Sida Evaluation 00/28

AIDS, STD Health Action Project in Mumbai, India

An evaluation of ASHA

Anjali Gopalan
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Asia Department

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Sida Evaluation 00/28
Commissioned by Sida, Asia Department

Registration No.: U11 Bi/1.2.3-6.
Date of Final Report: November, 1999
Printed in Stockholm, Sweden 2000
ISBN 91 586 8868 4
ISSN 1401–0402

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Executive Summary

The MMC ASHA project supported by SIDA is primarily set out to promote safer sex, provide condoms and health care services to offer treatment for STD's among women in prostitution and male clients in Kamathipura and Kethwadi areas of Mumbai. The project underwent a redesign in 1995 and therefore was more focused in its approach by deploying community development officers (CDO) and animators (peers) to work closely with the community. The project cycle ended as of June of 1999 and SIDA called for an evaluation of the project achievements.

The project has achieved its principle objectives during its course. It has reached 5000 women in prostitution periodically and about 20,000 male clients. There are well-organised components in the project that have functioned efficiently and effectively. The project has vital lessons learnt through its development/deployment of outreach and services. Through implementation of the project the project team has accrued enormous technical experience and expertise. ASHA has also been able to reach other community based organisations in the geographic area of operation It has forged a close collaboration with CBOs and NGOs that offer other programs in the community. There has been a good degree of transfer of knowledge and skills between them and this has made collaboration effective.

MMC has offered the support that it had committed to the project in the form of providing personnel (CDOs) from the MMC and the premises as well as dedicate the clinics for women and men through the Community Health Care Unit (CHCU) and the Belasis road Male STD Clinic.

The female component that targets women in prostitution and madams has a dedicated band of animators (peer workers) who reach the women on a daily basis. They deliver health messages, convene meetings among them and help in referral of women to the CHCU and in follow-up. They are trained by the CDOs on the MMC in smooth conduct of their work. Though they first began as animators who provide information they have very quickly taken the job of referral. Their work seems be beyond the work hours since they also take women to the hospitals that the CHCU refers them to.

This component has had a limited coverage in comparison with the actual need in Kamathipura and Kethwadi and therefore attention has to urgently be given to scale up to a 100% coverage in the geographic area. There is also evidence of community self-organisation, though nascent and the project will need to develop programs around such an initiative coming from the women in the community.

The Male component has been functioning as an awareness raising and male referral component. There is good participation of the general male public of the geographic area where Asha Project functions. There are sustained referrals through this component to the male STD clinic for diagnosis and treatment of STDs among men. The component has also been enabling men who seek voluntary testing to get the services.

The Asha Project has undertaken networking and capacity building of NGOs in the location that they work. There have been many partner NGOs that have worked closely with Asha project in providing support services like child care for women in sex work and communal harmony.

The overall productivity of the project is high despite many obstacles and staff movement. The project is at a point where the next steps in the promotion of safer sex, provision of care and support, and development of self help and community self organisation coupled with community

development initiatives have to be thought through for attaining better coverage and better delivery of health services.

Currently with the emergence of Mumbai Municipal Corporation AIDS Control Society and its mandate to provide financial and technical support through the National Program/NACO and the role of USAID and its support for the city of Mumbai for development of intervention among hard to reach population, it is imperative that SIDA considers providing inputs in conjunction with these players in the promotion and development of community self organisation and sustainable human development among the women in sex work

Chapter 1

1.1 Background and Introduction

The Mumbai Municipal Corporation had started working on HIV/AIDS prevention since mid 1992. This initiative had begun with the technical and financial assistance from the WHO (GPA) program in conjunction with the National AIDS Control Orgnisation and was undertaken in the areas of Kamathipura and Khetwadi in Mumbai. SIDA was asked to provide resources to the development and implementation of the project activities soon after an assessment had been done and a protocol for intervention had been developed. SIDA, WHO, NACO and MMC had called for a project review in 1995 and there after a reprogramming mission worked on reformulation of the project. Subsequently, MMC through its AIDS Cell, initiated a project AIDS STD and Health Action (ASHA) with financial and technical support of SIDA. This project came to a close in the June of 1999 after an extension period of one year. SIDA had not been requested for resources around the time the project was coming to an end, hence resources had not been made available to the project post June 1999. Since request for continuation of funding has come from MMC/ASHA SIDA called for an evaluation of the concluded project to make decisions on financing a subsequent phase of the project.

Mumbai has been identified as a priority State in India by NACO and therefore a Mumbai District AIDS Control Society has been formed for which the MMC Commissioner is the Chair and the Additional Commissioner is the Vice Chair. USAID has also identified Mumbai City as its priority area for intervention and has just (Oct 1999) launched their 5-year, 48 Million USD Avert Project. Apart from this the Maharashtra State AIDS Control Society (MSACS) deals with the rest of Maharashtra with support from National AIDS Control Organisation/World Bank assistance.

During the recently held sentinel surveillance study that was undertaken by NACO it is clear that there is a raising trend of HIV infection in Mumbai. The infection among Women in prostitution seems to have crossed the 60% mark. Given this scenario it is imperative that programmes that address the needs of the marginalised communities should be stepped up.

1.2 MMC/ASHA Project Synopsis

The ASHA project is designed to work with women in sex work and their male clients in Kamathipura and Kethwadi area of Mumbai City. The project works with women in brothels, brothel keepers and men who are part of the environment (musclemen and pimps and police personnel) these forms the female component of the project. The male component raises awareness among the potential male clients (hotel boys, men who are in the general project area and may visit brothels) and influence them to seek treatment for STDs and motivate them to use condoms. The project also works with a limited number of NGOs and CBOs in the project area to compliment their efforts and upgrade their skills and capacity. The project runs two clinics under the auspices of MMC. The women's clinic is a Comprehensive Health Care Unit and the Men's clinic is the Belasis Road STD clinic[1]. The project intended to cover 5000 women in prostitution and build rapport with 125 brothel keepers and contact 20,000 male clients every year within the scope of their operation. Further more the project envisaged to promote acceptance of safer sex practices among male clients, increase the number of clients accessing STD treatment.

[1] This is one of the oldest clinics in Mumbai city and run by the City Corporation.

Chapter 2

2.1 Mission Objectives

SIDA commissioned a two-member team[2] to conduct a review and provide recommendations for future course of action[3]. The main objectives of the mission were as follows

1. To assess the overall impact of the SIDA contribution to the project
2. To identify the strengths and weaknesses of the project including the management
3. To identify the issues of importance within the project components
4. Analyse describe and draw conclusions of the development of the project with regard to fulfillment of objectives, effects on the target groups, cost effectiveness, sustainability and management of crosscutting issues.

2.2 Mission Methodology

A participatory method was developed to conduct the mission. This comprised of

- In-depth interviews with key stakeholders and staff of the MMC/ASHA.
- group meetings with animators and individual meetings with authorities of the Municipal Corporation and associated government structures.
- detailed review of project documents and meetings with technical assistance providers (for documentation and for ongoing monitoring)

2.3 Mission Briefing and leveling of expectations

The review mission began with briefing meeting with SIDA in Delhi and with MMC in Mumbai. The meeting with SIDA[4] was to understand their expectation of the mission and key issues that were to be addressed during the review and to go over the TOR. The briefing that SIDA provided to the review team highlighted an overall satisfaction with the functioning of the ASHA project. The team was also given copies of key documents that the project generated and submitted to SIDA, the framework for SIDA functioning in the area of development assistance and a document on Sweden's International Response to HIV/AIDS.

The briefing meeting with the MMC top management included Mr.K.Nalinakshan, Municipal Commissioner and Chairman MDACS (Mumbai District AIDS Control Society), Mr. Gill the Additional Municipal Commissioner and Vice Chairman MDACS, Mr. Sahastrabude, Deputy Commissioner Health, Dr. (Mrs) A.Karande, Executive Health Officer and Dr. Lalchandhani, Deputy Executive Health Officer and Team leader ASHA project, Dr. Alka Gogate, Project Director MDACS. The mission objectives and the methodology were explained and their inputs were solicited. It was important for the review team to make it clear that we were to review the ASHA project in the context of SIDA's involvement. It was also clarified that, if the review found the need for continuation of the project, it was incumbent to identify project components that reflected

[2] Ms.Anjali Gopalan – Naz Foundation (India) Trust and Dr.S.Sundararaman – ARFI

[3] See TOR Annexed

[4] Y.Z.Roy, Owe Anderson, and Jonas Lovkrona

"value addition" to an ongoing program. It was recognized that the SIDA supported project had come to an end by June 1999 but the MMC was able to support skeletal activities to be continued by the ASHA project during the recent six months with the support of MDACS. The period under review was May 1998–June 1999.

Mr.Nalinakshan, The Commissioner of the Mumbai Municipal Corporation expressed in summary that

- The overall commitment to ASHA project is assured
- The need for ongoing mechanism of monitoring and evaluation
- The need to know what has been achieved so far and what action can be taken
- To find answers to questions such as "how can political will be generated"
- The ASHA project should not work in isolation

Chapter 3

3.1 Findings of the review

Overall Findings

During the project period the project has achieved its primary objectives and has met its target coverage of women in prostitution and male clients and work with NGO/CBOs.

The project has been able to continue with its primary activities, addressing women in prostitution, despite no financial input from SIDA. (Contracted period ended in June 1999). Therefore the review team was able to see the project in action. This has been possible because of the commitment of the top management of MMC and the timely support by MDACS for salaries of the male and female animators.

However, what was affected was major outreach activities among male clients. Though this were suspended, the services for women and men referred to the Health care unit and the STD clinic have been continuing since the project personnel are paid for by the MMC (CDOs, DEHO and support staff and the clinic staff).

With the formation of MDACS and MSACS there has been an exodus of staff at all levels namely the team leader, deputy team leader, project manager and medical officers (CHCU and Male STD clinic at Belasis road). This reflects the good quality of ASHA staff, who were solicited for and absorbed by structures that have come into existence because of the Phase II of the NACP. However this had and impact by creating a vacuum in the program. This has also highlighted the non-existence and unpreparedness of the system in effecting a smooth transition.

The review and reprogramming mission that was undertaken during 1995 and thereafter a review mission by Drs. Tarun Roy and Sundararaman have pointed out the need for women CDOs to be deployed in the project. These positions have not been filled up through the life of the project. So much so there are only three women CDOs working in the project (one as a manager and two others as counselors). This has left a serious gender disparity in the project.

The quality of work undertaken by the animators and the CDO at the community level is commendable. There is a palpable level of community involvement in the project. The animators are all well trained and there are regular meetings held with the animators. The animators who work among the women in prostitution are primarily functioning as community support agents and therefore much of their time is spent on making referrals to the CHCU and following up women at their homes. Hence it appears that the female animators are "on call" by the community.

The counselling that is provided to them at the community or at the CHCU is of good quality. Thought this is the case it is not clear why those who come for review are not provided an opportunity to see the counselors on an ongoing manner.

The civic services and the amenities to the women in Kamathipura and Kethwadi, still seem to be very poor. This is the primary responsibility of the MMC. This was seen as a crucial step to build comfort and credibility in the minds of the women in these areas right from the time the project was reprogrammed and a new design was in place. This calls for intervention at the highest level in MMC administration and is urgent.

Though the project has performed very well, the overall technical quality could be better. The specific section on Technical Issues will discuss this in detail in this report. Nonetheless, the review felt that there has been very limited proactive technical input by SIDA. The limited external support that the project had purchased in M&E as well as documentation has been timely and helpful.

The project is developed to be bi-directional. It is designed to address women and work with men in improving the scope of safe sex by creating a climate of acceptance by men. This is through the intervention among "male clients". This component has been functioning as an intervention among "potential male clients" instead and therefore has put the overall onus of safer practices on women.

The men are addressed in general community setting through "street corner" programs, theatre presentations and working among hotel boys. The coverage has been as per projected target and the communication has been of good quality. The referrals have been on a daily basis to the STD clinic and the number of people treated for STDs is impressive. One of the concerns is that there is a declining number of sexual health seekers in the clinic and this needs to be closely investigated.

ASHA project has been following sound ethical framework and does not violate people's rights. But the turn over of staff and the inconsistent orientation to the project has led to situations that could have been easily avoided. There are anecdotal evidences of where the physicians have made decisions on behalf of clients especially in the issue of HIV testing and therefore disregarded principles of informed consent.

More recently there has been an episode of forcible testing of women in prostitution under the guise of "voluntary testing". The project management and the MMC management have to develop a Project and organisational policy to avoid this in future.

Though there has been adequate time for preparation for the next phase of the project and solicitation of renewed resources, for reasons unknown the project had not developed a protocol and secured funds in a timely manner. There fore there has been a precipitated situation of ambiguity and has produced immense hardship to the grassroots workers- the animators. This has had a direct impact on the morale of the project and therefore impeded momentum and weakened community linkages.

ASHA project is currently poised to move to the obvious next stage in development of such community projects. The project has come to a point where women in the community of Kamthipura and Kethwadi are ready to form "community collectives" or "community self-organisation". This offers a unique opportunity to support/nurture such initiative, that could lend a long term "reduction of impact of HIV" as well as long term "suitable sustainability"

There are several emerging issues on the role and responsibility of the main organisational stakeholders to the project and the relationships that these agencies will have in future. This is specifically with regard to the role of MMC, AHSA project, MDACS and the Community self-organisation. This needs to be worked out very carefully so that it does not compromise the community in any way and paves way for greater cohesive working. This is specifically important with the emerging role of MDACS and the confusion that the project staff have in identifying them as "resource and technical assistance provider Vs implementers"

Specific Findings with reference to the Components of the project

Female Intervention

- Out reach
  - There are about 18 animators covering a sex worker population of 5000 in Kamathipura and Kethwadi

- All the animators are trained and skills development is an ongoing process which is reflected in the literacy classes that are held for them.
- There is a high level of confidence and self esteem, evident by their discussion with the MMC commissioner during the meeting held with him.
- Though the women work with the community on a daily basis, there is no clear outreach plan or an outreach cycle. Most of their work is around getting women to the health care facility.
- While prior to the project the women in the community seldom go to the municipal hospitals, now there is a significant number of women wanting to and getting treated at the municipal hospitals and the CHCU
- Police harassment continues to be a serious challenge to the ongoing work at Kamathipura and Kethwadi
- The animators are unable to provide anything tangible for women who are terminally ill and are thrown out of the brothels, so much so they see a role of a hospice. A similar situation exists with older women who have retired from the profession.
- Over the period of time since their level of confidence has improved the women in the community see them as a credible source of information and service facilitators. This is reflected in women accessing health care services within a couple of days of discomfort as opposed to in earlier times when they used to postpone medical attention.
- Women in prostitution and the madams are provided with regular supply of condoms.
- Condom availability and accessibility is in tune with the demand of the community but the non-involvement of key gatekeepers in buying into the project jeopardizes consistent condom use.
- Most of the information on condom use is "anecdotal" and there is no inventory or studies that reveal condom use rate in the community.

· Coverage

- The coverage fulfils the target but does not cover all the residents of the project area
- Continued input to the women is limited since the project has a overemphasis on health care and access to CHCU and therefore limited its role and scope of work in "empowerment" and "decision making"
- Since there is no "100%" coverage there is an increasing trend in HIV infection in the community.

· Human resources

- The CDOs and the animators are the backbone of the project and they have demonstrated that this project is viable even during the critical period of limited financial resources available.
- The animators are primarily engaged in bringing women to CHCU as well as taking care of them in emergency health situations and therefore it is not uncommon for the women animators to be working late hours.
- There is no Human resource development plan and therefore there is limited scale training on community issues. Despite this limited skills development input the women in the community in conjunction with the animators express desire to develop community self-organization initiatives.

- The project has not explored the possibility of absorbing them or mainstreaming them to provide them assurance of continuity.
- Cross utilisation of animators and CDOs with special skills could offer an added advantage to the project. – e.g. establishment of a center for children of women sex workers.

· The project operation timing

- the project is fashioned as a "Day Time" project and not in sync with the needs of the community, at the time that they require the services

Male Component

· The outreach to potential male clients are through a range of activities like

- Addressing hotel boys
- Street corner infotainment
- Working with street children
- Exhibits in male locations

· The male component is very outreach based and therefore the activities that are undertaken have created an atmosphere where people are able to ask sensitive questions to the outreach staff (animators)

· The coverage has been as planned but repeat contact reinforce communication or provides skills specifically for adopting safer behaviour has been low. Nonetheless, the condom distribution and condom acceptance is very high but there are no means to verify usage.

· The direct link of male component to the female component is ambiguous

· The male component has not considered targeting the regular sexual partners of women in prostitution and therefore "risk of transmission of HIV/STD" remains.

· All these activities have come to a stop in the last 6 months due to resource limitations.

· The male component is in pursuit of "awareness" rather than behavior change.

· The quality of communication is excellent and the tools and methods used in communication are of high quality.

· The outreach is able to identify people with STDs on self-reporting and they are referred to the STD clinic.

· The men outreached by the animators feel comfortable in being taken to the STD clinic. There is also a high expectation that they will get better services from the Government health facility if they are accompanied by the animators.

Services

Comprehensive Health Care Unit (CHCU)

· The CHCU has come into existence and has matured into a credible, friendly, accessible service to the women in the community despite limitations in diagnostic services and referrals.

- The CHCU is located within the community and therefore closer to the women. Due to the interface offered by the counsellors, the service is being increasingly used by women in the geographic area who are not sex workers. The CHCU also caters to Eunuchs and widows as well.The overall accessibility of the CHCU by the women is due to the animators and CDOs who put in efforts to create sensitive linkages within and outside.
- Some of the sexual health needs (STD/RTI) of the women are attended to in the CHCU apart from some primary health care.
- Linkages with other MMC institutions including the institution that the CHCU is housed (Gaurabai Hospital) are very weak.
- As a matter of fact referrals have not been institutionalized and still happen on the basis of personal contacts and goodwill that the project personnel enjoy with their counterparts.
- The number of attendees show a decline over the last 18 months and there is no clear reason for this, but the project attributes it to the movement and migration of women in prostitution to other locations in Bombay. This needs better understanding to design the future course of health care services.
- The doctors have been replaced during this phase of the project since they have been absorbed by MDACS and the project has not been able to come up with orientation and training plan for the new personnel at the CHCU. This has led to varying levels of professionalism in service provision as well as understanding women in difficult situations.
- The support staffs in the CHCU have a discriminatory attitude towards women from the community and this calls for sensitization and orientation programs that are ongoing. Similar inputs over a period of time with pharmacists and lab technicians have shown a tremendous change in attitude among them.
- The medical officers disregard the advice of counselors and the opinion of the women who seek services. They do not have clarity on issues of counselling and this had in the past led to situations of conflict. This poverty in understanding comes from a relatively poor knowledge of "what counselling is for".
- The timing of the CHCU are conventional timings that a hospital offers and therefore not the timing that probably will have more health care seekers from the community. Now that there is a decline in service seekers there is a need to undertake measures that will ensure utilisation.
- The CHCU has been able to link itself with some of the NGOs in the community and provide some nutritional supplement for women who need them.
- Changes that will enhance the role of CHCU will need to determined so that there will be greater chance of coverage of women with health morbidity in the community.

STD Clinical Services

- There is a good quality STD service being provided at the Belasis road clinic
- There is a full complement of staff in the clinic which includes two male counsellors
- The attendance is more among men who choose to seek the service themselves rather than men referred through the outreach. However the male outreach program is critical and has to be targeted communication that will involve the community and promote community volunteers who will motivate their peers to access services.

- There is a changing trend in STDs. Infections like Syphilis and Gonorrhea shows a downward trend, however there is an emergence of Herpes and Tinea. This indicates that there is a significant prevalence of HIV in the community among men.
- The overall attendance to the clinic is showing a decline and there is no clear reasons attributed to it.
- The follow up rate is very high but the opportunity for behavior change counselling is low since the returning clients do not see the counselors.
- As HIV is becoming a long term infection, there are emerging issues that the counsellors face, like marriage of HIV positive individuals, emerging needs of children of HIV positive parents the counsellors require reorientation and ongoing training.
- As the VTC (an initiative of MDACS) is situated in close proximity (same premises) to two other free testing sites, it has created a lot of confusion about scope of services.
- The clinic records are maintained well but information is not interpreted about the changing trends of STDS. There is a need to undertake a community STD prevalence study to establish a sound baseline.

NGO/CBO component

- The project has achieved collaborative arrangement with several CBOs and NGOs in the geographic area. These range from organisations that work with street children, drug users, communal harmony, children of sex workers, and other caregivers.
- The mutual support and respect that the project and the partners have is commendable
- The main focus of this component is providing technical input to partners.
- There are several ongoing training and skills development programs.
- The partner agencies include ASHA project beneficiaries in their programs (e.g.. Picnics, shelter, advocacy and nutrition)

Chapter 4

4.1 Technical Issues and recommendations for technical strengthening

- The project needs periodic technical inputs to enable it to maintain quality services. Though there has been some assistance from SIDA the future course of the project should be planned with a proactive technical assistance plan.
- Therefore the quality of services in the CHCU and STD clinic are good but just basic.
- There is a need for ongoing training for skill development across the human resource ladder.
- There is a need for institutionalising linkages with MMC health care institutions to provide appropriate referrals. Therefore there may be requirement to train the medical staff in those institutions as well.
- Mandatory posting of all MMC doctors in the ASHA project for sensitizing them would be very useful in the long run.
- The project has not developed systematic monitoring indicators and tools in order to make midcourse corrections possible. Therefore the next phase of the project should be planned and designed to integrate monitoring and evaluation.
- There needs to be a closer linkage between components especially the male and female interventions
- The project has minimal research capability and this should be strengthened.
- The project has not had clinical and behavioural data that will help the personnel to understand the progress and gains that the project is achieving. Therefore establishing baseline data for both areas is imperative.
- With the current movement of sex workers to newer sites in Mumbai, there is a need to scale up HIV interventions among women in prostitution. This is not possible by ASHA project. There are valuable lessons to be learnt from the project and this should be shared with emerging new initiatives like MDACS. Similarly, the danger of straight jacket programming should be avoided so that we don't make mistakes in taking a "photocopier approach" to HIV/AIDS prevention. Nonetheless the ASHA project must scale up its activities to have 100% coverage in Kamathipura and Kethwadi.
- Since the community is poised towards "self organisation" or collective formation, ASHA project has a responsibility to facilitate this. Therefore it is imperative that future programming takes consideration of this expressed need.

Chapter 5

5.1 Management and Institutional Issues

- The strength of ASHA project has been the high level of functional autonomy that it has. The MMC structure having offered personnel had enabled continuation of the project despite lack of resources in the last six months
- There has been several staff who have moved out of the project to the newly developed MDACS and the Team Leader has been replaced. This has had an impact on the progress since "orientation" to the new staff has been limited.
- There is no written policy that ASHA project or the MMC has which will allow for smooth transitions as well as enabling better technical understanding. The policy is also critical, to uphold gender equity, rights and promote a climate that ensures confidentiality to the clients of the project.
- Currently there are 2 project managers (one male and one female), which leads to a lot of ambiguity in roles and responsibility.
- The management of the project as well as the top management of MMC had been undecided about soliciting new resources for the continuation of the project. This has led to a break in the momentum and low morale.
- Though MMC had undertaken to provide for more female CDOs during the life of the project, this has not happened. This has led to serious gender imbalance in the project, which is primarily aimed at women.
- There is a general lack of management skills and capability in the project. Skills upgadation and capability must be built within the program
- The staff is pulled in all directions as and when a need arises and therefore they are responding to disparate demands, which are outside the scope of the project.
- The overall commitment that MMC made to improve civic amenities in the project area has not been accomplished and therefore the project area continues to suffer. This could have serious impact on the project by eroding the hard-earned credibility among the community.
- In the context of "promotion of community development", MMC needs to take stock of emerging needs and thereby address issues which will facilitate this process.
- The MMC management should look at emerging needs of a highly evolved program and therefore consider multiple sources of funding for future innovative programming.
- It is imperative at this stage of the project roles of MMC, AHSA project, MDACS be defined and issues that could create conflicts be discussed and program developed.

Chapter 6

6.1 Key Recommendations and Conclusion

Recommendations

1. The Asha project is after a long incubation period is in a situation of collective community action and therefore to be supported
2. The project has to be supported in conjunction with the MDACS and should be scaled up to cover 100% of the population of women engaged in sex work in the geographic area of operation of the Asha project.
3. The Municipal Corporation has to provide leadership by making referrals a reality in the hospitals that are run by the corporation so that women are able to access better quality treatment and care for illnesses that they encounter
4. An Asha project policy in conjunction with a BMC AIDS policy should be drafted and a strategy for the next five years has to be outlined.
5. Within the scope of the project a definitive plan for community care and support has to be drafted and that should be treated as a priority for action along with the prevention program
6. Staff training and strengthening technical inputs is crucial and the plan has to articulate these needed inputs
7. The gender disparity in the project has to be addressed and more women CDOs have to be employed in the project since the principle beneficiaries of the project continue to be women
8. Closer coordination with MDACS is very necessary while maintaining the autonomy of the Asha project
9. BMC should continue to support community development activities and strengthen the civic amenities for the women in sex work.
10. SIDA should continue to have a role in the project and should provide key technical inputs in the development of community self organisation which is bound to herald a community mobilisation and a greater control of their lives by the women.
11. A reprogramming mission which will work with all the key stake holders and develop a plan of action should take place and should come up with roles and responsibilities of the participating parties
12. A coordinated action plan with the participation of the key stakeholders alone holds hope for the population that has recorded over 60% HIV infection.

Conclusion

The review and evaluation mission was undertaken with the total involvement of SIDA, BMC and the Asha project. The primary objectives of the review were met and all the parties were made aware of the findings and recommendation during the debriefing at BMC, SIDA and the National AIDS Control Organisation. The reviewers would like to thank and acknowledge the time and involvement of SIDA, BMC and Asha Project for a smooth and successful conduct of the evaluation.

Annex 1

Terms of reference for the evaluation of the aids, STD health action (ASHA) project, Mumbai Municipal Corporation

1 Background

The high concentration of HIV/STD incidence among women in prostitution in the Kamathipura and Khetwadi areas of Mumbai coupled with their pathetic living conditions and the larger reality of their powerlessness which puts them in the most vulnerable situation to diseases, infections and malnutrition, led the Mumbai Municipal Corporation (MMC) to initiate a pilot project in April 1992 with Sida support and technical assistance through WHO/GPA.

After three years of project implementation, an Evaluation, Reprogramming and Protocol Development was carried out during mid January to June, 1995 with active participation of the project functionaries leading to an ownership of the project, which had been a major drawback during the initial protocol development.

During April 1995 the MMC established an AIDS Cell under the Public Health Department with separate budgetary provision. The project was renamed as AIDS STD Health Action (ASHA). In 1996, with the dissolving of WHO/GPA, Sida directly got into an agreement with the AIDS Cell from January 1997. The agreement came to an end on 30 June 1999. The total budget allocated from January 1997–June 1999 was approx. SEK 1.2 million.

The *broad objectives* of the project are:

- to reduce the incidence of STD and HIV infection among women in prostitution and their clients in the target areas of Kamathipura and Khetwadi;
- to function as an implementing, research and resource unit of MMC AIDS Cell for STD/HIV/AIDS intervention programmes (with marginalised, unorganised and vulnerable persons of the community) by generating and then offering/sharing innovative approaches, strategies, methodologies, actual skills and experiences gained through this project with MMC AIDS Cell and other agencies working in this field.

2 Purpose and Scope of the Evaluation

The project has seeked further support from Sida. Before any decision on future support is taken, a process evaluation of the project to assess its development and impact since the previous evaluation will be undertaken. The evaluation is will take place during November 1999. The ASHA project could benefit from the evaluation and modify its implementation from this lessons learnt exercise. Moreover, the conclusions drawn from the evaluation may also form a basis for replicating similar intervention programmes in the city of Mumbai. The recently formed Mumbai AIDS Control Society may also benefit from the outcome of the evaluation. The project and the AIDS Cell have given their concurrence for the proposed evaluation.

3 The Assignment (issues to be covered in the evaluation)

- assess the overall impact of the Sida contribution to the project;
- identify the strengths and weaknesses of the project including the management;
- identify the issues of importance within the project components;

- analyse, describe and draw conclusions of the development of the project with regard to fulfilment of objectives, effects on the target groups, cost-effectiveness, sustainability and management of cross-cutting issues.

4 Methodology, Evaluation Team and Time Schedule

The Embassy of Sweden will appoint two Indian consultants with expertise in management of STD/HIV/AIDS, its social and economic consequences and issues related to gender.

The consultants will visit the project area, have discussions with the project staff, community members and the concerned personnel at the Municipal Corporation of Greater Mumbai and other project partners.

The consultants will be provided with the project documents, progress reports, review and evaluation reports, any research/study documents and any other relevant documents on the project.

The evaluation, covering field visit and report writing, is planned during 5–15 November 1999.

5 Reporting

The report shall be written in the English language and 5 copies of the draft report should be submitted to the Embassy of Sweden no later than 20 November 1999.

Within 2 weeks after receiving comments on the draft report from the project and the Embassy, a final version of the report shall be submitted to the Embassy in 10 copies and on a diskette in Word 6.0 for Windows or in a compatible format.

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