The Methodist Rural Public Health Programme

Evaluation January 2006

Content of report

Foreword

The present evaluation was carried out by a multi-professional team from India and Norway. It has been the intention of the team that the evaluation should be as transparent and participative as possible. Continuous input from the project management as well as the project staff has therefore been important.

The evaluation work is a joint effort between the team members and all have contributed valuable input. The final the evaluation report has been written by the team leader based on joint conclusions from the group. All the team members have contributed and have had the possibility to give specific input to the report. However, the final wording of the report is the responsibility of the team leader.

On behalf of the entire evaluation team take the opportunity to express my gratitude to the project director and the entire staff of Mursan Rural Public Health Programme for the effective and valuable assistance provided to the team during the evaluation.

Nils Atle Krokeide
Team leader

1. Introduction

1.1 Brief history

The Methodist Public Health Centre was started in1962**.** The work in Mursan started some years earlier when a team from CFC Hospital Vrindaban visited Mursan once a week. The project received the first support from NORAD already in 1978 and from 1986 NORAD has been among the main donors through the United Methodist Church in Norway. The work has gradually increased from a mobile clinic into a mayor public health work supported by three small clinics of which the centre being the clinic at Mursan with a total of nine beds.

MRPHP has been evaluated several times, the last was in 2002. Since then the work has been shifted to include one new component of different activities related to prevention of the spread of HIV/AIDS. The present evaluation has looked into both the previous health work in this report called "general health work" and the new HIV/AIDS work.

1.2 Evaluation methodology

The evaluation has been carried out as a transparent participative evaluation. The project staff and management have been invited to participate in the discussions of the evaluation team and this has permitted direct feedback on different questions from the evaluation team. The evaluation has been qualitative, and the main evaluation instruments that have been applied are:

- Desk studies of project plans, annual plans, activity reports, annual reports and financial reports.
- Observations of clinic activities as well as outreach.
- Interviews and dialogue with staff management and employees.
- Interviews with cooperating partners.
- Conversations with clients and target group.

Two minor workshops were conducted with the project staff as part of the evaluation. The first workshop was held as plenary session. The second started with separate groups for men and women and a plenary session at the end. The staff gave valuable contribution to the evaluation during the sessions.[1]

A detailed list of the evaluation schedule and the different sites and activities visited is included in the appendixes. The evaluation field work was carried out from January 9th through January 16th 2006.

1.3 Evaluation team

The evaluation team has been multi-professional covering general management and development expertise, health professionals as well as social science. The evaluation team members were:

- Mr. Nils Atle Krokeide, team leader (management & development issues).
- Dr. Marcia Waran, MD, expert on HIV/AIDS
- Dr. Ms Suneel Qamra, Assistant Director, social scientist
- Dr. Madhup Kaushal, MBBS, public health govt. of India.

[1] A summary of the conclusions from the staff workshops is included as an appendix to this report.

1.4 Evaluation report

The evaluation report is divided into three main parts. The first part covers the introduction and general conclusions and recommendations. The second part covers the general health work and the third part the HIV/AIDS work. Part two and three of the report are structured based on the evaluation model shown below.

Graphic 1 Evaluation model

Objective hierarchy.	**Input and activities**	**Output**	**Project objective**	**Goal**
How the resources are managed?	Efficiency			
If the objectives are reached or not?		Effectiveness		
Level of impact? Positive or negative changes? Expected or surprises?			Impact	
If the programme focuses the "right" problems or if there are other more pressing problems in the area?		Relevance		
If the programme is sustainable (able to cover the cost)?	Sustainability			

No particular terms of reference has been made for the evaluation.

1.5 General conclusions and recommendations

The work of MRPHP is in many ways impressive. The project is located in a small village Mursan in the district of Hathras in Uttar Pradesh. Uttar Pradesh is one of the most impoverished states in India and a classic example of how the rural part of the country is lagging far behind the rapid growth of the urban parts mostly in the south of India. The general socio development indicators of Uttar Pradesh are similar to what one can find in Africa south of Sahara and far from comparable figures from the "modern urban India".

In this very difficult context MRPHP has managed to establish efficient and effective general health services prioritising services to women and children. The project has managed to establish good relations to the communities surrounding the centres as well as to public authorities and to other NGOs. An indication of the first is the high number of patients seeking the services provided by MRPHP, an indicator of the second e.g. the approval of MRPHP as a diagnostic centre in the DOT programme, the joint eye and sterilisation camps and thirdly one should notice the ability of the organisation to network effectively with other NGOs.

The organisation has shown ability to change and to adapt to new challenges. One indicator of this is the quick and well implementation of the new HIV/AIDS work and e.g. the very fast response in finding an alternative solution when the organisation had to leave the Methodist Hospital in Mathura and find an alternative location for the new counselling office and delivery services along national highway number 2.

The quality of the services of the organisation and the competence of the staff is considered to be good. It is also important to point out how quickly the staff was able to absorb new knowledge related to the new epidemic of HIV/AIDS and to efficiently and effectively implement the new HIV/AIDS project.

Based on the sustainability model applied by the office of Norwegian Missions in Development, one can conclude that the work is well in balance with the context (the needs of the population of the region), and the activity profile (the services provided by the organisations). The weaknesses of the organisation are related to the organisational capacity. The evaluation team has not detected weaknesses in the operational daily activities but related to overall project management and finance.

The present plans are based on a funding agreement with the main donor in Norway covering the period from 2003 to 2007. The activities are based on two different plans, one for the general health work and one covering the new HIV/AIDS work. There are deficiencies in relation to both these documents regarding how the projects were to be monitored regarding the achievements of the objectives. All activities are well supervised and monitored, but the higher level of monitoring of objectives is weak and not as described in the project plans. This weakness has also been pointed out in previous evaluation reports e.g. in 2002.

The second weakness is the high level of dependency upon foreign donors. The general health work is financial self sustainable for 46% of the project cost while the new HIV/AIDS work only covers 1% of the project budget from local income.

Recommendations

Based on the above considerations the evaluation team does not find it necessary to recommend major changes in the operational activities. Any programme will be in the need of constant improvement, but the staff of MRPHP should be well prepared to do that. However, the organisation should strengthen the project management function. This could e.g. be done as a combination of stronger staff involvement and specific input from outside experts as e.g. temporary advisors with experience in field service management when needed. It will be particularly important that the organisation takes time to prepare a well structured plan for the next funding period starting in 2008 and make sure that the proposed activities, monitoring and supervision is in accordance with the organisation's competence and capacity. Based on the previous experience the evaluation team wants to point out the necessity of good monitoring mechanisms not only about daily activities, but also on vital statistics monitoring project objectives.

MRPHP should also seriously look into the possibilities of increased financial sustainability. This is particularly important concerning the general health work as there are clear indications from the main donor that one cannot expect additional funding after 2007. The HIV/AIDS work is presently almost totally dependent on foreign funding. Although there is a reasonable change to obtain funding for a new period starting in 2008 onwards, the organisation should

seriously consider both how the activities can become more self-sustainable and consider other sources of funding.

1. The general health work

2.1 General health work introduction

The general health work has throughout the years been the backbone of the activities of MRPHP. The health work has its basis at three small clinics and is combined with an extensive community work reaching a total of 10 blocks in three districts of Uttar Pradesh. The main clinic is situated in Mursan which is a small village with approximately 1.000 inhabitants in Hathras district. MRPHP is the only major provider of preventive health care in the region. The programme coordinates and networks extensively with public authorities as well as with traditional leaders and civil society organisations in the area. A new project plan was made prior to the new funding agreement with NORAD through the Methodist Church in Norway. This funding period starts in 2003 and ends in 2007

2.2 Health work activities – output and efficiency.

The health work is built on a wide conceptual model of preventive health and combines this with curative health services as well as a wider range of public awareness raising, strengthening of civil society organisations as well as supporting individuals in claiming the services that they are entitled to. The main target group of the work is mostly women and children in the area covered by the programme.

2.2.1 Training activities

Training of Traditional Birth Attendants

One of the main training activities indicated in the project plan was training of Traditional Birth Attendants (TBA) with a target to train 1.000 TBAs per year. However, this training has been stopped and the reason given is that there is no longer a need for additional TBAs as around 10.000 TBAs have already been trained and still more than 6.000 TBAs are actively practising in the villages. Based on information from the project staff there are at least one or two TBAs practising in every village. A copy of the core curriculum of the training course is included as appendix one.

Nurse Aids

The Nurse Aids course is a four months intensive course given at MRPHP centre in Mursan. This training programme has been developed by the project and the main emphasis has been on mother and child related preventive health care, but this has now been extended to also include HIV/AIDS training. A short description of the training course is included in appendix two. There is a constant demand for this training and the fact that all the trained persons easily find jobs should be a good indicator of the value of the course. According to the project plan the target is to train 24 new nurse aids per year and to give refreshing courses to another 100 nurse aids that have been trained in previous years. The programme has reached its target of training the specified number of new nurse aids every year but has not conducted refresher courses for previously trained nurse aids. Several members of the project staff have received this training.

Other training activities

In addition to the above mentioned training activities there are two additional elements that are not mentioned in the project plan but are regularly conducted. Both are student practise programmes where students from other institutions come to Mursan to practise and observe. The first one is a training programme for midwives/nurses that come from hospitals in India.

The second is in cooperation with Rikshospitalet Norway that sends medical students for 4 weeks practise at MRPHP.

2.2.2 Strengthening of civil society

Strengthening of civil society organisations and awareness raising activities are included in different ways. Widows are encouraged to register with the public authorities so that they can benefit from their rights as offered by the government of India. Special emphasis has been put on facilitating the formation of women clubs and youth clubs. Women clubs are open to young and adult women. Youth clubs consist of young men from 18 to 35 years. MRPHP encourages the formation of both kinds of clubs but does not take part in the operations of the clubs. Once a club is officially registered with the corresponding public authority, the villages where the clubs are located benefit from different government schemes. E.g. when a youth club is registered the government shall provide electricity for twenty poor families in the village. The target has been to facilitate the creation of one youth club and one women club every year in each block where the programme is working. The programme has successfully done this but from the original objective to work in 17 blocks, they are now working in only 10 blocks and the number of new clubs has been reduced accordingly.

2.2.3 Preventive health activities

The programme carries out a range of preventive health care activities. Specific targets have been set for each activity and monitoring is done to follow up. The different activities are shown in the tables below.

Table 1 Antenatal care

Centre	**Year**			
	Target	2003	2004	2005
Mursan	800	1502	2 233	2174
Karhari	900	1160	1 229	1414
Beswan	900	1451	1 261	1319
Total	**2600**	**4113**	**4 723**	**4907**

Antenatal care has been one of the primary activities of the programme and the demand for this care is still rising.

Immunisation programmes

MRPHP carries out all normal vaccination programmes in coordination with public health authorities. The table below shows that the number of vaccinations has been going down in Mursan, increasing in Karhari and going down in Beswan from 2004 to 2005.

Table 2, Immunisation programme 2003-2005

	Mursan			**Karhari**			**Beswan**		
	2003	**2004**	**2005**	**2003**	**2004**	**2005**	**2003**	**2004**	**2005**
BCG	135	272	181	179	200	271	128	73	83
Measles	92	194	112	113	574	509	56	50	56
Tet Vac	403	435	258	332	290	362	321	349	261
DPT Total	517	976	537	643	779	909	309	315	301
Zero Dose	301	298	282	112	106	127	135	91	117
OPV 1st	183	401	222	278	252	229	369	128	122
OPV 2nd	139	233	137	154	119	174	71	88	81
OPV 3rd	112	152	98	101	81	129	61	53	60
Booster	107	284	80	137	458	419	222	594	41
Sub total	842	1368	819	782	1016	1078	858	954	421
D.T.	20	53	29	59	282		3	4	168
Other	5528	9566	6874						
Total Vaccine	**7537**	**12864**	**8810**[2]	**2108**	**3141**	**3129**	**1675**	**1745**	**1290**

[2] The very high number of immunizations in Mursan in 2004 is because one sub centre from the government was included in the statistics that year. The government later cancelled that cooperation. The figures of Mursan in 2003 and 2005 are comparable.

2.2.4 Curative health activities

All the three centres are open to the public 24 hours a day. Each centre treats its patients according to their possibilities and more demanding cases are either referred to the main centre in Mursan or to other health centres or hospitals. The centre in Mursan has a staff consisting of a professionally trained medical doctor, nurses/midwifes, lab technicians and the necessary support staff. The Karhari clinic is run by one traditionally trained doctor with long experience and his wife who is a trained by the project as a nurse aid and TBA. The centre has also a lab technician. The centre in Beswan is also run by married couple the wife being a nurse/midwife and the husband a lab technician. The statistics of the different centres are shown below.

Table 3, statistics of curative health care

Centre/activity		Year		
Mursan	**Target**	**2003**	**2004**	**2005**
Outpatients	12000	17373	15825	13519
Inpatients	700	875	916	1091
Deliveries	350	310	314	298
Laboratory tests	6100	7190	8633	14193
Sub total	19150	25748	25688	29101
Karhari	**Target**	**2003**	**2004**	**2005**
Outpatients	5000	6747	6819	7022
Inpatients	125	325	286	350
Deliveries	65	123	112	133
Laboratory tests	2300	3855	4181	5968
Sub total	7490	11050	11398	13473
Beswan	**Target**	**2003**	**2004**	**2005**
Outpatients	4600	6224	5542	3562
Inpatients	175	358	255	311
Deliveries	120	139	113	117
Laboratory tests	2600	3899	3744	4727
Sub total	7495	10620	9654	8717
Total MRPHP	**Target**	**2003**	**2004**	**2005**
Outpatients	21600	30344	28186	24103
Inpatients	1000	1558	1457	1752
Deliveries	535	572	539	548
Laboratory tests	11000	14944	16558	24888
Grand total	34135	47418	46740	51291

DOT Programme (Direct Observed Treatment)

The DOT programme is created by WHO (World Health Organisation) and implemented by the government of India. MRPHP was approved in October last year as a DOT centre authorised both as a diagnostic (microscopic) as well as treatment centre. All medicines and test supplies in this programme are provided and paid for by the government of India. The government will also pay some additional expenses related to the programme.

Poor people's clinic
One day per week a special offer is made called Poor People's clinic. The offer consists of the normal services offered by the centre at Mursan, but at reduced prices. The centre is very crowded on this day as a large number of persons take advantage of the offer.

2.2.5 Other health related activities

Eye camps
Eye camps are special campaigns where MRPHP cooperates with public health authorities in undertaking eye treatment including minor surgeries. The camps are held at Mursan but the work is done by public doctors. All expenses are also paid by the government. Last year 36 patients were operated in Mursan in this programme.

Sterilisation camps
Similar camps are held for sterilisation. The number of persons seeking sterilisation has been increasing year by year from 170 in 2003, 177 in 2004 and 327 in year 2005.

Day care centre
The purpose with the Day Care Centre is to show the importance for the children to go to school from early childhood. However, the centre is not a school, but a place where the children can play, and in between also learn a bit of ABC. The children admitted to the Day Care Centre should be from 1 year to 4-5 years of age, or the child should at least be able to walk. During the day in the Day Care Centre the child will have different opportunities to play, learn ABC and also learn some poems etc. During the day the child will also get a small and simple meal and a glass of milk will also be served.

MPRHC has an agreement with three different nursing schools that all send their student to the project for practice. These students have part of their practice at the day care centre. Medical students having practice at Mursan also spend one day at the day care centre.

The day care centre was started in 1992 and looks as good as new! There are 50 odd children who attend the centre for Rs 3,50 pr. day from 9 a.m. to 3 p.m. There are 4 montesari teachers looking after the children and the students at the nurse aids course have practice and training at the day care centre.

Handicap camps
The handicap camps is a multipurpose activity carried out twice a year on average which means that the 10 blocks covered by MRPHP will have a handicap camp every 5 year. The camps are coordinated between MRPHP, other NGOs, as well as public authorities. The purpose is multiple and among other things the following activities are carried out:

- Registration of persons with handicaps so that they can claim the different services they are entitled to.
- Promotion of preventive health e.g. explaining how polio vaccination can prevent infection and later deformations due to the disease.
- Distribution of mechanical aids to handicapped persons e.g. tricycles, crutches etc.

The sub centres of the project actively register handicapped persons throughout the year so that one does not depend on the special camps in order to be entitled to the different public schemes. The evaluation team took part in one handicap camp and it was quite impressing to

observe the level of effective networking among the different parties involved as well as seeing how well the staff integrated the different aspects such as prevention and care.

Reproductive Health Care (RHC)
According to the approved project plan the programme should carry out RHC in 7 villages in Mursan and in 8 villages in Iglas block. These activities were supported by the government of Uttar Pradesh in collaboration with NIRPHAD. This support was stopped by the government and the activities have subsequently not been carried out by at all. However, the government is planning to launch this programme again and it is expected that MRPHP will be one of organisation to be involved in the implementation.

Environmental hazard reduction
MRPHP had initially planned to include some health related preventive work against environmental hazards. The intended activities were promotion of soak pits, smokeless stoves, latrines and waste disposal systems. These activities have not been important tasks during the years covered by this funding period. However, some of these activities are indirectly promoted throughout the women and youth clubs.

2.2.6 Summary and conclusions health activities

MRPHP has successfully carried out most of the activities that are indicated in the general plan for the period 2003-2007. The work observed is of good quality and efficiently implemented. It is of special importance to note how the project staff is able to integrate the different components in the programme in a viable manner. MRPHP has not continued the training of TBAs as the original target of training 10.000 TBAs has been reached and it is considered that such training is not any longer an urgent need. The planned nurse aid refreshing course has not been undertaken and reproductive health care and focus on environmental hazards have not been implemented so far.

2.3 Project objectives and effectiveness

2.3.1 Project goals and indicators

MRPHP has formulated a number of project objectives and corresponding indicators or achievement for the project. These objectives are shown in the table below.

Table 4 Project objectives indicator matrix

Project objectives	**Proposed indicators**
Reduced mortality in communities where services are carried out.	Number of maternal deaths in villages
Empowered women and hence improved status of women	# of women trained
	# women clubs formed
	# of widows registered to receive their rights
Reduced mortality and morbidity of children below five years.	# of deaths
	# illness
Better quality of life for the disabled and their families	# tricycles
	# crutches
	# other aids
	# of handicapped registered so they can benefit from government rights.
Reduced public health hazards from environmental conditions	# soak pits
	# smokeless stoves
	# latrines
	# waste disposal systems

As seen in the previous chapter, the project has a systematic way to monitor its activities. Unfortunately the project has no similar systematic way of monitoring if the proposed objectives are achieved or not. This is a weakness in the project and the same weakness has also been pointed out in previous evaluation reports. We will in the following part make brief comments regarding each of the objectives formulated by the project.

- Reduced mortality in communities where services are carried out. (objective)
    - Number of maternal deaths in villages. (indicator)

No systematic registration of maternal deaths has been made but one can hear comments like "we haven't seen such deaths for a long time". As the information is neither systematic nor can be verified, it is impossible for the evaluation team to make a qualified judgement to if the objective has been reached or not.

- Empowered women and hence improved status of women. (objective)
    - Number of women trained. (Indicator)
    - Number of women clubs formed. (indicator)
    - Number of widows registered to receive their rights. (indicator)

In relation to this objective one cannot find systematic and verifiable statistics. A large number of women have previously been trained as TBAs but this training has been terminated as there was no longer an urgent need for such training. A limited number of nurse aids (24 per year) have been trained during the last years and indirectly a number of women have been

trained in the women clubs. The programme has reached its target of forming one women club per year in each block where the project is working. The number of participants in each women clubs varies from 18 to 25 and the total number of clubs is 128.The project is also facilitating the registration of widows but no systematic statistic is available.

- Reduced mortality and morbidity for children under five. (objective)
    - Number of deaths. (indicator)
    - Number of illnesses. (indicator)

No systematic information is available of this objective and the corresponding indicators.

- Better quality of life for the disabled and their families. (objective)
    - Number of tricycles distributed (indicator)
    - Number of crutches distributed (indicator)
    - Number of aids distributed (indicator)
    - Number of handicapped persons registered so they can benefit from government rights.

There is well documented information on these indicators. Distribution of these technical devises is normally done at handicap camps that are organised once or twice a year. This is combined with direct efforts to identify persons with handicaps and distribution of technical advices is only done based on a qualified judgement. The registration of handicapped persons so that they can claim their rights is very important as this is not an instant assistance but gives the persons access to defined rights for the years to come. Based on the available information and the observations by the evaluation team we find it correct to say that the project has fully reached its objective on this issue.

- Reduced public health hazards from environmental conditions (objective)
    - Number of soak pits (indicator)
    - Number of smokeless stoves (indicator)
    - Number of waste disposal systems (indicator)

These activities are not implemented by the project but some similar activities are promoted in the women clubs and youth clubs. The evaluation team has not been able to verify the existence of such work.

2.3.2 Project objectives – effectiveness conclusions

Due to limited practise in the project to document project achievement compared to the stated objectives, it has been almost impossible for the evaluation team to draw clear conclusions regarding project effectiveness. This does not mean that the evaluation team has concluded that the project objectives have not been reached. It simply means that there is neither reliable evidence that can confirm the achievements based on the indicators stated by the project, nor is there any indication of the contrary. The evaluation team has due to the limited time set aside for work neither been in position to undertake any systematic research in order to obtain additional information. The evaluation team has, however, a general impression that the general health work is effective and in accordance to the need of the population.

One should also mention that the project with the present project staff and competence is not in the condition to be able to monitor efficiently some of the “higher order” indicators that are stated in the project plan. E.g. this is the situation regarding indicators such as “infant

mortality and morbidity rates, and maternal mortality and morbidity rates". The project should therefore review if these indicators are suitable for the project or if other indicators could be more viable. The project staff may also need additional training to be able to carry out such monitoring.

2.4 Long term project goal and impact

The long term project goal is formulated as:

- Improved general health in rural Uttar Pradesh, especially among the poorest women, children and in communities where services are carried out.

The specific target group is:

- Mostly women and children in rural Uttar Pradesh who are trapped in a vicious circle of poverty and bad health.

There is no proposed indicator in the project plan regarding the achievement of the long term project goal. Neither has the project any systematic monitoring procedures regarding the fulfilment of the long term goal. However, the evaluation team is of the opinion, based on the observations during the evaluation, the verification of operating statistics, the good relationship established with local communities as well as with public authorities and institutions that the project has contributed to the achievement of the long term goal.

2.5 Project relevance

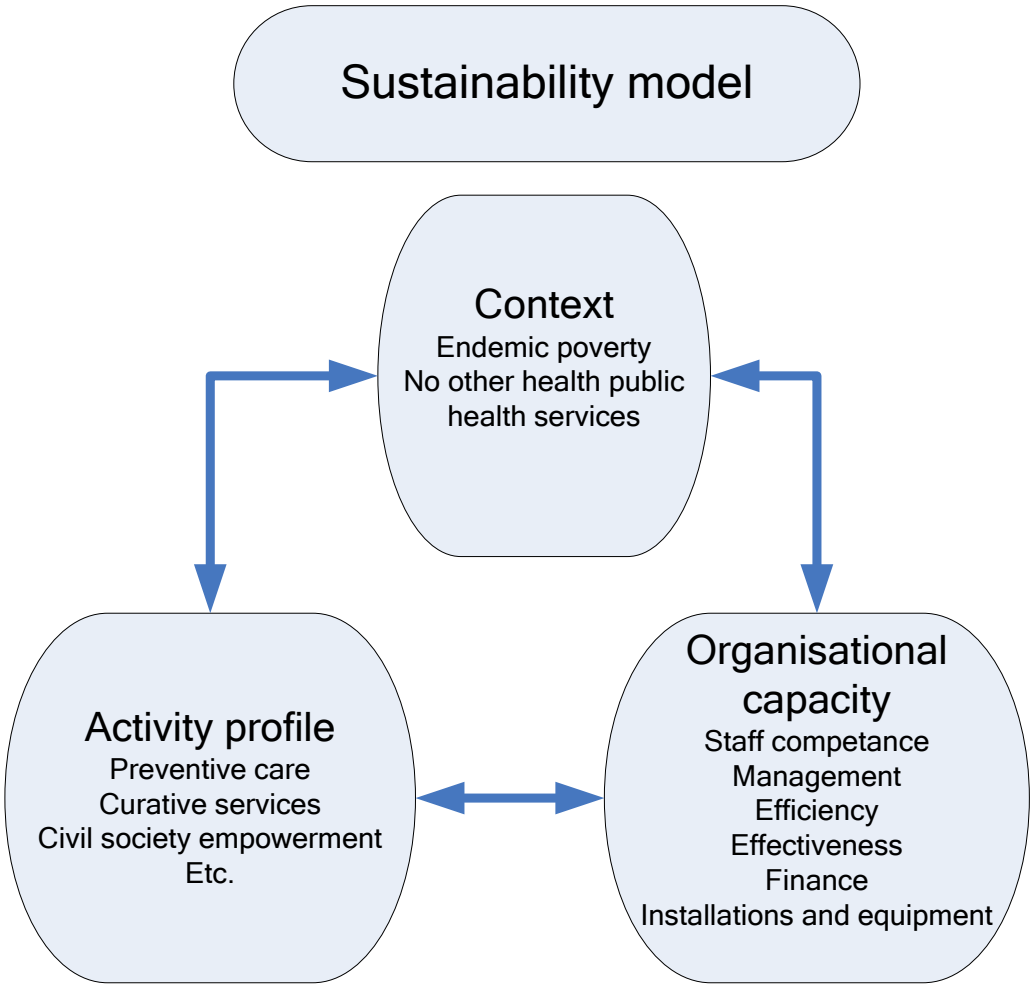
The question of project relevance relates to the question if the project activities, output, objectives and goals have relevance to the observed needs in the project area. The evaluation team finds little doubt that the project work is highly relevant. The basis of this judgment is a combination of various aspects such as:

- The project focuses health activities that are priorities of the national health authorities.
- There is a large demand from the population in the area.
- The project has achieved a considerable level of outreach to the community at the same time as it undertakes effective networking with public authorities and other relevant institutions and organisations.

2.6 Project sustainability

The figure below illustrates a theoretical model for sustainability. A project can be judged to be sustainable if there is a balance between the three different elements of the model. The context which expresses all the needs and the possibility in the area, the activities carried out by the project and the organisational capacity to carry out the work.

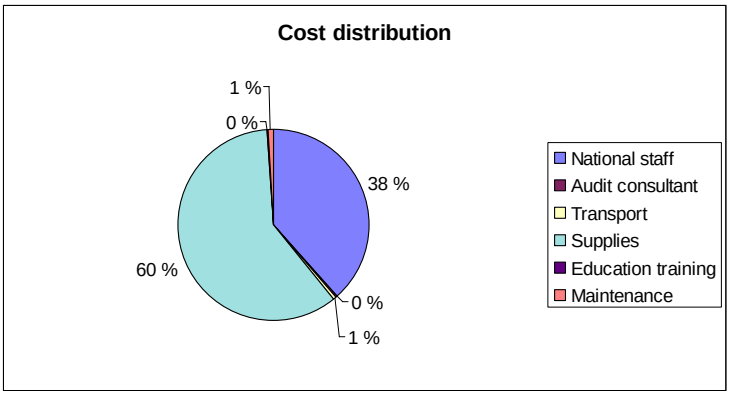
Graphic 2 Sustainability model



The evaluation team finds that there is little doubt about the ability of the project to adjust its activities to the needs of the population in the area. The work that is done is of good quality resulting in a large demand from the population. However, two questions should be made. Firstly, the project director has been Norwegian for more than two decades and the present director is not likely to continue in the position for many additional years. It is not likely that under the present visa regulations in India, a permanent visa for another expatriate director will be given. The project should therefore look into options for a national director within some time.

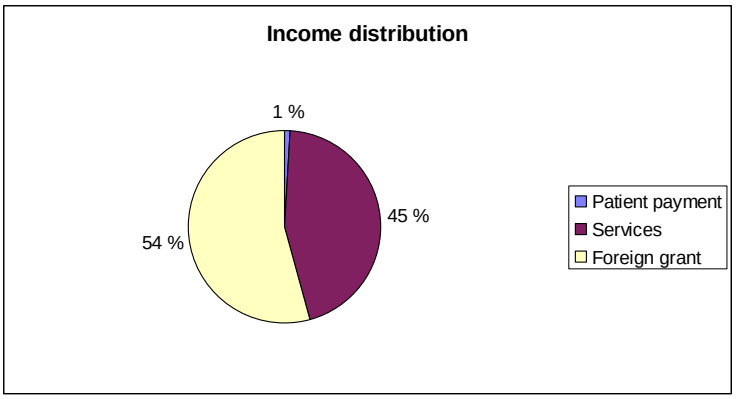
Secondly there is a need to consider alternative sources of income or reducing cost in order to achieve full organisational sustainability. A limited analysis of the income and expenses of the project was done during the evaluation and the result is graphically shown below.[3]

Graphic 3 Cost distribution general health work



Based on the project budget for 2006 the total cost is Rs. 4 816 588. The major cost items are general supply of approximately Rs 2 874 241 and salaries of Rs. 1 847 943. The cost does not include salary to the expatriate director.

Graphic 4 Income distribution general health work



Of a total budgeted income of Rs 4 816 588 only 46% is generated by the project in India. Of the foreign grant just above Rs 2.340.000 is grant from the Norwegian government and some Rs. 260.000 is grant from the United Methodist Church in Norway

The financial situation described graphically above obviously is a challenge to the organisation. This becomes more urgent as there are clear indications that the financial support for the general health work will only be granted for year 2006 and 2007. It is therefore recommended that the project management as well as the other staff look into this situation. Is it possible to reduce the cost of the work with almost 50 %? Can additional sources of income be found? The best answers to these questions can probably be given by the people concerned with the daily operations of the project.

2.7 Conclusions and recommendations health work

The overall conclusions from the evaluation team regarding the traditional health activities are that the work is of good quality, efficiently carried out and relevant to the needs of the population in the area. MRPHP has managed to build an extensive network with public authorities, other NGOs and institutions. The community outreach is in many regards impressive. The weaknesses of the work is on one hand connected to the lack of relation between project planning and project monitoring as it is very difficult to document effectiveness the way suggested by the project. A second weakness is the dependence upon foreign grants.

[3] The financial analysis is based on the budget for 2006 presented in the application for public funding in Norway and cost distribution data provided by MRPHP director. The exchange rate for currency conversion is 1 Irs = 0,1483 NOK.

3. HIV/AIDS

3.1 HIV/AIDS introduction

The HIV/AIDS work started in 2003 as a response to the alarming spread of the disease in the area. A new project plan was prepared taking into consideration the experience during more than two decades of community health work in the area and incorporating new experiences from other organisations. Of special importance was contribution from the work of The Salvation Army in Ahmednagar. Several of the staff members that are now strongly involved in HIV/AIDS were previously working in the general preventive health work. It is also important to emphasise that the HIV/AIDS work in no aspect is fully independent from the other health activities. It is probably more correct to describe it as an extension of the general health work.

The evaluation team has used the same evaluation model for the HIV/AIDS work as has already been described for the general health work.

3.2 HIV/AIDS activities and efficiency

3.2.1 HIV/AIDS introduction

The starting point of the activities was to train the existing staff so that they could efficiently and effectively include the HIV/AIDS perspective in all their activities. This was done through visits to The Salvation Army in Ahmednagar. The training has obviously been good and it is impressing to see how well the staff is able to carry out the work.

The second line of training has been to train the existing TBAs so that they can include HIV/AIDS related issues directly to their work within the communities. MRPHP has previously trained 10.200 TBAs and of these have 7.000 been given retraining. Although the evaluation team has neither been able to directly verify the effect of this training nor been able to observe the practical work of TBAs in the communities, can one presume that using the traditional birth attendants as extended arms in all the villages can be a very important strategy. The training of TBAs in HIV/AIDS awareness is also a good example to how MRPHP is able to integrate the new challenge of HIV/AIDS into an already existing network of people with good relations to their neighbours.

It should also be mentioned that the project has implemented separate deliveries rooms for HIV/AIDS infected mothers. These rooms have a higher standard than traditional delivery rooms. Separate delivery rooms are made at Mursan and the two cooperating hospitals of NIPRHAD.

A central strategy guiding the activities has been formulated as to:

- Work in depth at community level within the communities surrounding our clinics.

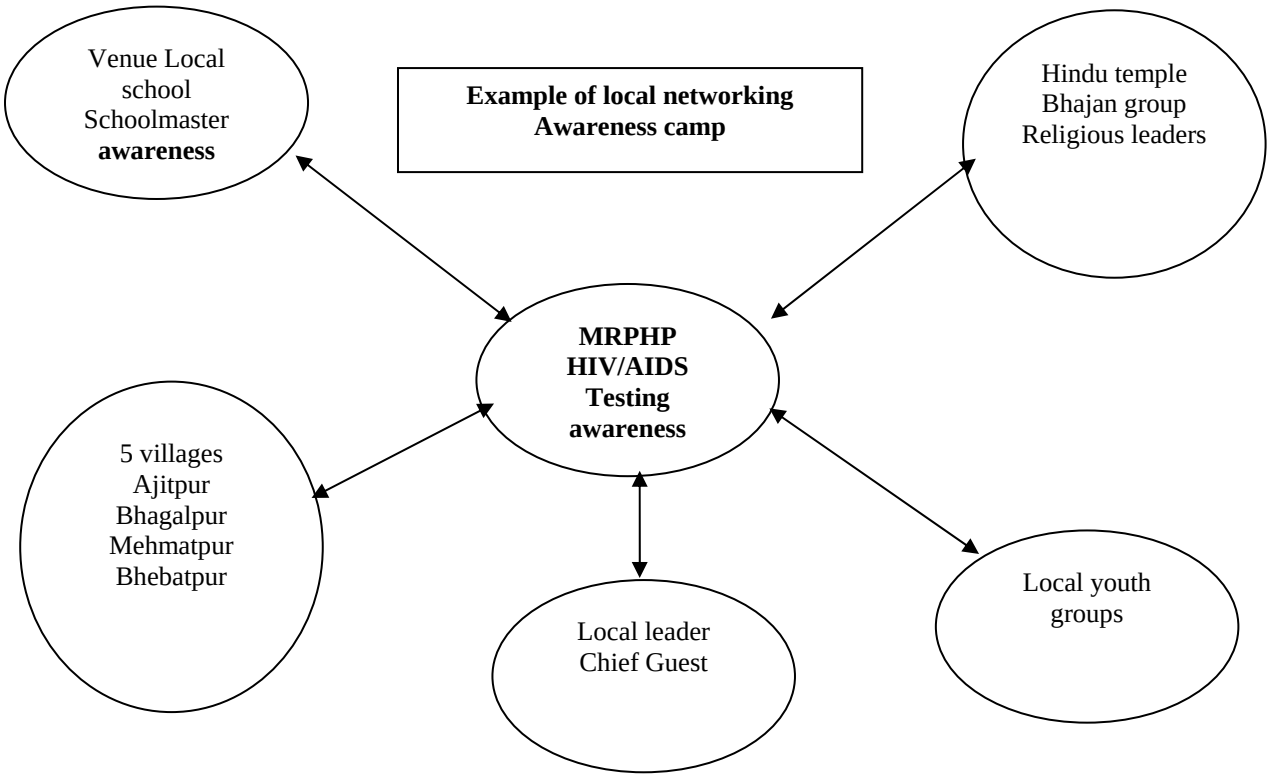
The evaluation team has been able to verify how this is effectively done incorporating the HIV/AIDS work into the general health work including the empowerment of civil society activities in youth clubs and women clubs as well as into the handicap camps. The graphic in section 3.2.2 shows a bit of the efficient outreach that was observed during one HIV/AIDS awareness raising/ test camp.

3.2.2 Camp meetings

A camp meeting is a combination of different activities of which the most important are:

- Individual and family counselling
- Awareness raising through a combination of written posters, direct oral information through speeches, dramas, songs and music.
- Voluntary testing

Graphic 5 Local networking HIV/AIDS test camp



An impressive number of awareness raising and test camps have been held. As for the year 2005 which is the first full year with statistics shows the following result.

Table 5 HIV/AIDS awareness raising voluntary test camps

Camps	Participants	Voluntary tests	Positive tests
696	20.074	5.212	56

An average of only above 7 tests has been taken from each camp. However the number of tests taken per camp has risen sharply. In one camp observed by the evaluation team 114 tests were taken but the staff was not able to satisfy the demand and a second camp had to be planned for the same village one week later. The prevalence of HIV positive test of the samples taken is 1,07 % which is higher than the official average of India of 0.8 %. A sub group of tests taken from a high risk group of truck drivers and people living near to the main highway number two shows a significantly higher prevalence of 1,36% or 26% higher than the general prevalence. However, the number of cases from the truck driver sample is limited

so the level of uncertainty is high. The tests are analysed at Mursan centre where adequate testing equipment is installed and where there is trained staff to do the work.

3.2.3 Support groups

One central activity is to give support to those persons already affected by HIV/AIDS and their families. One support group is organised at the main centre in Mursan. The evaluation team participated in one meeting and it was impressive to observe how directly and openly the affected persons and families were sharing among themselves. Strong testimonies were heard how the existence of the support group has helped people to move on in spite of the diagnosis. The support group is held once every month. At the time of the evaluation only one support group was active but there are plans to start a second group that will be located at the SWARJAYANTI SAMUDAIK Hospital run by NIRPHAD.

3.2.4 Home visits and counselling

Home visits are a central strategy work. All test camps and other public programmes are preceded by home visits and other individual counselling. The home visits are conducted by different persons. It can be by a voluntary, one of the staff members or by a pastor/evangelist. In this way is pastoral care incorporated in the work.

MRPHP has also established counselling in coordination with two hospitals run by a national NGO, NIRPHAD. This counselling service is another example of effective networking. MRPHP provides trained counsellors that offer services at the two hospitals.

3.2.5 Dhaba work

A dhaba is a road side hotel or rest place where truck drivers stop regularly. MRPHP has started a work among 25 dhabas that are situated on a stretch of 65 km along the main highway number 2. This highway goes from Delhi to Mumbai and passes through Uttar Pradesh where MRPHP is working.

During the journey the truck drivers often stop at “dhabas”, for food and rest and other activities. They are frequently involved in undesirable activities and high risk behaviour. Consequently they are crucial in spreading STD and HIV infection throughout the country. MRPHP has therefore made a plan to organize awareness program in selected Dhabas periodically initially for a period of one year with the following aims and objectives:

- To create awareness about preventive measures and transmission of HIV/AIDS.
- To do voluntary HIV testing.
- To create awareness in surrounding areas through peers approach so that individuals involved in multi-partners sexual relations can be identified.

The dhaba programme was originally not included in the project plan and should be seen as an important extension targeting two high risk groups for HIV/AIDS.

- Truck drivers that are the main users of dhabas.
- Persons living close to the dhabas and selling sex services to the truck drivers.

The dhaba project includes the following main activities:

- HIV/AIDS awareness camp along with provision of medical assistance shall be put up in Dhabas once a month.
- Required material supply.
- Quires of people and relevant problems shall be intended solved.
- Volunteer training of HIV/AIDS shall be given.
- To enhance the awareness activities and promptly find the root cause of problems.
- Peer educators shall be selected and trained.

As indicated in section 3.2.2 the results so far indicate that the prevalence of HIV positive persons is 24% higher among the persons tested in the dhaba work than in the rest of the samples taken by MRPHP. Although the truck driver sample is limited, it is an indication that it is important to establish an effective work targeting this group of people.

Originally the dhaba work was planned to be done in coordination with Methodist Hospital, Jaisinghpura, and Mathura. The hospital later decided not to be involved in any HIV/AIDS work and MRPHP has therefore decided to make NIPRHAD, a previous mentioned NGO running two hospitals along the highway, one of the main partners in the dhaba work. A more detailed presentation of the dhaba work is included as appendix 3 of this report.

3.2.6 Summary and conclusions HIV/AIDS activities

MRPHP has managed to implement a far reaching HIV/AIDS work during a relatively short period. From the inception in 2004 starting with training of the existing staff of MRPHP it has quickly penetrated not only the existing area of influence but been able to extend its coverage exemplified by the dhaba work and the coordination with NIRPHAD. It is the opinion of the evaluation team that the work is well done and efficiently carried out.

3.3 Project objectives and effectiveness

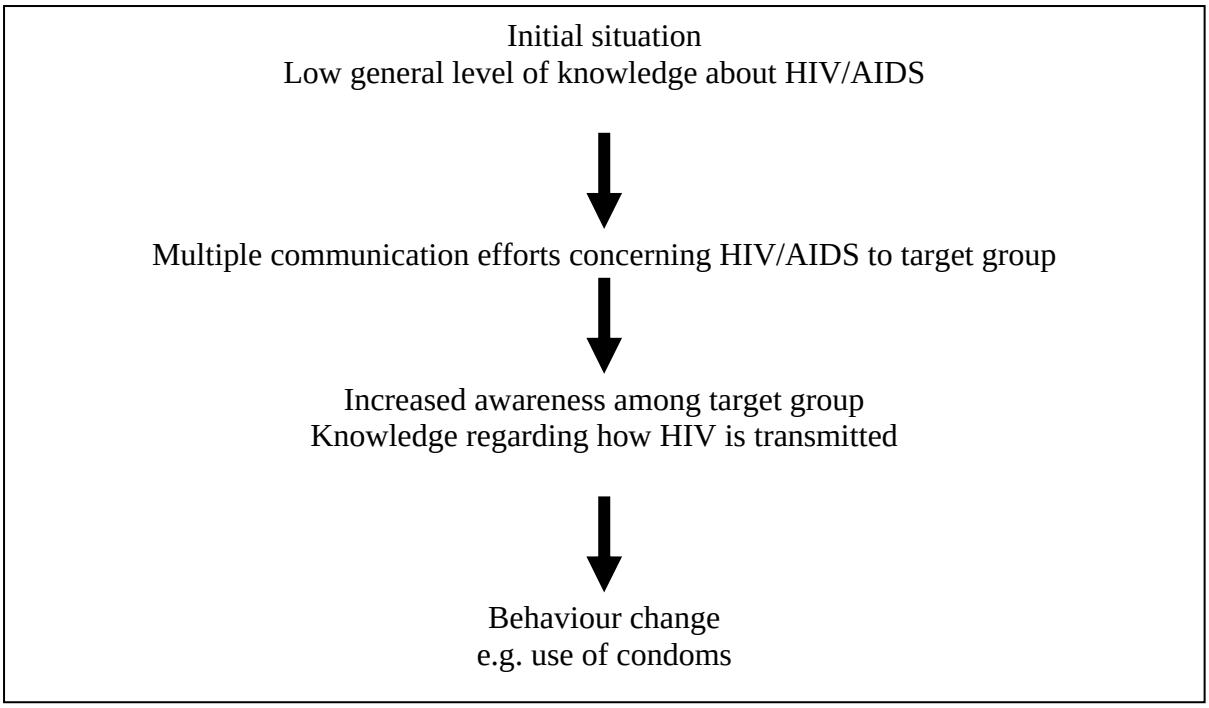
MRPHP has formulated the following project objective for the HIV/AIDS work:

- To create behavioural change relevant to the spread of HIV/AIDS virus.
- Change the attitudes towards those already infected or affected by HIV/AIDS

The project has not proposed any indicators to measure the level of achievement of the project objectives, and there is no systematic project monitoring at a higher level than project activities.

To create behavioural change relevant to the spread of HIV/AIDS virus
Measuring behaviour change is a complicated task and clearly outside the possibility of an evaluation with one week of field work. However it is possible to postulate the following possible relation of cause and effect as described below.

Graphic 6 Possible effect of HIV/AIDS information etc.



A survey conducted by the project among the target group indicates that around 10% of the population is aware of the risk of HIV and that they know how HIV is transmitted and how the risk of transmission can be reduced. The increasing demand for voluntary testing is also an indication that awareness among the target group has been created. The project has also registered a considerable consumption of the free supply of condoms to e.g. the dhabas. Although there is no certain easily verifiable indication of behaviour change, there is little doubt that awareness is increased and that the project is on the right way to achieve behaviour change among the target group.

Change the attitudes towards those already infected or affected by HIV/AIDS
Concerning this objective it is possible to construct a similar graphic concerning e.g. public stigma in relation to HIV/AIDS positive persons. As long as the mechanisms of transmission of the infection are not known, one can presume that people will keep distance to those affected. Increased knowledge may convince people that there is no reason to keep HIV infected persons isolated in the community. This may then lead to behaviour change among the population with a higher level of knowledge.

A second important issue is the creation of the HIV/AIDS support group. Facilitating the creation of such support groups is an effective intervention. The people already affected may be the best qualified to help other persons in the same situation. Once a support group is established it becomes practically self sustainable as the main contribution is from the participants themselves. Based on our observations during the field work and on a reflection like the one described above, the evaluation team has concluded that MRPHP has effectively contributed to reaching the project objectives.

3.4 Long term project goal and impact

The long term project goal formulated for the HIV/AIDS work is:

- Reduce the spread of HIV.
- Improve quality of life of HIV/AIDS victims

The project has neither suggested any indicator to measure achievement of the objective nor is there any systematic monitoring relevant to this objective.

The long term goals of the project are closely related to the stated project objectives. If the project objective is to create behaviour change, it is most likely that this will contribute to the reduction of spread of HIV. In the same way if one can observe changed attitudes towards those already infected or affected by HIV/AIDS, it is likely that this will improve the quality of life of HIV/AIDS victims. One can therefore conclude that it is reasonable to believe that the project has contributed to the fulfilment of the long term project goals stated in the project plan.

3.5 HIV/AIDS project relevance

The HIV/AIDS epidemic is one of the major health treats in India today. It is therefore no doubt that the HIV/AIDS work of MRPHP is highly relevant. It is also important to notice that the target work has been increased since the start of the work. Originally the target group was defined as:

- HIV/AIDS patients that come to the clinics
- Families of HIV/AIDS patients
- Communities of HIV/AIDS patients

This target group is closely related to the previous health work of MRPHP. However, the project has now been expanded to include two high risk groups that are outside the traditional focus of the traditional health work. These high risk groups are:

- Truck drivers on national highway number 2.
- Persons living close to the dhabas on highway number 2 offering sexual services to the truck drivers.

As mentioned before in this report, the preliminary test results indicate that the prevalence of HIV infected persons is higher in this group than what is found in the other samples taken by the project. This fact indicates that the extension of the project make the work even more relevant.

Lately an additional target group has been added consisting of patients referred to MRPHP by the two hospitals cooperating with the project. MRPHP has established counselling rooms in both hospitals and equipped rooms for deliveries for HIV positive mothers.

3.6 HIV/AIDS project sustainability

The same model for sustainability has been applied in this analysis as was described in section 2.6 of this report. If a project shall be considered to be sustainable, there should be a balanced relation between the three factors context, activity profile and organisational capacity.

Context and activity profile

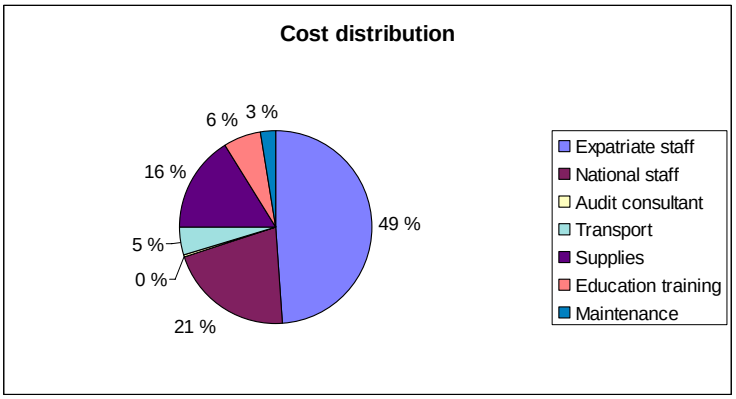
There is little doubt that there is a real and urgent need in the area related to prevention of the spread of HIV/AIDS. The project has been able to increase the awareness a fact that makes it reasonable to believe that the activities are well adapted to the needs of the population.

Organisational capacity

Even though the project staff had no or only limited experience with HIV/AIDS related issues, they have during a relatively short period been able to achieve the necessary level of competence and to turn this into effective practise. It is worth mentioning that in addition to their resources in the project, MRPHP is effectively networking with other institutions both on a local, district as well as regional level. This increases the efficiency as well as the effectiveness of the project.

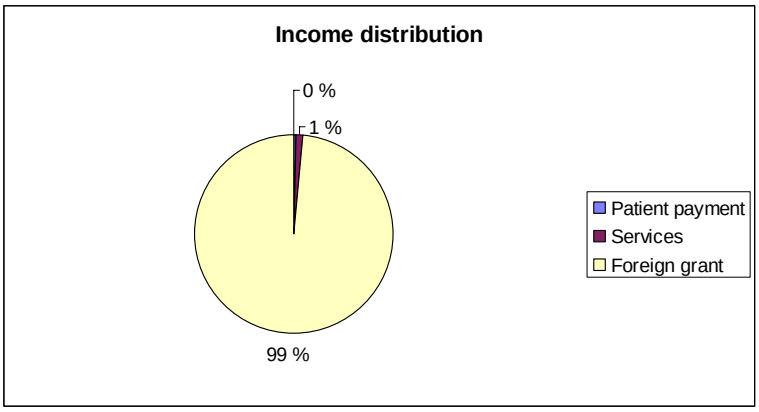
A similar financial analysis of the HIV/AIDS project has been done as for the general health work. The result of this analysis is shown graphically below.[4]

Graphic 7 Cost distribution HIV/AIDS Project



Of the total project cost of Irs 5 163 183, the three major cost items are expatriate staff Irs 2 528 658 or 49%, general supplies of Irs 834 457 or 21% and national staff of Irs 1 085 300 or 16% of total cost.

Graphic 8 Income distribution HIV/AIDS Project



As one can see from the graphic, the project is almost totally dependent upon foreign grant of which 90% comes from the Norwegian government and 10% from United Methodist Church in Norway.

[4] The financial analysis is based on the budget for 2006 presented in the application for public funding in Norway and cost distribution data provided by MRPHP director. The exchange rate for currency conversion is 1 Irs = 0,1483 NOK.

The project has received information from the main donor that an application for a new funding period starting from 2008 will be considered. However, it is obvious that the project must seriously consider alternative income sources if the intention is to continue the work for a longer period of time.

3.7 Conclusions and general recommendations HIV/AIDS project

MRPHP has during a relatively short period of time managed to train its staff and to implement a considerable preventive work related to HIV/AIDS. The project has clearly benefited from an already positive and well established relationship with the communities surrounding the centres but has also managed to deepen its outreach including the coverage of 25 dhabas along the national highway number 2. The project staff and management have shown creativity and it is particularly important to point out the good integration between the new HIV/AIDS work and the previous general health work. It is also worth mentioning the close networking with the different parts of the society from the local community to higher level public officers as well as representatives from the civil society. The work is well carried out in an efficient as well as an effective manner. The overall weakness of the project is the nearly total dependence upon foreign donors.

4. Appendixes

4.1 Training of traditional birth attendants

CSSM/CSSM *Methodist Public Health Centre*
TBA's Training *Mursan, District Hathras, Uttar Pradesh.*
Core curriculum

Theoretical Training of TBA's:
During a period of 5 days the below mentioned classes will be given to all the TBA's in the different Blocks. Beside this the TBA's also need training in the villages about:
1. Practical conducting of delivery 2. Teaching of the Mothers and Home visits
.
Prenatal Care:
1.1 Symptoms of early pregnancy
1.2 Past History of prenatal case, medical and surgical.
1.3 Prenatal examination
1.4 Advice to prenatal case
1.5 Danger signals during the prenatal period
1.6 Care to mothers in a prenatal clinic

Internal Care:
2.1 Preparation for delivery before labour starts
2.2 Preparation as soon as labour starts
2.3 Care during first and second stage of labour.
2.4 Immediate care of the new-born.
2.5 Care of mother during the third stage of labour.

Care of mother and the new born baby
3.1 Immediate care of the mother and the new born baby
3.2 Diet of the mother
3.3 Breastfeeding
3.4 Postnatal visit.

Infant care
4.1 Infant feeding and weaning
4.2 Baby bath

Care of child under 5 (<5 yrs)
5.1 Simple measure for healthy living
5.2 Immunization - needs and schedule
5.3 Oral Re hydration Therapy, ORT
5.4 Treatment of diarrhoea

Family Planning and medical termination of pregnancy
6.1 Need and advice for family planning
6.2 Contraceptive methods and MTP

HIV/AIDS

7.1 What is HIV/AIDS?
7.2 How does it spread?
7.3 How does it not spread?
7.4 Signs and symptom, Treatments
7.5 Testing, Counselling.

Remember: When you are motivating and calling the TBA's for training, see that you take TBA's whom will continue be working as TBA's / Dais. She must also be present for the whole training

The Director, MPHC, Mursan, September 2003

4.2 Nurse Aids training programme

Methodist Rural Public Health Program
Mursan 204213, District Hathras
U.P. INDIA

AIMS AND OBJECTIVES FOR

NURSE AID AND CHILD HEALTH CARE WORKER COURSE

***During 4 months Course the Nurse Aid and Child Health Care Worker will learn to*:**

- To conduct teaching classes in the villages on Ante Natal, Vaccination, HIV/AIDS, Malaria and Sanitation.
- To encourage The Village Women to go for Ante Natal Check Up's and also to get the tetanus vaccine
- To detect High Risk Cases and refer them to proper Hospitals
- How to do PV during labour
- To conduct clean and safe Deliveries in the villages
- Diet during Pregnancy, labour and Post Delivery
- Breastfeeding and weaning
- To encourage the mothers to take their children for inoculations and treatment.
- Diet during 0-2 yrs.
- Care of children 0-5 yrs.
- Vaccination of children
- Smokeless Chula
- Safe drinking water
- Sanitary Latrines
- HIV / AIDS, How it spreads and how it does not spread.
- Government Schemes of self Employment

4.3 The dhaba programme

HIV/AIDS Project on Delhi – Agra High Way
Dhabas Awareness Camps / screening and testing

Methodist Rural Public Health Programme, Mursan
Methodist Hospital, Jaisinghpura, Mathura

HIV / AIDS Project on Dhabas, Delhi – Agra High Way
From Farah to Kosi about 65 Km
The project to start May 2005

Dhabas: During the journey the truck drivers often stop at "dhabas", road side hotels for food and rest and other activities. They are frequently involved in undesirable activities and high risk behaviour. Consequently they are crucial in spreading STD (Sexual Transmitted Disease) and HIV infection throughout the country. It is therefore plan to organize awareness program in selected Dhabas periodically initially for a period of one year with the following aims and objectives:

To create awareness about preventive measures and transmission of HIV/AIDS
To do voluntary HIV testing
To create awareness in surrounding areas through peers approach so that individuals involved in multi-partners sexual relations can be identified.

Methodology used is discussed below:

Staffing: Staff leader + 2 field workers + supervisor
Sources
The help and advice of consultant advisor shall be sought fortnightly, depending upon her availability and need of the centre.

Project to be performed by:
Methodist Public Health Centre, Mursan
Methodist Hospital, Jaisinghpura, Mathura

Persons Responsible:

Ms. R. Refsdal, Director
Mr. P.P. Lall, Hospital Administrator

Dr. M. Kaushal, Coordinator of project and responsible for the training of LVG and other HIV/AIDS workers

Consultant Advisor: Dr. Suneel R. Qamra, Assistant Director, Central Jalma Institute for Leprosy
(Indian Council of Medical Research)

Job responsibilities:

Mr. P.P. Lall, Administrator, Methodist Hospital, Mathura shall be responsible to depute the work and supervise periodically the ongoing work on the Dhabas. Mr. Sandeep Sikroria, Team leader and counsellor shall be responsible to carry out the work as schedule in Dhabas and shall prepare records from the workers in addition to planning for the team from Mursan. The team leader will be responsible for the training of LVGs (Local Volunteers Groups) activities, who will be selected, and also see/decide what is their activities.

Only take account of work, this shall be ongoing activities duty. To identify Dhabas by the Team leader and Team members (Workers and Lab. Technicians). Simultaneously they shall constantly supply/replace the materials and solve their queries.
To carry out the work need based mode of transport shall be provided.

Methodology – Program and activities

Daily the team leader situated in Mathura with a supervisor as in charge will visit the project sites, all the Dhabas during the week. IEC (Information-Education-Counselling) Materials and condoms will be distributed.

Man to man rapport building activities will be done and the team workers shall also keep record of IEC Materials and condoms distribution. The IEC materials and condoms will be provided to the principal stake holder (Dhabas Malik) so that the ultimate beneficiary (truck drivers) can get it easily.

A questionnaire will also be made for the team so that the project can have a record of how many have been counselled etc.

Days of activities:

The team leader and team from Mursan activities: The team leader will visit the project twice in a week – Monday and Thursday. Following activities will be done:

- HIV/AIDS awareness Camp along with provision of medical assistance shall be put up in Dhabas once in a month.
- There after required material supply.
- Quires of people and relevant problems shall be attempted to solve.
- Volunteer training of HIV/AIDS shall be given.
- To enhance the awareness activities and promptly find the root cause of problems.
- Peer educators shall be selected and trained.

Activities on Monday:

On Monday the team will visit the project with the HIV/AIDS workers situated in Methodist Hospital, Mathura, and in the beginning selection of the LVGs will be done. One HIV Worker from Mursan with rich experience in HIV/AIDS field should come along to help the LVGs and HIV/AIDS workers of the Methodist Hospital, Mathura for starting the project. On this day the following activities will be done:

- Selection of Dhabas. Normally Dhabas where truckers stay and take rest.
- Awareness activities using different techniques.
- Distribution of IEC Material.
- Identification of LVGs followed by training prior to start work.

Criteria for selection of LVGs

- Preferably high school pass.
- Good Communication Skills.
- Social influence and acceptable
- Knowledge of local areas and practices.
- Preliminary knowledge of HIV/AIDS. (Through training)
- Preventive Measures. (Through Training)

The job of LVGs

- To give local people some knowledge of HIV/AIDS to disseminate awareness about prevention Measures of HIV/AIDS and how it transmits to others.
- To inform Dhabas and local people about Thursdays activities.
- Queries, advice and demands of the community

Identification of other sides in Community beside Dhabas:

- Repair Shops for example tyre and truck repair shops
- Waiting areas for Bus, train etc.
- Establish and mobile sex workers
- Village close to the Dhabas, whom might provide girls to the truck drivers for sex.

Activities on Thursday

I.E.C. Information, Education, Counselling

1. Permanent Board Display on each of the Dhabas
2. Pamphlets a. Knowledge of HIV/AIDS, b. Wrong believes of how HIV/AIDS spreads.
3. Stickers inside the trucks
4. Cassettes: Punjabi and Hindi film songs, in between HIV/AIDS messages. To make one master copy > Duplicate copy

This is the day when cassettes can be given to the truck drivers. The cassettes will consist of popular film songs, and in between the songs will be small messages about HIV/AIDS. Stickers with facts of HIV/AIDS will also be given and put inside the trucks, so it is easy to see for the people sitting in the truck. This will also remind them about how to live, so they shall not be infected, or if they are infected already, how to live.

Saturday will be used for:

1. **Reporting of whole weeks program**
2. **Planning of the next week**

The Report must be given weekly to the Director

Signature:

R. Refsdal, Director
Methodist Rural Public health Program,
Mursan 204213, District Hathras, U.P.

Questionnaire / Survey for Truck Drivers or other who will undergo Pre-counselling and HIV Testing

Name: Age: Sex:

Father's/Husband's name:

Full Address:

Education:

Marital Status: Single / Married / Widow / Widower / Divorced

Children: How many

Monthly Income:

Truck No. License No: Phone No.: (If any)

- Average days separation from family :
- Knowledge about HIV/AIDS: Yes / No
- What they know about HIV/AIDS:
  1.
  2.
  3.
  4.

- Willingness to know about HIV/AIDS:
- Sexual Practices, do they keep multi sexual relations?
- Areas of availability / Mobile Sex Workers:

Sexual History:

- Average expenditure on Sex:
- Do they take inject able drugs with Common syringe :
- Use of Preventive Method:
- Any Persisting / Prolonged Disease:
- Any symptoms / signs suggestive of HIV/AIDS:

- Queries:
  1.
  2.
  3.
  4.

- Advices and demands:
- Usual stoppages (Dhabas) in the Survey area, up/down:
- Whether satisfied with the information / preventive technique told:

Signature of Counsellor / Project worker: Date:

GLOSSARY

AIDS:	Acquired Immune Deficiency Syndrome
HIV:	Human Immune Virus
LVGs:	Local Voluntary Groups
IEC:	Information, Education, Counselling
STD:	Sexual Transmitted Disease
DHABAS:	Roadway restaurant where the truck drivers stop for food, rest and other activities.
Screening:	Screening and testing for HIV/AIDS means to counsel people so they will be ready to undergo a test, screening will be done to know the amount of HIV+ people in this area etc.

4.4 Documents from staff workshops

Evaluation workshop
Tuesday January 10th 2006 Historic perspective
Plenary session

Vision	Concern	Desired outcome	Achieved output	Activities done	Challenges faced	Lessons learned.
Reduce the incidence of HIV in the villages near the dhabas	No NGO working in these high risk communities	Awareness/home visits in high risk communities.	Dhaba work.	Working in the nearby Dhabas 25 in all. Covering 65 km along the main highway.	Many not ready for HIV testing. Anti retro virals are expensive.	MRPHP Mursan has the capacity to work in the communities around.
TBA to be involved in HIV and counselling. CSSM	Illiteracy	Training of TBAs in HIV counselling for community work to be done. Volunteers to be involved. Local village "doctors[5]" need ongoing training along with the clinic at Mursan.	TBA earning and taking care of ANC cases.	Home visits for ANC & counselling are going on. Good rapport building.	Involvement of local health workers like TBA etc. to make village people aware of HIV-AIDS. About 20% migratory labourers in villages. (Working in cities) high risk group.	Every village in Hattras and Augarh district has one or two TBAs trained by MRPHP.
To care for HIV/AIDS patients in the health centre.	Space may be too little. Supportive treatment and care are needed.	To increase the care and support programme in the centre. Train TBAs for Home based care.	Good support group. Space insufficient now.	Youth clubs and women clubs involved. Training of uneducated TBAs.	Some field workers are rejected in HIV + homes.	Good rapport established by working with the youth
There is a need for better lab set up to diagnosis diseases.	Many patients have to be referred to Hattras.	Better care of patients. It could be used for income generation for the centre. Local doctors will refer more patients.	Better patient care with the DOT tuberculosis programme.	ELISA reader helps newer tests to be done. More TB patients are cared for.	Training of LAB technician.	Care and support help in the overall vision of the clinic.
Ultrasonograph/ x-ray to upgrade the clinic.	Many patients have to be referred for basic investigations elsewhere. We lose patients.	Many patients will be cared for here.	Better facilities give better quality care to patients.	Fetal Doppler helps in safer deliveries.	Training of the doctor will be necessary.	Our visibility becomes wider with better facilities.

[5] Local village"doctors" are not trained medical doctors but traditional practionars.

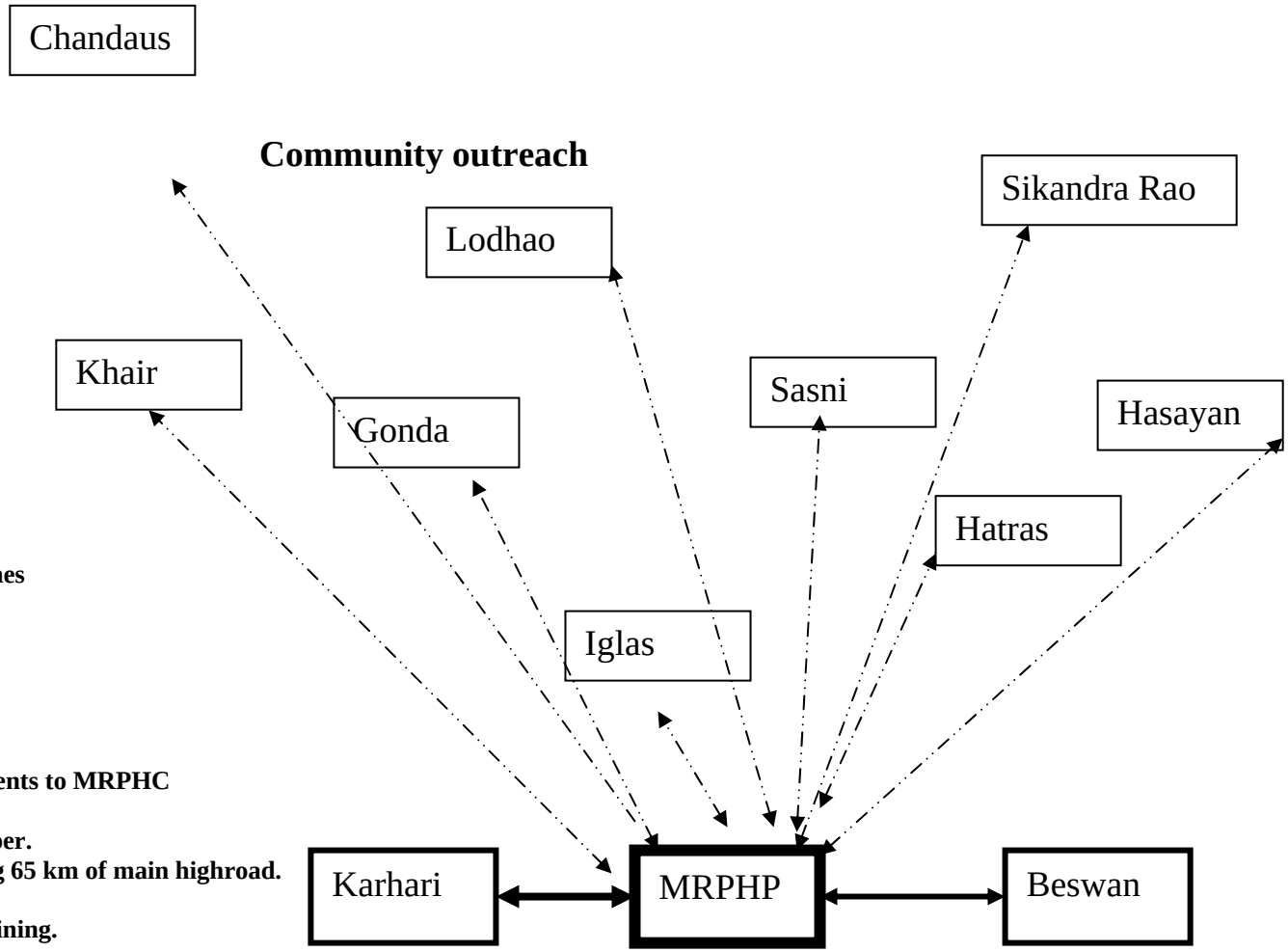
Thursday January 12th 2006.
Future perspective

Female

Vision	Concern	Desired outcome	Actions
Increased awareness in the community	Financial constraint	More patients will be aware or come forward for testing.	More training of the staff- Ahmednagar or call/invite some authorities to teach staff.
Increase our work efforts.	Because of increased home deliveries and increased infant mortality rate.	More people will know about our work.	Retraining of TBAs.
Home visits in the villages.	People are not available to talk to, have left for work or hide because they are afraid.	Increased number of patients in antes natal care and HIV.	Increase the awareness about the services available here at low cost.
Increase awareness among TBAs about HIV AIDS.	Difficult for them to come and go.	More patients will be brought to the centre.	MRPHP will continue to go to the as they always have done.
Home based care.	Sometimes poor understanding.	Door to door visits by volunteers, TBAs/community health workers etc.	Training/ teaching about home remedies.

Future perspective

Male			
Vision	**Concern**	**Desired outcome**	**Actions**
Strong centre to support the field work.	Funds	Better community services.	Develop income generating services: a) X-ray and ultrasound. b) Upgrading lab services. c) Vice versa licensing with government as DOT, LTD camps, eye camps, handicap camps etc. d) Better patients care and network in the field. e) Judicial use of funds.
To use existing centre for outreach in community in a way so that more and more patients come to the centre and community health status rises.	To direct and retrain the existing network.	To improve community health.	a) Re-gearing and overhauling the existing staff of field workers. b) Advertisements. c) Informational and educational activities. d) Proper planning and programming.
Block activities a) HIV / AIDS awareness. b) CSSM. c) DOT. d) Immunization. e) Empowerment of local people. f) General awareness.	Retraining and follow up. Local voluntary groups. Liaison with government.	Good community development.	a) Village to village coverage. b) To identify resource persons. c) Government cooperation. d) Proper monitoring and self-evaluation. e) Self motivation and commitment.

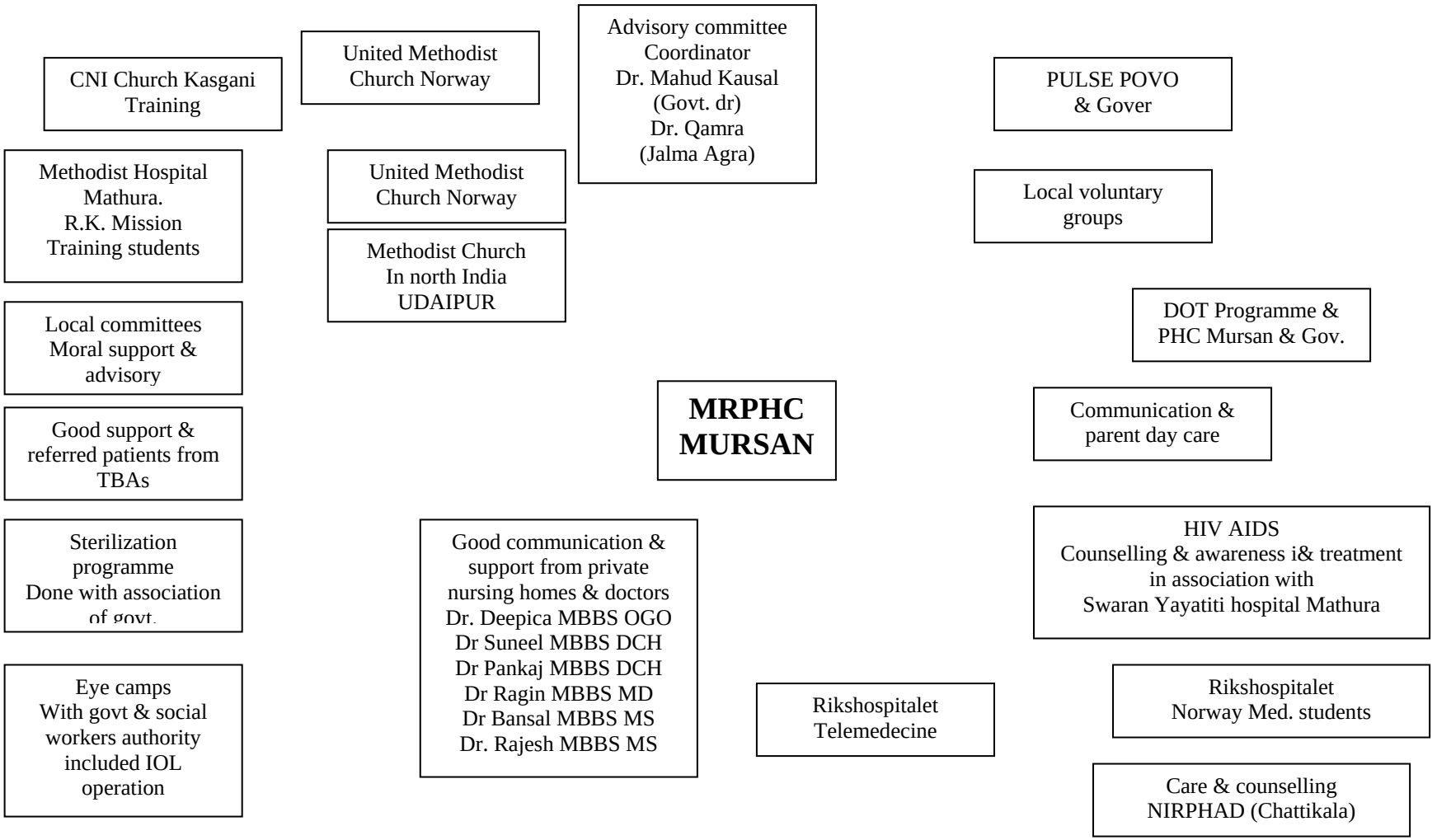


Block activities

1. **HIV AIDS awareness**
2. **HIV AIDS testing**
3. **Youth Clubs**
4. **Mahila Mandal (women Clubs)**
5. **Centre activities**
    a. **Ante Natal care**
    b. **Family planning**
    c. **Vaccination**
    d. **Post natal care**
    e. **TBAs**
    f. **TB positive (DOT)**
    g. **General care**
    h. **National health programmes**
6. **TBAs**
7. **ICDS worker**
8. **Local voluntary groups**
9. **DOT**
10. **Handicap**
11. **Baby shows**
12. **Referral from blocks of needy patients to MRPHC**
13. **General awareness**
14. **LTO (Laparoscopic Tuberctony oper.**
15. **Dhaba activities at 25 dhabas along 65 km of main highroad.**
    a. **HIV AIDS awareness**
    b. **Local voluntary group training.**
    c. **IEC material**
    d. **Condom supply**
    e. **Awareness boards**

1.

Networking towards sustainability



4.5 Evaluation programme

January 9th Monday	Evaluation team leaving Delhi for Mursan. On the way see the Chhatigara Clinic; NIRPHAD and counselling room in Swarn Jayanti Samucaik Hospital both on the national highway number 2 Mathura.
January 10th Tuesday	Welcome by staff Visit the centre, HIV/AIDS building, Elisa Reader and Day Care Centre. Workshop with staff Meeting with Test camp Sasni block
January 11th Wednesday	Poor people clinic, testing, Elisa Reader, DOT programme, HIV/ AIDS support group, nurse aids training. Youth club and Women club
January 12th Thursday	Handicap meeting (camp) at Kher Block.
January 13th Friday	Beswan Centre and Karhari Centre, Baby show arranged by Day Care Centre Mursan
January 14th Saturday	Mathura, Dhaba project with mega camp. Visit to Swarn Jayanti Samucaik Hospital. Meeting with hospital director and staff.
January 16th Monday	Evaluation team meeting. Feedback to project staff
January 17th Tuesday	Travel to Delhi
January 18th Wednesday	Meeting Norwegian Embassy, Bishop N. Christian Methodist Church.