



Field visit report

The field visit report (max. 5-8 pages) is prepared by the WDF based on the findings of the WDF representative(s) during the field visit. The partner may provide factual comments to the report. The report is a working tool for continued project implementation with concrete recommendations and shall be shared with the partner no later than 4 weeks after the field visit. The report is also shared with the WDF Board of Directors.

1. Basic project information

Project title	Preventing GDM among women living in slum
WDF project number	WDF15-1213
Country/State/Province	India / West Bengal / Kolkata /
Partner (PPA signatory)	Greater Calcutta Leprosy Treatment and Health Education Scheme (Grecaltes)
Project responsible	Dr Gitanjali Saha
Total project budget	EUR 147,235
WDF grant	EUR 114,115
Instalments released to date	3 (EUR 63,000)
Original project period	From 01/02/16 to 01/05/19.
Expected completion date	01/05/19
Dates of field visit	From 24/04/17 to 25/04/17.
Previous field visits (month/year)	None
WDF participant(s)	Programme Manager Mette Skar
Report prepared by	XMSR, June 2017

2. Purpose of the field visit

The purpose of the field visit was to monitor and assess project progress of projects WDF15-1213 (present report), WDF15-1284 and WDF15-1241. Reference is made to FVR of WDF15-1241 and WDF15-1284 released in parallel for full overview of the field visit.

3. Country health system framework and portfolio overview

Reference is made to FVR of WDF15-1241 for background information on West Bengal State.

Project WDF15-1213 targets urban slum areas in the Kolkata Municipal Corporation. In 2001, 1.5 million people, or one third of Kolkata's population, lived in 2011 registered and 3500 unregistered slums. The living conditions in these areas are difficult, with high levels of poverty, low literacy rates, poor housing and limited access to health, hygiene, drinking water and sanitation. In particular, women and children have limited access. With accumulation of risk factors such as urbanisation, high intake of fast food, low level of physical activity, alcohol and smoking consumption rates of diabetes are increasing. The prevalence of gestational diabetes among the pregnant women in the slum areas is also on the increase. But the pregnant women in the slum areas do not have access to pre-natal and post-natal care. Consequently, they are seldom screened for hyperglycaemia during pregnancy.

Health care services in the slum areas are provided either by public health clinics or by traditional doctors. The public health clinics have limited staff, are poorly equipped and diabetes screening and care is not a priority. The traditional doctors consists of Registered Medical Practitioners (has 1 years training on community health), homeopath doctors and Ayurveda doctors, who have very



limited capacity within diabetes care. The slum dwellers tend to prefer the traditional doctors as service provider as cost is low and they are working in the proximity.

4. Project outline

Fact box						
WDF Interventions:	<input checked="" type="checkbox"/> Access to Care		<input checked="" type="checkbox"/> Prevention		<input type="checkbox"/> Advocacy	
WDF focus area(s)	<input type="checkbox"/> Type 2 diabetes	<input type="checkbox"/> Diabetes foot care	<input type="checkbox"/> Diabetes eye care	<input checked="" type="checkbox"/> Pregnancy and diabetes	<input type="checkbox"/> Type 1 diabetes	<input type="checkbox"/> TB and diabetes

The aim of the project is to provide prevention and management of diabetes and GDM to women in reproductive age (18-40 years), living in slum areas of Kolkata. To achieve this, the project partner is building diabetes and GDM capacity of doctors and other healthcare providers (registered medical practitioners, traditional healers, homeopaths, ayurveda doctors, community health providers), conducting diabetes awareness and screening camps for women in the slum areas, providing GDM screening and referral services at specialised GDM screening camps and ensuring proper follow-up of identified women.

The project is developed and implemented by a dedicated project team consisting of 12 members working at the Greater Calcutta Leprosy Treatment and Health Education Scheme (GRECALTES).

The partner organisation is a community health NGO which was established in 1975, with the initial aim of providing leprosy services in the slum areas of Kolkatta, an aim which have broadened to also include tuberculosis (DOTS providers and TB clinics) and lastly also diabetes and GDM services (last 5 years). The partner is working closely with a range of networking partners who help facilitate the implementation of the activities taking place in the communities. The networking partners are based in the communities and thus have access to and are familiar actors in the communities which facilitate the successful implementation of the camps.

5. Findings

5.1. Project implementation status incl. partner performance

The project achievements vis-à-vis agreed targets can be seen in the below table. As can be seen, the project implementation is going according to the plan and all agreed targets as of February 2017, have been achieved.

Main activities / PPA milestones	Target by end of project	Status (%)	Remarks
Development of awareness materials, incl. health manual for medical practitioner on diabetes and health manual on GDM	Materials developed and distributed	Done	
Training of doctors in diabetes and GDM care and management	50 doctors trained	50 (100%)	Doctors working in slum areas are trained in basic diabetes and GDM care.
Training of CHW to provide basic diabetes and GDM	150 CHW trained	75 (50%)	
Education, awareness and screening camps	468 camps	156 camps (33%)	
Sensitisation of women during camps	51,000 women	16,657 (33%)	All women attending the camps receive health talks, watch video and street play and are thereby sensitised
Identifying at-risk women and	15,000 women	5,723 (38%)	All women attending the



screening them for diabetes	screened		camps are screened for risk factors (BMI, family history). Those identified at-risk are screened for diabetes using FBG.
Health check-up and screening camps for pregnant women	36 camps	12 (33%)	Special camps are conducted for pregnant women living in the slums.
Pregnant women screened for GDM	1,500 pregnant women screened	479 (32%)	
Referral system established	4,500 women diagnosed with diabetes referred to hospital for treatment. 300 women with GDM referred to hospital for treatment	1,164 (26%) women with dm referred. 54 (18%) women with GDM referred	
Follow-up of women diagnosed with diabetes	All women diagnosed shall be followed-up	1,164 women with diabetes followed up and 54 women with GDM followed up.	

The project is implemented by a very dedicated partner, who has demonstrated strong project management skills. A large amount of work have been done in the first year of implementation (i.e. arranging 156 camps during the second milestone) and all agreed milestone goals have been fulfilled, without compromising the quality of the work. The first annual audit has been conducted with an unqualified report, thus confirming that also financial management is good. Reporting is timely and detailed.

5.2. Site visits

During the field visit the WDF representative participated in one diabetes awareness and screening camp, a GDM Health check-up and screening camp, met with the trained doctors and HCPs working in the slum areas and visited three women who had benefitted from the GDM camps and the follow-up home-visits. A meeting was held with representatives of the networking partners to discuss their role in the project. Lastly, a meeting was held with the Superintendent of Sambhu Nath Pundit State General Hospital to discuss the referral mechanism. The findings and observations from the field are summarised below and structured according to the main components of the project.

Screening and awareness camps

The main activity under the project is to organise screening and awareness camps for women in the reproductive age, living in slum areas. Prior to each camp the project team does a lot of work to raise awareness in the community and to urge all women in the reproductive age to attend the camps. The project team distribute IEC materials, use mikes to broadcast messages and they do a pre-survey. The pre-survey is used to record the name, age, and exact residential address of the women in the reproductive age group, residing in the targeted slum. While doing the survey, the health workers also raise awareness of diabetes and its complications to motivate them to attend the camps. The field staff will attend to the houses of the registered women who do not show up at camp and persuade them to attend the next camp. The record also functions as a reference point when the field workers conduct the follow-up.

When the target area is sensitised the screening and awareness camp is set-up in collaboration with a local networking partner. The visited screening camp was organised at in collaboration with Tangra Mollajan Social Welfare Society at their office in a slum area of Kolkata. The duration of a



camp is one day and on average 100 women from the slum area will attend. The women receive health talks, participate in discussions and group meetings and view a video about diabetes and hyperglycaemia in pregnancy. Street drama is also used to attract the slum dwellers to the camp. The site visit demonstrated that awareness raising and education plays an important role at the camps and by using different means to communicate it could be anticipated that the learning outcomes are better. It would appear as the street drama attracted many people from the whole area and it appeared to be an effective way to communicate about difficult topics and to explain i.e. why it is better to go to a trained medical doctor rather than an uncertified doctor.

All the women who attended the camp are firstly registered. Hereafter a risk factor assessment is done to identify the high-risk women. Height and weight are measured to be able to calculate BMI, and family history of diabetes is recorded as well. Hereafter, fasting blood glucose is measured on those who are identified as high risk. The partner Dr Gitanjali Saha explained that they had included blood pressure measurements of all the women attending the camps. This is a way to ensure that all the women feel they get something out of attending the camp, without having to test all for diabetes. It would appear as this arrangement was acceptable for the women and thus a good cost-effective strategy.

The site visit to the camp demonstrated a well-organised and efficient camp. It would appear as the project team, including the doctor and diabetes educators played an important role in terms of educating the attending women about diabetes and hyperglycaemia in pregnancy.

Women detected with FBG levels indicating diabetes are provided with a referral slip and encouraged to attend to the hospital for confirmatory diagnosis and treatment. The site visit confirmed that the project team is very committed to ensure that the women seek care at the hospital. It was clear that a lot of efforts, incl. home visits and phone calls were used to motivate and empower the women to seek medical care. It would appear as the referral mechanism was operational and working as intended. This was confirmed by the Hospital Superintendent of Sambhu Nath Pundit State General Hospital, which functions as a referral hospital. The Superintendent confirmed that collaboration is established and also confirmed that GDM was an increasing issue. As he was not involved in clinical care he could not clarify the services and treatment provided at the hospital or the number of diabetes/GDM cases seen.

Health check-up and screening camps for pregnant women (GDM camps)

Specific GDM camps for pregnant women are another important component of the project. The WDF representative participated in a camp held at Tiljala Blue Star Club in another slum area of Kolkata. The camps are exclusively for pregnant women and in addition to the project team, endocrinologists and gynaecologists are present during camps. The women are registered and each woman gets a unique number for recording purposes. The women are requested to attend to the camps in fasting state. The pregnant women are also measured (height and weight), BMI is calculated and the fasting test is done. All the women get a consultation with the gynaecologist and during the site visit it became apparent that this was the first time many of the women were seen by a doctor. Other women brought their data from their visit to the hospital and were able to get advice by the doctors. Women identified with elevated FBG are referred to a hospital for confirmatory diagnosis and treatment. Hereafter, the project team conducts follow-up home visits.

The project team confirmed that for a large proportion of the pregnant women living in the slum areas, young age and low BMI, are more prevalent than hyperglycaemia in pregnancy. However,



the data shows that even in this group of women, living in urban slum areas hyperglycaemia remains an issue.

The project partner explained that they had an issue with the screening methodology. Currently, they are only doing FBG test during the camps. The partner had discussed screening guidelines of pregnant women as per DIPSI guidelines for Gestational Diabetes Mellitus with the Endocrinologist of KPC Medical College & Hospital and NRS Medical College & Hospital. While DIPSI guidelines are being followed at hospital level, the endocrinologist suggested that the partner administered 50 g of glucose during OGTT, rather than 75 g. This recommendation was given to avoid problems like abdominal distension and vomiting and community aggression if the pregnant women develop any sort of side-effects during camps. Potential solutions were discussed during the field visits and the partner was interested in WDF input on the implications of introducing OGTT during camps, but with a reduced glucose load.

After the camp the WDF representative visited three women who had attended the health check-up and screening camps. The women were diagnosed with GDM during the camps and had now given birth to healthy babies. It was a truly rewarding experience to meet the women and it was heartening to see how the continuous efforts by the project team were the main contributing factor to ensure that the women had received the proper care. The visits also confirmed the harsh living conditions under which the women are living and which makes it difficult to comply with the treatment. Nevertheless, the visits showed that it was doable: i.e. one woman borrowed the refrigerator in the neighbouring kiosk to store her insulin and another woman described how her supporting husband ensured that she received her medicines. (Reference is made to the three patient stories released in parallel).

Training of HCPs working in slums

The project also seeks to strengthen access to diabetes services in the slum area, and thus a training component has been included to build capacity of doctors (govt., private, homeopaths, registered medical practitioners) working in the slums. A five days training have been conducted by endocrinologists and diabetologists. The training program covered management and care of diabetes and gestational diabetes.

The WDF representative visited 3 registered medical practitioners in different slum areas. They expressed satisfaction with the trainings and confirmed that they had gained new knowledge and skill and felt able to provide proper diabetes care for the slum dwellers. At the visits they demonstrated the IEC materials, incl. the health manual they had received at the training. The registered medical practitioners also demonstrated their glucometers and weighting scales and it would appear that they were able to provide the basic care. The practitioneres explained that complicated cases would be referred to the nearest hospital

Data collection and patient registers

The field visit showed that a very high quality data collection system has been developed. Through the system the partner is able to trace the women screened at the camps and compare it with the follow-up data collected by the CHW during home-visits. This is possible because each women is given an individual number. Consequently, the partner has quasi cohort data of women in the reproductive age living in slum areas in Kolkata. The WDF representative encouraged the partner to proceed with data analysis and publication. The partner has research experience from their TB work and high quality publications would be expected.



5.3. Exploration of potential strategic areas for future WDF investments

WDF is currently supporting a growing number of small-scale projects in West Bengal. Based on the observations and findings during the field visit it would appear as the time is right to try to consolidate the efforts and to elevate the level of engagement. It is clear that the partners could benefit from sharing their experiences and it could also be envisaged that their joint efforts could create a renewed interest from state level authorities to engage in provision of diabetes care in West Bengal. Thus, it is proposed that a partner meeting could be arranged as part of the partner2partner academy.

6. Conclusions

Project WDF15-1213 appears to be highly relevant in the target area as diabetes and GDM services would not otherwise be available. In particular, the emphasis on both building capacity of health care providers working in the slums and the efficient referral mechanism, incl. follow-up visits will seemingly ensure proper treatment, and also strengthen the sustainability of the intervention.

Project management is assessed as very strong and a dedicated and devoted project team is working hard to implement the project. The field visit confirmed that the partner has a strong focus on follow-up and treatment, and is not only focusing on awareness and screening. This focus was demonstrated by the seemingly in-depth counselling that are provided by the doctors during the screening camps, but also the determination expressed by the project team to ensure that the women seek health care at the referral hospitals. The site visits to the women identified with GDM confirmed that these women would not have had the courage and capacity to attend the hospital without the motivation and encouragement from the project team.

As describe above, the screening methodology continue to be a challenge and thus currently the partner is only measuring FBG. It is clear that the DIPSI guidelines would be the golden standard for GDM screening. However, implementing screening during camps is different than undertaking screening in the clinical setting. Thus, when considering that all the women identified with elevated FBG during camps will be referred to the hospital for confirmatory diagnosis, it could be reasonable that the partner continue to do FBG and that OGTT (75g) would be undertaken at the hospital level.

7. Recommendations

1. The partner is encouraged to continue to collect high quality data and to proceed with analysis and publication.
Action by: project partner
2. It is recommended that options within the Partner2Partner Academy are considered, incl. organisation of partner meeting in West Bengal and / or regular peer programme
Action by: XMSR



At the GDM Health-check-up camp: measurements and health education



Visit to a registered medical practitioner in slum area

WDF Board Comments to the report

Internal comments to be inserted upon review of report.

**Annex I - List of people met and institutions represented:**

Name	Title/function	Institution represented
Dr. Gitanjali Saha	Director	GRECALTES
Mr. Gautam Das	Project Coordinator	GRECALTES
Mr. Sanat Dutta	Supervisor	GRECALTES
Mr. Tapan Bagchi	Supervisor	GRECALTES
Mrs. Kasturi Ghosh Chakraborty	Project Health Worker	GRECALTES
Mrs. Srabani Ghosh	Health Worker	GRECALTES
Mrs. Dilruba Begum	Health Worker	GRECALTES
Mrs. Dipti Chakraborty	Health Worker	GRECALTES
Mrs. Pallabi Lal	Community Development Worker	GRECALTES
Mrs. Deepa Roy	Community Development Worker	GRECALTES
Mrs. Salma Ara	Community Development Worker	GRECALTES
Mr. Suvasish Banerjee	Community Development Worker	GRECALTES
Santi Chakraborty from Mahila Sangha Samiti, Mrs. Sipra Dasgupta from Harijan Mallick Sudhar Samiti, SK. Firojuddin Ahmed from Mominpore Tarun Sangha and Dr. Shahin Al Hussain, Community Medical Practitioner		
Dr. Soumabha Dutta	Hospital Superintendent	Sambhu Nath Pundit State General Hospital

**Annex II – Programme for field visit**

TIME	PROGRAM DETAILS
At 08.30	Receive you from Kolkata Airport then move to hotel.
At 09.30	Leave for GRECALTES Office from hotel.
At 10.15	To be received by the staff of GRECALTES.
10.15 to 10.30	Breakfast Tea/ Coffee
10.30 to 10.45	Activities of GRECALTES at a glance
11.00 to 12.00	Visit to awareness generation and education camps on diabetes, GDM and lifestyle changes and detection of at risk women for diabetes and screening of at risk women for diabetes at Panchanantala Road, Kolkata-92.
12.30 to 01.00	Visit to our referral hospital (SambhuNathPandit Hospital, Kolkata-20/ Sealdah ESI Hospital, Kolkata - 9
01.30 to 02.00	Lunch at GRECALTES Office.
02.00 to 03.00	Visit to traditional healer, homeopath trained on DM and GDM by GRECALTES in collaboration with WDF at the community level at Kolkata 19.
03.00 to 03.30	Visit a women detected with DM through our screening Camps at the community level.
04.00 to 05.00	Meeting with the religious leader and other community key people who played a vital role for implementation of the project and members of steering committee at Kolkata -19
06.00 to 06.45	Meeting with Director and Project Coordinator to discuss your observation.
25 th April	
08.30	Pick up from hotel and move to GRECALTES office
09.00 to 09.30	Breakfast at GRECALTES office
10.00 to 11.00	Visit to a special health check up camp and screening camp for pregnant women at 47 Tiljala Road, Kolkata-46.
11.30 to 12.30	Visit to a women detected with GDM at Ward No 58.
01.00 to 02.00	Lunch at GRECALTES
02.00 to 03.00	To exhibit IEC and training materials on DM and GDM AND RECORD AND REPORT MAINTENANCE BY PROJECT STAFF.
03.00 to 04.00	Discussion regarding the project specially the challenges faced.
04.00 to 05.00	Farewell cultural program in presence of all the staff of GRECALTES.