

2014

Evaluation findings of Social Health Project in Sundarbans implemented by IGF-JGVK during 20011-2013



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05/30/2014

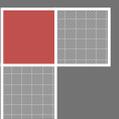


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Abbreviations

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwifery
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AWC	Anganwadi Centre
BMOH	Block Medical Officer of Health
BPHC	Block Primary Health Centre
FHW	Field Health Worker
IGF	India Group Funen
JGVK	Jaygopalpur Gram Vikas Kendra
H&FW	Health & Family Welfare
IMCI	Integrated Management of Childhood Illness
MIS	Management Information Centre
MO	Medical Officer
NQPP	Non Qualified Private Practitioner
PRI	Panchayati Raj Institution
SC	Sub Centre
SHG	Self Help Group
ICDS	Integrated Child Development Scheme
PHC	Primary Health Centre
PPP	Public Private Partnership
JSY	Janani Suraksha Yojana
CISU	Civil Society in Development

Acknowledgement

We have taken efforts in this evaluation task under Sundarbans Social Health Project that was implemented during 2011-2013 jointly by IGF and JGVK. However, it would not have been possible without the kind support and help of many individuals and organizations. We would like to extend sincere thanks to all of them.

We are highly indebted to members of various Self Help Groups and Village Committees, Medical Officers, Block Medical Officer of Health (Basanti), ANM, AWW, ASHA and other stakeholders for their enormous inputs towards undertaking this evaluation.

We would like to express our gratitude towards FHWs, doctors in the clinic, staffs of JGVK for their kind co-operation and encouragement which helped us in completion of this task.

We would like to express special gratitude and thanks to Dr. Ganesh Sengupta, Dr. Lene Kieler Jensen and Inga Hjortkjaer Hansen from IGF for providing constant feedback and inspiration during the process.

Our thanks and appreciations also go to our colleagues in developing the plan and people who have willingly helped us out with their abilities, but here their names not mentioned.

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Summary

Sundarban Social Health Project - Phase II was implemented by IGF & JGVK jointly during 2011-2013. Women of childbearing age and their families in 18 villages were identified as beneficiaries during this period. Overall goal is to contribute to the improved health status and awareness generation on the rights of health issues among the poor population in the Sundarbans, West Bengal, India.

The evaluation is conducted to review and assess the progress made, activities accomplished, and on the project implementation based on the work plan. It is expected from the evaluation to suggest and bring forward the future needs in the communities and any new possibilities emerged from the current project.

The evaluation team conducted the full task of evaluation during the period from 5th April to 30th April, 2014. Important respondents of the research are women belonging to Self Help Groups (SHG), Field Health Workers (FHWs), Medical Officer of the clinic at JGVK, Panchayat, ANM, AWW and ASHA workers, Block Medical Officer of Health (BMOH) and members of Governing Body (GB). Secondary data were collected from various MIS reports from JGVK submitted to IGF, records of Hb% estimation on MCPC card (Cohort Register), minutes of the meetings of the staffs, HMIS reports of the BPHC (Basanti) and literature review from various Annual Reports of H&FW Department, Govt of West Bengal, Annual report of JGVK and others.

Activity wise and process wise achievements are very good including timeliness of the activities performed. At outcome level and impact level, the targets were not achieved up to the fullest due to many social constraints, inertia in public health system and natural adverse situations in the areas. However, there has been a great achievement in social issues, in mobilizing the community towards health facilities and providing scope to JGVK to grow as a healthcare organization. Government healthcare providers have become inclined towards JGVK supports and FHWs have become a strong & committed health work force remaining within the local areas. Local advocacy was good enough and therefore, the Panchayat, Medical Officers, ICDS work force, ANM and including BMOH of the block rural hospital are willing to partner with JGVK for future intervention on health especially for hard to reach areas on issues like outreach camps and immunization coverage.

Regarding sustainability, the existing FHWs will continue to cater the community with health messages. They are local volunteers. The community mobilization with regards to referral to government facilities got a hike. People's confidence on government settings have increased. Therefore, to some extent the work will continue even though the project is not continued.

Future of the project may be designed for a block level as minimum administrative unit of intervention. A comprehensive healthcare programme for the community through advocacy among members of the SHGs may be designed so that health becomes priority of the groups, not merely income generation. Outreach camps for different public health programmes including camps for cataract, eye & ENT check up, oral health etc may get priority. There is need to address overall public health response in the block. Facility preparedness at PHC, BPHC and JGVK level may be another focus in the next project design. JGVK can explore scope of its future work through these issues.

1. Background of the Sundarban Social Health Project and its formulation

Sundarban Social Health Project - Phase II was initiated in 2010 January for four years and was completed in 2013, with an extension for three months from January to March 2014. Prior to this, the Phase I was implemented for three years from 2006 to 2009. From an understanding of weak governmental primary health service delivery system in these areas of South Sundarban region and need expressed by the communities; Jaygopalpur Gram Vikas Kendra (JGVK) approached India Group Funen (IGF), Denmark to support towards the development of health status, particularly for women and children of the area. There were several examples of poor health conditions, beliefs and practices in the communities which made the situation worse, and IGF had a reason to consider.

IGF, Denmark with the support from JGVK as a ground level partner developed the proposal and submitted to CISU, Denmark to obtain the resources. At the JGVK level, ideas, thoughts, strategies to implement the project were drawn by technical persons from both IGF and JGVK. Dr. Amitava Chowdhury who attends the OPD clinic at JGVK and Dr. Lene Kieler Jensen, Member IGF actually designed the project. The Project Leader from IGF, Dr. Lene Kieler Jensen was the prime person to develop & obtain approval with series of planning meetings between JGVK & IGF with support from another IGF Member, Inga Hjortkjaer Hansen.

JGVK is 100% user-based and therefore, the local anchoring was very strong. All development activities have their starting point in the SHGs and the SHGs are formed with the help of JGVK. All staffs in JGVK are local people who work beside the development work as farmers, teachers and others.

1.1 Primary target group

Women of childbearing age and their families in 18 villages were identified as beneficiaries (approximately 100 pregnant women per year per village). Each family consists of around 5 -10 members. They are usually Hindus, but some are Muslims and Christians. The villages were involved in areas where the partner JGVK was already working through other activities. It was envisaged that number of villagers to be activated regarding advocacy in the 18 villages involved (3000 -5000 adults and children per village).

1.2 Secondary target groups:

Women who were trained as health assistants / birth attendants (63 women) are from JGVK, Self Help Groups (SHG), Village Committees (VC) and Local Government.

1.1 Intervention areas

The activities started in 18 villages spread across in four Gram Panchayats Viz. Bharatgarh, Jotishpur, Nafarganj, Jharkhali. However, during third & fourth year of implementation, at different times Field Health Workers left and the village or part of the village in case of big village was discontinued. Hence, in 15 villages all activities continued till the end of the project period.

Table 1: Areas of project intervention

Name of GP	Total No. of Mouza (covered)	No. of Households (covered)	Total Population (covered)	Name of the Mouza's	Mouza's discontinued
Jotishpur	5 (all)	3856 (3210)	19280 (15216)	Jotishpur, Joygopalpur, Ranigarh, Harekrishnapur, Radharanipur	Nil
Bharatgarh	7 (5)	5911 (5386)	29555 (25106)	Maheshpur, Garanbose, Anandabad, Kumirmari, Bharatgarh,	Shibganj, Chak Pitambar Dutta
Nafarganj	3 (2)	2937 (1778)	14685 (8325)	Nafarganj, Hiramnoypur	Birinhibari
Jharkhali	3 (all)	6237 (5417)	18711 (20,464)	Parbatipur, Laskarpur, Herobhanga	Nil

1.2 Basic Project design as the basis for evaluation

Project's objectives and success indicators

Overall goal (development objective) to contribute to the improved health status and awareness generation of the rights in health the issues among the poor population in the Sundarbans, West Bengal, India

Immediate objectives

- 1) On 1 January 2012 will at least 50% of pregnant women in 20 villages in the Sundarbans have received at least 3 visits during their pregnancy by a FHW, who have guided and informed the pregnant woman and her family about her pregnancy
- 2) On 1 January 2012 at least 50% of the birth giving women in 20 villages in the Sundarbans has been helped by a dai that has used her knowledge she has acquired.
- 3) On 30 June 2012 at least 50% of the population in 20 villages in the Sundarbans has been made aware of their rights to health care services, have understood the importance of advocacy and together with JGVK have worked out plans for advocacy with respect to how they can influence the local authorities in relation to the project.

Indicators of success

Objective (1)

- The pregnant women express that FHWs visit is a help and support.
- The families of pregnant women have gained greater understanding of the importance of caring for pregnant women (for instance adequate food, rest etc).
- FHWs can show logbooks regarding their activities.
- The pregnant women are willing to pay for the services to the FHWs

Objective (2)

- The new mothers express that they felt comfortable with BAs help at the delivery
- The families of the pregnant women have gained greater understanding of the importance of caring for the childbearing women.
- The BAs can produce logbooks regarding their activities.

Objective (3)

- Awareness meetings have been held in all 20 villages about their rights in health issues.
- Working groups have been formed which give priority to topics within healthcare.
- There are established working groups to discuss how they can influence the authorities.
- Meetings have arranged in all 20 villages about potential and advantages to be organized in groups when it comes to influence.
- JGVK has been working on strategy for advocacy

Key activities

It was implemented by local people with their full participation with active supports from some project staffs like 30 Field Health Workers (FHW), 7 Supervisors, 1 Project Coordinator and the full team led by 1 project Manager. The Governing Body of JGVK had a major role in implementing the project and through supportive supervision of IGF.

Key components of the project

- (a) Ante Natal Checkups – conduct ANC checkups: BP, weight, height, Haemoglobin, Urine Albumin, Fundal height measurement. Assist ANM, ASHA in outreach camps to ensure TT injection and accessibility of IFA tablets by the pregnant women. Identification of Risk Pregnancies and advise family for institutional deliveries
- (b) Health & nutrition education among the women – in small groups with the women SHG, village committee
- (c) Home visit – to follow up at the household level the advise provided in small group meetings
- (d) Advocacy with the service providers – attend Panchayat level 3rd. Saturday CHCMI meeting, 4th. Saturday Health, ICDS meeting. Share information's with the stakeholders, plan for different health activities. Visit CDC (community delivery center), attend all meetings organized by CDC.

Other activities

Take part in implementation of different National Programs e.g. Pulse Polio, Filaria eradication, Malaria eradication, Leprosy program, Anaemia control among adolescent girls, Permanent sterilization for birth spacing etc.

Evaluation task

The key interventions of the project were providing Ante Natal Checkups to pregnant women including T.T. vaccination, supplementation of Iron Folic acid tablets through Govt. ANM's, health education of women & mother-in-laws on household level care & support and behaviour change communication. Advocacy with Govt. service providers in health entitlements by the communities was also one of the prime components. The project has achieved a lot. However, there is a need to relook at the achievements and failures, if any, through scientific & participatory evaluation efforts.

Dr. Arup Chakrabarty, a Public Health Expert, who is also Founder & Secretary of a national level NGO, Health Vision and Research (www.hvr.org.in) in India, as an external evaluator has been engaged by IGF-JGVK along with other three persons like Project Manager, Project Coordinator and Secretary, JGVK to conduct a participatory evaluation exercise in the Month of April, 2014.

The evaluation will review and assess the progress made, activities accomplished, in the project implementation based on the work plan. It will suggest and bring forward the future needs in the communities and any new possibilities emerged from the current project. The recommendations will provide opportunity to look at the improvement of the overall health profile through inputs from IGF-JGVK during last three years from 2011 to 2013.

2. Methods of the evaluation

An evaluation framework was developed through participatory process. Please refer to the Evaluation framework - Annexure I that was guiding tool towards evaluation. Step by step following methods and processes were adopted in completing the evaluation task.

2.1 **Meeting stakeholders:** The external evaluator met project functionaries including members of the governing body for developing project clarity

2.2 **Developing tools:** Different survey and interview tools were developed to explore areas under research question. Important tools for research were developed for women belonging to Self Help Groups (SHG), Field Health Workers (FHWs), Medical Officer of the clinic at JGVK, Panchayat, ANM and ASHA workers, Block Medical Officer of Health (BMOH) and members of Governing Body (GB).

2.3 Methods of data collection

2.3.1 **Sampling:** The intervention was made in four Gram Panchayats (GP) and out of which two GPs were selected based on geographical situation, vulnerability and availability of respondents during the time of evaluation.

2.3.2 **Primary data collection:**

Primary data collection was done through group discussions, one to one interview with following respondents as detailed out in the following table.

Table 2: Sample of the survey

Level	Village & Sub Centre (SC)	Respondents	Method	Frequency
Gram Panchayat - Bharatpur	Bharatgarh IV (SC 54)	ANM, ASHA, AWW, Trained Dai, FHW	Group Discussion One to one interview	ANM -1, ASHA-3 Dai-1, FHW (JGVK)-2
	Bharatgarh IV	Women of SHGs Members of the community	Group Discussion	SHG member General people (n=26)
Gram Panchayat - Jharkhali	Laskarpur (SC 61)	ANM, ASHA, AWW, FHW	Group Discussion One to one interview	ANM -1, ASHA -1 FHW (JGVK)-2, AWW-2
	Jharkhali PHC	ANM, ASHA, AWW, FHW	Group Discussion One to one interview	ANM -1, ASHA -3 FHW (JGVK)-2, AWW-3
	Jharkhali 3 No	Women of SHGs Members of the community	Group Discussion	SHG member General people (n=22)
Block Town- Basanti	BPHC	BMOH BPHN BAM	Group Discussion One to one interview	Each one
JGVK	Jaygopalpur	FHW Supervisors	Group Work One to one interview Skill demonstration	FHW & Supervisor = 22
JGVK	Jaygopalpur	Secretary, Treasurer & President of JGVK, Manager & Coordinator of the Social Health Project	Interview	Each one

2.3.3 Secondary data collection

Secondary data were collected from various MIS reports from JGVK submitted to IGF, records of Hb% estimation on MCPC card (Cohort Register), minutes of the meetings of the staffs, HMIS reports of the BPHC (Basanti) and literature review from various Annual Reports of H&FW Department, Govt of West Bengal, Annual report of JGVK and others.

2.4 Data analysis

- Quantitative analysis was done in MS Excel in Windows 7.0 version and using SPSS10.0 version for further analysis. Frequency and percentages were used to analyse data.
- Qualitative data got standard analysis plan like –coding, editing & analyzing. Qualitative data will be used for complementing quantitative observations.
- Meta-Analysis for data from other sources was done.
- Triangulation of data were done between qualitative and quantitative data and between patient and providers' findings

2.5 Ethics of the research

During research standard ethical protocol was maintained and the research protocol was approved by the technical committee at appropriate level. Confidentiality was maintained at all level so that no one's name was taken in the findings and disclosure of information was done maintaining anonymity.

2.6 Period of evaluation

Desk research and tool development prior to field were done during 5th April to 15th April. Field work was done during 17th to 21st April, 2014. Analysis and report writing were done during 22nd April to 15th March, 2014.

3. Findings

3.1 Reflection on the process and activities

In this section we have described the accomplishment of the planned activities and how this intervention adhered to the planned processes. Following table depicts this facts and figures.

Table 3: Activity accomplishment towards objective 1 & 2

Sr. no	Planned activity	Accomplishment	Left out opportunity
1	Establish the project managing committee with JGVK	PMC (PIB: Project implementation body, with 5 members were formed and was functional)	None
2	advertise for candidates for FHWs	Advertisement were put up at local Panchayat offices, Village Committees, locally published newspaper	None
3	Selection of approx. 30 women to be trained	Selection of the FHWs was done through interviews. Total 63 candidates were selected, from where till the end 37 continued working	None
4	Enter into agreements with the capacity-building NGO (CINI / WBVHA)	Agreements were made for capacity building institutions, copy available in the sector	None
5	The project staff from DK participates in the preparations for the project regarding capacity building:	Capacity building plan prepared by the training institutions were finalized by DK	None
6	Prepare educational program with CINI / WBVHA	Training module were prepared by CINI & WBVHA	None
7	Prepare teaching material	Prepared by the training institutions and also by JGVK. IGF also helped in preparation of certain teaching materials	None
8	Hold meetings with SHGs and VCs in villages about responsibility,	As per activity plan once in a month of the FHWs, meetings were organized at least twice in all villages/ VC/SHG	None
9	Organize village meetings with information about the project implementation and strategy	Done along with VC/SHG meetings	None
10	Prepare house listing	Done by the FHWs for all the villages and computerized	None
11	Establish educational / training center	Training center accessories were made	Training Space as a Resource Centre
12	Training of FHWs	Training was organized for all 63 FHWs on basic health issues including ANC checkup, delivery care and post natal cares.	7 FHWs have not completed all the trainings

Sr. no	Planned activity	Accomplishment	Left out opportunity
13	Have examined / test before starting work in the villages	Written exam on both the components (as mentioned above) were undertaken for all those who completed the training.	Certification by independent external expert panel
14	Training FHWs in the villages under supervision	Regular hand holding support cum training were performed by the coordinators & Supervisors	None
15	Provide additional education / training for the "old" FHWs	18 old (continued from phase one) were provided refreshers, additional trainings.	None
16	Follow up with village meetings around FHWs work	Regular village meetings were followed up during field monitoring by the coordinators & Supervisors.	None

Table 4: Activity accomplishment table of objective 3

Sr. no	Planned activity	Accomplishment	Left out opportunity
1	Collect information about rights in health issues in Sundarbans	Information's on health rights were collected from internet, Panchayat officials, Block Development office, Basanti Rural Hospital e.g. RSBY, Ashyumati scheme, JSY, Govt. order on free medicines for all OPD cases, deficit in health infrastructure in the block, school health program by Health & FW department etc	None
2	Develop educational / information materials	Education materials like booklets containing different Govt. schemes, MDG issue, health education for SHG's were developed. These were shared with the FHWs and VC's as applicable.	None
3	Educate villages in the rights of health	At least twice a month FHWs conduct health education sessions with SHG, VC.	None
4	Teach advocacy	Training on advocacy techniques was imparted to FHWs. FHWs in turn guide SHG/VC is taking up advocacy with Panchayat, ANM, ASHA, AWW, primarily in 3 rd . & 4 th . Saturday Meetings held at Panchayat office. Few examples are initiation of ANM outreach camps in two places, improved performance of one ANM, storing of basic primary medicines with the FHWs where ASHA not working.	Advocacy plan at the hand of SHGs or VCs
5	Organize workshops	Yearly one workshop for staff of JGVK was organized in collaboration with IEC project staff to discuss on different Rights and available Govt. schemes.	
6	Support groups to	Local CBO network formed. Issues related	Formal shape with

	develop action plans	to Public health like water & Sanitation facilities (CLTS), environment protection, Women Abuse, Human & Child Trafficking etc. were taken up with Block Sanitation Cell, local Police Station by the support groups, led by JGVK	evidence Active male involvement from the community
7	Work within JGVK with advocacy:	JGVK formulated Advocacy Strategy Paper (as a part of PA project activity) and the same was shared with FHWs (Bengali translated version made). -Organizing trainings for JGVK core staff -Some general organizational advocacy materials were published e.g. At A Glance: Overview of JGVK in 12 Years -Written letter on infrastructure development like village road, electricity etc to Public Authorities	Sharing with SHGs, VCs in their language & way to ensure their ownership

3.2 Looking through indicators

In this section we have described how much the organization has achieved as per the stated objectives of the project during the intervention period.

Table 5: Results towards objectives

Sr. no	Objective	Results	Objectively verifiable indicators
1	On 1 January 2012 will at least 50% of pregnant women in 20 villages in the Sundarbans have received at least 3 visits during their pregnancy by a FHW, who have guided and informed the pregnant woman and her family about her pregnancy	<p>1.1 At the 1st July 2010 teaching/information material are produced regarding pregnancy for training of the FHWs and awareness meetings in the villages: <u>the different teaching/information materials are: booklets on malnutrition, safe motherhood, children's milestone in development, all training sessions hand out notes (reference for FHWs), Xerox copies of different health issues (pictorial & written)</u></p> <p>1.2 At the 1st July 2011 the education / training of 25-30 FHWs have been implemented.: <u>mentioned in the previous column</u></p>	<ul style="list-style-type: none"> • The pregnant women express that FHW's visit is a help and support. : <u>significant achievements from the village visit during evaluation was evident</u> • The families of pregnant women have gained greater understanding of the importance of caring for pregnant women (for instance adequate food, rest etc). : <u>achievements from the village visit during evaluation up to 40-50%</u> • FHWs can show logbooks regarding their activities: <u>FHW's daily diary, monthly</u>

Sr. no	Objective	Results	Objectively verifiable indicators
		<p>1.3 At the 1 August 2011 the FHWs are using their knowledge in the villages.: <u>FHWs started education sessions in the villages after completion of the trainings</u></p> <p>1.4 There are established teaching / training facilities: <u>available and in use</u></p>	<p><u>reports are available and being checked during evaluation visits by external evaluator. Internal consistency was observed.</u></p> <ul style="list-style-type: none"> The pregnant women are willing to pay for the services to the FHWs: <u>Around 20-25% beneficiaries are willing to pay, that was evident during evaluation visit</u>
2	<p>On 1 January 2012 at least 50% of the birth giving women in 20 villages in the Sundarbans has been helped by a dai that has used her knowledge she has acquired.</p>	<p>2.1 At 1st July 2010 educational materials regarding births are produced for training of BAs and awareness meetings in the villages. :<u>TBA training component was omitted and justification towards it was informed to CISU through Status Report</u></p> <p>2.3 At 1 August 2011 the BAs are using their knowledge in the villages.</p> <p>Special Note: understanding the role of Rural Medical Practitioners (Quack/ RMP) in conducting deliveries verses promotion of institutional deliveries through the project, in some cases arouse controversy. In bringing solution towards it, one day seminar was organized for RMPs where Basanti BMOH was the resource person to discuss the importance & benefit of institutional deliveries.</p>	<p>The new mothers express that they felt comfortable with BAs help at the delivery</p> <p><u>Not applicable</u></p> <p>The BAs can produce logbooks regarding their activities.</p> <p><u>Not applicable</u></p>
3	<p>On 30 June 2012 at least 50% of the population in 20 villages in the Sundarbans has been made aware of their rights to health</p>	<p>3.1 JGVK supported villages have organized meetings / workshops around organizing and advocacy by 1 February 2011. : <u>Several meetings in collaboration with IEC & Health project team organized in the villages. Among many issues few were on RSBY, SASPFAU, PROFLAL (both Labour depart</u></p>	<ul style="list-style-type: none"> Active working groups have been formed which have identified priority to topics within healthcare. : <u>Project Implementation Body is the working group. PIB made plans on priority health issues, implement the plan with the FHW's and JGVK GB. SHGs</u>

Sr. no	Objective	Results	Objectively verifiable indicators
	<p>care services, have understood the importance of advocacy and together with JGVK have worked out plans for advocacy with respect to how they can influence the local authorities in relation to the Partnership Activity project.</p>	<p><u>schemes on benefits for unorganized sectors labours on health, education, old age pension).</u></p> <p>3.2 Working groups in the villages has developed plans for advocacy within the health sector by 1 July 2011.: <u>advocacy plans were prepared particularly in two places: organizing Outreach camps and for improved performance of an ANM</u></p> <p>3.3 JGVK has prepared plans for advocacy in relation to the local authorities 1 July 2011.: <u>advocacy plans were made on : to obtain registration for JGVK Pathological Laboratory (problems faced by JGVK from local self governance), no specific Written plan were made</u></p> <p>3.4 Members of the working groups have held meetings with local politicians about health issues before 30.June 2012: <u>nothing from JGVK level</u></p> <p>3.5 JGVK has worked out plans/strategies for advocacy in relation to the local authorities before 30. June 2012: <u>only at discussion stage, nothing in writings</u></p> <p>3.6 Before 30th June 2012, JGVK had meetings with representatives of the local government about PPP programs: <u>three meetings were held between JGVK and BMOH, CDC doctor regarding initiation of NRC and CDC at JGVK.</u></p>	<p><u>are yet to make priorities on health issues.</u></p> <ul style="list-style-type: none"> • Meetings have been arranged in all 20 villages about potential and advantages to be organized in groups when it comes to influence: <u>at least four meetings in a year were held by the FHWs with the community people on group formation to conduct advocacy. In 2013 with the help of IEC project team, SHG's were trained and guided to prepare their development plan submitted to "Gram Sabha" - twice a year.</u> • There are established influence by the group on the authorities and it is documented: <u>SHG/ VC resolution copy available with the groups . However, influence on local stakeholders need to be evident. Male involvement in the project from the community was improved.</u> • JGVK has been working on strategy for advocacy: <u>Advocacy Strategy document prepared and shared with CISU during their monitoring visit on 2013</u> • Advocacy plan at hand – initiated by the SHGs & VCs and finalized by JGVK in consultation with the Governments: <u>Copy of the development plan by Panchayat, available with SHG & IEC staff at JGVK. Initiatives are to be taken by SHGs; not Panchayat.</u>

3.3 Other achievements during process

3.3.1 Capacity building initiatives

- (a) One batch of FHW's & Supervisors training on Basic Health Components – training provided by CINI
- (b) One batch of FHW's & Supervisors training on Basic Health components – training provided by WBVHA
- (c) Technical training on ANC checkups by Dr. Amitava Chowdhury
- (d) Special trainings for the FHW's:
 - NGO management, Leadership, Team Building
 - Documentation
 - Organization's strategy development
 - Advocacy techniques
 - BCC (Behaviour change communication)
 - Project management & planning
 - Mental health
 - TOT (Training of Trainers)
- (e) Refresher trainings conducted
- (f) Once a year the IGF project leader Dr. Lene & IGF member Ms. Inga visit India and each year conduct CB on some special issues, e.g. physical exercise as appropriate during pregnancy, after child birth, exercise on certain physical problems like in prolapsed uterus, problem in urination and some similar problems, methods of conducting health education sessions with the women, checklist for village level H&N education sessions.

3.3.2 Community advocacy

- FHWs have permanent seat at the 2nd and 4th Saturday Meeting, meetings organized by local self-governance (Panchayat) with government health department workers. They discuss health issues and decide on possible solutions.
- Through decisions on these Saturday Meetings a 3rd Sub center (Public Health Center) in the area has been granted and is now under construction.
- The Saturday meetings with the Government Health Department have been used as a platform for advocacy and the presence of the FHWs are now fixed by law.
- The position as Block Medical Officer of Health (a very influential position) is now filled out fulltime and the person pointed out for this position has initiated a corporation with JGVK.
- The FHWs are invited to social gatherings at the CDC (Community Delivery Clinic, the only alternative to the hospital, but without possibility for surgery)

3.3.3 People's access to different rights due to advocacy and help from the FHWs

- Because the government does advice for institutional deliveries, the FHWs advocate for that even knowing that there is only one hospital and one delivery clinic (CDC) on the whole island.
- It has nevertheless improved the service of the hospital significantly and the hospital is upgraded to a Rural Hospital (Basanti Hospital). Through proper advocacy and dialog with the hospital, planned Caesarean and Sterilisation have started once a week.
- Through advocacy and dialogue with the CDC Management, the quality standards of the CDC have been improved. FHWs were called for the monthly review meeting at CDC.
- The FHWs inform through the SHGs about the Nutrition Rehabilitation Centre for undernourished children and help the families with referral of the children to the Centre
- The number of sterilisation camps for women has increased and the FHWs inform the women about them and follow & support women during the operation.
- FHWs help poor families to achieve access to different social insurance programmes, like the National Health Insurance Scheme.
- In cooperation with the IEC3 project (a purely advocacy project) several booklets have been published dealing with health issues, nutrition, Governmental Health Programmes etc.

3.3.4 Ensuring comprehensive healthcare for the community

The people in the villages are now also informed about other Health Programs within other health topics:

- Leprosy program
- Program for Vector borne diseases
- Program for Permanent and temporary methods for child spacing
- Eye testing camps (Cataract, Refraction)
- Pathological/Laboratory testing camps
- Undernourished children
- Sterilization

3.3.5 Involvement of Non Qualified Private Practitioners (NQPP)

In the survey conducted with the TBA's it is learnt that now-a-days they promote institutional deliveries rather than home deliveries and are seldom called in case of home deliveries. Instead the Non Qualified Private Practitioners (local name, quack) is called. Training of TBAs is therefore not relevant.

So, JGVK decided not to give the quack a systematic training because there is a great risk that they will use this as an approval of their activities - a kind of certificate so to speak. Instead they are invited to Information Meetings. To do this JGVK has undertaken some preliminary activities as follows:

- Survey of the quack and Birth Attendants were conducted to assess the extent services rendered to the communities, their experiences on pregnancy care and deliveries
- From there the participants interested for information meetings was listed
- Education plan for capacity enhancement and information exchange of quacks and birth attendants were designed through PIB meeting

3.3.6 Experience gathering and dissemination of experience

During 2014

March 2014, experience sharing meeting organized by State level Forum Viz. “*Shramjivi Swasthya Uddyud, People for Health Care*” comprising of Doctors, Social Activists, Environmentalist, Scientists, Social Workers, business people, where JGVK was invited to share the experience of implementing Social Health Project, challenges, role of NGO and available government services in the Basanti Island. The report was published in one of local Bengali Newspaper *kalantar*

January 2014, JGVK organized in *Sundarban Lokosanskriti-o-Kutir Silpo Mela*, on inauguration day, in presence of Minister, Block & District Public Authorities & other dignitaries, JGVK’s health activities in four gram panchayat areas and its impact in the communities was shared.

During March 2014, IGF Health Project Team Leader Dr. Lene Kieler Jenson was invited by CISU in their partners project review meeting to share JGVK’s health project impact, with focus on impact of advocacy component underwent through health project.

During 2012 – 2013

In the quarterly review meeting of Sanitation program at Zilla Parishad (JGVK is one of the implementer of sanitary Mart Basanti Block), JGVK shared the success of Health project for the progress made in the areas towards *Nirmal Gram Panchayat*. This was done once in 2012 and once in 2013.

State Inter Agency Group, Disaster Management Cell, (JGVK is the member of IAG) in their planning meeting JGVK’s different development activities which includes health project also, in four gram panchayat areas of Basanti Island were discussed to understand how disaster preparedness & mitigation plan could be incorporated in weekly mothers meeting conducted by FHW’s.

In Feb 2012, 2013 and once in 2014, Basanti Block medical Officer(s) (during these period two different BMOH were responsible for Basanti Rural Hospital), Medical Officer visited JGVK to understand Health Project implemented by JGVK and the nature of collaboration from FHWs in promotional activities.

In 2012, a group of ten students of Environmental Engineering department from Danish Technical Universities (DTU), visited JGVK to learn on environmental consideration in implementation of different activities and health project sharing was done in this respect. The students expressed the project impact was high and meeting the desired norms. They shared this in their sharing session after return to their study at DTU.

3.4 Outcome analysis – qualitative

In this section we have described how much outcomes or results have been achieved. However, here the qualitative aspects have been emphasized to elaborate the perceptions, opinions, attitudes of different informers are addressed. This goes beyond any numerical achievements but more normative.

3.4.1 Women from Self Help Groups and the Community

Observations from the group discussions among members of SHGs are as following:



- Leadership was fixed and not rotational. Groups are vibrant. Members were active and dynamic and adequate to be believed that they have potentials to make some changes.
- While there is a preference by the community to conduct delivery at father's house; a majority has developed confidence in institutional delivery. People believe that at Govt. hospital, any time you go, you will get some assistance. JGVK should get the credit.
- Due to high waiting time as reported by the community, people in significant proportion believe that any clinical services; if would be arranged by JGVK; they may prefer to seek it from them; rather than from Govt. facilities.
- Eight participants out of 26 have commented that they may like to pay some incentives to the FHWs against their services like weight & BP measurement, Hb% test, urine test during pregnancy, so that FHWs can continue to serve the community even after withdrawal of the project.
- Ideas about pregnancy care, deliveries, post natal care including child care issues have been percolated among the groups more than 50%. SHGs as a vehicle or as a channel of communication; the idea or process could not be established.
- FHWs have been accepted very highly by the community not only due to their services they provide, but also for their good attitudes and skills.

- Understandings about 'at risk mother', cause of maternal death and infant death are average.
- Basic activities undertaken by these groups are mostly confined to livelihood issues and taking loans from Savings Accounts for these activities. Health as an issue has not been flagged neither as a community problem by the groups.
- Basic activities like group meetings, mother meetings undertaken by JGVK staff could bring about changes in knowledge level of the target group on Maternal & Child Health (MCH) issues. However, yet the health issues have come up as a community problem and or agenda of discussion by the groups themselves.
- Groups as a collecting force are yet to come up to identify, discuss and become accountable towards any unwanted health situations like infant or maternal death. The issue still remains on individual problem rather than as a group's problem.
- Women opinioned that FHWs are very much dedicated to their works and even more that Govt. staff.
- In this existing societal norms, in-laws have resistance to allow their daughter in law to go to hospital for institutional delivery, because in their time; they used to have home delivery. They still believe that at home traditional Dais (Birth Attendant) can deliver safely and that is a very healthy practice.
- Repeated girl child birth leads to loss of hope in the family as well as the women. The woman is poorly supported by the families and therefore, has least concern about her delivery.
- **'When the pregnant women is on labour pain, we are sent to the field for work, what inhuman these society and the family members, we are treated like beast, even they are also treated better'**, said a woman.
- Four to five women out of 22 attended reported to consume full course of IFA, i.e. 100 IFA. Poor compliance is due to bitter taste of IFA, offensive smell of it, constipation, nausea and vomiting after ingestion.
- The groups are yet to flag health as an agenda of discussion; rather it is economic cause driven. This is similar finding like the earlier group.
- It is perceived by the community that FHWs of this social health project are more beneficial to the community because they are available, friendly, acceptable and have more equipment to measure BP, Hb%, urine test, height; which often employers of Govt. like AWW, ANM or staff of CHCMI do not have.
- Scheme awareness on Janani Suraksha Yojana (JSY), Community Health management Initiative (CHCMI), Nischoy Jan etc. are not up to the mark.
- Participants agreed that the HWs may be paid some fees against the services they will continue to provide after withdrawal from April, 2014. This may be done by two ways- (1) pay against service by the respective household on the basis of the charges fixed by the FHW and (2) SHG members collect fees for groups and pay to FHWs in their locality.
- Members feel that the Social Health project should continue and jobs of FHWs should be retained. JGVK should something for that. The project and more of it, FHWs were of great help for them.
- Common health problems identified by the participants are related to sanitation, potable water and poor roads.

Adequate skills were observed when the two FHWs conducted health education sessions during group discussions. Introduction and startup were good. FHW's control over the group was nice. Her rapport with the members reflected her good field presence. The audience was attentive to the FHW. Her eye

contact and body language were however not moving but focused, reflecting her nervousness. Technical clarity was good, and however may be improved definitely. The supervisor then added issue of common illness out of poor complementary practices. She added value to the technical aspects when the session of the FHW was over.

3.4.2 Government Service Providers

Observations from the meetings among ANM, ASHA, AWW at different SC and PHC



- A stated by different service providers of Government, common services provided by the FHWs of JGVK are – complying full ANC along with early registration of all PWs, improved coverage, full immunization of children especially pulse polio, organizing health camps as supplementary to Govt. Apart from this during home visit, FHWs support in checkup of BP, measurement of fundal height of Pregnant Woman (PW), test of Hb%, urine test for albumin, birth weight measurement of newborn baby. These activities undertaken by FHWs of JGVK have helped the Government programme to comply with full ANC, risk identification of PW, monitoring growth of foetus in womb.
- **‘At least FWs of JGVK have helped in mobilizing the community towards Govt. hospital for routine checkup and institutional deliveries. Recent updates of PW, cross check of information conducted by ASHA or AW have become easier’** stated one ANM.
- According to one ANM of Laskarpur, FHWs are very good in providing health tasks on immunization, ANC, healthy diet practices. These have improved quality care during pregnancy.
- Because ANM, ASHA, AWWs are getting support for FHWs & JGVK, they also in return trying to support JGVK program day to day and remain present during their committee meetings. This proves that a good mutual cooperation exist between Govt. & JGVK.
- In Jharkhali, the institutional delivery is comparatively higher since 2011, i.e. since inception of the project undertaken by JGVK. It is presumed that the migrant population in the area are not

much aware about local facilities, have higher risk perception. In other words, they have higher healthcare seeking behavior. These facilitated persistent higher institutional delivery rate.

- Process of participation of FHWs in last Saturday meeting at panchayat office was explored. The meetings are presided over by Panchayat Pradhan, or Secretary of the Samiti or Swasthya Karmadhyakshya in presence of ANM, ASHA, AWW and including FHWs of JGVK. The resolution taken in these meetings are signed by FGHWs of JGVK also along with other participants. Opinions of FHWs are considered for identifying hard to reach areas or resistant population.
- Option was given to know, whether user fees will be applicable in the community through FHWs after project withdrawal. Providing fees to FHWs against their services after withdrawal of the project has been partly accepted by some ANM & ASHAs. In their opinion, the community may take some time to accept it, but gradually it will be accepted. After implementation of user fees by government for certain services, people took time to adopt it. Some of them feel that, this may not be a good practice, because, initially FHWs served voluntarily and if now for money, this may go against reputation of JGVK. While taking money, FHWs may not be allowed to remain associated with ANM of the government as it may raise question about their ethical integrity. In other words, people may think that ANMs may have any interest.
- One trained birth attended was present in a meeting with ANM & ASHA. She explored her happiness because community has now turned towards Govt. facility because of dedication of FHWs of JGVK. When labour pain prolongs, pregnant women are not waiting at home, but at the earliest they are being referred to Government hospitals.
- In each SC & PHC level, where interviews were conducted; it is felt that a good team has come out where FHWs have become integral part of it and therefore this participation has geared up some activities especially immunization, ANC coverage & institutional delivery.
- In Jharkhali PHC it was said by the 2nd ANM that out of 6 ASHAs, only 2 were in place. The role of FHW of JGVK is non-negotiable. In other GPs also vacancies exist as per recommended number of ASHA.

3.4.3 Field Health Workers (FHWs) under JGVK

Twenty two FHWs of the JGVK who worked under the social health project were met. Three groups were formed: A, B, C and they were assigned for group activities as followings:

Group A: Present role of FHWs, future role in project contained, future role if not continued

Group B: Demonstration of basic services by FHWs- measurement of BP, Hb%, weight, urine for albumin, oedema and general health survey

Group C: Design a future project: MCH only or comprehensive

Observations and extracts from the group presentation among FHWs at JGVK

- FHWs are well aware about their roles defined in the project.
- Community has been mobilized adequately as per the project aims.
- The project could involve family members also to strengthen the work, not only pregnant woman.

- Services were accessed from ICDS centers also which is being interpreted for good convergence with other department for the same cause.
- Adequate awareness efforts were taken up on different schemes under Panchayat including others like JSY, RSBY, Nischoy Jan, Ayushmati Scheme.
- Some more issues were opportunistically addressed in the project like adolescence, family planning, vegetable gardening, sanitation issues which complemented to the stated project objectives.
- FHWs could demonstrate their skills on BP & weight measurement of pregnant women, estimation of Hb%, urine test for albumin, pallor examination. However some gaps remain to improve their skills on quality of testing issues which need further capacity building.
- FHWs are highly motivated. They are committed to continue basic services like ongoing health camps, providing once in a month ANC checkup if requested by pregnant woman and arrange basic tests required for the tests like Hb%, urine and others, if JGVK provides resources.
- FHWs recommended that the future project plan should include sanitation, adolescent health, and general medicines for pregnant woman including child health issues as part for basic maternal health care.

Observations and extracts from the groups through further explorations after presentations by the groups at JGVK



- Pregnant woman learnt to have a special menu each day to add special nutrition to their existing menu.
- Kitchen garden was practiced by members.
- Handicraft was introduced to enhance economic status.
- Group was strengthened by the members through support from FHWs.
- Use of bio-manures in cultivation was introduced and gave good impacts.

Observations from the field work during visits to different places in the community including household visits and service delivery points of Government

The FHWs are also working with health in a broader perspective with positive outcome which are beyond scope of evaluation numerically, but it happened.

- Improved healthcare seeking behavior of people for MCH issues was understood. This has been reflected through:
 - Increased coverage of full ANC
 - Pregnant woman being accompanied by in laws, husbands during ANC care
 - Change in neonatal care practices like avoiding carbon in eyelash (Kajol)
 - Early bath and shaving of scalp of the neonates
 - Pregnant women stopped taking bath in pond
 - Some resistant families from the community started going to hospitals
 - During postpartum, some women started doing pelvic exercises
 - Babies are not any longer left unprotected in the sun greased in oil
 - Babies will have the colostrums= the first milk
 - New mothers are now allowed to take bath and drink free

- The FHWs are very much aware of high risk pregnancies and their location in the community.
- The FHWs have much attention to very weak and poor families
- The FHWs are greatly respected in the villages and very much supported by their families
- The FHWs are often called to deliveries together with the quack/dais because she is known to have greater knowledge (it is often recommend to shift to institutional delivery if necessary)
- If the delivery is institutional (planned or acute) the FHW follows the pregnant women and stay with her until the baby is born. This is very much appreciated by the women
- More and more families are listening to the good advices and follow them
- Hygiene status of the households has improved in the villages:
 - village people now use water from hand pump for bath and making food
 - number of latrines has increased
 - for home delivery the place for the delivery is now a clean light place in the house, not the darkest and dirtiest

Observations in relation to partnership and cooperation with the government health system

- The FHWs always join the Outreach camps (Ante Natal Check and vaccination camp), which are held by the ANM. Without the help from the FHW she will not be able to fulfil her duties.
- The FHWs have now permanent seat at the 2nd and 4th Saturday Meeting. Meetings are organized by the local self-governance (Panchayat) with Government Health Department workers. Here they discuss health issues and decide the possible solutions.
- The FHWs are invited to social gatherings at the CDC(Community Delivery Clinic, the only alternative to the hospital, but without possibility for surgery)

3.4.4 Stakeholders

Synthesis of discussion with Medical Officer, JGVK

- 1) Approved activities of the project as per donor's priority vis-a vis community need had a little mismatch. Therefore many of the people's need could not be reached. The organization has very limited alternative sources to be resourced to afford this expectation.
- 2) As a doctor, here he was engaged in capacity building of Field Health Workers in different batches. Majority of the FHWs could gain adequate skills like measurement of fundal heights, assessment of Hb%, tests for urine, blood pressure measurement at household level to assess risks of the mothers. However, these has been technical dilution in application in a few FHWs due to poor supervision.
- 3) FHWs work force could mobilize the community to Government hospital (BPHC level), but there in patient care is sufficiently poor. This reverts back on the FHWs who refer patients to Govt hospital.
- 4) Component wise MCH care, child health care, especially malnutrition management should be integral part of the project.
- 5) The project should have factored provision of basic services like nutrition support to pregnant women, alternative IFA regime (ferrous fumarate instead of ferrous sulphate).
- 6) Through MCH schemes like JSY, Nischoyjan, IGMSY Govt. has boosted up motivation of women. About male involvement, perception is like, "Pregnancy care is responsibility of Government, not ours."
- 7) Skilled FHWs present in the community will act as local resource and well wishers, health activists in the region, which will continue to support the community even after withdrawal of project funding.
- 8) It will be premature to comment (or SHGs are premature groups) that SHGs have become a pressure group to hinder mal practices of non-qualified private practitioners (in other words, they can become alternative to Non Qualified Private Practitioner i.e. quacks)
- 9) To comment on future direction of the this project from previous experiences:
 - a) JGVK should plan for a comprehensive healthcare programme with integration of MCH, public health issues& also including commonly prevalent problems like Cataract, Diabetes, Hypertension, Genital prolapse, Skin diseases, Anemia, oral health problems & anemia.
 - b) The programme should have few components –
 - Community mobilization outreach services for demand generation.
 - Providing basic services at JGVK clinic
 - Provision of user fees for substantial to afford recurring costs
 - Capacity building of FHWS as a part of community demand generation
 - Advocacy at the provider level in Govt facilities to ensure sources of availability of basic services.
 - Adequate HR provision to ensure quantity of services (monitoring) like 1 FHW/500 HM supervisors/ 4FHWs, 1 health assistant/supervisor.

3.4.5 Synthesis of discussion with Block Medical Officer, BPHC, Basanti

Block Medical Officer of Health (BMOH), Block Primary Health Centre (BPHC), Basanti was met along with his team members like Block Public Health Nurse (BPHN), Block Accounts Manager (BAM). It was evident from the meeting that JGVK has good rapport with the BPHC that is a first & higher level facility to conduct normal delivery, assisted delivery and Caesarean Sections along with supportive measures for neonatal emergencies. It is nomenclature as First Referral Unit (FRU) hospital also. JGVK has put lot of efforts to work in convergence with the existing health system. FHWs from the JGVK helped the field staffs of BPHC to implement various health programmes successfully. Most importantly, it may be mentioned that for immunization coverage, full ANC coverage, promotion of institutional deliveries; role of JGVK was evident. The BMOH expected proposals from JGVK to work with the NGO in partnership at block level also. He expressed his ideas that some FHSw from JGVK may be assigned in Kata Jangal areas in Jharkahli Gram Panchayat for reach hard to reach people. There is scope for collaboration with JGVK for IMNCI trainings of health care providers at different level.

3.4.6 Feedback from members of the Governing Body of JGVK

Members of the Governing Body like President, Secretary and Treasurer could be met to understand the project, its implementation process and their experiences through this project. This social health project was a first time big volume project which was handled by JGVK. Therefore, many activities were implemented as a beginner and naturally graduation phase was long. However, the NGO has a very strong root level presence by dint of its SHGs with whom it has been working. They have maturely handled and used this group network as an umbrella for implementation.

The members opined that their future plan is to continue with this project, but with new design based on the requirement of the community. They may like to start a midway clinic based multi-facility health centre so that community can avoid long waiting time in the government hospital. JGVK will take minimum user fees for providing services that will suffice the recurring expenses of their project. But quality of care should be ensured at any cost.

3.4.7 Understanding roles of other stakeholders

All stakeholders were not met. But review of project documents, discussion over phone, perception of the evaluator during evaluation visit helped to explore and document the following areas about the stakeholders related or will be related with the project.

Table 6: Understanding of stakeholders and their role

Stakeholders	Strengths	Weaknesses
Beneficiaries	<ul style="list-style-type: none"> Interested in improving their own / family health Aware about health issues Aware about health facilities and service providers Can raise their voice towards access to healthcare 	<ul style="list-style-type: none"> Negotiation skills poor Advocacy skill as independent person needs improvement
Men / families	<ul style="list-style-type: none"> Interest in the development of society 	<ul style="list-style-type: none"> Involvement in health improvement of female, pregnant mothers, adolescents is poor
JGVK	<ul style="list-style-type: none"> Strong local roots, many years of experience in development work, have a good cooperation with local government Recently stepped into health project and fast learner 	<ul style="list-style-type: none"> Capacity in advocacy on health issues with local government may be improved
Gram Panchayats	<ul style="list-style-type: none"> Supported implementation Allowed JGVK in health meetings 	<ul style="list-style-type: none"> Low capacity, bureaucratic, corrupt.
Health Department	<ul style="list-style-type: none"> Willing to extend partnership with JGVK 	<ul style="list-style-type: none"> Yet to improve capacity for doing advocacy with bureaucrats

Note: Panchayat could not be interviewed because during the period of evaluation, election campaign was going on. Indirect interviews and secondary information was used.

3.4.8 A good practice: Concerted effort in Sabita's Safe Motherhood

Parbatipur is a remote mouza of Jharkhali Gram Panchayat. Prasanta Joadder, a very young man had to start working as daily labour along with his mother in Kolkata city to meet both end in the family. Mother & son stayed at work place leaving behind the father who was sick and without any earnings. The only way out in the family to continue household chores was to bring a daughter in law. The family decided to bring a young girl thinking she would be able capable to work hard in the family. Sabita's poor parents were very happy to marry of their daughter for two reasons; she could stay in the village and there was no demand from Prasant's family. Finally Sabita at the age of 14 got married and came to Prasant's family. But from the very beginning she was in immense difficulty to take up all responsibilities single handedly. Mother-in law and husband visit village once a month and instruct Sabita to be a family perfectionist. On the first year of marriage Sabita got pregnant, and was in more difficult position. She was not allowed to consume any additional food, no egg, no sour, and many more.

Tumpa, Asima the local FHW's of JGVK registered her name in Sundarban Social Health Project and also with govt. ANM. She was advised by the FHWs on food, rest, household activities during weekly house visit. Tumpa accompanied her to the Anganwari Center to fetch supplementary food and ensured that she consumed food. But Sabita's Mother-in law's had strict instruction on not to consume egg. AWC provided egg 3 days in a week. She had refrained from egg consumption. Even in absence of the mother-in law, her father-in law has no say except to follow the instruction from mother-in law. FHWs were in a dilemma what strategy to follow in such situation. The third FHW from the next village and few women of the village tried their best to convince the mother-in law but that could not give any result as they could only see the mother-in law once a month for few days only.

Institutional delivery was not approved in the family. Tumpa, Asima called Madhabi & Jamuna (all FHWs of JGVK) to convince the family. Understanding that they will not take Sabita to hospital for delivery, on the onset of labour Tumpa forced Sabita to the Community Delivery Centre (CDC). After reaching CDC, the doctor checked and found that the delivery would take some more hours, 4/5 hours. Hearing this, Tumpa returned home leaving her mother- in law and others at the CDC. Once Tumpa returned the family did not stay and brought Sabita back home. Finally, the delivery was at home and the baby was only 1.100 gm. And 5/6 hours after delivery of Tumpa, her Supervisor Asima visited Sabita and found her lying with the new born on the floor on a torn mat only and the room was dark (room light was turned off). After great difficulty and discussion with the family, Sabita with the new born was shifted on the bed and she instructed the family to cover the child & mother with a clean cloth and to put on the room light to keep it warm.

The next challenge came for the FHWs after delivery in care for the new born baby and her mother. FHWs advised on child & mother care through regular visit to the family on every second day. By this the family found it difficult to avoid the care as repeated visits were made. To get rid of this, Sabita was sent to her maternal uncle's house thinking these FHWs would not come any more to see the child. Fortunately another FHW, Madhabi Sardar's house was in the same village and once Sabita started staying at her maternal' uncles house, Madhabi started visiting their house and would suggest all health related messages to the family. After staying for almost four months, Sabita returned back to her Husband's house.

Observing the constant effort from the group of FHW's, the family was impressed and convinced and started taking care to the child & mother properly. The small child now aged 1 year 11 months weighs 8.5 Kg in April 2014.

3.5 Outcome analysis – quantitative

In this section, we will more talk on achievements more on numerical aspects against the stated objectives or some indicators those are related as outputs, outcomes from the inputs those went to the community through interventions.

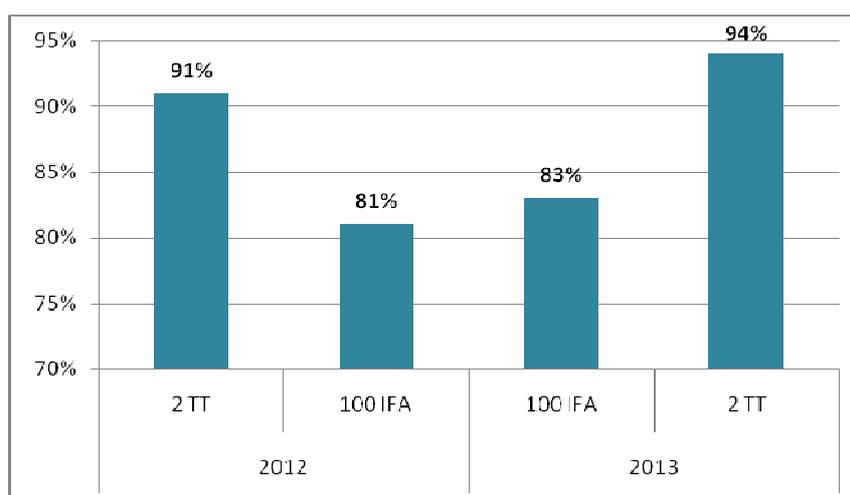
Coverage data on ANC care (TT injection and 100 IFA coverage) as reported by JGVK have been used for this report writing purposes. No data were available which could be produced as authentic including the soft copy of the data set shared with us by the BPHC.

The following table and the chart clearly show that there has been improvement in the proportion of institutional delivery, T.T. injection & 100 IFA coverage among the pregnant women. TT and 100 IFA coverage have increased respectively from 91% & 81% in 2012 to 94% & 83% respectively in 2013. Because no authentic data was available for rest of the Gram Panchayats, therefore, the increase cannot be compared with neighboring Gram Panchayats.

Table 7: TT & IFA coverage among Pregnant women

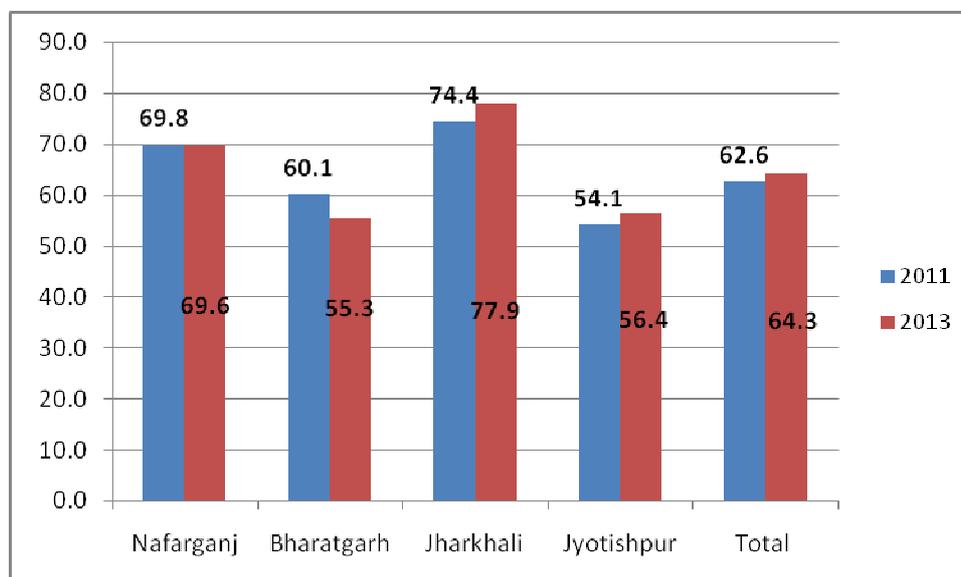
Name of GP	2012		2013	
	2 TT	100 IFA	100 IFA	2 TT
Nafarganj	240	240	148	148
Jharkhali	164	139	176	193
Bharatgarh	461	398	375	480
Jotishpur	268	226	212	213
	1133	1003	911	1034
Total	91%	81%	83%	94%

Chart 1: TT & IFA coverage among pregnant woman



The institutional delivery has come up from 62.6% in 2012 to 64.3% in 2013. Intervention of JGVK has contributed towards this increase. In other words, we can say that from 2012 to 2013, out of total deliveries of 1234, 1.7% i.e. 21 deliveries have been contributed by JGVK intervention. However, the outcome is not limited to this numerical change; however, lot of social changes and advocacy processes those have become possible, are also results of this intervention.

Chart 2: Institutional delivery among Pregnant women



Prevalence of at risk mother with anaemia (here defined as Hb% less than 10 gm%) remains static over the period of time during 2013 and point prevalence is 27.0%, calculated with blood samples collected from attending pregnant women in outreach camps organized in 12 months during 2013. Details of the distribution are provided in following table.

Table 8: Prevalence of at risk mother with anaemia among pregnant mother in 2013

Month	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
<10 gm%	29	44	53	30	36	46	32	28	39	44	32	30	443
Fn	141	165	163	139	134	156	107	104	160	150	97	122	1638
% *	20.57	26.7	32.5	21.6	26.9	29.5	29.9	26.9	24.4	29.3	33.0	24.6	27.0

[* % of at risk anaemic mother, Hb% < 10gm%]

Prevalence of anaemia (Hb% <11 gm%) among them have been consistently high in the area. It is around 73% to as high as around 96% and overall 82.3%. Please refer to the following table.

Table 9: Prevalence of anaemia among pregnant mother in 2013

Month	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
<10 gm%	104	125	139	117	110	132	95	88	119	133	93	104	1359
Fn	141	172	169	139	134	156	107	104	160	150	97	122	1651
% *	73.76	72.7	82.2	84.2	82.1	84.6	88.8	84.6	74.4	88.7	95.9	85.2	82.3

[* % of anaemic mother, Hb% < 11gm%]

A cross-sectional study was conducted by S.K. et al in 2008-09 among the pregnant women in three administrative divisions of West Bengal to undertake a rapid assessment about the magnitude of the problem of anaemia in pregnancy. The findings revealed that the occurrence of anaemia in these three divisions were very high to the extent of 86.39% and popularly known as 'Raktasunyata' or 'Raktalpata' to the common people. As per WHO guidelines (< 40% prevalence) it could be considered as public health problem of very high magnitude.

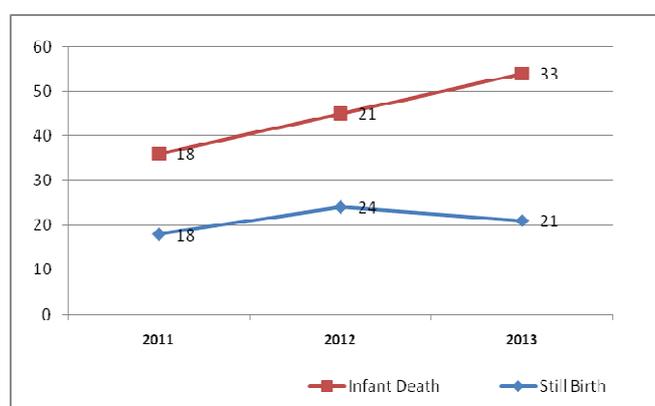
Infant & maternal deaths

Number of infant deaths is very much multi factorial and not merely due to wrong practices at the community or an issue that may be handled through type of intervention strategies adopted in this project during the project period. However, total number of infant deaths as reported by JGVK during the project period is as followings.

Table 8: Trend of still birth and infant deaths during 2011-2013

Number	2011	2012	2013
Still Birth	18	24	21
Infant Death	18	21	33

Chart 3: Trend of still birth and infant deaths during 2011-2013



4. SWOT analysis

Strength

- SHGs are active and may be used as collective force in the community
- JGVK has high level of acceptance in the community
- Eight FHWs are also working as Governmental Link Person and get paid for their service.
- Another four FHWs are working for CHCMI (Public Health) of Zilla Parishad.
- FHWs are getting paid when taking the pregnant women to the hospital and stay with her for delivery there
- FHWs are called by the Government Health Department for different National programs (Filaria Prevention & control Program, Pulse Polio).
- 10 FHWs have been attached to a local voluntary health program at JGVK and have obtained training in “Integrated Management & Neo Natal & Childhood Illness” (developed by UNICEF and WHO).
- Many FHWs are engaged in the CHCMI program (an Integrated Child development scheme, a social obligation handed over from the local government to a well-run SHG).

Weakness

- Panchayat (local government at village level) is still a problem. Lack of motivation and accountability towards the job responsibilities are a daily challenge in the Panchayat system.
- The general impression is that the understanding and capacity of the civil society in relation to advocacy has increased significantly.
- It is still our experience that advocacy and the achievements within rights are not always carried out as a result of an intended plan. Often it is an offshoot of another activity. Also the synergy and cooperation between different projects have to be mentioned. More of the advocacy activities done by the FHWs have occurred in either the IEC3 or the Sanitation projects. Therefore, the NGO has not made explicit plans for advocacy towards the local government. Pressure from the civil society has been used in several cases; an example is a demonstration of 80 women for better service for pregnant women in some remote areas of Sunderbans. We are still observing that if the government wants to implement health programs they very often select an area where the project is working!

Opportunity

- Scope for a comprehensive health project in the whole Basanti block that include RCH and common public health issues
- Operating Medical Guidance Centre – in three remote pockets of the program -conducted by the Medical Doctor attending JGVK main clinic. Since August 2011 till mid January 2012, the centres have catered to 341 cases. Service charge was given by the people attending the centre. **This can be channelized as outreach camps.**
- Running a rural Ambulance – with the technological support from DTU (Danish Technical University) JGVK has made a Rural Ambulance (three wheeler manual cycle cart, modified into an Ambulance) and is operating in the local villages. This was managed by one Village Committee. Transportation cost is paid by the user and portion of it goes to VC fund,

remaining to the driver. **This can be integrated into the new project and upgraded facility for emergency transport facility for different cases.**

- The MCH clinic at JGVK can be upgraded as a multi-facility centre offering dental, eye, ENT and paediatric services so that this becomes more popular and acceptable to the community.

Threats

- No major natural disasters occurring / epidemics in the region
- Experience from the previous project materialize
- The pregnant women and their families will use the learned knowledge
- FHWs / BAs work conscientiously
- Village people understand the importance of advocacy

5. Discussions

JGVK-IGF partnership has been able to mobilize the community in bringing many changes in the intervention community in respect of positive healthcare seeking behaviours, motivation towards government facilities and develop SHGs as a collective force for community development. The SHGs are yet to adequately flag health as an agenda of their thrust activity, but nevertheless a good breakthrough where people had lot of stigma, much poverty and therefore, more discussion & dialogues about health within the community indicates that the community responded to inputs gone through the partnership of JGVK-IGF.

A good health workforce prevails within the community which is nothing but Female Field Health Workers who belong to the community and who worked for the community. By the dint of their activities during last few years, they have established their identity within the community as credible healthcare providers. After withdrawal of the project, this workforce even is ready to continue some basic services free of cost. On the other hand, the community is ready to provide user fees for their services they might continue to render. FHWs have high acceptance within the community.

As a nascent organization in providing healthcare services, JGVK has earned good credibility within the community and increased their capacity for future intervention. The community has given good acceptance to the organization. So the organization can think of greater challenging programmes in coming days. Community feels that JGVK will be a good facility centre for them, if clinical services are more and more available at its door steps. Services like oral health, eye, ENT, gynaecological issues, water borne diseases should encompass a comprehensive healthcare model in future project.

Local advocacy was good enough and therefore, the Panchayat, Medical Officers, ICDS work force, ANM and including BMOH of the block rural hospital are willing to partner with JGVK for future intervention on health especially for hard to reach areas on issues like outreach camps, immunization coverage. Presence of FHWs in last Saturday meeting of Panchayat has made some positive changes in the process of these meetings. However, the process needs more handholding, so that in coming days, the last Saturday meetings become more structured and issue focussed. Capacity of Panchayat members need to be more enhanced to take leadership in these meetings.

Even though entrusted for maternal and child health programme, JGVK could understand the greater need of the community on other public health issues like hygiene, sanitation, menstrual hygiene, malaria and water borne diseases. To meet up this requirement of the community, JGVK has extended hands to join with local stakeholders and health functionaries. This has made JGVK understand overall health needs of the community.

Many of the outcome indicators like institutional delivery, immunization coverage, TT coverage, prevalence of anaemia and others have improved, even though not significantly. This is not fair reflection of the achievements; but qualitative aspects like processes those have taken place, dialogues & discussions held within the community & its gate keepers since last few years and change of behaviours & perceptions of the people on health issues are far more reflective of project achievements rather than these quantitative achievements.

However, the extent of advocacy and its results achieved at the BPHC level is not very much prominent; which could have been far more solid and effective. For example, presence of JGVK representative during MIS meetings of BPHC, their presence in meeting of Rogi Kalyan Samiti (RKS), sharing of regular project reports to the block and district could make the work far more visible, than what it is now. However, it is also to be stated that many activities, participation in workshops at different level have been facilitated by JGVK to make their work prominent and replicable. May be the efforts given and advocacy & visibility effect at higher level did not match because there was no constant available person within the organization who could technically (Public Health) advocate their efforts, constraints and experiences to stakeholders at higher levels with statistics, demographics and other determinants of health outcomes.

Regarding sustainability, the existing FHWs will continue to cater the community with health messages. They are local persons. The community mobilization with regards to referral to government facilities got a hike. People's confidence on government settings have increased. So, to some extent the work will continue even though the project is not continued. However, the JGVK may require affording basic supports like providing equipment for health check up, providing reagents for different tests to be conducted during pregnancy etc. Exit strategy was adopted within the project through continuous capacity building of the FHWs, through advocacy with healthcare providers of government including Panchayats. SHGs have agreed to pay user fees towards FHWs against their work. Referral trend has been increased and the SHGs will work as vehicle towards sustenance of the basic activities.

Therefore, the evaluation report recommends that following steps in future may be taken up by JGVK to match supply and demand side of a comprehensive healthcare.

Demand side preparedness

- The coverage areas may be increased at least to cater a block level. This will help any achievements to compare with the neighbouring non intervention block and estimate cost-effectiveness.
- Competency based retention of FHWs and their further skill buildings on RCH issues as a whole along with other public health issues to make them suitable for demand generation for a comprehensive healthcare service. The FHWs may be certified by a group of experts – internal and external. They will continue MCH service like earlier period.
- Design a comprehensive healthcare programme for the community through advocacy among members of the SHGs, so that health becomes priority of the groups, not merely income generation.
- Facilitation of last Saturday meeting in a structured way so that at all levels facilitation is uniform and objective oriented.
- Outreach camps for different public health programmes including camps for cataract, eye & ENT check up, oral health etc. There is need to address overall public health response in the block. 4 out of 10 Blocks where highest number of Kala- azar cases was reported are under Canning Sub Division. The four Kala- azar reported areas are

Canning I, Canning II, Gosaba and Basanti Blocks. The highest number of reported Kala-azar cases were from 2 GP's of Basanti Block Viz. Phulmalancha & Kanthalberia. The same is for Malaria cases.

- Problem of Snake bite – The HDR 2009 stated clearly that treatment for snake bite is usually done by *ojhas* (traditional healer) as people do not get service from govt. facilities and it is far to reach after the incidence
- Outreach camps on government, government aided and private schools to take care of basic health screening on eye, ENT, oral health, cardiology etc.
- Initiation of user fees for basic services to be provided and that should be factored within the budget.

Supply side preparedness

- Supply side facilitation at PHC and SC level is possible through ensuring supply of basic drugs for public health diseases. This is possible through either advocacy or through direct providing proportion of basic drugs to the centres.
- Response towards common public health problems like malaria, Kala-azar, snake bite, water borne diseases may encompass a new design.
- At the JGVK level, preparedness for clinical services on eye, ENT, oral health, gynaecology and others; so that after demand generation, these patients can access services from JGVK.
- At the PHC level, providing support towards patients requiring hospital admissions and doing advocacy for that with Panchayat.
- At the BPHC level, provision of specialist doctors on eye, ENT, gynaecology etc on periodical basis. This will boost up relationship between JGVK and BPHC. JGVK will become integral part of the block health system.
- This is important that at PHC and BPHC level, some facility preparedness will be required. No. of Health care facilities at Basanti vs. shortfall are significant. Number of PHC required as per population norms is 9, against available 3 and number of CHC required is 2 against available nil. This is either possible by setting up of new facilities at the level of JGVK, or improving efficiency of government facilities through additional resource support or through advocacy for better resource allocation.
- In the Health Phase II of the project, focus was on pregnant women. Child survival part was not much taken care of except primarily on Management of Childhood illness. JGVK initiated in a small scale the training of selected FHWs on IMCI. FHWs started caring for children at the village and to identify at risk cases for referral apart from providing care at home. In the next part JGVK may plan to take up some activities on child survival.

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Annexure 1

Evaluation Framework (Social Health Project: IGF-JGVK)

#	Activities accomplished (Target) (Achievement)	Result (Target/Achievement)	Objectively verifiable achievements	Methods of data collection	Tool to be applied	
1 Development objectives of the project						
1.1	Improved health status & awareness generation of the rights in the health issues among poor population.....					
2 Immediate objectives of the project						
Obj 1	January, 2012; at least 50% of the PW in 20 villages had 3 ANC.....	<p>a. establish the project managing committee with JGVK</p> <p>b. advertise for candidates for FHWs</p> <p>c. selection of approx. 30 women to be trained</p> <p>d. enter into agreements with the capacity-building NGO (CINI / WBVHA)</p> <p>e. The project staff from DK participates in the preparations for the project regarding capacity building</p> <p>f. prepare educational program with CINI / WBVHA mm</p> <p>g. prepare teaching material</p> <p>h. duplicate teaching materials</p> <p>i. hold meetings with SHGs and VCs in villages about responsibility, implementation and strategy.</p> <p>j. organize village meetings with information about the project.</p> <p>k. prepare house listing</p> <p>l. establish educational / training center</p> <p>m. training of FHWs</p> <p>n. have examined / test before starting work in the villages</p> <p>o. training FHWs in the villages under supervision</p> <p>p. provide additional education / training for the "old" FHWs</p> <p>q. follow up with village meetings around FHWs work</p>	<p>1.1 At the 1st July 2010 teaching/information material are produced regarding pregnancy for training of the FHWs and awareness meetings in the villages</p> <p>1.2 At the 1st July 2011 the education / training of 25-30 FHWs have been implemented.</p> <p>1.3 At the 1 August 2011 the FHWs are using their knowledge in the villages.</p> <p>1.4 There are established teaching / training facilities</p>	<p>The pregnant women express that FHWs visit is a help and support.</p> <p>The families of pregnant women have gained greater understanding of the importance of caring for pregnant women (for instance adequate food, rest etc).</p> <p>FHWs can show logbooks regarding their activities.</p> <p>The pregnant women are willing to pay for the services to the FHWs</p>	<p>Conduct FGD among SHGs</p> <p>Triangulation between observations from participants of FGDs, PWs and respondents of households through household visits</p> <p>Check FHWs' activity/tour diary</p> <p>Check annual report of the project submitted to IGF</p> <p>Analyze any exercise done by the team of IGF-JGVK and its report, if available</p> <p>Secondary data available from Government service providers, like ANM, BPHN of BPHC, Dy. CMOH III at district level or from Health on the March , Annual Health Bulletin of H&FW Dept. Govt of West Bengal</p> <p>Conduct meetings among FHWs, supervisors &</p>	<p>FGD tool for SHGs</p> <p>Check list for data to be collected</p> <p>Interview Guidelines for FHWs & Supervisors</p>

#	Activities accomplished (Target) (Achievement)	Result (Target/Achievement)	Objectively verifiable achievements	Methods of data collection	Tool to be applied	
				<p>other related staffs of JGVK for understanding their skills</p> <p>Institutional facilities for organizing trainings</p>		
Obj 2	January, 2012; at least 50% of birth is assisted by trained Dai.....	As above (Obj 1, common)	<p>2.1 At 1st July 2010 educational materials regarding births are produced for training of BAs and awareness meetings in the villages.</p> <p>2.3 At 1 August 2011 the BAs are using their knowledge in the villages. 2.4 There are established teaching / training facilities</p>	<p>The new mothers express that they felt comfortable with BAs help at the delivery</p> <p>The BAs can produce logbooks regarding their activities.</p>	<p>As mentioned above</p> <p>Check pregnancy cohort register available with the FHWs</p> <p>Delivery register of Community Delivery Centre, PHC, BPHC</p>	<p>FGD tool for SHGs</p> <p>Interview Guidelines for BAs</p>
Obj3	June 2012; 50% of the population are made aware on the issue, understood importance of advocacy, worked out advocacy plan & has influenced local authority in Partnership Activity.....	<p>a. collect information about rights in health issues in Sunderbans</p> <p>b. develop educational / information materials</p> <p>c. educate villages in the rights of health</p> <p>d. teach advocacy</p> <p>e. organize workshops</p> <p>g. support groups to develop action plans</p> <p>h. work within JGVK with advocacy</p>	<p>3.1 JGVK supported villages have organized meetings / workshops around organizing and advocacy by 1 February 2011.</p> <p>3.2 Working groups in the villages has developed plans for advocacy within the health sector by 1 July 2011.</p> <p>3.3 JGVK has prepared plans for advocacy in relation to the local authorities 1 July 2011.</p> <p>3.4 Members of the working groups have held meetings with local politicians about health issues before 30.June 2012.</p> <p>3.5 JGVK has worked out plans/strategies for advocacy in relation to the local authorities before 30. June 2012</p> <p>3.6 Before 30th June 2012, JGVK had meetings with representatives of the local government about PPP programs</p>	<p>Active working groups have been formed which have identified priority to topics within healthcare.</p> <p>Meetings have been arranged in all 20 villages about potential and advantages to be organized in groups when it comes to influence. There are established influence by the group on the authorities and it is documented</p> <p>JGVK has been working on strategy for advocacy</p> <p>Advocacy plan at hand – initiated by the SHGs & VCs and finalized by JGVK in consultation with the Governments</p>	<p>Conduct FGD among SHGs;</p> <p>Group Discussions with community (heterogeneous participants possible)</p> <p>Check for any stakeholder analysis report & advocacy plan and its use by the developers</p> <p>Meeting with Local Self Governments (Panchayat), ANM, ASHA, Medical officer of Government Hospital (PHC, BPHC) including Medical Officer of JGVK</p> <p>Meeting with key project staffs</p> <p>Meeting with GB member of JGVK</p>	<p>FGD tool for SHGs</p> <p>In-depth interview tool for Panchayat & Medical Officer</p> <p>Interview Guide for FHWs & Supervisors, PM</p> <p>Interview Guidelines for GB members</p>

Other areas/indicators of evaluation

- Prevalence of anaemia as a proxy to overall nutrition index of Pregnant Women (Source of information: Pregnancy Cohort register maintained by FHWs during 2013) over the period of time in last three years
- Number of infant deaths over the period of time in last three years
- Number of dead born baby over the period of time in last three years
- Trend of institutional deliveries & deliveries by TBA
- Trend of BCG vaccination coverage
- Trend of full ANC coverage (at least 3 ANC, 2 T.T. & 100 IFA coverage)

Annexure 2

Interview guidelines with Female Health Workers for Final Evaluation of Health Project in Sundarbans by IGF-JGVK

1. Name of the respondent
2. Designation
3. Day to day activities performed
4. Please tell me in if brief something about the project.
5. How did this project contribute to the community health?
6. What is at risk mother?
7. Safe motherhood, what is it?
8. Please demonstrate following methods:
 Measurement of fundal height, Urine test, Hb test, others as done by you during home visit
9. Please describe your acceptance in the community
10. Please tell me, how much people have accepted JGVK project during last few years?
11. How the project could be further value added?
12. Please provide me some case studies to get insight into the efforts those have been made since few years.
13. What are the challenges in implementation of such project in your community?
14. How can you contribute to any further clinical services which may be rendered through institutional facilities at JGVK?
15. Others, if you like to mention, which I forgot to mention

Annexure 3

Interview guidelines with ANM & ASHA for conducting Final Evaluation of Health Project in Sundarbans by IGF-JGVK

1. Name of the respondent
2. Designation
3. Day to day activities performed
4. Do you know about the Health Project in Sundarbans by IGF-JGVK ?
5. If yes, your type of involvement it ?
6. Please tell me in if brief something about the project.
7. How did this project contribute to the community health?
8. How many HFWs do you know, who are associated with you?
9. Do they help you someway in your work?
10. How do they help?
11. Please tell me more about strengths and weaknesses about the project?
12. What changes the project could make in the community as a whole – merely on health issue & overall development perspective?
13. Have you ever discussed about the project with your concerned Medical Officer? Has it been ever discussed in the meeting of BPHC? If yes, what issues were discussed?
14. Was ever this project being discussed in Panchayat meeting? Please tell more about it.
15. Is there any village level health advocacy plan available with you? If yes, who developed? What was the follow up with this advocacy plan?
16. Others, any, please comment, which has been missed out in our conversation, please.

Annexure 4

FGD Guidelines for conducting Final Evaluation of Health Project in Sundarbans by IGF-JGVK, among SHGs

1. Name of the SHG
2. Village & GP, it belongs to?
3. Basic activities undertaken by the SHG (health & others)
4. Leader of the SHG and how she is elected?
5. Have you learnt anything on MCH care?
6. Who have taught you? How? Frequency?
7. What are the basic components of MCH care? Please describe.
8. Where from, we should seek care?
9. What facilities are most acceptable to you for maternal services (ANC, NC, PNC)?
10. Any member of this SHG, if given birth to a child in last one year?
11. If yes, describe the pregnancy period including all cares received. Then please describe child rearing practices taken up in your case.
12. Do you know about any of your friend, who gave birth to a child in last one year? If yes, describe situations as above.
13. What are the difficulties you face during pregnancy, delivery and in post partum period in accessing services for MCH? How did you overcome them?
14. How do you take care of (for Mother-in law in the group) your daughter in law when she was pregnant? How was it (care) different when you were pregnant and when your daughter in law was pregnant?
15. How many of you have undergone ligation? How many of your husbands have done vasectomy?
16. Please do an exercise as a group and write down on the following (Chart paper, sketch pen to be provided)
 - Number of ANC
 - Care during pregnancy
 - Basic tests to be done during pregnancy
 - Place of delivery
 - Basic neonatal care (0-28 days)
 - Immunization of a child
 - Growth monitoring of a child
17. Have you people ever developed any Plan for betterment of your village?
18. If yes, can you please show it to me? Who took leadership in developing it? Why did you make it? How have you used this? Any result in doing this?
19. What among these services, you or your community have gained from JGVK?
20. How will you rate two types of service providers – FHWs from JGVK and from Government (ANM/ASHA)? Who is more likeable and why?
21. How do you like to see your community especially from maternal & child health perspectives?
22. What do you as a group like to help the community for better maternal health?

23. What are your suggestions to improve MCH status in your community?
24. How JGVK can help in this endeavour?
25. Please share some of your experiences (good or bad) with JGVK in last few years
26. Do you think that a society like JGVK should be entrusted for undertaking more health work in this area? Why?
27. If JGVK comes in as curative service provider, what is your opinion? What issues on the part of the beneficiaries should be looked at for doing this?

Annexure 5

Interview Guidelines for conducting Final Evaluation of Health Project in Sundarbans by IGF-JGVK, among Panchayats

1. Name
2. Village
3. Gram Panchayat
4. Designation
5. Responsibilities
6. What is your opinion about JGVK?
7. What do they do?
8. How has your village/Gram Panchayat been benefited by it?
9. Their project is over on 31st March, 2014. What is your reaction? How will it affect on you?
10. Do you know about any plan that this village or GP has developed and being developed by any women's group?
11. If yes, have you gone through it?
12. If yes, how was it good to reflect people's health need?
13. How do you conduct last Saturday meeting and place health issues in discussion? What was role of JGVK in this meeting?
14. How has your workforce been benefited by FHWs of JGVK?
15. Are you happy with health status of your village/GP?
16. If yes, if no; why? What can be done to improve further?
17. What role JGVK can play for doing that?
18. Please share some of your experiences (good or bad) with JGVK in last few years.
19. Do you think that a society like JGVK should be entrusted for undertaking more health work in this area? Why?
20. Please enlighten me more about the project undertaken by JGVK, your journey with this, your involvement and what could have been done?

Annexure 6

Interview guidelines with Governing Body Members of JGVK for conducting Final Evaluation of Health Project in Sundarbans by IGF-JGVK

1. Name of the respondent
2. Designation in the organization
3. Type of involvement with the organization
4. Type of involvement with the project
5. Please tell me if brief something about the project
6. Clarity about the match between the project undertaken and the organization's aim
7. SWOT of the organization and positioning of the project undertaken within it
8. What is the future plan about this project – how will the activities be continued, if fund is supported by IGF, if not supported?
9. What changes the project could make in the community as a whole – merely on health issue & overall development perspective?
10. How does this project help JGVK to enhance its own credibility as a healthcare organization?
11. Please comment on your organization's linkage with health system – SC, PHC and BPHC?
12. Will you call it a model project to be implemented in other places? Yes/No, Why?
13. As a learning organization, what does this project convey to you? In other words, if given opportunity to replicate; how will you redesign the project? Or will you replicate the whole as it has been implemented?
14. What is your future plan after this phase till 31st March, 2014? (More on strategies & interventions)
15. Suitability of a development organization in carrying out health project along with Government?
16. Others, any, please comment, which has been missed out in our conversation, please.

Annexure 7

Interview Guidelines for conducting Final Evaluation of Health Project in Sundarbans by IGF-JGVK, for Medical Officer in JGVK clinic

1. Name
2. Designation in the project
3. How do you manage to operate in this geographical area?
4. What is your role in this project?
5. Please tell me some of the challenges those you faced in this project?
6. What are best achievements?
7. What could not be achieved?
8. Why?
9. What could have been there to make everything successful?
10. Role of JGVK in community mobilization?
11. What still can be done to improve health status especially MCH?
12. The future project, if any, should be MCH based or comprehensive? Preventive only or curative also? Why?
13. What constrains we may face in new design you are proposing in this area?
14. Any suggestions to overcome them?
15. Are you a member of the Governing Body?
16. If no; please comment me your perceptions about the management?
17. In Sunderbans, availability of doctor is a challenge. Any idea, how to mobilize doctors for any new initiative?