments

(Signature)
Jyoti Jagtap
Technical Specialist
FHI (Family Health International)
New Delhi

Certificate from Dissertation Advisory Committee

This is to certify that **Kapil Dev Sharma**, a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled **"Trends analysis and interpretation for recent past with regard to NGO data under project Samarth in FHI (Family Health International)New Delhi"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. NITISH DOGRA
Assistant Professor
IIHMR, New Delhi

JYOTI JAGTAP
Technical specialist
FHI(Family Health International)

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*I am sincerely thank full to Dr. Bitra George country director FHI for granting me the opportunity to work in esteemed organization that gave me the scope for playing an active role in different activities. I would like to express my heartfelt thanks & gratitude to Jyoti Jagtap , technical specialist in programme SAMARTH ,FHI (Family Health International) India,, without whom this project would not have been a reality.***,** *my external guide who provided me a caring and supporting throughout my training period.*

A special vote of thanks to Sunil Nanda director programme SAMARTH and dr.Prasanta Bandyopadhyay associate director –technical for their kind assistance during the study.

*I am thank full to the IIHMR,, New Delhi for having provided me with the invaluable learning experience***.**

I acknowledge the moral support and encouragement provided by my friends at the every stage of my study.

Kapil Dev Sharma

ACRONYMS

AIDS : Acquired Immuno Deficiency Syndrome

HIV : Human Immunodeficiency Virus

NGO : Non Governmental Organizations

STDs : Sexually Transmitted Diseases

STIs : Sexually Transmitted Infections

WHO : World Health Organization

NFE : Non Formal Education

LSE : Life Skills Education

A : Abstinent

AB : Be faith full

OI : Opportunistic infection '

ART : Anti retro viral therapy

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PART 1 :- TRAINING REPORT:

1.1 ORGANIZATIONAL PROFILE

At Family Health International, we bring research and public health programs together to improve people's lives. Our researchers increase understanding of the technologies and health care systems best suited to people in need. Our public health professionals combine this scientific information with best practices from the field -- and our experience of 37 years -- to deliver evidence-based health programs that have real impact. FHI's public health programs respond to the public health needs of the world's most vulnerable people in more than 40 countries. Our goal is to prevent the spread and reduce the impact of HIV/AIDS, tuberculosis, malaria, and other infectious or chronic diseases. With funding from various donors, governments, and the private sector, we work with many organizations to strengthen the ability of countries and communities to implement their own responses to these problems.

Our work supports implementing partners to design, deliver, and evaluate local responses to the most pressing public health problems in resource-poor settings. Through our research, we identify and develop effective, evidence-based strategies and interventions. We also identify and disseminate best practices, and tailor cutting-edge approaches and programs to local needs.

Our Mission

Family Health International (FHI) improves lives worldwide through the synergistic strengths of research and programs in public health.

Our Vision

Family Health International (FHI) will advance global development by supporting health and offering hope worldwide.

Our Values

- Excellence driven by the highest standards of science, ethics, and operational performance. Integrity in what we do and how we work. Responsiveness to the evolving needs of individuals, families, and communities within dynamic environments.
- Respect for human rights, the diversity of local cultures, and the contributions of our partners and colleagues at all levels.
- Dedication to the pursuit of FHI's mission through the collective wisdom and experience of a committed staff.
- Accountability to those who benefit from our work, those who entrust us with their resources, our collaborators and each other.

Our Guiding Principles

Building Sustainable Capacity

FHI strengthens capacity to develop local responses to critical needs.

Establishing Partnerships

FHI pursues partnerships with governments, foundations, nongovernmental organizations, faith-based groups, and businesses to maximize impact.

Ensuring Quality

FHI continuously ensures quality by defining standards, measuring performance, and applying results to exceed expectations.

Sharing Knowledge

FHI leads scientific research and program innovation and shares findings, tools, and approaches with stakeholders at all levels.

1.2 Depatment worked

Samarth Project

Duration: October 2006 - September 2011

Partners:

Christian Medical Association of India

Indian Network for People Living with HIV/AIDS

Solidarity & Action Against the HIV Infection in India

Family Health International (FHI)

Geographic Focus: National with a focus in Andhra Pradesh, Karnataka, Maharashtra, Pondicherry, and Tamil Nadu

Description:

India has the third largest population of HIV infected persons. The Indian states of Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu including Pondicherry are geographic "hot spots" for the country's HIV epidemic. It is feared that the epidemic, now concentrated among high-risk groups, could spread farther to the general population.

The Samarth project is one of three components under the umbrella of the $49-million Enhance Project that works to address HIV/AIDS in India. The project contributes to implementing HIV/AIDS prevention, care, and treatment through technical assistance, capacity-building, and institutional strengthening of government and civil society institutions. The key strategic approaches of the project are capacity building, engendering bold leadership and demonstrating best practices.

The project provides needs-based capacity-building assistance and builds leadership at different levels (community, district, state, national) to government and non-government stakeholders using workshops, conferences, site visits, and exchange programs. The project supports placement of program and technical experts at the national, state, and district levels of government. The Samarth project also provides tailored technical assistance to individuals and organizations at the national, state and district levels. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) also benefits from technical assistance to strengthen the leadership and governance of the County Coordinating Mechanism Secretariat.

Four demonstration projects in Delhi receive program management support to demonstrate promising practices in HIV prevention interventions for adolescents, especially girl children in communities of most-at-risk populations like traditional sex workers and street children; and other care and treatment interventions for orphans and vulnerable children.

AIMS & OBJECTIVES:

The aims and objects for which the society is established are as under :-

To identify, strengthen and develop local non-government agencies/ associations in urban slums / socio economically , educationally backward communities /areas for integrated development and enable them to continue and sustain.

Mobilize local resources to reconstruct slum / village into model one with optimum multiple welfare facilities for different age groups

TASK PERFORMED: - The work data analysis, interpretation and trends analysis of NGO Salam Balak Trust and Wag…Chelsea under project Samarth. That The data is retrieved from the software CMIS. Some data is collected from ngos old records manually. Then the data was segregated accordingly as per the age and other demographic characters. The financial year is starting from October to September. So data is taken for the three years for the year Wag…Chelsea for the years 2006-07.2007-08 & 2008-09. For salaam Balak Trust this same data was taken from the records for two years as 2007-08 and 2008-09. Then data is organized accordingly. This data analyzed in software SPSS12. Tables were retrieved for analysis then the charts were plotted and drawn conclusion from the data.

PART 2 : DISSERTATION-TRENDS ANALYSIS AND INTERPRETATION FOR RECENT PAST WITH REGARD TO NGO DATA UNDER PROJECT SAMARTH IN FHI

2.1 OBJECTIVES AND LITERATURE REVIEW

The adolescents knowledge and attitude on reproductive health is a very significant factor influencing various demographic and health parameters and also the overall quality of life. Prevention from STI and AIDS is closely linked with the behavioral practices of the individual. No matter of which culture, economic class, occupation or educational standard an individual belongs\behavior of an individual is guided by his/her awareness or knowledge on a particular issue. Research studies on behavioral sciences have proved that it is the knowledge that results in one's attitude towards anything, which in turn results in a certain kind of practice or behavior.

"Believe me, the more accurate and proper information young men and young women get about physiology, the dangers associated with early sexual contacts, pregnancy, venereal diseases, the more responsibly they will behave towards themselves and their partners."

--Gabriel

Street children constitute a marginalized group in most societies. They do not have what society considers appropriate relationships with major institutions of childhood such as family, education and health. The continuous exposure to harsh environments and the nature of their lifestyles make them vulnerable to substance use and this threatens their mental, physical, social and spiritual wellbeing. In many regions most of these children use alcohol and other psychoactive substances. In addition, these children are confronted with discrimination and view health and social services with suspicion. Street children live a transitory life style and are vulnerable to inadequate nutrition, physical injuries, substance use, and health problems including sexual and reproductive health problems. These factors reduce the effectiveness of interventions that target street children. (Schurink, W)

Street children exist in every part of the world and large groups of children unsupervised by adult shave appeared in almost every country during some part of history. Most are found in large, urban areas of developing countries. The problem has worsened across the globe in recent years because of economic problems, political changes, civil unrest, increasing family separations and conflicts, the epidemic spread of diseases and natural disasters. It is estimated that there are between 10 and 100 million street children in the world today. These children live a transitory life style and

are vulnerable to inadequate nutrition, physical injuries, substance use, and health problem including sexual and reproductive health problems. Some street children are part of entire families who live on the street. Others are born to older street girls. Some street children are 'on the street,' which means that they still see their families regularly and may even return every night to sleep in their family homes. Children 'of the streets,' on the other hand, have no home but the streets. Even if they occasionally spend time in institutions for children or youths, they consider the streets to be their home. In this document, the term 'children' refers to both children under the age of 10 years and young people aged 10-24 years. Although street children support themselves in many different ways, they need the assistance of caring adults and charitable services provided by governmental or non-governmental organizations. Despite peer solidarity and support through charitable services, street children have extremely high rates of morbidity,disability and mortality. (E.schurink, m tiba)

Improving the quality of life of street children is a difficult and challenging task. In response to this, WHO developed a project focusing on psychoactive substance use among street children Initially, project activities were piloted in seven countries around the world and a draft training package was developed. Between 1993-1997 the project was expanded to 23 sites with 70 government and nongovernment agencies participating in 20 countries. Over 700 professionals, street educators' volunteers and others participated in pilot training sessions utilizing the draft training package. This training package is a result of many years of experience on the part of WHO on the street children project. The initial focus for the WHO street children project was to develop a training package for street educators on substance use. However, following extensive field-testing of the initial training package, the target groups indicated the need for a more comprehensive package that would include issues related to sexual and reproductive health. Indeed sexual and reproductive/HIV/AIDS/STDs are closely linked to substance use. Hence the inclusion of these issues in this final training package, making the package more comprehensive.(WHO)

THE IMPORTANCE OF EDUCATION FOR STREET CHILDREN.

Street education is a very effective way to support street children as it occurs at locations where they live. Street education can involve many types of activities, for example, counseling about harmful effects of substances or about prevention of STDs, improving literacy and educating street children on the importance of seeking assistance on health issues or other social problems that could be addressed. The World Health Organization recognizes that street education can be of vital importance in meeting the needs of street children in the areas of substance use, sex education, life skills, health education and literacy.

The term street educator applies to anyone who works directly with street children. They are workers who actively engage the children, gradually gain their trust and confidence, help raise their self-esteem, and support them as they try to become active, healthy adults who are accepted within the community.(1)

Adolescence is a time of tremendous opportunity and change. It also is a Time of heightened vulnerabilities. While adolescence generally is a healthy period of life, but adolescents often are less informed, less experienced, and less comfortable accessing reproductive health services than adults to obtain the reproductive health information and services they need. They therefore may be at increased risk of sexually transmitted diseases (STDs), HIV, unintended pregnancy, and other health consequences that can affect their futures -- and the future of their communities -- for many years to come. As a result, Adolescent reproductive health is an increasingly important component of Global health.

Although the typical age of a street child varies from place to place, the age range includes children in the adolescent period. Sexual behavior begins before adolescence; during adolescence, major physical and psychological changes occur. These include rapid physical growth and development, social and psychological maturity which bring about enormous social and psychological pressure. Young people, especially boys are exposed to continued pressure from peer groups as sexual experiences may be viewed as achieving or demonstrating competence. Street children are exposed to situations that make them vulnerable to sexual and reproductive health problems on a day to day basis. Their vulnerability to these situations is increased by their lack of understanding of the changes associated with adolescence, the lack of knowledge and skills which could help them to make healthy choices and their inability to access the appropriate services.

This module presents some aspects of sexual and reproductive health and a variety of potential

1. Sexual and reproductive health problems, although more emphasis is placed on sexually transmitted diseases (STDs), HIV and AIDS. The Modified Social Stress Model is then presented as a framework for understanding the factors that may contribute to these health problems. The six components of the model (stress, normalization of behavior and situations, effect of behavior and situations, attachments, skills and resources) influence the likelihood of risk behaviours. An understanding of these factors may be helpful in developing intervention strategies related to sexual and reproductive health including HIV/AIDS/STDs. (www.naco.nic.in)

SEXUAL AND REPRODUCTIVE HEALTH

Sexual health.

In broad terms, sexual health is a personal sense of sexual well being as well as the absence of disease, infections or illness associated with sexual behavior. As such, it includes issues of self-esteem, self-expression, caring for others and cultural values. Sexual health can be described as the positive integration of physical, emotional, intellectual and social aspects of sexuality. Sexuality influences thoughts, feelings, interactions and actions among human beings, and motivates people to find love, contact, warmth and intimacy. It can be expressed in many different ways and is closely linked to the environment one finds oneself in. The environment can hinder or enhance sexual expressions.(3)

What is meant by reproductive health?

The WHO defines reproductive health as a state of complete physical, mental and social wellbeing.and not merely the absence of disease or infirmity in all matters relating to the
reproductive system and to its functions and processes. This definition suggests that people with.adequate reproductive health have a satisfying and safe sexual life, can have children, and can make.a choice as to whether they would like to have children and if so, when and how to have them.

Normal adolescent development

Adolescence is the transitional period between childhood and adulthood. It begins with the biological changes associated with puberty and proceeds through a process of psychosocial changes. Each aspect of maturation does not develop at the same rate. Development in adolescence can be uneven and deviations from the norm can cause alarm in the adolescents and those around them. The general information below will give you an understanding of the importance of sexual reproductive health among street children, most of whom are in this phase of development.

Puberty

Puberty refers to the sequence of physical events by which a child is transformed into a young adult. The characteristic physical changes include those in the reproductive organs and the external genitalia in sexes, breast development and hip enlargement in the female, facial hair growth and change in voice-pitch in the male. Puberty leads to menarche (onset of menstrual flow) in females and to the onset of ejaculation (of seminal fluid) in males.

Psychosocial development

Identity

Adolescents select characteristics from many people,- peers, parents, teachers, relatives, religious leaders and famous people. They blend certain of these people’s

features with their own characteristics to become a unique new person. The new person or identity is not one's final self, but it forms the basis of what one will become. If adolescents manage to work through the contradictions of this process they will develop positive and healthy feelings towards themselves.

Sexuality.

The advent of sexuality and the need to manage it in some way are major features of the adolescent experience. Uncertainty, conflict and a struggle often accompany the awakening of sexual feelings over appropriate avenues of expression. Cultural factors also play an important role in the psychosocial aspects of adolescent development and in the sexual conduct and meaning adolescents generate concerning sex.

Gender roles and sexual identity.

Adolescence serves as the intermediate stage between the shaping experiences of the gender in childhood and the development of the full-blown male or female adult identity.

Meaning attached to sexual experiences.

Sexual activity may signify different things to different people. Such meanings are derived from collective, individual and interpersonal experiences and expectations. Below are some of the important meanings attached to sexual experiences by street children:

Comfort sex.

Street children have a great need to fill the void of normal relations because many have left their families or do not have a family. Street boys sometimes describe sex as "play between friends". Comfort sex is often exploitative in nature, even though such a relationship provides the child with shelter, basic needs and protection.

Sex for power.

Sometimes, street children use sex as a way of expressing physical power. The younger street children comply for fear of being beaten. Some street boys have said that they have sex with prostitutes because it is a symbol of strength and being a 'real man', and to show friends that they are in control. Sex is used to control other street children and make them obey demands and respect 'hierarchies' on the street. A street child in Mwanza, United Republic of Tanzania said, "he rapes me because he wants me to know who is in power" (Kuluena street children project, United Republic of Tanzania). (7)

Initiation sex.

This type of sex occurs to initiate newcomers to the group. It is thought to be a way of making the new street children feel they ‘belong’. It is a passage to identity formation. Usually the victims are threatened with violence if they do not agree. Most street children see this type of sexual experience as something inevitable.

Sex for punishment.

When a street child is found not to be ‘going along’ with the group (norms), they may be punished for not abiding by the ‘rules’. Sexual assault is used as a way of punishing a street child.

2.2 OVERALL OBJECTIVE

To assess the current level of street children living in shelter homes and know the trends over the past three years by analyzing the data regarding the services indicator provided to street children under project Samarth.

3. METHODOLOGY:-

As a data analysis interpretation and trends analysis is done for the three ngo as Wag…Chelsea and Salam Balak Trust. Data source consist of details available from CMIS software Brief data according to indicator is extracted from different NGOs. As for years 06-07, 07-08 & 08-09 for the ngos.

- Wag...Chelsea
- Salam Balak Trust

The population group included males and females of all age group till the age group < 18 years for Salam Balak trust. For wag...Chelsea this is more than age 18 years also there.

3.1. Selection of study area: Study was undertaken in two ngo as Wag..Chelsea and Salam Balak Trust. Salam Balak Trust is working for street children and wag..chelsea is working for children affected or infected `with HIV/ AIDS. They are providing them services as per the requirement of the population.

3.2. Selection of study population: Population is taken as per the year coverage which is covered in that particular year. All services are given under few indicator.

3.3. Data collection study tool-Questionnaire: The data ils collected from the software CMIS. Some data is collected from ngos old records manually. Then the data was segregated accordingly as per the age and other demographic characters. The financial year is starting from October to September. So data is taken for the three years for the year wag…Chelsea for the years 2006-07.2007-08 & 2008-09. For salam balak trust this same data was taken from the records for two years as 2007-08 and 2008-09.

3.4 Field work: Data for ngos was collected.

3.5. Data analysis: Data entry and management- For the ease of analysis questionnaire was code and data analysis is done using software package SPSS 12.

Annexure :- All the tables for data analysis is attached with the annexure in the last.

4. DATA ANALYSIS RESULT & GENERAL FINDINGS

SALAAM BAALAK TRUST: - The following categories for data analysis are given-

- Age & Gender
- A/AB message
- LSE (life skills education)
- HIV referrals
- STI referrals
- Psychosocial support
- Vocational support
- Health care services
- NFE (non-formal education)
- Nutrition
- Mental health counseling

4.1.1 Age and Gender Profile Over the Past Three Years**:-**

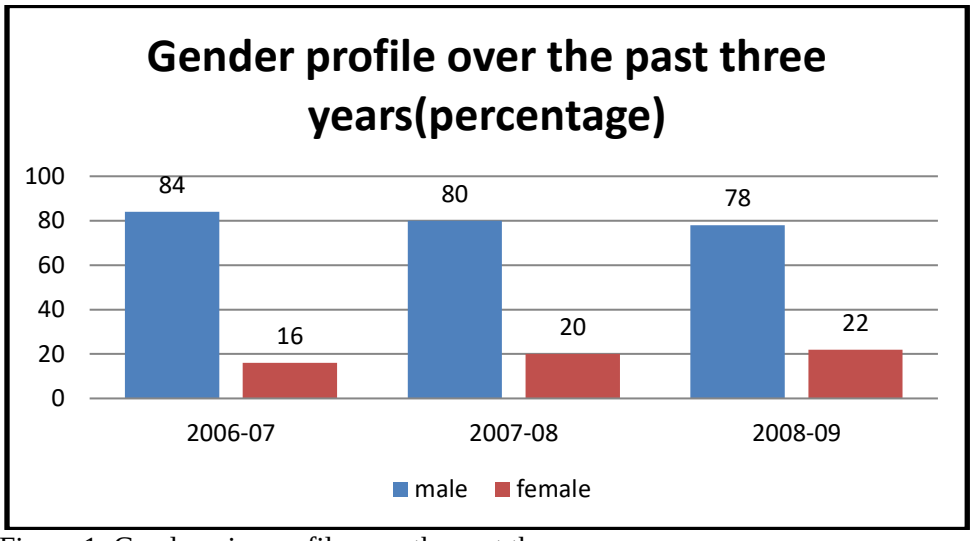


Figure 1: Gender wise profile over the past three years.

Year	Male	Female	Total
2006-07	1799	349	2148
2007-08	1459	359	1818
2008-09	1526	425	1951

Table 1:- male female ratio over the years .

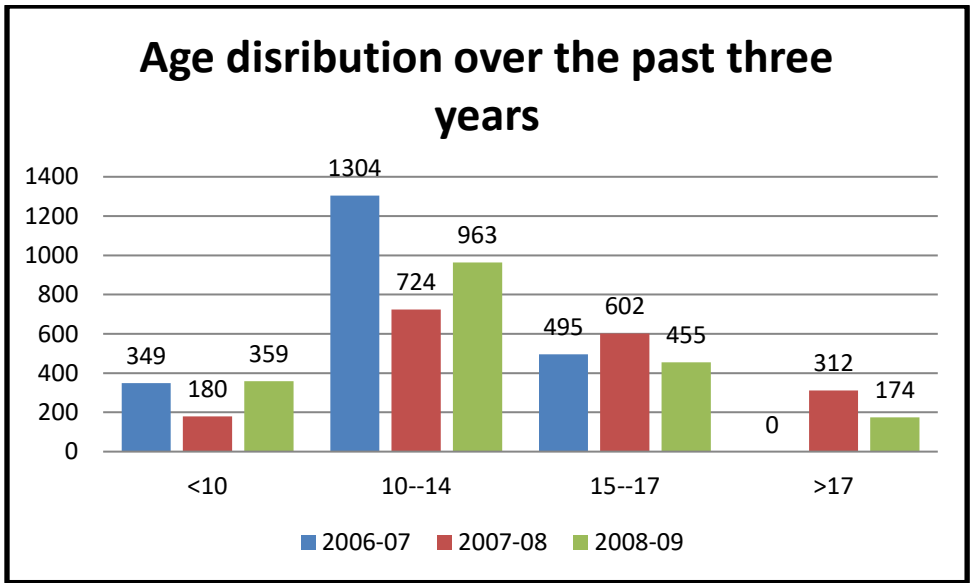


Figure 2:- Age distribution over the past three years.

The gender and age profile of the runaway children who are living in shelter homes is presented in this section. Includes both males and females in a ratio of 4:1 respectively; males are more in number due to ease of availability and accessibility. The Age composition of children (Table 1) reveals that children of varying age group exist in the shelter homes ranging from 5-20 years. The mean age being 14 years approximately. As per the previous studies done in the same shelter homes, more than half of the subjects were from North India including states like Uttar Pradesh, Bihar, and probable reason of more runaway children from state like Uttar Pradesh reflects the population burden and the consequences of the same. The rest came from other states of India such as Maharashtra and Rajasthan Central part of India including states like Madhya Pradesh, East India including states like Assam, Southern part of India including states like Karnataka and Kerala, Delhi and the remaining came from neighboring country Nepal.[1]

The Age composition of children as in 2008-09 year data reveals mean age group to be approximately 13 years and age group ranging from 4-21 years. Data set consist of both males and females in the same ratio as of 2007-08 data set i.e 4:1 respectively. Dispersion of age group from its mean is (+-) 3.4.

[1](As per the study done by Shivangini kar and Rajesh singh in SBT regarding KABP survey in street children)

LSE Sessions:-

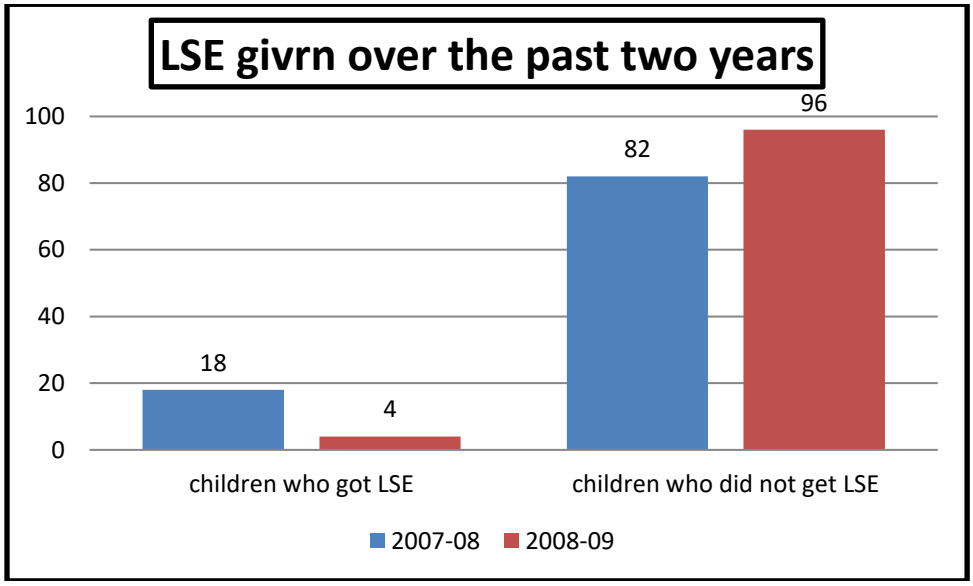


Figure 3:- LSE given over the past two years.

Year	Children who got LSE	Children who did not get LSE	Total
2007-08	254	1137	1391
2008-09	61	1472	1533

Table 3:- number of children who received LSE sessions.

Analyses of the results regarding life skills education sessions (LSE) attainment for the year 2007-08, reveals that majority of the children (constituting to approximately 82%) living in shelter homes, have not gone through the sessions. There are only 18% children who got LSE sessions once or more than 6 times in a year. There are just 2% children who got LSE sessions 10 times or more than 10 times in a year.

For the year 2008-09 data is presented in the table. In this 96% children did not get the any LSE sessions. While there is only around 1% children who got LSE sessions six times or more than 6 times in a year.

In the data being enumerated, comparatively LSE session has been decreasing over the years from 18%(254) to 4%(61). For years 2007-2008 and 2008-2009 respectively eligible children for LSE were 1391 & 1533 respectively; whereas percentage of children who were covered in LSE sessions were very less for the two consecutive years.

As per the requirements of LSE sessions 6 modules need to be completed in a maximum time frame of one year. Minimum sessions required for the completion of modules are 6 in number. Analysis of the above data sets reveal that the NGO should have covered more children for betterment of street children ; the reasons may be further investigated for further improvement in the functioning of the NGO as well for better service delivery to the street children.

AB MESSAGE:-

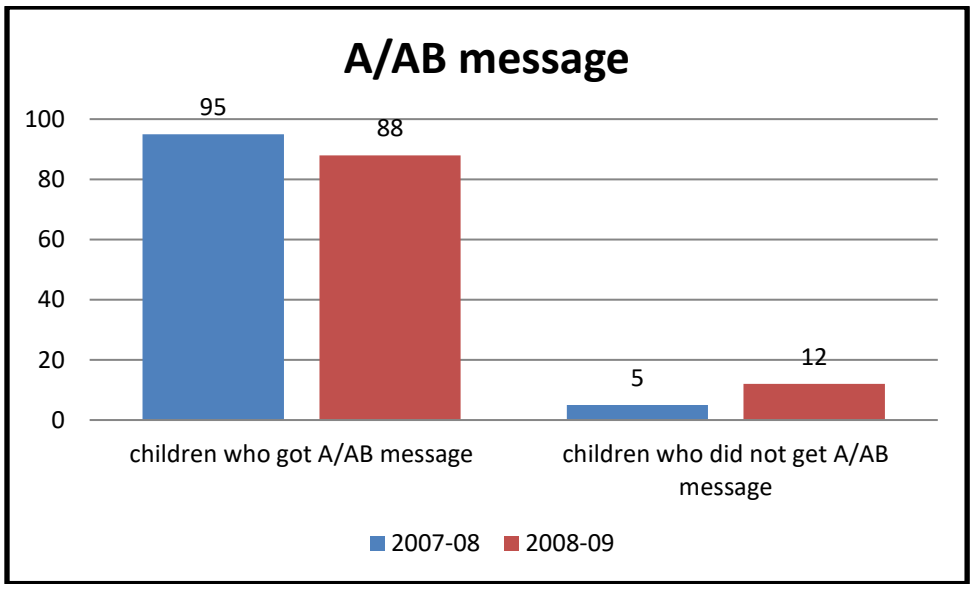


Figure 4:- A/AB message

It had been known that individuals could take action to either reduce or avoid altogether the risk of becoming infected with HIV through sexual transmission. The risk could be avoided altogether by avoiding any sexual activities that could cause transmission of HIV (i.e. Abstain).The risk could also be reduced, through avoiding sexual intercourse other than with a mutually faithful uninfected partner (i.e. Be faithful).

As this population is highly sexually active, the requirement of delivering the knowledge and information to the same population is a basic requirement. The data set reveals that majority of children (95% & 88%) have been given A/AB message at least once a year for the two consecutive years as 2007-08 and 2008-09. A/AB message coverage is quite appreciable as compared to other indicator in the same year. In the year 2008-09 ,88% children were given AB message. Over the year the frequency of giving AB message is decreasing if compared to the previous year. This may be further investigated. This may due to high mobility rate of street children.

STI & HIV**:-**

As per the study done in past its quite sad to share that majority of the children (40%) had their first sexual intercourse at an age ranging from 8 to 12, (25%) had an experience at an age of 12 and beyond that and rest had no such experience yet. (32.5%) had sexual indulgence several time a year; out of all the respondents who reported of sexual indulgence, majority have not used condom (57.5%); (15%) of respondents had multiple sexual partners, with friends as the dominant sexual partner.;(62.5%) were unaware of partner' s STI/HIV status, on a contrary majority (67.5%) had no idea regarding this topic.

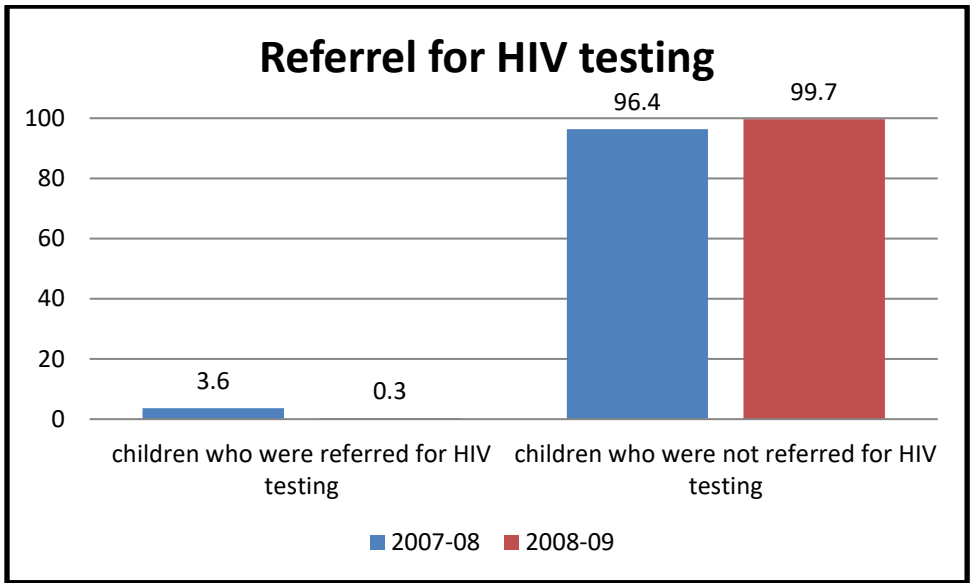


Figure 5:- Referrals for HIV testing.

As per the data analysis for HIV testing majority of children have not been gone through HIV testing. Just 3.6 and 0.3 percentage children have gone through HIV testing. This is need based service which is provided as per the requirement of individual or as per the doctor's recommendation if he or she any sign and symptoms.

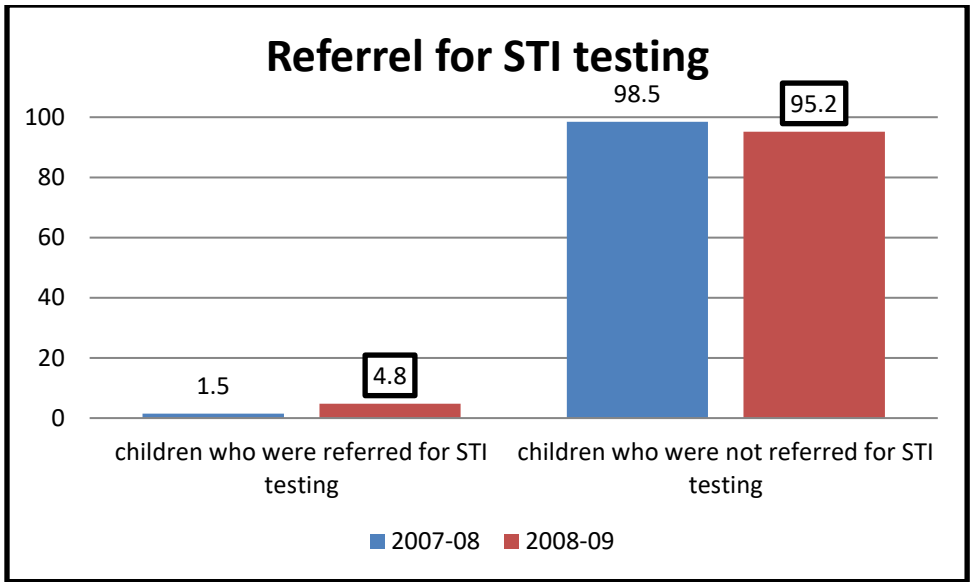


Figure 6:- Referrals for STI testing.

So they are more prone to be vulnerable for STI. As per the data shown in this table majority of children were not referred for STI checkup (98.5%) as well as none of the street children had undergone any STI treatment. Though these children indulge in sexual activities with high risk behaviour for HIV/AIDS and vulnerable to all kind of dangers (exploitations and abuse).

Psychosocial Support **:-**

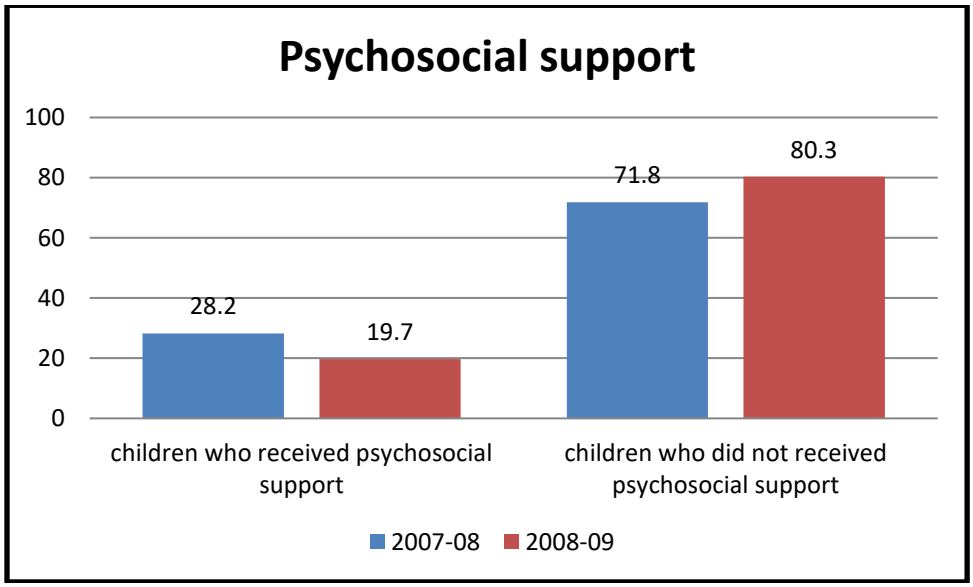


Figure 7:- Psychosocial support.

Compare to last year (07-08) percentage of children decreased who received psychosocial support. Just one fifth of the total population received psychosocial support in the year 2008-09.
So analyzed data reveals that no of individual decreased over the past two years who received psychosocial support. This is also need based service so we can say no of children who need psychosocial support is decreasing over the past two years. There also might be some other factor also like some times counselor does not wish to go at site where children could be available and provide service at the shelter home. So it might also lead to missing to some children. High mabolity rate of street children is also play an important role in low coverage of any indicator.

Vocational Support **:-**

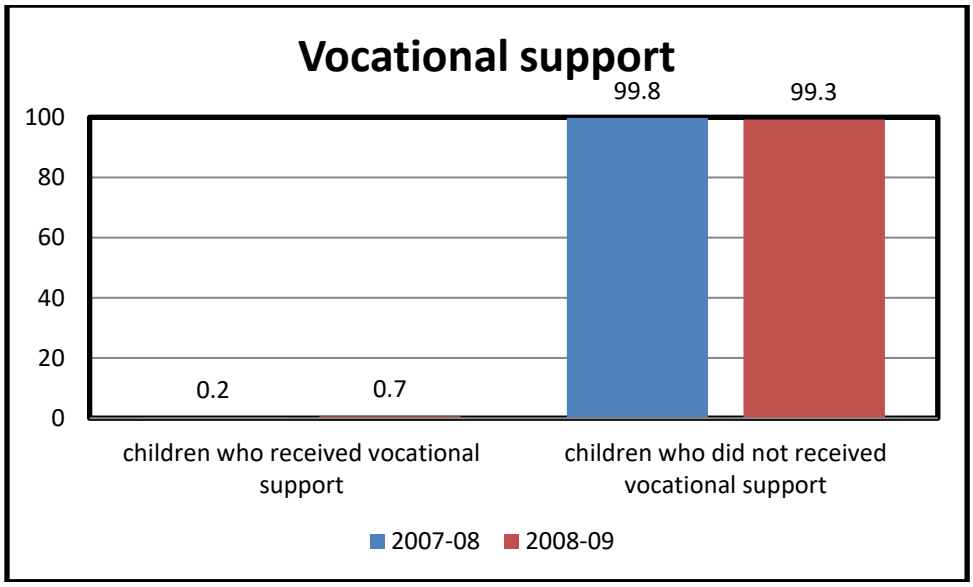


Figure 8:- Vocational support.

year	*Children who received vocational support*	*Children who did not received vocational support*	*Total*
2007-08	**2**	**784**	**786**
2008-09	**5**	**691**	**696**

Table 3

Data reveals the vocational support status among street children. As Very few children opted for vocational courses as the higher mobility rate.
Data indicate that just 0.2% and 0.7 children have been opted for vocational courses for the two respective years. While number of eligible children is 786 & 696 for the both respective years.
Frequency of opting vocational courses has been more than triple over past two years. But number of children is very less against eligible children. Which could be due to less motivation or some other characteristics may also affect.

*(Eligible children means age group 14-17)

Non-Formal Education**:-**

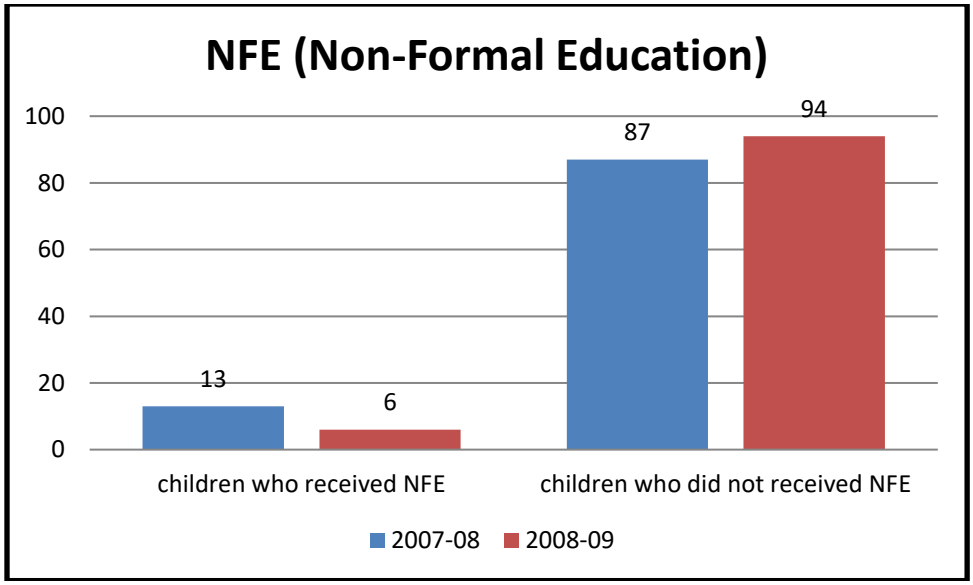


Figure 9:- NFE(Non-Formal Education)

year	*Children who received support*	*Children who did not received NFE support*	*Total*
2007-08	**120**	**784**	**904**
2008-09	**84**	**1238**	**1322**

Table 4:- number of children who received NFE support.

Analysis of the information regarding the Non-Formal education in the year 2007-08 & 2008-09 indicate that majority of the children (87% & 94%) were not engaged in NFE related activities . No of children who are getting NFE 5 times or more than 5 times in a year is very less just around 2%. As per the NFE guidelines one children should have gone through 10 NFE classes minimum. Total percentage of children who got NFE once or more than once is 13% & 6% for the respective years..

For the both the respective years eligible children were 904 & 1322 while just 120 & 84 children received the service against these eligible children that is very less comparatively.

In year 2008-09 just around 6 % children involved in NFE activities. So compare to last year (2007-08)NFE participation is also decreasing. So majority of children are not engaged with NFE activities due to many reasons. Like their past life style also prevent them to get involve such type of activities. So this is also a big challenge to get them in NFE like activities.

*(Eligible children means age group <15)

Nutrition Support **:-**

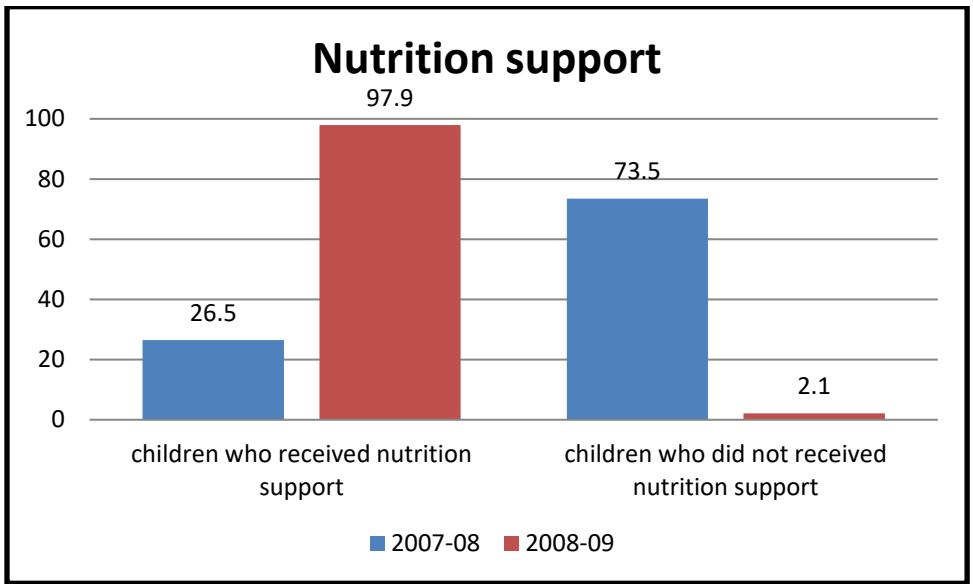


Figure 10:- Nutrition support.

According to the analyzed data most of respondents (97.9%) got nutritional support in the year 08-09 while this is was very poor in 07-08(26.5%).So coverage of nutrition support increased compare to last year. Nutritional support has been increased for the year 08-09 compare to year 07-08 that is quite appreciable. In this year 08-09 they started giving nutrition support to all shelter homes while it was not there in the year 07-08. So the total coverage of nutrition support increased.

Mental Health Counseling**:-**

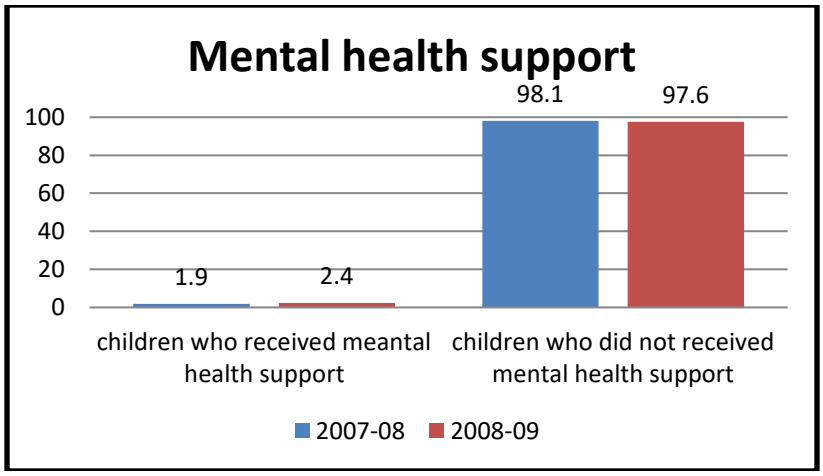


Figure 11:- Mental health support.

Mental health counseling also provided by the organization as per the requirement and condition of individual. In the year 07-08 and 08-09 just 1.9% and 2.4% children received mental health counseling for the consecutive years.

Over the past two years data analysis for the mental health counseling, it is found that no. of individuals has increased who needed mental health counseling. It might be due to circumstances where they live.

WAG...CHELSEA DATA ANALYSIS

The following categories for data analysis are given-

- Age & Gender
- A/AB message
- LSE(life skills education)
- HIV referrals
- STI referrals
- Psychosocial support
- Vocational support
- NFE (non-formal education)
- Nutrition
- Health care services
- Recreational support
- Received OI
- Referred for ART
- Palliative care

Age and Gender profile:-

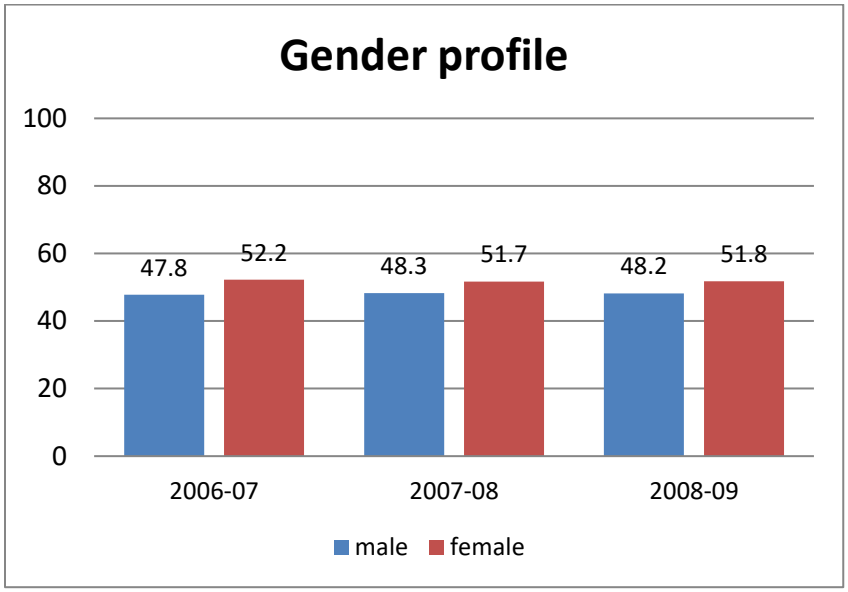


Figure 1:- Gender profile

The age and gender profile of the population covered by Wag Chelsea in urban slums in Delhi is shown here in the chart for the all three years. Maximum population is migrants or labour class or truck drivers who are living in slums. Here there is a big diversity in the age. All age group population is covered under the programme. For the year 06-07 age and gender description is shown here in the table. As per the table age group less than 10 to more than 24 is covered in this year. Maximum contributor age is less than 18 which is 57.5% of total population. Female (52.2%) are quite higher in numbers as compare to men (47.8%). The mean age group is

But in the year 07-08 this age ranging from 1 to 74. Here again female (51.7%) is quite high in numbers comparing to men (48.3%). Mean age is 19.57; dispersion from its mean is 13.37. Age group range varies from 1 to 74 years. Both male and female ratio is almost 50-50 between male and female numbers. Female (51.8) numbers are a bit higher than male (48.2%) might be due to female priority. The mean age is 19, age group dispersion from its mean is(+-) 14.59. Major contributing age group is below 18 which is 54.9% while second major age group is 25-44 which is contributing 33.66% of total covered population. Total covered population is also increasing year by year which is also a appreciating thing for Wag..Chelsea.;

LSE SESSIONS:-

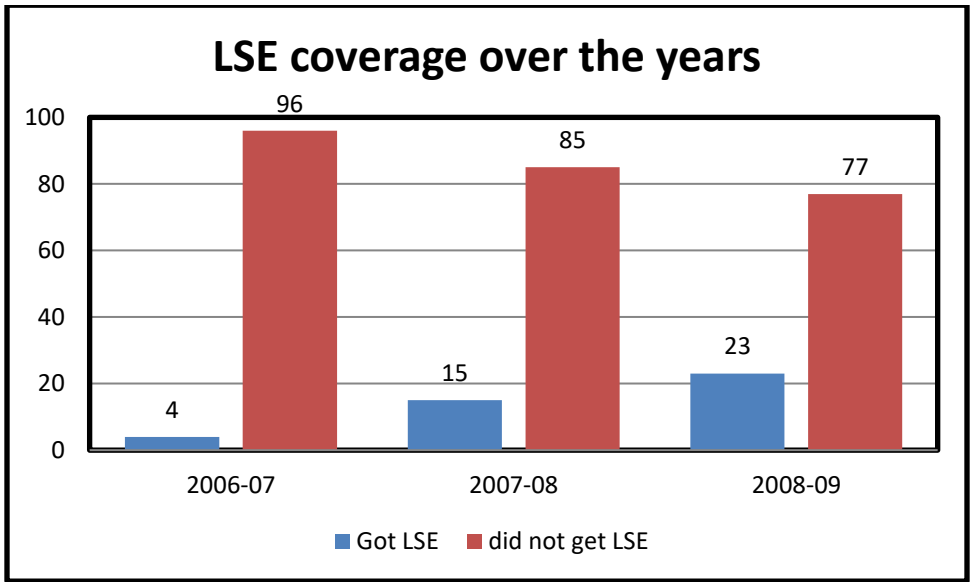


Figure 2:- LSE coverage over the years.

Year	Children got LSE	Children did not get LSE	Total
2006-07	7	168	175
2007-08	39	223	262
2008-09	49	160	209

Table 1:- number of the children who received LSE sessions.

Life skills education aims to develop the ability of an individual to deal with the variety of situations that life throws up. Such education helps in the overall development of children, including physical, mental and social well-being, building greater self-confidence in life.

The modules that we follow are developed jointly by Family Health International and HIV/AIDS Alliance, and include subjects like: knowing myself, communication, relationships, decision making, coping with emotions, growing up, preventing and living with HIV, substance abuse & reaching one's goals. These modules are facilitated through discussions, stories, drama, puppets and role play, songs and poems, indoor and outdoor games and question box. The modules have been modified to suit the needs of street children. After Conducting life skills sessions, it can now emphatically state that they have had a huge positive impact, which is tangible in increased self-awareness, less risky behavior, greater ability to deal with peer pressure, and a greater commitment to their future and their careers.

As per the analysis of results yield from table regarding LSE sessions attainment for the all three year (06-07,07-08,08-09) indicate that majority of population has not gone through LSE sessions. Only 4%,15% and 23% (7,39 & 49 children)children have gone through Lse sessions for the three consecutive years. For years 2006-07,2007-2008 and 2008-2009

respectively eligible children for LSE were 175, 262 & 209 respectively; whereas percentage of children who were covered in LSE sessions were very less compare to eligible children.

But in the data being enumerated, comparatively LSE session has been increasing over the years. This is quite appreciating thing for Wag.chelsea. It means they are being more efficient to get involved population in the LSE sessions over the past three years. But as compare to eligible population percentage its very less. So the reasons may be further investigated for further improvement in the functioning of the NGO as well for better service delivery to the slums population. Programme guidance also varied for initially years that is also a reason for less numbers.

***(Eligible children means children 9-17years of age)**

AB message

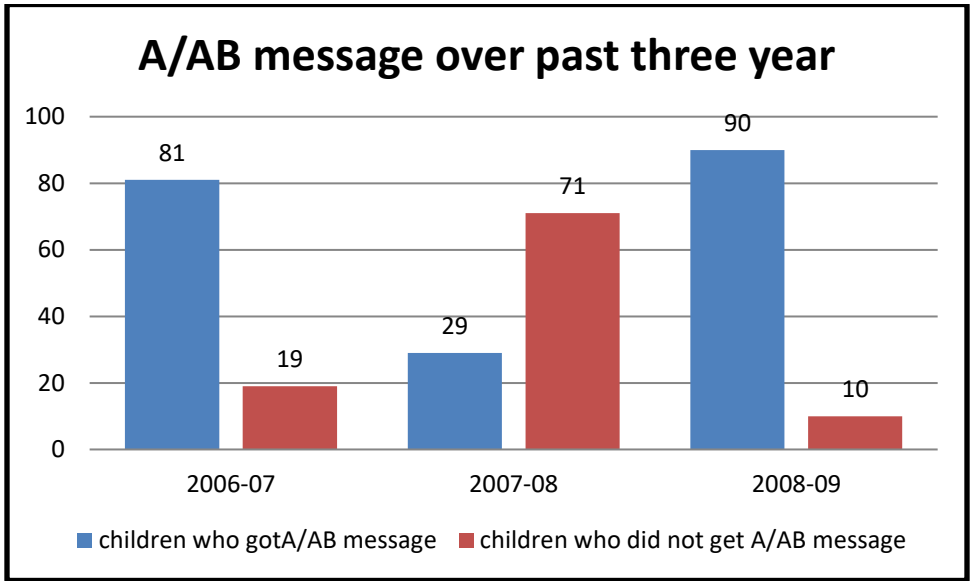


Figure 3:- A/AB message over pasr three years.

Year	Children got A/AB message	Children did not get A/AB message	Total
2006-07	138	33	171
2007-08	64	158	222
2008-09	150	16	166

Table 2:- number of children who received A/AB message.

It had been known that individuals could take action to either reduce or avoid altogether the risk of becoming infected with HIV through sexual transmission. The risk could be avoided

altogether by avoiding any sexual activities that could cause transmission of HIV (i.e. Abstain).The risk could also be reduced, through avoiding sexual intercourse other than with a mutually faithful uninfected partner (i.e. Be faithful).

As this population covers all age group in which around 60% are below age 18 years. This population requires A/AB message to avoid risk of hiv/aids. As per the data analysis indicate the number of covered population which have gone through A/AB message. For the all three consecutive years as 2006-07, 2007-08 and 2008-09 total 138,64 & 150 children were covered. So data reveals that majority of population have not been given A/AB message for the year 2007-08. Over the years the frequency of giving AB message is decreasing if compare 06-07(138 children against 171 eligible children) to year 07-08 (64 children against 222 eligible children). That is drastically degradation in numbers. Although it has been increased in year 2008-09 (150 children against 166 eligible children)

So the frequency of A/AB message given to children against eligible children is less. So this could be increased by putting more efforts in this particular segment.

STI & HIV:-

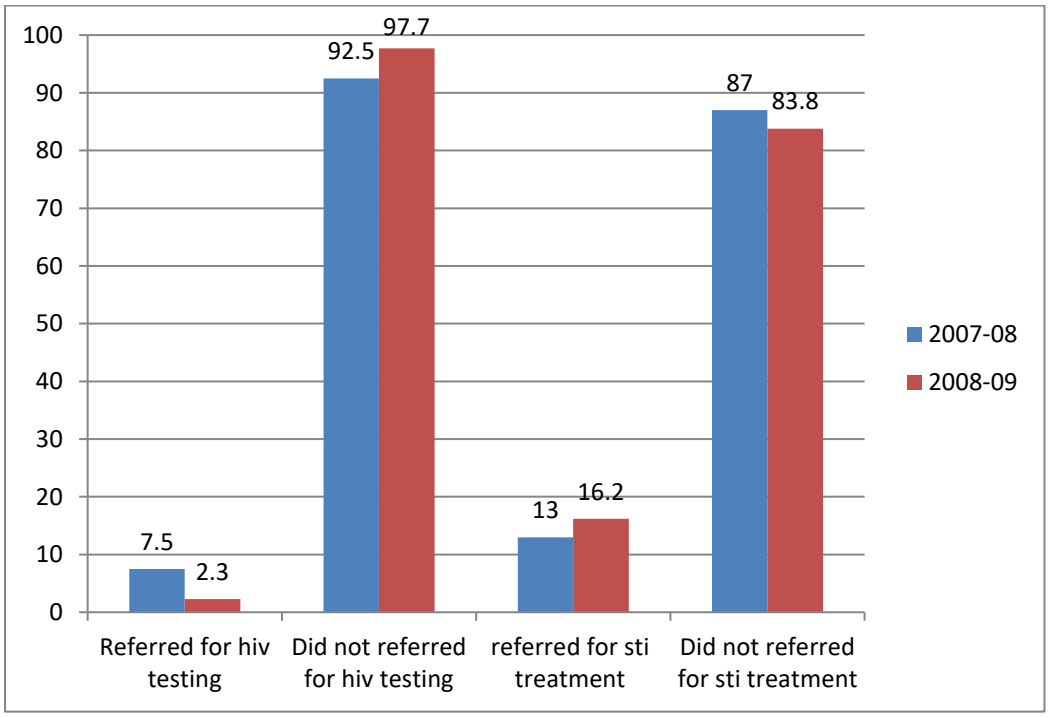


Figure 4:- STI & HIV trends.

As per the data shown here in the chart over the years frequency of referring for HIV testing is quite decreased from 7.5% to 2.3%. But the figure for STI referring is quite increased over the past two years from 13% to 16.2%.

Age distribution for HIV shows that maximum number of cases are pisperce age group belo18(15) and age group 25-45(44) out of total 65 cases in the year 2007-08. While this has been decreased in the next year 2008-09 with below 18 (12 cases) and 25-45 (8 cases).So we can say that HIV prevalence is quite high in urban slums in these two age groups. But it has also decreased in the same age group may be due to impact of A/AB message or LSE sessions which has also increased in the same year.
But in case of STI treatment figure has increased over the past two years from 2.3% (07-08) to 16.2 %(08-09). In the age group below 18 (14) is constant in terms of cases over the past two years. But age group 25-45 shows drastically growth in number of cases in year 2008-09(117 cases) compare to year 2007-08 (69 cases).

So this may be area of serious concern or challenging area to improve for the Ngo. Because it shows quite high prevalence of STI in urban slums. There might be several reasons behind this but it should be focus area to improve for coming years.

PSYCOSOCIAL SUPPORT:-

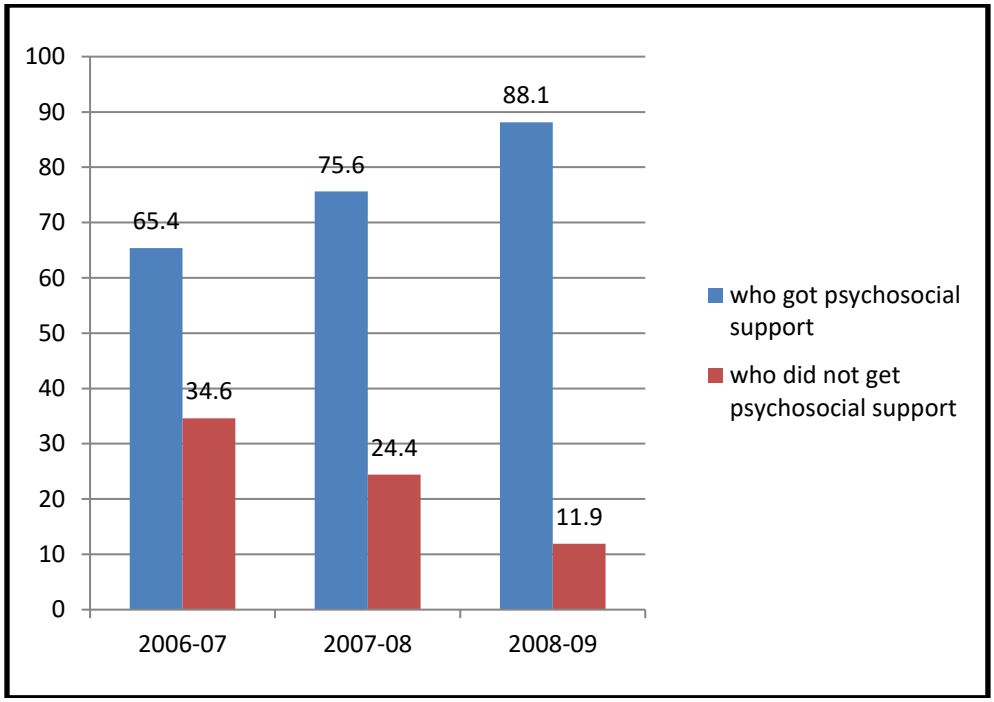


Figure 5:- Psychosocial support.

Psychosocial support is provided as per the need of individual. If the counselor seeks the need of psychosocial support then provided to that individual. Psychosocial support data analysis reveals that over the past three years frequency of giving psychosocial support is increasing. As per the chart 65.4%, 75.6% & 88.1% got psychosocial support for the three consecutive years. So we can say that urban slums population need this service more frequently compare to others , there might be some reason like it may be helping them to reduce their social

stigma or other mentally problems. This could be impact of this service that covered population is also increasing year by year.

Vocational Support:-

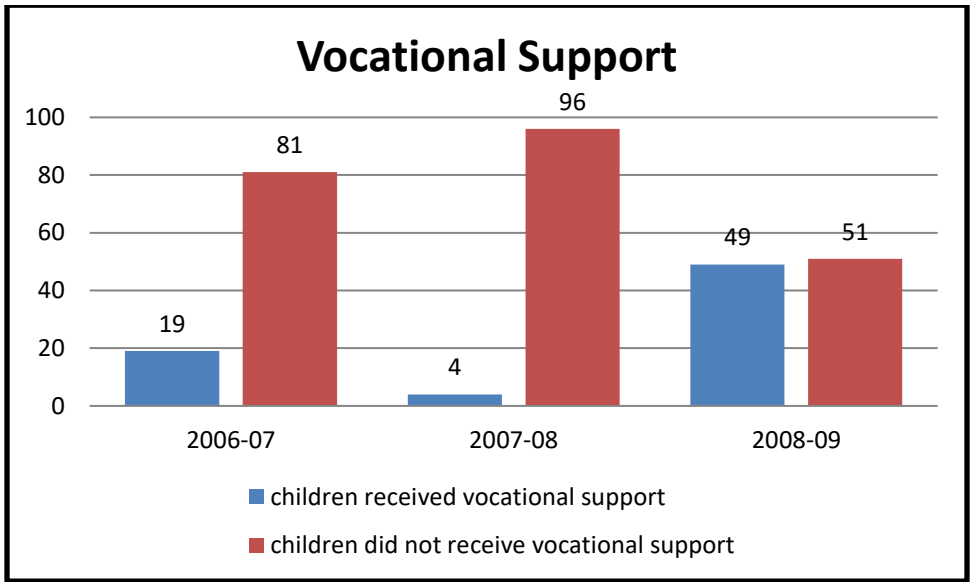


Figure 6:- Vocational support.

Year	Children who received vocational support (%)	Children who did not received vocational support (%)
2006-07	19	81
2007-08	4	96
2008-09	49	51

Table:- number of children who received vocational support.

Data analysis indicate that majority of population is not indulge in vocational courses. Just 22, 4 & 31 children have been given vocational support. While eligible children were 96,97 & 63 for the three respective years. So number of participants who participated in vocational courses have been reduced from 2006-07 to 2007-08 drastically. This has also increased for the next year but that year eligible children also has been reduced. This shows lack of motivation among eligible children for vocational courses. Although there may be some other reason for the lack of motivation but more number could be involved in vocational courses by putting more efforts to make them motivate.

*(eligible population means age group 14-17 age group

NON FORMAL EDUCATION:-

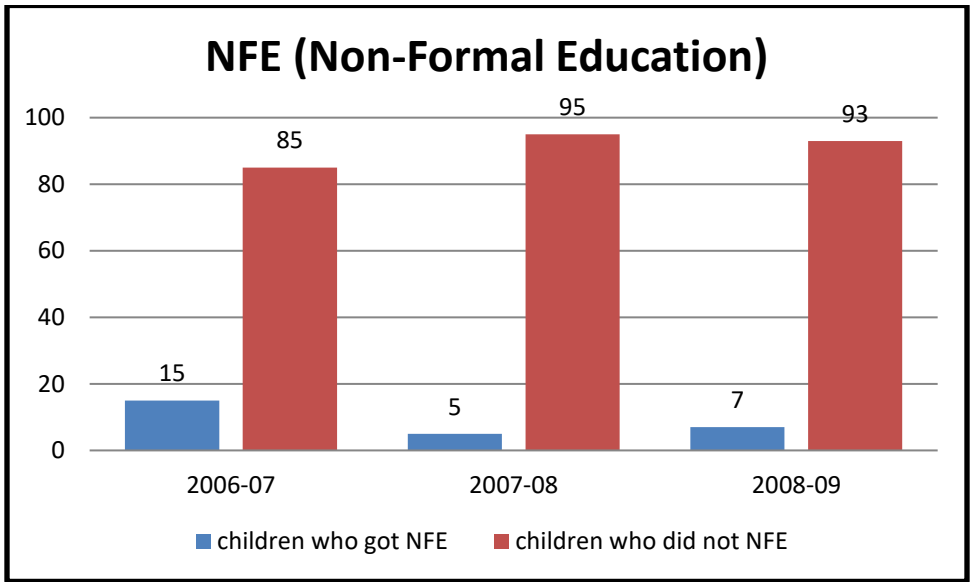


Figure 7:- NON FORMAL EDUCATION

Year	Children who got NFE	Children who did not get NFE	Total Eligible children
2006-07	49	278	327
2007-08	21	394	415
2008-09	35	461	496

Table 3:- number of children who received NFE.

Analysis of the information regarding the Non-Formal education, indicate that majority of the children were not engaged in NFE related activities. No of children who were eligible for NFE for the year 2006-07, 2007-08 & 2008-09 is 327,415 & 496 for the consecutive years. No of female children enrollment for NFE is quite high over the past three years compare to male children as shown .But frequency of children who got enrolled is very less just 49, 21 & 35% for the respective years.

This shows gradually reduction in number of participants in NFE activities over the years. This could be reason of extra concern for ngo. Although this may be due to lack of awareness among population or may be other children are getting education from other sources.

***(Eligible children means below age 15)**

NUTRITION SUPPORT

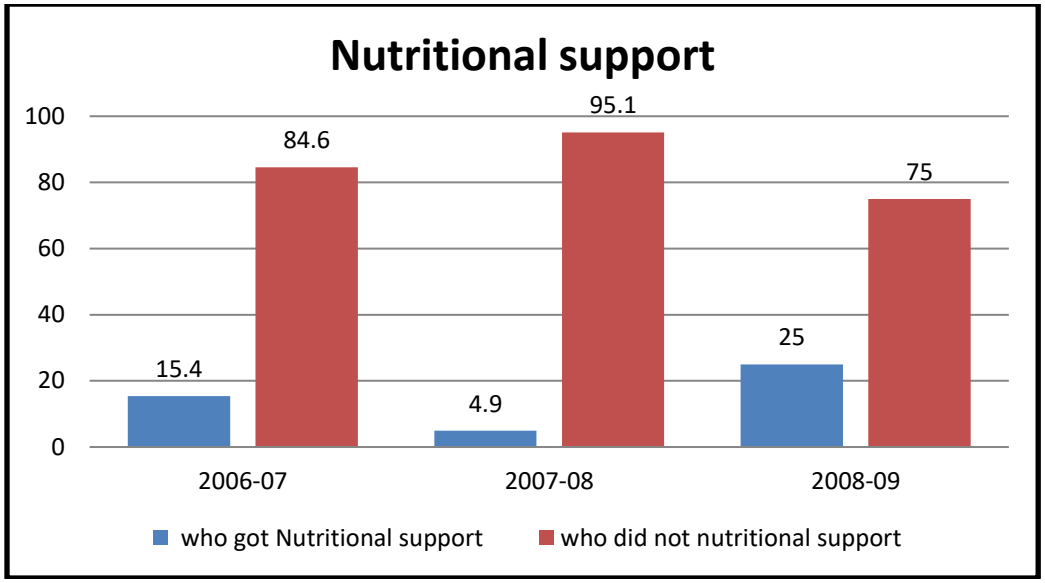


Figure 8:- Nutrition support

Over the past three nutritional supports has been given a defined population as may be due to shortage of funds or due to some eligibility criteria. As shown in chart percentage population who were getting nutritional support has been decreased drastically from year 2006-07(15.4%) to year 2007-08(4.9%) but also increased in the next year 2008-09 (25%). This gap may due to some specific reasons like eligible population, resource constraint etc.

Health care facility

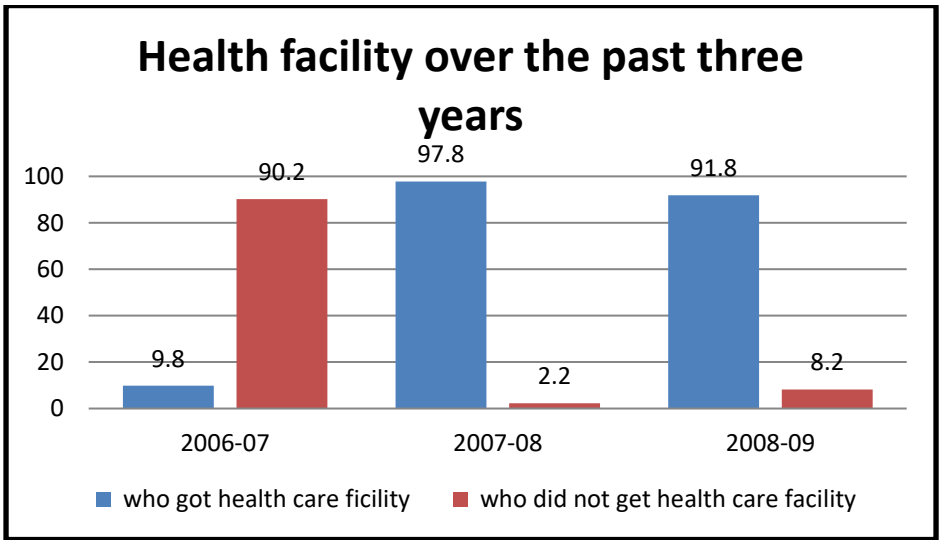


Figure 9:- Health care fecility over the past three years.

Health care facility is provided as per the need of individual. In year 2006-07 major population has not been covered. But next consecutive two years majority is covered under health care facility as shown in the chart.

Recreational support:-

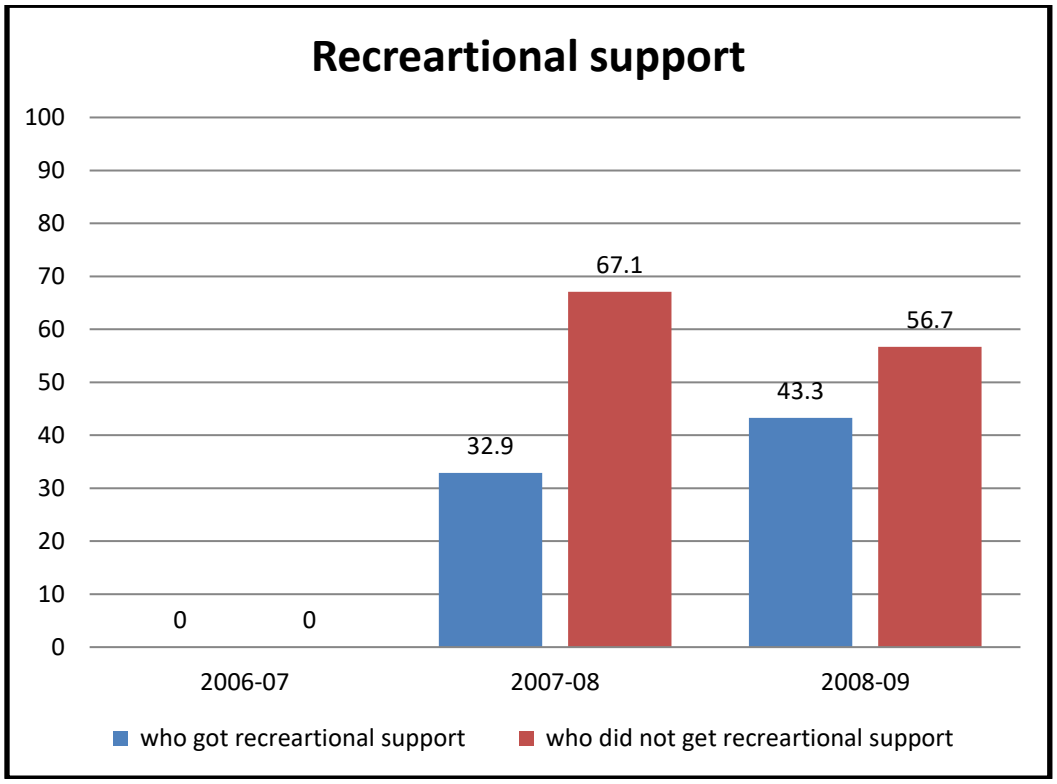


Figure 10:- Recreational support trends.

Recreational support is provided to children at the centre of ngo. In the first year(2006-07) Recreational support is not provided but in coming next years 32.9 % and 43.3% children were covered for the consecutive years.

Received OI:-

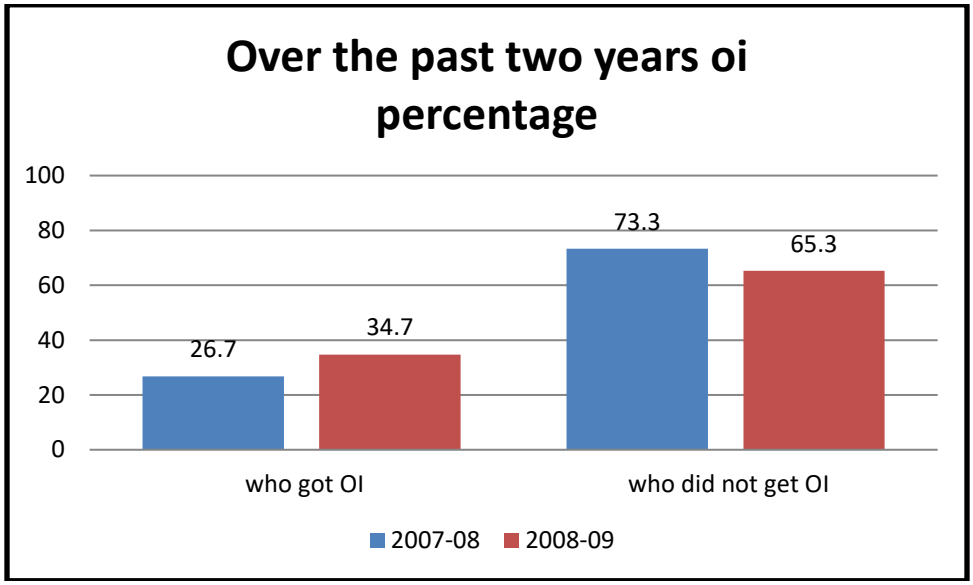


Figure 11: OI trends.

Analysis of data reveals that this percentage of OI is mostly including hospital cases, which took place during hospitalization. OI is a major issue which is increasing year by year as in year 2007-08, 26.7% population got OI while in 2008-09 34.7%got OI. Maximum cases were took place in hospital so reason may be many but he reasons may be further investigated for further improvement in the functioning of the NGO as well for better service delivery to the slums population

ART REFERRELS:-

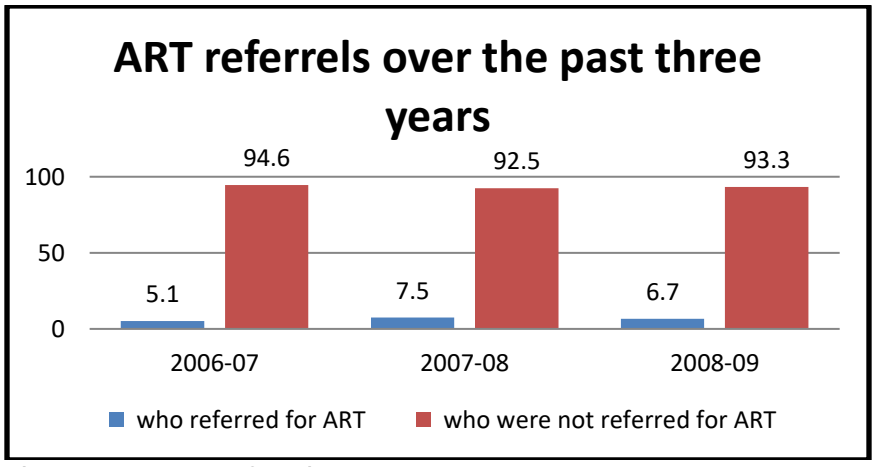


Figure 12:- ART referrals.

		who referred for ART			
		2006-07	2007-08	2008-09	Total
age of the population	<10	5	20	18	43
	10-14	4	9	1	14
	15-17	3	7	1	11
	18-24	7	4	12	23
	>24	14	25	36	75
Total		33	65	68	166

Table 3:- number of population who referred for ART.

There is the percentage of population who were referred for ART. This figure is fluctuating over the past three years from 5.2% to 6.7%. over the past years data indicate that percentage is increasing for art referrals. Maximum patients dispersion is in 25 or above 25 age group. Almost 50 % cases are from this age group, because this is the most sexually active age group. Although these patients dispersing in all age group but in 24+ and >10 is high prevalence age group as shown in the table.

Palliative care

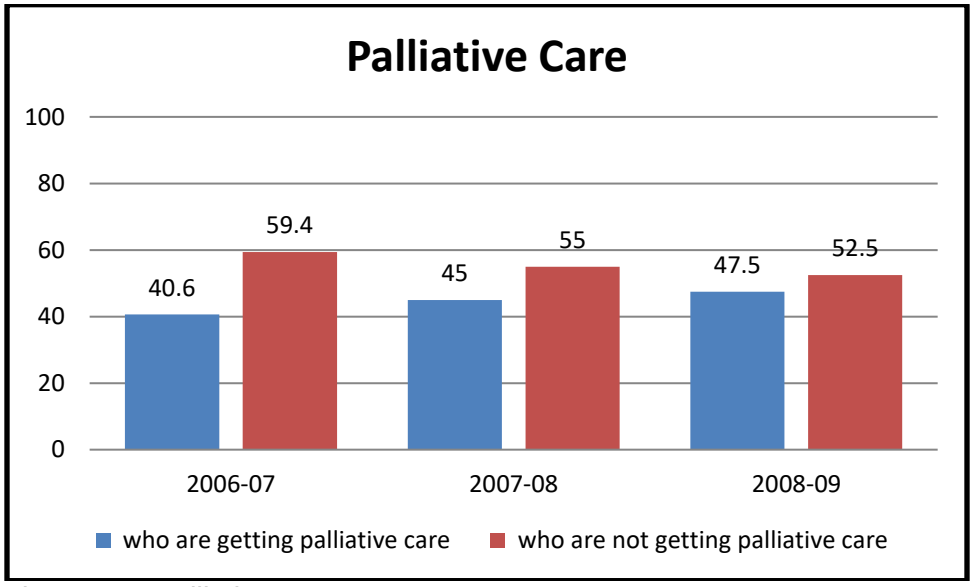


Figure 13:- Palliative care

Palliative care is given for the hiv affected or infected family. Variety of services is given under this service as nutrition, medical care etc. As per the data analyzed for palliative care indicate the increasing percentage over the past three years. There might be several reasons as OI also increasing over the years that also leads to palliative care.

5. TRENDS ANALYSIS

Trends Analysis Wag..Chelsea :-

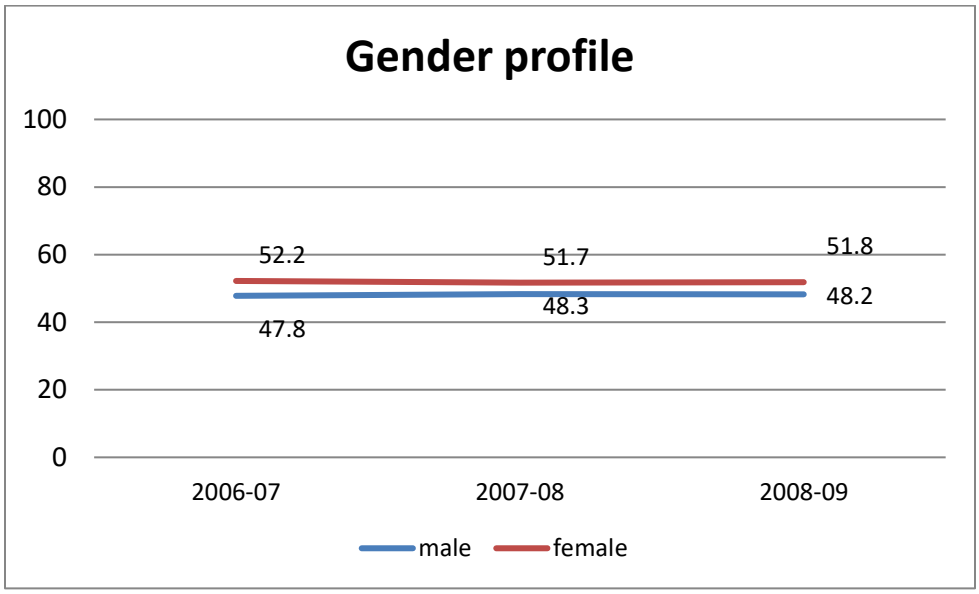


Figure 1:- Gender profile.

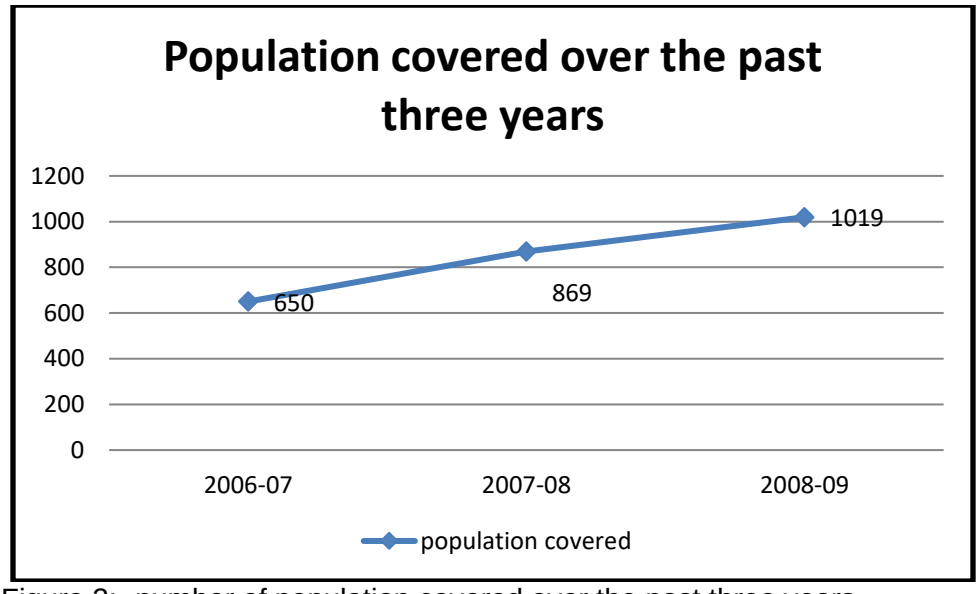


Figure 2:- number of population covered over the past three years.

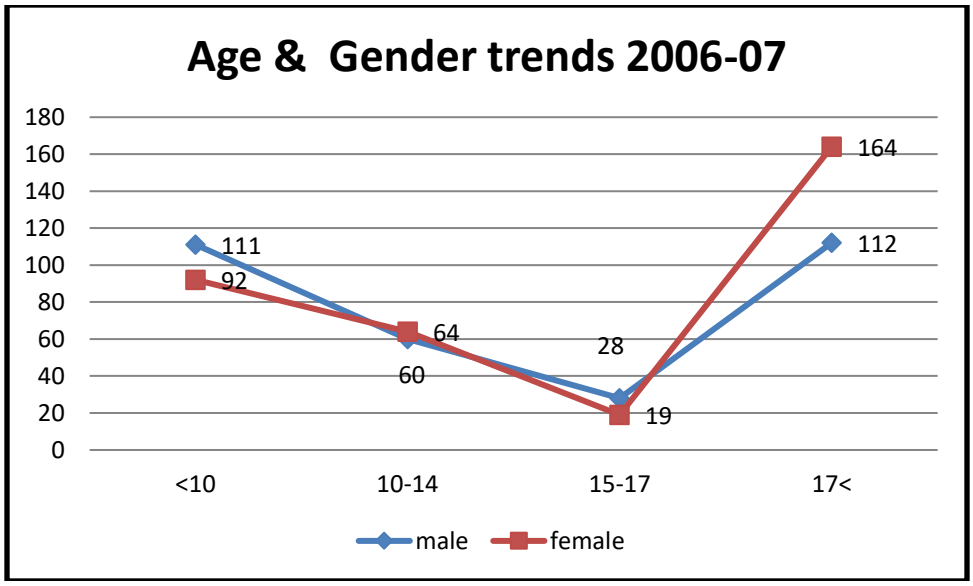


Figure 3:- Age & Gender trends.

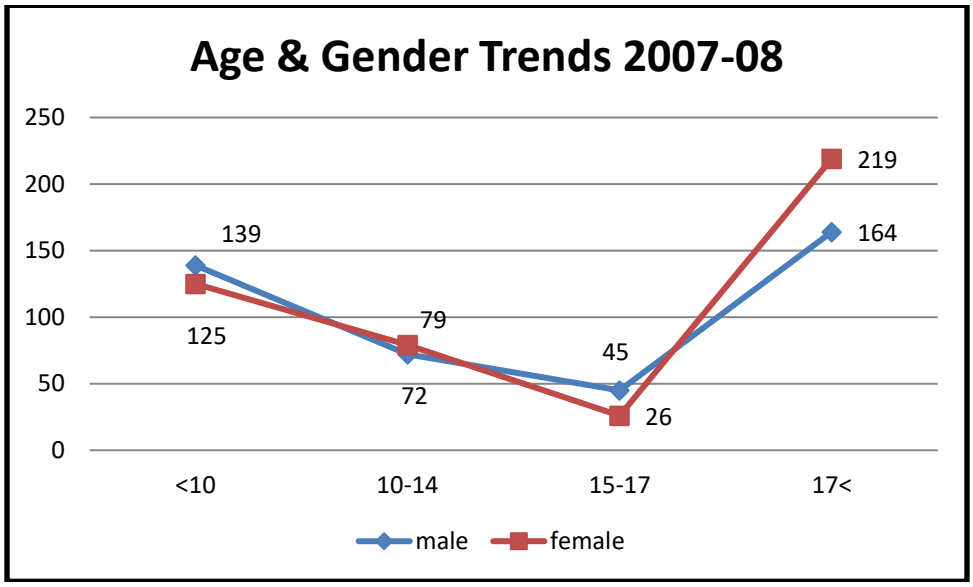


Figure 4:- Age & Gender trends

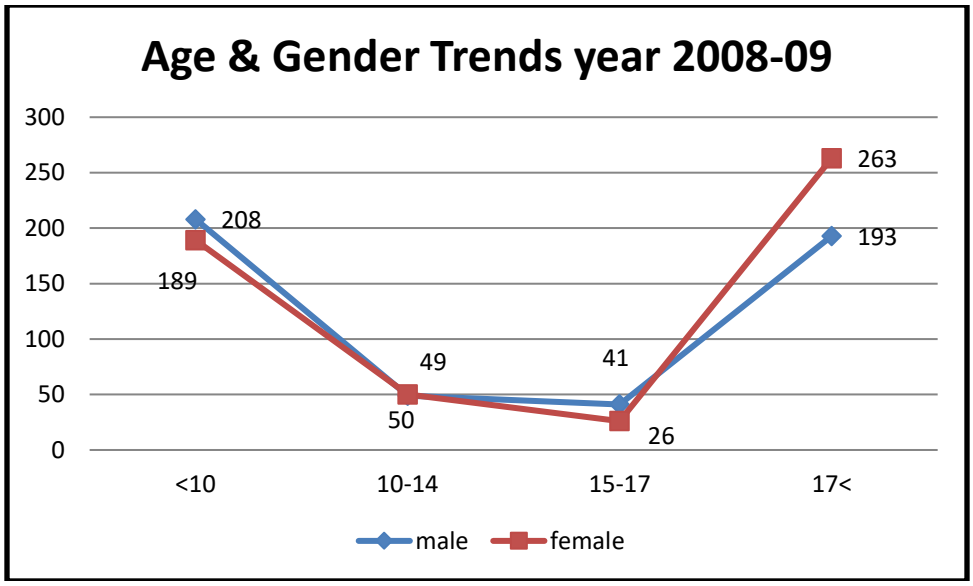


Figure 5:- Age & Gender trends

Here data shows the age and gender trends over the past three years. As the number of population covered increased over the years. It means Ngo is covering more and more population every year. Age wise female number is almost more than male. But in age group <10,10-14 & 15-17 male numbers are more compare to female numbers while female number are high in age group 17<.

LSE(Life Skills Education):-

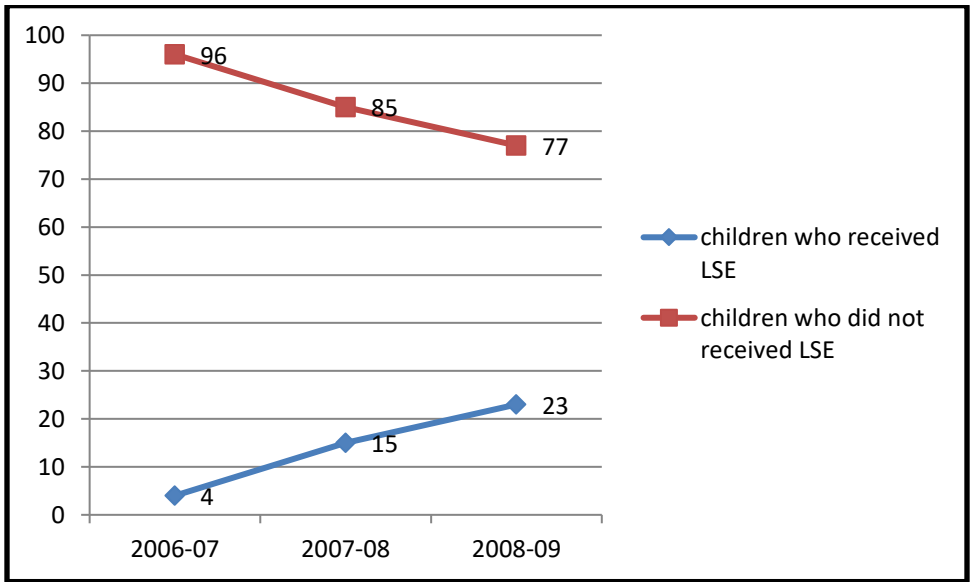


Figure 6:- LSE trends.

LSE is play very important role in overall development of children. This Includes enhancing the decision-making ability of the children in their daily lives, as well as

providing them with livelihood options through vocational training, education and job opportunities. The program is supervised by a full-time life skills coordinator within the organization, and implemented by counselors, who work with structured modules and guidelines that have evolved from our extensive experience in the field.
As data trends emerged that percentage of children covered under LSE is increasing over the past three years. This thing is quite appreciatable for NGO.

A/AB message:-

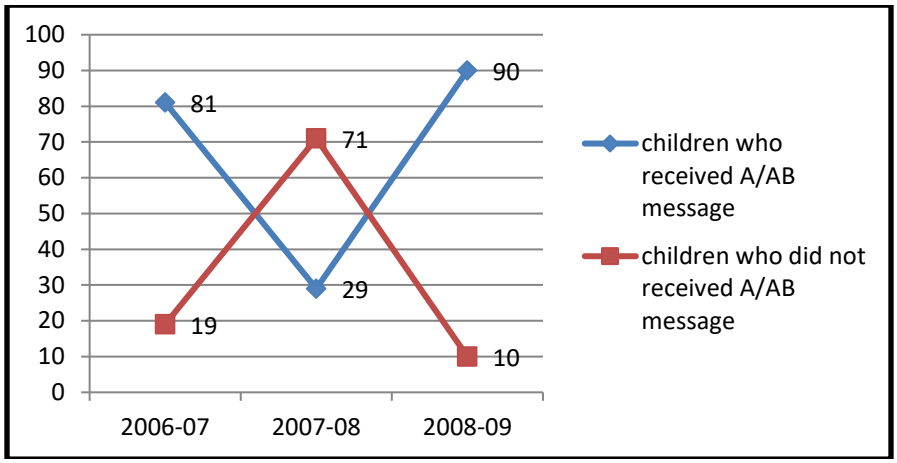


Figure 7:- A/AB message.

Over the period of years frequency of giving A/AB message is also fluctuating. Initially it has been decreased. But in the last year this figure again has been increased as 90%. So they almost covered maximum children who were eligible for the A/AB message as per the requirement.

Psychosocial support:-

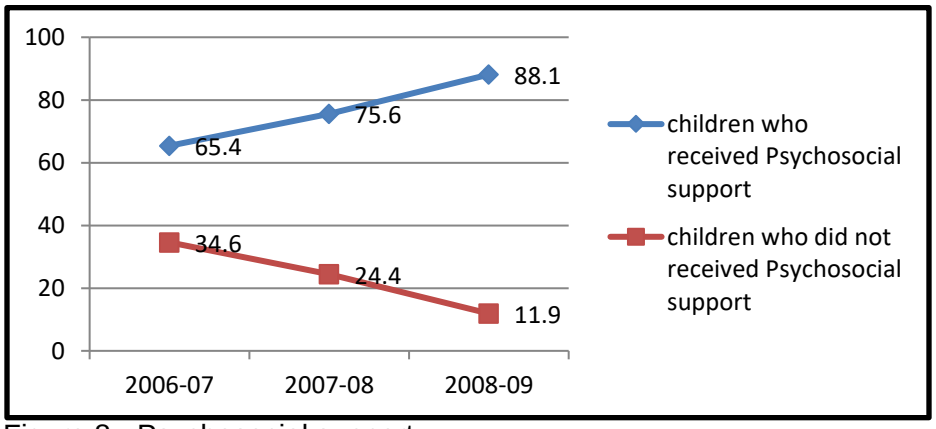


Figure 8:- Psychosocial support.

As per the data analysis reveals trends of psychosocial support. Over the past three years number of population who received psychosocial support is increasing. So we can say that maximum population need this service.

Vocational support:-

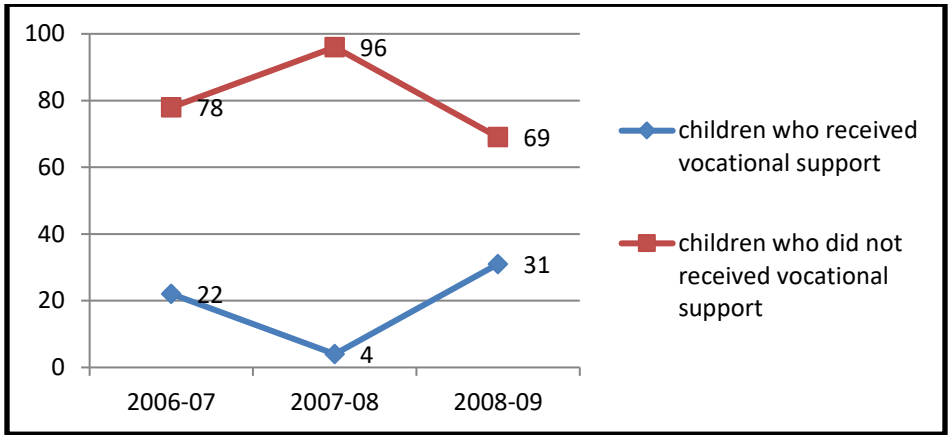


Figure 9:- Vocational support.

Population have been trained in a wide variety of trades, such as multimedia animation, film editing, photography, desk top publishing, web & graphic design, care- giving, housekeeping, computer applications, puppetry, karate, theatre and macramé's per the trends reveals for vocational support indicate fluctuation during the past three years. Which shows quite detoriation as compare to 2006-07. But it also increased in year 2008-09. That is also quite appreciatable for ngo. This vocational support depends upon interest of individual. So number of population who opted for vocational courses can vary.

Non-Formal Education

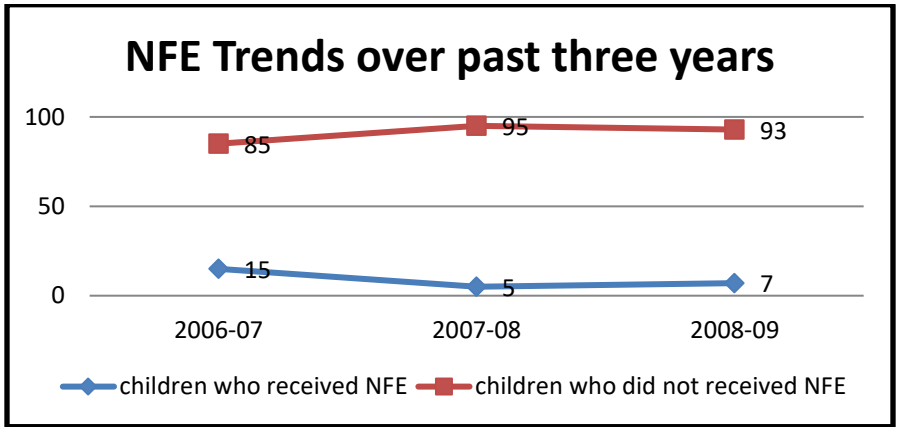


Figure 10:- Non-Formal Education

Non-formal education modules provide basic education and literacy, and cover child rights, computer literacy, general information, reading and recitation, health and hygiene, social skills, moral values, basic mathematics, and money management.
As trends indicate that percentage has been decreased over the past three years for Non-Formal education. Year by year this figure is going down for Non-formal education.

Nutrition:-

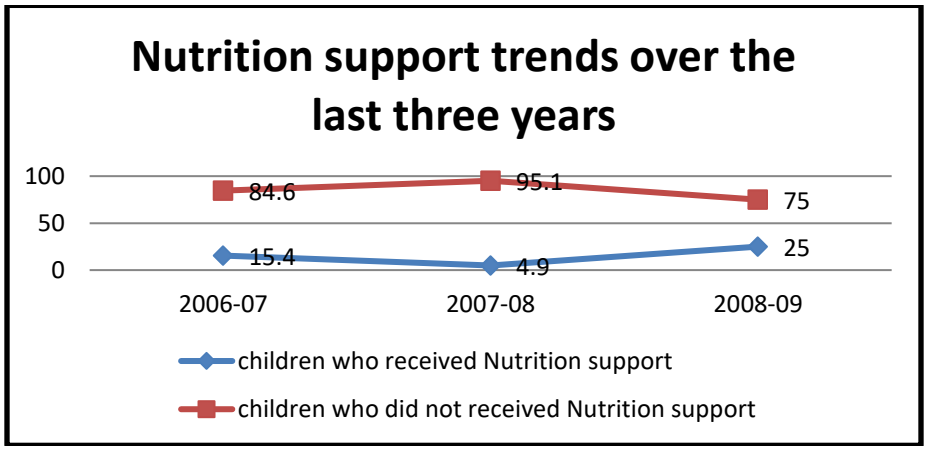


Figure 11:- nutrition support trends.

As per the trends emerge from the data sets shows that nutrition is provided on the need basis or per the ngos criteria. According to chart nutrition service is provided by ngo is increasing as compare to 2006-07. This might be due to coverage, that is also has been increased over the past three years.

Health care facility

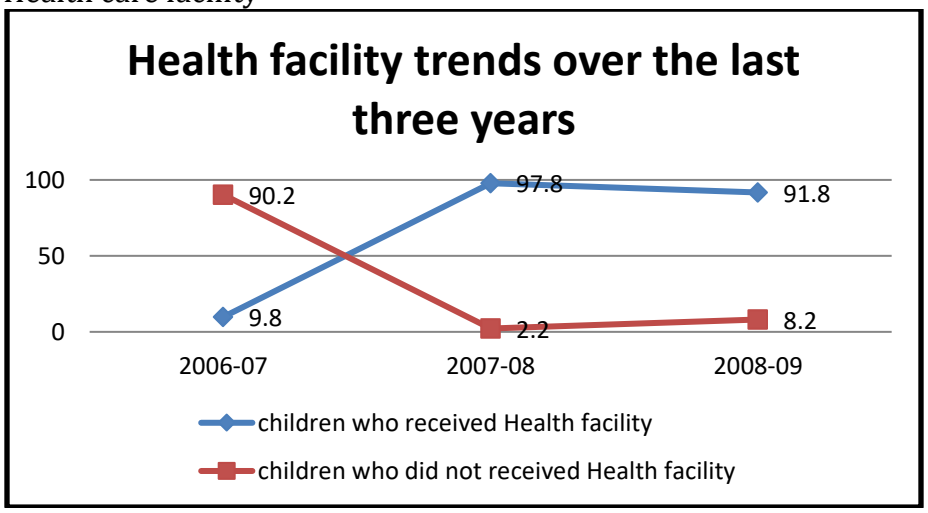


Figure 12:- Health care facility support.

As per the chart health facility provided to population is increased drastically from year to year. Trends shows huge demand of health care facility in urban slums.

ART Referrals:-

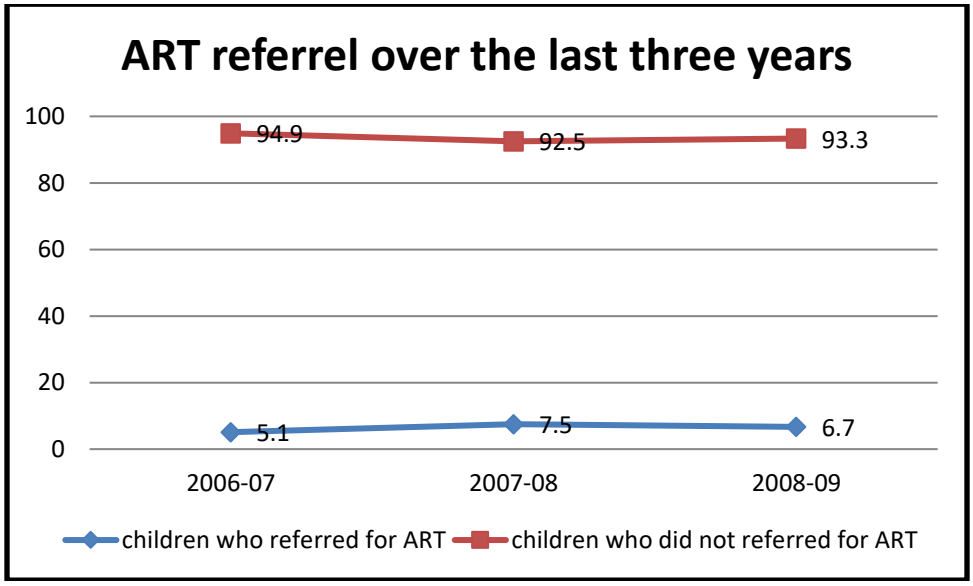


Figure 13:- ART referrals over the pasr three years.

As per the chart patient referred for ART are increased over the past three years. That is quite slow but number is increasing that shows that HIV prevalence is also increasing in urban slums.

Palliative care:-

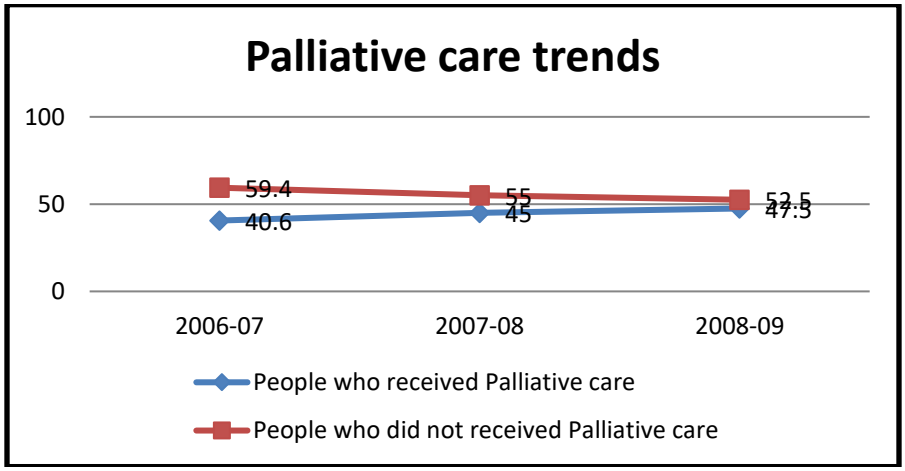


Figure 14:- Palliative care support trends.

This is the service which is provided to the people who are living with HIV infected or affected people. So as per the trends emerge from data shows that over the past three years percentage is increasing for palliative care.

6. CONCLUSIONS

As per the data analysis and trend analysis both the NGOs working well in their field. As Salaam Baalak Trust is covering more than 2000 children per year average that is good as coverage point of view. They are serving street children in all areas.

1. Girls ran away for a reason. They are abused emotionally and physically. Runaways are more likely than not, are victimized by their families. Yet they are betrayed by further punishments on the street by others. As it is already authenticated by the data analysis that the number of girls who run away from their homes is in continuous rise.
2. It has been found that over the years the NGO had been unable to provide required number of Life Skills Education, A/AB message and NFE (Non-Formal Education) to street children on continuous basis, the reasons of which are needed to be further probed out.
3. Nutrition service is provided to children has been increased over the last years so that is good for the betterment of the street children.
4. Though there has been increase in the number of street children referred for STI testing (which may be a situation of routine examination), it has been noticed that the number of street children for HIV testing have reduced over the same period, the cause of which may be infrequent STI affected cases in the NGO and decrease in the risk taking behavior of the street children residing in the shelter homes of the same. This depicts the better service delivery of the organization as a whole.
5. Psychosocial support addresses the ongoing psychosocial and social problems of HIV infected individuals. Services for the psychosocial support have decreased over the same time period which depicts that the requirement for the same have decreased and the status of street children with respect to these is better than the previous years.
6. Mental health support also has been increased over the past years that is need based service so might be number of children who needed this service has been increased over the years.

WAG…CHELSEA is covering almost average 800 population in a year. They are srving people of all age group. They are giving many services including palliatice care and other services.

1. Life skills education aims to develop the ability of an individual to deal with the variety of situations that life throws up. Such education helps in the overall development of children, including physical, mental and social well-being, building greater self-confidence in life. So over the years percentage of children who have participated in Lse sessions have been increased which shows that maximum number of children are more self motivated, more mentally developed compare to past years.
2. For the respective years the percentage of children receiving A/AB message is highly fluctuating, though there is sudden increase in the sessions in the last year which is a positive sign.

3. It has been noticed that the number of population for HIV testing have reduced over the same period, the cause of which may be infrequent STI affected cases in the NGO and decrease in the risk taking behavior of the population residing in the urban slums. This depicts the better service delivery of the organization as a whole.
4. Over the years need for psychosocial support is also increased. That depicts that population who need psychosocial support have been increased. Means they are having more mentally or psychosocial problems.
5. Vocational and nutrition support also have been decreased over the years that is need based or interest based services so may be this reason this has been reduced. Or resource limitation might be other reason.
6. As this data shows opportunistic infection also has been increased. This not only for in house infection, maximum are from hospital. So palliative care is also increasing that's why ART referrals also increasing.

7. RECOMMENDATION

1. As per the conclusion Salaam Baalak Trust need to take serious concern for the area of LSE, NFE and A/AB message which is depicting continuous degrowth.
2. Wag..Chelsea is doing well in almost all area. But in area of HIV/AIDS need to take on priority as number of OI , STI referrals , ART referrals and Palliative care is increasing. Need to improve population's mental and psychosocial health as they demanding more each year.

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