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Third Annual Report

CASP-PLAN Maternal Health and Child Survival Project

Cooperative Agreement No FAO-0500-A-00-5019-00
Child Survival XI Project

Implementing Agency

PLAN International
Delhi Field Office, India
in cooperation with
Community Aid and Sponsorship Program (CASP)

Location

India
Sangam Vihar An Urban Slum in South Delhi

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Ending Date 29 September 1999

A

Acronyms

| | | |
|---------|---|---|
| AIDS | - | Acquired Immune Deficiency Syndrome |
| ANC | - | Ante-natal care |
| ARI | - | Acute respiratory infection |
| CASP | - | Community Aid and Sponsorship Program |
| CBO | - | Community-based organization |
| DDC | - | Diarrheal disease control |
| DIP | - | Detailed Implementation Plan |
| EPI | - | Expanded Program in Immunization |
| FP | - | Family planning |
| FPAI | - | Family Planning Association of India |
| GOI | - | Government of India |
| HIV | - | Human Immuno-Deficiency Virus |
| IEC | - | Information, education, and communication |
| IUD | - | Inter-uterine device |
| MIS | - | Management Information System |
| MOHFW | - | Ministry of Health and Family Welfare |
| NGO | - | Non-governmental organization |
| OC | - | Oral contraceptive |
| ORS | - | Oral Rehydration Solution |
| PC | - | Project Coordinator |
| PEM | - | Protein energy malnutrition |
| PI | - | Project indicator |
| PIC | - | Project Implementation Committee |
| PNC | - | Post-natal care |
| PRA | - | Participatory Rapid Appraisal |
| PVO | - | Private Voluntary Organization |
| RMP | - | Registered Medical Practitioner |
| SCH | - | a local NGO |
| SHIKSHA | - | a local NGO |
| STD | - | Sexually Transmitted Disease |
| TT | - | Tetanus toxoid |
| TBA | - | Traditional Birth Attendant |
| TOST | - | Training of Survey Trainers |
| UNICEF | - | U N International Children's Emergency Fund |
| USAID | - | U S Agency for International Development |
| VSC | - | Voluntary surgical contraception |
| UI | - | USAID indicator |
| WHO | - | World Health Organization |

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1. INTRODUCTION

1 1 Organational Background

1 1 1 PLAN International

PLAN International is an international child-focused sponsorship organisation, with support base in fourteen countries and direct operations in forty developing countries. PLAN has been working in India since 1979. Due to legal framework in India, PLAN operates in the country in partnership with local NGOs.

1 1 2 CASP

Community Aid and Sponsorship Programme (CASP) is a local NGO working largely in urban areas.

1 1 3 CASP-PLAN

CASP and PLAN have worked together in Sangam Vihar, an unauthorised slum settlement in New Delhi, since 1986. CASP-PLAN has had on-going child-sponsorship and integrated health and community development programs in this settlement.

1 2 Background to the Project

1 2 1 Health Needs Assessment

A survey was conducted in June 1995 to gather information on health problems of women and children in the slums of Govindpurī and Sangam Vihar. Acute Respiratory Tract Infections, Diarrhael Disease and vaccine preventable disease were seen as priority problems of children and women's reproductive health problems were almost universal. CASP-PLAN proposed to implement a child survival and reproductive health project in Sangam Vihar in 14 out of the 21 blocks in Sangam Vihar covering a population of 51 665 at the time of the baseline survey in 1995.

1 2 2 Project Funding

In August 1995 PLAN received a 4 year USAID Child Survival Grant (cooperative agreement no. FAO-0500-A-00-5019-00 Child Survival XI Project). A 2-year Reproductive Health Grant from MacArthur Foundation (cooperative agreement no. 95-29066) served as the match grant for the first two years. On 1 September 1995 CASP-PLAN initiated the Child Survival and Reproductive Health Project in Sangam Vihar.

2. PROJECT PROFILE

2.1 Demographic Profile

| | |
|---|--------------------------------|
| • Total project area population 51,665 | Females 46% |
| • 50% population below 18 years | Males 54% |
| • 60% of married couples below 30 years | |
| • Population in reproductive age group (15 to 49 yrs) 27,000 | |
| • Average number of children below 5 years 1.4 per family | |
| • Average household size 4.6 | |
| • Nuclear family 74% | Uttar Pradesh 72% |
| • State-wise break-up | Bihar 12% |
| • In-migration rate 25% | Madhya Pradesh & Rajasthan 16% |
| • Out-migration rate 10% | |
| • Religion | Hindus 75% |
| | Muslims 18% |
| • Caste | Scheduled castes/tribes 17% |
| • Male Literacy 67% | |
| • Female literacy 42% | |
| • Age at Marriage (less than 18) | 75% |
| • Teenage Pregnancies (less than 20) | 60% |
| • Couples having 2 or more children | 80% |
| • Couples having 3 or more children | 53% |
| • Couples having 4 or more children | 31% |
| • Females totally unemployed or employed on part time basis 97% | |

2.2 Community Constraints

- Lack of public services like water supply, sanitation services and electricity
- Lack of public health care systems
- Public transportation
- Continuous migration
- Low female literacy rates
- Limited opportunities for female work participation
- Homebound situation of women

2.3 Health Care Access

The area has about 100 private practitioners, most of whom are not qualified. There is no government health facility in the area; the closest public hospitals are 15 kms away. There is a private for-profit hospital adjacent to the colony.

2 4 Project Collaborators

- Ranbaxy Laboratories for mobile general clinics,
- Parivar Sewa Sanstha (Marie Stopes) for family planning
- FPAI (International Planned Parenthood Federation) for Sexual Health workshops for adolescents,
- Sakshi for communication skills workshops,
- Siksha, SACH, ORDA, VHAD and Kamala Khetrpal Trust for women's awareness programs,
- Love and Care for Immunization,
- DCWA for child health program,
- Food and Nutrition section of Non-Formal Education Department, GoI, for nutrition education program,
- Health and Family Welfare Department, Government of Delhi for contraceptives and MCH kits, and
- UNICEF and Heart Care Foundation for IEC materials

2 5 Target Population

Out of 51,665 people living in the project area, a total of 37,709 have been identified as potential project beneficiaries for services (but not for educational interventions) The break-up of the target population is as follows

| Population Group | No of Potential Beneficiaries |
|-------------------------|-------------------------------|
| Infants (0-11 months) | 2 159 |
| Children (12-23 months) | 2,021 |
| Children (24-49 months) | 6 407 |
| Women (15-49 years) | 12 059 |
| Men (15-49 years) | 15 063 |
| Total | 37,709 |

2 6 Project Components

- 1 Diarrhael Disease Control
- 2 Maternal health care
- 3 Family Planning
- 4 STD/HIV prevention and Control

2.7 Project Goals

| | |
|---|--|
| 1 To improve the prevention and case management of diarrhoea cases in children less than 5 years (with priority in children less than 2 years) | 3 To assist in the achievement of the couple's reproductive preferences To reduce maternal, infant and child mortality through better family formation patterns (e.g. reduced family size, birth spacing) |
| 2 To reduce maternal and neonatal mortality, by enhancing the coverage and quality of prenatal care, birth delivery and emergency management of obstetric complications | 4 To prevent the spread of HIV/AIDS through education and motivation for behaviour change, the provision of condoms and the detection and case management of STDs |

2.8 Project Approach and Strategy

2.8.1 Integrated Community-based Approach

- | |
|---|
| 1 Clinic-based Interventions 2 Home-based Interventions 3 Community level Interventions |
|---|

2.8.2 3-pronged Strategy

- | |
|--|
| 4 Health Promotion through Information Education Communication and Counselling 5 Health Service Provision Risk Screening and Referral 6 Community Organisation Social Mobilisation and Demand Generation |
|--|

2.9 Project Organisation

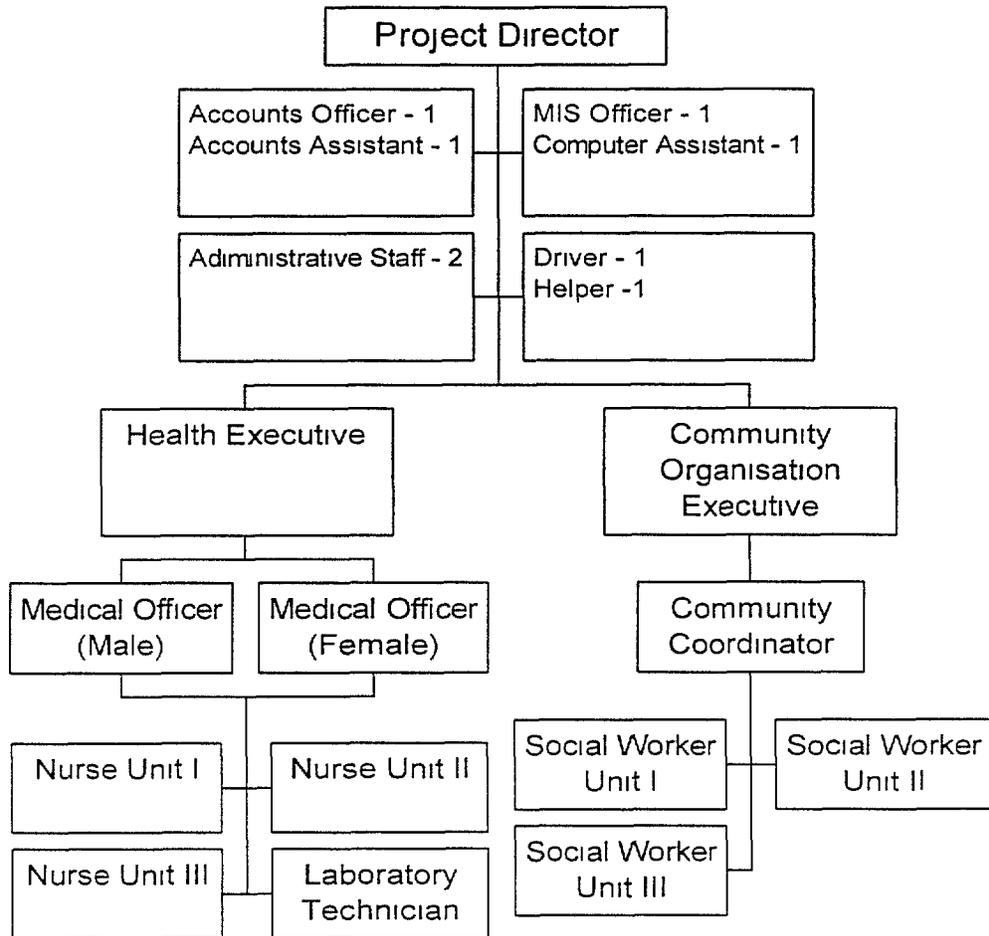
2.9.1 Community Organisation

The project area is divided into 3 units and further divided into 10 development areas. CASP-PLAN sponsorship program has a Community Development Officer (CDO) responsible for sponsorship and program interventions in each area. They supervise the activities of the community-based organisations in their area. The CBOs include Mahila Mandals (women's group), Youth Groups and Income

Generation Project (IGP) groups There are, in all, 89 CBOs but many are not active The project has re-activated 69 CBOs as Neighborhood Family Associations (NFA)

Each unit has approximately 30 CHGs, each covering on an average, 130 households Each unit also has a CHG association There are 65 TBAs and also a TBA association There is also an Ambulance Association

2 9 2 Project Organogram



3. ACCOMPLISHMENTS AND CONSTRAINTS

3 1 Extent to which Project is being Implemented on Schedule

Most of the activities detailed in Table C **Schedule of Field Project Activities** of the DIP have been implemented on schedule, as outlined below

3 1 1 MIS

A census database system with details on all the eligible women from the Eligible Women's Register (EWR) was created this year. Summary data from the three units, both from the field and the clinics, are entered in a spreadsheet for the purpose of generating periodic reports. There has been some delay in developing a relational database linking community-based and clinic based activities to the computerized EWR. At present, the system is tracking household contacts of CHGs, ensuring that all eligible households are visited at least once every month. A computer-based system was developed to verify the activities and services of the CHGs. This is helpful when determining payment of incentives to CHGs. MIS design and development is still in the process of refinement.

3 1 2 Training

Training activity has been on schedule. Training of Trainers (TOT) and continuing education and in-service training of CHGs and TBAs is an ongoing activity. Competencies training in the skills required for the project components was initiated this year. Protocols for quality assessment of skills have yet to be developed. Technology updates in contraceptives, simplified syndromic management of STDs and Reproductive and Child Health (RCH) program of Government of India are planned to be conducted in the forthcoming quarter.

3 1 3 Procurement

There was no procurement of major equipment during the third year and there are no plans to procure any further equipment in the last year of project.

3 1 4 Delivery of Services

The service delivery, both community-based and clinic-based, in all four components were initiated on schedule during the first year and there was increasing demand for these services during the second year. The community perceived them to be of good quality when compared to the same services provided by unqualified practitioners in the community.

Soon after the mid-term evaluation, in an attempt to de-medicalise the project, a premature phase over of clinic-based services was initiated. In a bid to hand over clinic based activities to other NGOs in the project area (i.e. Ranbaxy, DCWA, etc.) as a sustainability strategy, the quality of first referral clinical care within the community area has deteriorated.

3 1 5 Technical Assistance

After the mid-term evaluation, there were two visits from PLAN USNO headquarters Ms Karla Steele's visits before and after the independent internal audits by Price-Waterhouse were very critical to the project With her support and inputs, the financial controls on the project were streamlined and financial reporting rationalized

There were two visits by technical advisors, the first by Ms Nancy Vollmer to conduct LQAS training for project staff The second technical visit from headquarters was by Dr Joe Valadez to follow-up on the actual use of LQAS in project monitoring and supervision The team found it a useful instrument to identify areas of poor performance or quality, and to enable the project to focus on certain geographical areas, CHGs or project activities that needed more attention

SEATS, which supports USAID funded family planning programs also made two follow-up visits and provided useful insights into improving the quality of FP component of the program

The North Zone Manager of PLAN ICO provides management support to the project and PLAN's Country Health Advisor provides technical support Technical assistance is also provided by CASP Health Advisor and Financial Consultant of CASP-PLAN provides oversight of project expenditures and finance reporting

3 1 6 Progress Reports

The progress of the project is monitored periodically through the Project Implementation Committee (PIC), in which PLAN and CASP officials and project staff participate at least once in two months Recommendations of the MTR are also tracked at the PIC Monthly financial reports are reviewed by PLAN and sent to USNO The results of all reviews and reports are discussed with the communities and at the PIC

The project ends in August 1999 Since schools close for about 10 weeks between May and July and most women and children go to their villages for holidays, the project requests that the final evaluation of the project be undertaken in April-May August, being the monsoon season is also not suitable for evaluation

3 2 Comparison of Planned and Actual Inputs/Outputs

The following tables compare the targets for inputs/outputs contained in the DIP with actual measures at Mid-Term Evaluation and at the end of the third year For most of the indicators the current achievement level exceeds end of project targets

3 2 1 Diarrheal Disease Control

| S No | Output / Inputs | Mid-Term Targets | Mid-Term Actual | Third Year Targets | Position as on 31 8 98 | End Targets |
|------|--|------------------|-----------------|--------------------|------------------------|-------------|
| 1 | Number of mothers of children (0-23 mo) educated on the household case management of diarrheal diseases | 1500 | 2884 | 2500 | 3925 | 3000 |
| 2 | Number of mothers of children (0-23 mos) who can identify the danger signals of severe diarrhoea/dehydration, and know what to do | 1350 | NA | 1800 | NA | 2100 |

3 2 2 Maternal Health Care

| S No | Output / Inputs | Mid-Term Targets | Mid-Term Actual | Third Year Targets | Position as on 31 8 98 | End Targets |
|------|---|------------------|-----------------|--------------------|------------------------|-------------|
| 1 | Number of married women educated on maternal care and signs of danger during pregnancy | 4000 | 8261 | 6500 | 11830 | 10000 |
| 2 | Number of pregnant women with 2 sessions of antenatal care | 1000 | 1699 | 1500 | 1774 | 1713 |
| 3 | Number of pregnant women receiving iron-folate supplements | 1000 | 1538 | 1500 | 1774 | 1713 |
| 4 | Number of pregnant women with TT2 | 1000 | 1690 | 1500 | 1774 | 1713 |
| 5 | Number of home deliveries using a clean birth kit | 450 | 1180 | 700 | 977 | 857 |
| 6 | Number of TBAs trained and supervised regularly * | 35 | 48 | 65 | 57 | 65 |
| 7 | Number of pregnancies with delivery attended by a qualified provider | 850 | 2045 | 1300 | 1490 | 1713 |
| 8 | Number of obstetric emergencies referred to and cared for by a qualified institutional provider | 130 | N/A | 210 | | 289 |

* this refers only to number trained and not regularly supervised

Indicators at S Nos 2 3 4 and 5 in the above table are based on birth records

** Hospital deliveries + births attended by trained TBA

3 2 3 Family Planning

| S No | Output / Inputs | Mid-Term Targets | Mid-Term Actual | Third Year Targets | Position as on 31 8 98 | End Targets |
|------|---|------------------|-----------------|--------------------|------------------------|-------------|
| 1 | Number of women of reproductive age and men married to women of reproductive age educated on family planning | 9000 | 11653 | 15000 | 16164 | 20000 |
| 2 | Number of condoms distributed (thousands/year) to married couples (Couple Protection Rate Assumption 144 condoms/couple/year) | 250 | 520 | 500 | 333 (2079) | 755 |
| 3 | Number of married couples using a modern birth control method | 2800 | 4014 | 4300 | 4535 | 5760 |

3 2 4 STD/HIV Prevention and Control

| S No | Output / Inputs | Mid-Term Targets | Mid-Term Actual | Third Year Targets | Position as on 31 8 98 | End Targets |
|------|---|------------------|-----------------|--------------------|------------------------|-------------|
| 1 | Number of women of reproductive age and men married to women of reproductive age educated on HIV/STDs/AIDS prevention and control | 9000 | 11653 | 15000 | 16164 | 20000 |
| 2 | Number of STD cases managed using the WHO syndromic approach | 1300 | 1725 | 2000 | 1682 | 2700 |

3 2 5 Community Empowerment

| S No | Output / Inputs | Mid-Term Targets | Mid-Term Actual | Third Year Targets | Position as on 31 8 98 | End Targets |
|------|---|------------------|-----------------|--------------------|------------------------|-------------|
| 1 | Number of Community Health Guides trained and supervised regularly | 35 | 97 | 65 | 82 | 65 |
| 2 | Number of Healthy Family Promoter couples trained and supervised regularly * | 35 | 31 | 65 | 45 | 65 |
| 3 | Number of neighborhood family associations with leaders trained in the management of Child Survival activities | 25 | 3 | 45 | 4 | 65 |
| 4 | Number of neighborhood family associations which analyse CS activity results in their monthly meetings and, based on the results, plan new activities | 25 | 3 | 45 | 45 | 65 |
| 5 | Neighborhood family associations with an emergency transport and referral system in operation | 25 | 3 | 45 | 70 | 65 |
| 6 | Number of institutional facilities equipped and supplied for maternal care and family planning and HIV /STD AIDS services | 4 | 3 | 5 | 6 | 5 |
| 7 | Number of providers from local institutions trained and supervised regularly * | 35 | 43 | 55 | 43 | 80 |

* this refers only to number trained and not regularly supervised
Indicator at S No 7 in the table above refers to training of RMPs

3 3 Comparison of Planned & Actual Project Outcomes

Three surveys have been done to measure certain knowledge and practice indicators of beneficiaries. Due to the difference in methodologies adopted in the surveys drawing of comparative inferences is difficult.

The Baseline Survey was done using a 30-cluster sampling technique sample size was 210, and the sampling frame consisted of mothers with children in the age group 12 - 23 months. At the Mid term Survey in July 1997 the 30-cluster sample was used again but the sampling frame consisted of mothers with children in the age-group 0 - 23 months sample size was raised to 328. This sample frame

was better suited for this project as it covers the priority beneficiary group, half of whom were excluded from the Baseline Survey. Since the questions relate to knowledge and practice of maternal and child care, the time since delivery and the age of the child could make a significant difference to the outcomes. So comparing these two results with each other would raise some problems, but they could be compared separately with the targets.

The third year survey was done on 101 mothers with children in the 0 - 2 month age group. However, there was no randomisation used in the selection of respondents. They were selected arbitrarily during house visits and at meetings. This data should be interpreted with caution. It is recommended that the End of Project Survey should use the same methodology as either the Baseline or the Mid Term survey to make meaningful comparison.

The following tables give a comparison of the outcome indicators at Base Line Survey, Mid Term Evaluation and end of third year.

3 3 1 Diarrheal Disease Control

| S No | Indicators | June 1995 | July 1997 | August 1998 |
|------|---|-----------|-----------|-------------|
| 1 | 60% of diarrhoea cases in children aged 0-23 months will be managed at home using home fluids/ORS packets (UI) | 51% n=96 | 69% n=163 | 80% |
| 2 | 60% of diarrhoea cases in children aged 0-23 months will be managed at home with continued or increased feeding | 50% n=96 | 44% n=163 | 77% |
| 3 | 60% of the mothers of children aged 0-23 months who breastfeed will continue breastfeeding as usual or more during diarrhoea (UI) | 64% n=96 | 65% n=163 | 82% |
| 4 | 60% of mothers of children aged 0-23 months will know at least four reasons to refer a child with diarrhoea | NA | 50% | 58% |

It is observed from the table above that women have difficulty in recalling all the criteria for diarrhoea referral. In other areas too, recall for multiple factors is poor as indicated in the respective tables.

Maternal Health Care

| S No | Indicators | June 1995 n=210 | July 1997 n=328 | August '98 n=101 |
|------|--|--------------------|--------------------|---------------------|
| 1 | 80% of married women with children aged 0-23 months will know at least three signs of danger during pregnancy and what to do about them | NA | 16% | 50% |
| 2 | 80% of mothers of children aged 0-23 months will have at least two antenatal sessions prior to the birth of her youngest child (UI), by card | 77% n=30 | 92% n=52 | NA |
| 3 | 80% of pregnancies will receive adequate iron-folate supplementation through a qualified provider or a trained TBA | NA | 70% | 84%@ |
| 4 | 80% of pregnant women will be immunised with TT2 before the birth of their youngest child (UI), by card | 77% n=30 | 88% n=49 | 84% @ |
| 5 | 80% of home deliveries will use a clean birth kit | NA | 33% n=243 | 84%@ |
| 6 | 80% of mothers of children aged 0-23 months will have had their last delivery attended by a qualified provider | 34% | 26% | 84% ** |
| 7 | 90% of women experiencing an obstetric emergency will be referred to the next level of care | N A | N A | N A |

** The figure for Home Deliveries attended by qualified attendants for this years data includes those conducted by trained TBAs Previous years data did not include TBA deliveries

Family Planning

| S No | Indicators | June 1995 n=210 | July 1997 n=328 | August 98 n=101 |
|------|--|--------------------|--------------------|--------------------|
| 1 | 80% of mothers with children aged 0-23 months will know at least three methods of contraception | NA | 51% | 74% |
| 2 | 50% of couples with children aged 0-23 months who desire no more children in next two years or are not sure will use a modern contraceptive method | 31% | 32% | 83% |

3 3 4 STD/HIV Prevention and Control

| S No | Indicators | June 1995 | July 1997 | August 1998 |
|------|--|-----------|--------------|-------------|
| 1 | 80% of women with children aged 0-23 mos, will know the natural history of HIV/AIDS | NA | 76% n=185 | 89% |
| 2 | 80% of women with children aged 0-23 mos, will know at least two modes of transmission of HIV | NA | 64% n=185 | 70% |
| 3 | 80% of women with children aged 0-23 mos, will know the importance of condom use in preventing HIV | NA | 60% | 52% |
| 4 | 80% of women with children aged 0-23 mos will know the importance of treating STDs in preventing HIV | NA | 10% n=185 | 55% |
| 5 | 80% of women of reproductive age attending CASP-PLAN gynecology or family planning clinics will be screened for STD symptoms | NA | NA | 100% |
| 6 | 90% of cases of vaginal discharge found during screening will be clinically assessed and treated according to the WHO syndromic approach | NA | NA | 100% |

3 4 Other Outstanding Achievements

3 4 1 Diarrheal Disease Control

The following table reflects interesting trends in impact indicators of Diarrhoeal Disease component (in Under Fives)

| INDICATOR | Julv 96 - June 97 | Julv 97 - June 98 |
|--|-------------------|-------------------|
| Diarrhoeal Episodes Reported | 7506 | 11281 |
| Diarrhoeal Deaths Reported | 33 | 8 |
| Case Fatality Rate | 0 44 % | 0 07 % |
| Total Deaths Among Under Fives | 153 | 104 |
| Proportionate Mortality Due To Diarrhoea | 21 6 % | 7 6 % |

There is a marked increase in the number of diarrhoeal deaths reported. In the absence of any real epidemic this could be attributed to better reporting by the CHGs. It must be recognised that the cash incentive that CHGs receive is based on their reporting of such events. There is a marked fall in the absolute number of diarrhoeal deaths from 33 in 96-97 to 8 in 97-98. These two factors have

contributed to the reduction in the Case Fatality Rate. Total deaths reported in the under-five population is also down by almost a third. This is a very interesting trend. However, it is too early to tell if this change will be sustained.

3 4 2 Maternal Health Care

Antenatal care for the pregnant women in the community is being provided at 3 fixed clinics in the area. A year ago, there were bi-weekly clinics run by CASP-PLAN in all 3, a total of at least 24 clinics a month. It is now reduced to 8. From April 1998, the government health department has conducted ANC clinics on the 10th of each month at the 3 clinic sites.

The CHGs have begun to do ANC check-ups at home for women in their areas, to the extent to which they have been trained. They take case histories and record on maternal cards. All pregnant women are registered with the CHGs and are followed by them till the time of delivery. High Risk cases are flagged, and more intensively cared for. They are advised of institutional delivery and registered at government maternity centres. On an average, there are about 900 pregnant women at any point of time in the project. The next table depicts the number of visits made at the clinic for antenatal care.

| Period | New Visits | High Risk Cases |
|------------------|------------|-----------------|
| Sept 96 - Aug 97 | 3177 | 376 |
| Sept 97 - Aug 98 | 2755 | 1835 |

The number of births each year is less than 1800. The larger number of new cases is due to non-project patients being served and a high rate of abortions being registered by project staff.

The High Risk cases as a percentage of the total pregnancies in the previous year was less than 12% when the risk scoring was done by the Medical Officer at the clinic. This year, when the CHGs are registering and flagging the high-risk cases, it is 66%. This indicates that the instrument used needs to be refined if the High-Risk approach is to be useful for prioritisation for special care.

The table below shows that the bulk of the ANC registrations are now in the second trimester and there appears to be a significant shift towards early registrations.

| Period | Trimester I | Trimester II | Trimester III |
|------------------|-------------|--------------|---------------|
| 1996 | 11.1% | 32.9% | 56.0% |
| 1997 | 30.0% | 48.0% | 22.0% |
| 1998 (Till Aug) | 26.8% | 50.2% | 23.0% |

3 4 3

Family Planning

The following table gives a profile of the Family Planning Acceptors in the project as of 1 3 98

| | |
|------------------------------|--------|
| Population | 50,302 |
| Eligible Women | 10,610 |
| Pregnancies | 930 |
| Primary infertility | 365 |
| Net available women for FP | 9,315 |
| Mothers who want children | 1120 |
| Condoms | 2079 |
| OCP | 293 |
| Cup - T | 414 |
| DMPA (Injection) | 22 |
| Tubectomy | 1700 |
| Vasectomy | 27 |
| Couples protected | 4535 |
| Unmet need for contraception | 3660 |

Condoms are the most frequently chosen method of contraception. This is different from most studies done in India. The preference seen here is due to the amount of education CASP-PLAN has put in on the dual benefits of condoms for contraception and prevention of STDs and HIV infection. Tubectomies are the second most common option for contraception. The Couple Protection Rate is 43% and unmet need is still about 35%.

3 4 4

STD/HIV Prevention and Control

The weekly Gynaecology Clinic catered to women with problems relating to reproductive health especially STDs. At the time of the MTR there was an overwhelming demand for STD/RTI services. Since then project run clinics were discontinued and Ranbaxy took over these clinics. However they were not able to provide quality services and have now completely withdrawn. The gynae cases seen at clinic have been declining and reduced by 50% over last month.

Of the 4216 visits to the gynae clinic in the past year profile of RTI/STD cases is given in the following table

| Category | Sept 97 to Aug 98 | |
|------------------------|-------------------|---------------------------------------|
| | No | % of total gynae cases seen at clinic |
| Cervicitis – Vaginitis | 1044 | 24.8 |
| Cervical Erosion | 387 | 9.2 |
| P I D | 249 | 5.9 |
| TOTAL | 1680 | 39.9 |

The following table gives the Gynae Clinic Attendance Incidence of RTI, as calculated from this data, shows a decline

| Period | Total Visits | New Visits | Follow up | % of new cases |
|------------------|--------------|------------|-----------|----------------|
| Sept 96 - Aug 97 | 3883 | 3041 | 842 | 78.3 |
| Sept 97 - Aug 98 | 4216 | 2812 | 1404 | 66.7 |

Regular clinic services for males began in November 1997. By August 1998, 889 males had been seen at the clinic and screened for RTI/STD. Of them, 516 were found positive and treated appropriately.

345

Community Empowerment

a) Enhancing Effectiveness of Community Health Guides

The Community Health Guides have been nurtured and enabled to become the first line of health care providers, trainers and health activists. This is a considerable achievement given the vulnerable situation of these women's lives.

Self-confidence

There has been a dramatic upswing in their self-confidence, even to the extent of being able to address public health education sessions for male audiences on topics as sensitive as HIV, contraception and sexuality.

Competence

CHGs have now reached a level of competence at which they are able to provide antenatal care in the homes with identification and referral of High Risk Cases.

Credibility

There has been a quantum change in the acceptance, respect and status that the CHGs enjoy in the community. The effectiveness and relevance of the CHGs in the community has been one of the outstanding accomplishments of the year.

b) Consolidation of Community Based Organisations

The DIP envisaged the formation of 65 Neighborhood Family Associations with a view to enhance community participation and long-term sustainability. However, at the time of the Mid Term Evaluation last year, there were only 3 in place. Earlier on, there were 89 CBOs in the project area (under the regular CASP child sponsorship program) that oversaw different aspects of the health and community development activities. Unfortunately, several of these became defunct when this project started. During this year, the CASP-PLAN team has worked to reactivate these CBOs for participation in this project. 69 CBOs are now

functioning They meet on a monthly basis to discuss relevant issues In addition, there are 3 Associations of Health Guides, one of Trained Birth Attendants and one association to co-ordinate the ambulance services In one of the project units, 6 CBOs have formed a federation

c) Sustainability of Community-Managed Ambulance Services

The dire need for an ambulance to transport patients to hospital, especially in obstetric emergencies, was a felt need of the community, and a priority for the project Through CASP-PLAN, an ambulance jeep was provided to the community This service has strengthened the referral linkages of the community and the project with the referral hospitals Over this year, this service has worked towards both operational and financial sustainability

Operational Sustainability

An Ambulance Association was formed, comprising of members of the community including CHGs, to oversee the ambulance service Information about the service is disseminated through the network of CHGs and CBOs There is a driver on call, with contact phone numbers The association is able to operate the service efficiently

Financial Sustainability

The project income from the community is able to cover the cost of operations including the driver's salary and basic maintenance work The money for this comes from the ambulance users' contributions, income from social marketing of condoms and ORS, and some money from the clinic users' fees

d) Promotion of Social Marketing

Up until 1997, ORS and condoms were provided free of cost From January 1998 ORS is being sold through the network at Rs 2 00 per packet and the Masthi brand of condoms at Rs 4 00 The Nirodh brand of condoms continue to be available free of charge This experiment with social marketing is doing well There was the expected initial drop in uptake, but demand has since picked up as the community got used to the idea In each block one of the CHGs has been identified as a depot holder who stocks supplies CHGs are being trained to maintain stock records and estimate commodity requirement

e) Developing Street Theatre Groups

CHGs were trained by professionals to produce and stage street plays for IEC Three Street Theatre Groups have been formed one in each unit This alternative media has proved to be an effective communication channel One of these street plays was featured on Star News TV channel

Factors Contributing to Success

- 1 CASP-PLAN has been working in Sangam Vihar since 1986. The credibility and trust CASP-PLAN enjoyed in the community paved the way for the new interventions.
- 2 Child health interventions such as growth monitoring, nutrition programs, immunization and medical care for children in the community was already in place. Therefore, it was easier to integrate maternal health, and other more sensitive components such as family planning, reproductive tract infection and HIV interventions.
- 3 STD services for men encouraged male involvement in the program and is slowly increasing male responsibility for family planning and also for the health of women and children.
- 4 The HIV prevention component attracted the adolescents. Their enthusiasm spills over into other project areas of child care, family planning, maternal and reproductive health. Often the entire family is involved and support the project activities.
- 5 Some staff members were familiar to the community, and this facilitated rapport building and project initiation.
- 6 The location of this project in an unauthorised, and therefore uncared for slum, increased the potential for effectiveness. The community has few options other than CASP-PLAN for accessible, available and affordable health care.
- 7 The provision of clinic-based curative services, which is always a felt need in such communities makes an excellent entry point. The credibility and rapport built through the clinics has been utilised to effect the more difficult aspects of social change.
- 8 The project inherited several trained health workers with strong experience in community-based primary health care from the ongoing project. It was not difficult to re-orient them to the new project interventions.
- 9 CHGs belonging to the community itself, partly educated and highly motivated form the backbone of this program. The empowerment of these women is probably the most important factor in the achievement of progress.
- 10 The network of the Community Based Organisations, again a legacy of the Child Sponsorship program gives a broad base to the project. If their enthusiasm can be sustained and channelled it could make a powerful difference in the long-term.

- 11 The CBOs were already trained in managing community-based interventions such as the safe water and sanitation program. It was not difficult to build on this experience and introduce the concept of community-managed reproductive health interventions.
- 12 Collaborative relationships have been a very positive factor both with the Delhi state Government and with the various resource groups utilized for training.
- 13 This year's increased training and capacity building inputs have shown results. The nurturing process of the last two years has begun to bear fruit.
- 14 The CHG's communication skills are very important and have been enhanced this year through a variety of training inputs.
- 15 The new training methodologies the CHGs have learned are more participatory than didactic, and include initiatives like role play, etc. This has resulted in improved mothers' recall.

3 6

Constraints

The following are some of the constraints experienced in project implementation.

- 1 The lack of governmental provision, as Sangam Vihar is an unauthorised settlement, is a major constraint. The result is an unhealthy environment with no controls. Diarrhea is one of the four components of the project but the project has not addressed safety of drinking water, sanitation and education for prevention of diarrhea.
- 2 The changing and growing population has increasing health needs and demand for services. The MTER estimated that there is 25% migration into the area and 10% migration out each year. This makes interventions difficult to implement, and even more difficult to measure. Furthermore, the new entrants have health needs which the project cannot meet. The project has responded to this problem by deciding to freeze the beneficiary list as of September 1997.
- 3 Maternal and reproductive morbidity continues to be high in the area. Demand for clinical reproductive health services is increasing but CASP-PLAN has discontinued gynae clinics.
- 4 The main providers of health care in the area are a large number of small clinics run by RMPs of varying qualifications and standards. The original project had envisaged training inputs for the RMPs to improve their quality of care. However, with the enacting of a law restricting all doctors to the practice of only that system of medicine in which he or she is qualified, training inputs have been disallowed. The Project has therefore had to abandon that planned activity.

- 5 CASP-PLAN's U-five clinics were discontinued, and diarrhea referrals were made to other NGO mobile clinics, whose services were not completely reliable. It is not known how many children actually go to the quacks and are treated irrationally with IV drips and hazardous anti-diarrheals. Consumer awareness on rational drug use will have to be emphasised and other local providers sensitized to the issue. Verbal autopsies have shown deaths due to severe malnutrition and persistent diarrhea. These need to be tracked and appropriately managed.
- 6 The sustainability of the CHG's item-based incentive system is questionable. The CHGs have been trained to be the community's health care providers. At present, they are compensated by the project by a system of item-based incentives for each activity performed or report submitted. The question remains of how long such a system can keep people motivated, and what will happen if the incentives stop at the end of the program. It is hoped that if given sufficient skills, the Health Guides may be able to continue working by charging for services.
- 7 Non-convergence of CASP-PLAN interventions in Sangam Vihar has been a constraint. The resources of PLAN in the project area are not optimally used, which greatly reduces the cost effectiveness of programs.
- 8 In pursuit of quantitative targets set out by the project, inadequate attention is paid to quality of services. The SEATS study of the family planning component has identified several lacunae in the quality of the FP intervention.
- 9 Skills in Computer Applications and Information Management are lacking. The program generates a vast amount of data but there is no computerised database management system. If the staff were enabled to extract necessary information, interpret and harness it for program interventions, the effectiveness of the project would improve.
- 10 The collaborators identified for clinical services were not able to deliver quality services and some have completely withdrawn.

Steps Being Taken to Overcome Constraints

- 1 As per the DIP, CASP-PLAN sponsorship project will undertake water quality testing. Jointly the project will emphasise safe water, sanitation and prevention of diarrhea education.
- 2 The DIP had envisaged that service provision be restricted to the potential target population but educational inputs made available to a wider population. The sponsorship program will be strengthened to address the larger health needs and service provision demands of the community.
- 3 Gynae and under-5 clinics which were discontinued by the project will be re-started by the sponsorship program and will augment the project interventions in maternal and child health including STD case management.
- 4 It may not be possible to conduct training programs for RMPs given the legal constraint. But the project may produce pamphlets as clinical updates and distribute to all private practitioners. The project will also run a campaign on rational drug use.
- 5 CHGs will follow-up all diarrhea cases for proper case management and also track severe malnutrition cases under 5 years and persistent diarrheas.
- 6 The project will jointly explore with the sponsorship program, increased cost recovery and alternate financing of health care including continuing support to CHG activities.
- 7 As a result of the findings of the third annual review, the integration issue was taken up at the Project Implementation Committee (PIC) meeting in October 1998. The CASP officials (President and Executive Secretary) announced that the integration process will begin in November 1998. The detailed plan with budget is under preparation.
- 8 To improve the quality of care a series of technology updates are planned in December. Process indicators and other quality indicators will be developed and tracked by the project.
- 9 Attempts will be made to develop a computerized database on the project and skills for retrieval, analysis and interpretation will be imparted to staff.
- 10 New referral linkages will be identified and strengthened.

4 CHANGES IN PROJECT DESIGN

4 1 Target Population

At the onset of the program, there was a change from the proposal, wherein it was decided to work with only the Sangam Vihar community and not the Govindpurī community. The population coverage was similar. This was recorded in the DIP and the Mid Term Evaluation.

The Mid Term Evaluation noted that there is a 25% migration into the project and a 10% migration out every year. This raises problems in coverage, building on awareness, and measuring change. In discussions with the MIS Consultant, it was decided to freeze entry to the register of beneficiaries as of September 1997, and to concentrate activity for that population. New entrants to the area subsequent to September 1997 are not included in the program.

4 2 Diarrhoea Disease Control

The first goal as per the DIP is

‘To improve the prevention and case management of diarrhoea cases in children aged less than 5 years (with priority in children less than 2 years)’. The 4 project objectives under this goal include two that refer to the children aged 0-23 months and their mothers. The other two refer to the case management of children (up to five years) with diarrhoea. However the Mid Term Evaluation refers to this goal as ‘To improve the management and treatment of diarrhoea in children 0-23 months’. Also, in the list of Planned Outputs and the list of Indicators the two case management objectives, relating to CHGs/RMPs and to CASP-PLAN/MOHFW clinics were not mentioned. After mid-term evaluation the project has tended to follow these lines. So with the MTE the focus area under this goal as envisaged in the DIP appears to have been decreased from under-fives to under-twos.

4 3 Risk Approach

The DIP emphasises the risk approach in the project in all four components. This approach is not being followed in the diarrhea and STD/HIV component. One of the major goals of the project as spelled out in the DIP is the prevention of the spread of HIV/AIDS through education and motivation for behaviour change, the provision of condoms and the detection and case management of STDs. However there is no information available on the possible epidemiology of HIV transmission in the project area. The inputs provided are awareness programs, condom supply through the women and the STD program. The methods are focused on the interruption of heterosexual intra-family transmission of HIV. However if the transmission routes in the community are found to be related to IV drug use, homosexuality or commercial sex workers, these activities are not addressed. The MTE Report mentions that CASP-PLAN plans to seek technical advice from staff on the Sponsorship program who have more experience in reaching these special groups. This has not been done. Nor was any attempt made

to access information on the epidemiology of possible routes of transmission of HIV in the Project Area, from other groups working with comparable communities, or through an independent study

4 4 The Roles of the CHG, Nurse and Doctor

The DIP envisaged a two-pronged approach to health care provision - community-based and clinic-based. The CHG was meant to be the liaison with the community, an animator, mobiliser and communicator, spending nearly 100% of their time in the field. Programme Coordinators, as primary supervisors of CHGs, were to spend 80% of their time on field-based activities. The nurse and the doctor were to be health-care providers. Prenatal Care was to be provided within CASP-PLAN clinics by the nurse and the MOs. MOs and nurses were to be clinic-based, spending 10% of their time in the field, engaged in educational or promotional activities. However, the roles of MO and nurse have been greatly diminished and changed.

4 5 Demedicalization

During the discussions that formed part of the Mid Term Evaluation in September 1997, there was a discussion on the role of medical professions in the project vis-a-vis the devolution of medical responsibilities to the CHGs. This discussion, however, is not mentioned in the MTER. However, the entire team was under the impression that the MTER had strongly recommended 'de-medicalisation' of the project's services. This, coupled with an increased emphasis on 'Sustainability' appears to have dominated the thinking behind many of the changes in direction this year. There have been two interesting outcomes of this misunderstanding - one very positive, and the other, less healthy for the project.

The positive consequence was the promotion of the CHGs to the top of the agenda, giving them a much larger and more vital role in providing health care than had been envisaged earlier. The not-so-positive effect has been the concurrent decrease in the role of the medical officers and the clinic-based services. At present there are fewer doctors on the team than planned with the Health Executive doubling up as Medical Officer for one of the units. The fact that one of the other two doctors is a male means fewer female doctors are available for the Gynaecological and Obstetric work. There has also been a toning down of some of the clinic-based services. The rationale for this was understood to be increased potential for sustainability. On the face of it this appears to be a premature phasing out based on a misunderstanding of the MTE recommendations. It does not appear to fit into the basic objectives and plans as envisaged in the DIP.

5. RESPONSE TO THE MID-TERM REVIEW

The Mid Term Evaluation of the project undertaken in 1997, made 29 specific and important recommendations, in order to improve the efficiency, effectiveness, sustainability, and overall quality of the project of these, 14 were further designated as the Key Recommendations. The MTER was discussed with the project team, and with the CHGs and the community through the CBOs.

This section addresses these recommendations (in italics), providing an update on developments over the last year.

IMPROVE MIS

- *An effective system to verify the accuracy of data collected by the Health Guides in the field should be established and implemented.*

A system has been created for the verification of data submitted by the Health Guides. The Project Co-ordinators (PCs) spend two days each week on supervision and validation checks. Two Health Guides are selected for visits each week. From their reports, two beneficiaries are randomly selected for each of the 4 project interventions, namely diarrhoea control, maternal health, family planning and the control of STD and HIV. These eight beneficiaries are visited by the PC and the validity of the report is corroborated. An additional two beneficiaries not in the report are selected from the Register, and they are visited to check for missed reports. These ten verification visits are done for eight Health Guides in each Unit, resulting in all Health Guides being reviewed each quarter.

Since CHGs receive cash incentives for reporting key variables, the likelihood of missing reports is less. To avoid spurious over-reporting, a system of disincentives has been set up involving withholding of pending incentive money if false reports are submitted.

- *MIS Staff should switch from a manual to computerised system of compiling information submitted monthly, and of generating reports.*

The MIS staff now have computer access. Part of the information management process has now been computerised (database of Eligible Women). Still, most of the time, only summary data is maintained in a spread sheet unit wise. The compilation of data is still done manually, the computer being used as a calculator or word processor for producing the reports.

- *Senior staff should be trained in the use of data to monitor work at all levels and take decisions for strengthening project activities*

This has not happened Senior staff would benefit from training on Health Information management, including exposure to the potential of a computerised HIS This would help them extract optimum information from the wealth of data being collected, the inferences of which could be fed back into the program through better focused interventions

- *The use of information collected in the MIS, especially in clinic registers should be reviewed Information not being used should not be collected*

The information being recorded was reviewed, but it was found that there was no unnecessary information being collected All the data was being used either for administrative, clinical or program monitoring purposes

- *Information on community health should be “in the hands” of mothers*

The staff have made an attempt to share the information from the MIS with the Health Guides and the CBOs This allows them to understand the health status of their communities their health service needs and responses to be made There is still the need to have a simplified MIS that can be handled by the CHGs and CBOs and shared with mothers and the larger community

- *New indicators need to be developed for STD/HIV prevention*

The DIP envisaged that laboratory back up would be available for the STD component and prevalence data on the different STDs could be generated It had even suggested Pap smear and HIV screening Data on RTI/STD prevalence indicators on laboratory and syndromic screening criteria could easily be generated

The following were the indicators suggested

STD Prevalence

Point prevalence of white discharge per vagina, a proxy for STD

There is data available in the EWR registrar on this indicator as of the first year of the project A quick survey now would give an update, and a final survey next year would make it a relevant indicator

$$\text{Point Prevalence} = \frac{\text{No of Eligible Women with White Discharge} \times 100}{\text{Total No of Eligible Women}}$$

Percentage of persons symptomatic for STD who actually take treatment from the CASP-PLAN clinic or other health-care facilities

$$= \frac{\text{Total Patients who underwent treatment for STD}}{\text{Total Persons complaining of symptoms of STD}} \times 100$$

INCREASE COVERAGE

- ***The catchment area of each Health Guide needs to be carefully defined to reduce or eliminate undeserved areas***

The Health Guides' areas were reviewed for coverage. It was found that some areas were underserved, and therefore, these areas were redefined.

- ***Monitoring should be intensified in areas further from the CASP-PLAN clinics, possibly using the rapid sampling techniques***

As recommended, there was a renewed focus on the monitoring of services in the areas furthest from the clinics. LQAS techniques were instituted for this. Furthermore, it was made compulsory that Health Guides visit each of their beneficiary households at least once a month. Regular house visits of CHGs are now tracked. Each month they are expected to visit each household. In August 1998, 84% households were visited by the CHG and in October 89% households had an effective CHG contact. A minimum essential tasks are to be undertaken by the CHG to record as an effective contact.

INCREASE MALE INVOLVEMENT

- ***The effectiveness of male educational activities needs to be monitored***

Male education activities have been strengthened by the addition of a male physician. However, the impact has not been measured. The Midterm Evaluation raised the issue of failing to sensitize the men to the philosophy of the project. It was found that if awareness and treatment sessions focus only on women, the men are left behind and often prove to be obstacles in the achievement of positive social change. The MTER recommended Increased Male Involvement including provision of educational activities, monitoring, recruitment of male volunteers and clinic services for men. Based on this recommendation, a male medical officer joined the team in late 1997. Over the year, he has provided evening clinics for the men including treatment and counselling services. The health exhibitions for men continue to be held on Sundays. This has been a major addition to the project.

- *Coverage should be increased for male educational activities [e.g. more eligible couple training and recruitment of Healthy Family Promoters (Male Health Guides)]*

Male education activities are carried on through Awareness Camps and Melas held on Sundays. The major constraint in all programs for men has been their non-availability. Most of the men in the project area work long hours, usually returning home after 8:00 pm each day. The programs for their education are therefore held on Sundays. Recruitment of eligible couples as Healthy Family Promoters has risen to 45. Not many men however are willing to consider becoming voluntary male health guides.

- *The curriculum for male educational activities should include support to wives'/children's health care needs*

The curriculum for all training and awareness programs for men now include these aspects, to increase their sensitivity of the specific health needs of their wives and children.

- *More clinics should be held for men*

After the Mid Term Evaluation, CASP-PLAN appointed a male doctor, Dr Sarkar, to specifically oversee the service outputs for the males. Evening Clinics for males were started in each unit in November-December 1997. The clinics include screening, counselling and treatment for STDs. Between 97 Nov and 98 Sept, 986 men were screened for STD/RTI, of whom 556 were found positive and treated. The initiation of Male Clinics has also improved Partner Compliance. The Male Clinic services are now being made available at the Male Education Melas each Sunday.

INCREASE MOTHERS KNOWLEDGE

- *Breastfeeding should be strengthened as a component of both Diarrhoeal Disease Control and Family Planning interventions*

The value of breastfeeding has been stressed throughout the program. Its importance in both Diarrhoea Control and in Family Planning has been re-emphasised as recommended.

- *Postnatal care should receive more emphasis*

As per this recommendation, the TBAs and the Health Guides were instructed to visit all postnatal women at least once and twice respectively. However, the care needed and signs of danger during this period have not been adequately addressed. This was discussed with team-members during this review, and it was suggested that the Health Guides need more input on the importance of Postnatal Care. It was further recommended that these visits could be structured to have definite purposes. The first visit within 48 hours would include checking the

baby's weight. A visit on the eighth day would report on the condition of the mother and the child. These reports over time would improve postnatal care and also aid in the generation of data regarding perinatal morbidity and mortality.

- ***Training of mothers should continue to be shifted away from collaborating organisations towards Health Guides***

As recommended during the MTE, the training of mothers was taken over by the CHGs. This gives greater effectiveness and longer retention of the knowledge and skills in the community itself, as the CHGs are also from the same community. The CHGs have undergone extensive training this year in participatory training methods, alternative communication media and the use of educational aids, to increase their capacity as trainers.

- ***Training of mothers should be non - didactic***

The MTE team observed that the training techniques used at that time for mothers were inappropriate and didactic. Based on this recommendation, participatory learning methods were incorporated and the CHGs who are now the first-line trainers, were equipped to handle the sessions.

- ***A competency-based approach towards training should be explored on a pilot basis***

Competency-based training was taken up by the medical officers, not just on a pilot basis, but for all the Health guides. It was found to be very useful.

- ***Training should be reinforced with messages repeated through multiple channels***

Many people are unable to retain all the messages received during awareness programs. Therefore it is important that the key messages be repeated and reinforced using a variety of channels. The project has done this in many innovative ways. Some of them are:

- * Blackboards were made in different parts of the area by smearing wallspace with the fluid from batteries. These blackboards are used by the respective Health Guides to announce clinic dates, health information and reiterate health messages.

- * 'Radio' Campaign. A Public Address system is used in one unit to broadcast health messages using audio cassettes. The system is rotated between the different Health Guide areas.

- * Video cassettes have been obtained on the relevant topics and these are shown in the area.

- * The messages have also been incorporated into street plays that are performed by the CHGs at different points.

* The regular monthly meetings of the CBOs is another opportunity being utilised to reinforce key messages

- *The retention of knowledge gained by mothers should be assessed periodically*

The knowledge retention of the women is being assessed by the LQAS method on a regular basis. Now that the PCs spend more time in the field, they are able to assess this regularly.

- *More audio-visual aids should be used*

As mentioned above, the channels for health information dissemination have been upscaled. The use of AV aids like video shows have also been increased.

IMPROVE SUPERVISION

- *An effective system of Health Guide field supervision needs to be established and implemented as soon as possible*
- *The supervision system should be periodically reviewed by the PIC*
- *The workload of Program Coordinators should be reviewed and their administrative and accounting burden reduced to allow time for field supervision*

At the MTE it was observed that the supervision of Health Guides in the field was inadequate. The Program Coordinators were so burdened with administrative responsibilities and accounts that they were unable to spend much time in the field. The MTE recommended that their administrative burden be reduced and their field time increased. It was also recommended that an effective system be devised for regular supervision of the Health Guides in the field setting.

As recommended, the bulk of the responsibility for administration and accounting was taken from the PCs. They now have more time available for actual field work. They spend two days of each week with a total of eight Health Guides. The time is spent making house visits with them, supervising their work and verifying reports. This time enables the PC to assess the CHG's work and their need for further inputs. A checklist has been devised for this purpose.

The clinics and meetings also provide further contact time with the Health Guides to interact, evaluate and advise. Based on the inputs from the supervision and evaluations, the Health Guides' work is graded into A, B, C or D grade. This helps plan the inputs needed by each individual CHG. The supervisory system is reviewed at the PIC meetings as recommended.

- *Supervision instruments / checklists should be developed and used at all levels*

The supervision of work in the CASP-PLAN project is at three levels. The Health Guides are supervised in the field by the Program Coordinators and Medical Officers. The PCs and MOs in turn submit their reports to and are supervised by the respective Executives. The Executives are similarly accountable to and supervised by the Chief Executive Officer. There are formats used at each level for reporting and supervision.

INCREASE COMMUNITY INVOLVEMENT

- *Family Neighbourhood Associations should be established and assisted to take over some project activities and to mobilise resources*

As mentioned in the overview, this was one of the deficiencies pointed out during the MTE. Whereas it had been envisaged that there would be 25 FNAs by the mid-term point and 65 by the end of the project, the MTER observed that only 3 had been set up. This recommendation was therefore given a high priority by the team this year. A lot of concentrated effort has gone into the implementation of this recommendation, so that today there are 70 community-based organisations functioning in the project area.

The CASP-PLAN Child Sponsorship and Community Development program is involved in a number of activities relating to income generation, day care centres for children, etc. As part of that program, a number of Community Based Organisations (CBOs) had been formed to oversee the various aspects of the work, each with membership ranging from 8 to 20 people. Over the years the enthusiasm of many of these groups had waned. In the meantime, this Child Survival and Maternal Health programme was started with a strong community volunteer component. The existing CBOs were enlisted and reactivated to take a greater interest in the health of the community. 69 such CBOs now meet on a monthly basis. In addition there are 3 associations of Health Guides, one in each unit. There is also an association of TBAs. With the provision of an ambulance for the community by CASP-PLAN, there is also an Ambulance Association made up of community members to supervise this service. They ensure that the jeep is available for emergencies 24 hours a day, with a driver on call. In fact the driver's salary and the cost of minor maintenance is now covered by the income from the ambulance users with help from the clinic income and the social marketing income.

COORDINATION / COLLABORATION

- *CASP-PLAN should explore, on a pilot basis in one unit, collaboration with the CASP-PLAN Sponsorship Program, or another PVO/NGO, the growth monitoring of children 0-23 mos of high-risk (e.g. children with chronic diarrhea, recovering from measles, with ARI, not breastfed, or whose mother has died)*

Growth Monitoring was one of the components of the CASP-PLAN sponsorship programme specifically for the beneficiary children. Prior to the MTE, the CASP-PLAN child survival team also did some growth monitoring even though it was not actually within the planned activities of the project. The MTER therefore recommended that this component could be tried on a pilot basis, specifically for high-risk children, by collaborating with some other NGO, or even the CASP-PLAN sponsorship program. However, this has not happened as yet.

It must be recognised that one of the major goals of this project involves control of diarrhoea in children. It is well accepted that diarrhoea and malnutrition form a vicious cycle, each fuelling the other. Once the minor diarrhoeas are taken care of, the more intractable problem of persistent or chronic diarrhoea will remain. Just awareness and ORS are not going to solve this subset of diarrhoea problems. There is a larger web of causation that has to be recognised. The holistic management of these children must include growth monitoring, if it is to be effective. Even the Verbal Autopsies done as part of the Mid Term Evaluation, showed that of the 12 deaths studied, 5 were children with Protein Energy Malnutrition. 4 of the 5 diarrhoeal deaths in the study were from this group. In other words, the combination of diarrhoeal disease and PEM is deadly, and they need to be looked at together. This is a reality faced every day in the field by the team.

Therefore the recommendation of the MTER that Growth Monitoring be introduced at least on a pilot basis and at least for the high risk children needs to be explored in association with some other group or even by the team itself.

INCREASE TBA INVOLVEMENT

- *New ways should be explored to train TBAs, including their involvement in antenatal and postnatal care at CASP-PLAN clinics*

57 Traditional Birth Attendants of Sangam Vihar have been trained by the CASP-PLAN project. Their situation is interesting in that they vary from simple women who are called by their neighbors to assist in deliveries at home, to others who have established clinic-like set-ups. There is a vast difference between the classical concept of a TBA who uses age-old trusted birthing techniques and those who practise reckless obstetrics including the use of injectables and medications. Whatever the category these are the women available in Sangam Vihar and if maternal health has to improve they have to be accepted, respected and involved.

The initiatives the project has undertaken for the TBAs include training programmes, opportunities for learning at the clinics, and monthly meetings at the unit level. There have also been three well-received meetings of the TBAs at a project level. Attempts are being made by the Health Guides to call on the services of only those TBAs who have undergone some training.

IMPROVE ADMINISTRATION

- *Delays in payments to collaborating organisations need to be eliminated and timely reporting of financial information improved, perhaps by hiring an accountant to do these tasks in-house rather than relying on an outside firm*

These problems in the financial system have been solved with the appointment of an accountant as recommended.

- *Computers and photocopier at the Project Head Office should be procured to improve the efficiency of office administration as well as to support MIS and accounting functions*

One computer has been purchased for the Accounts section, in addition to the one computer already in the project. The idea of a photocopier was abandoned as it proved cheaper to get materials photocopied outside.