

End of Project Evaluation of
“Creating a Women’s Health Movement in India to
Improve the Lives of Poor Women and their Families”

Evaluation Report

Dhar district,
Madhya Pradesh

August 2018

Submitted to



Hand in Hand India

Submitted by



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**EVALUATION REPORT
AUG 2018**

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Acronyms

AHS	Annual Health Survey
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	<i>Anganwadi</i> Centre
AWW	<i>Anganwadi</i> Worker
BCC	Behaviour Change Communication
CDPO	Child Development Project Officer
CMO	Chief Medical Officer
DAC	Development Assistance Committee
FGD	Focus Group Discussion
FST	Ferrous Sulfate Tablet
HCR	Headcount Ratio
HIH	Hand in Hand
ICDS	Integrated Child Development Services
IDI	In-depth Interview
IEC	Information, Education and Communication
IHHL	Individual Household Latrine
JEY	Janani Express Yojana
JSY	Janani Suraksha Yojana
KAP	Knowledge, Attitude and Practices
MDM	Mid-day Meal
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MO	Medical Officer
MPW	Multi Purpose Worker
MUAC	Mid Upper Arm Circumference
NITI	National Institute for Transforming India
NRC	Nutrition Rehabilitation Centre
ODF	Open Defecation-Free
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Centre
PNC	Post Natal Care
PRI	<i>Panchayati Raj</i> Institution
RSTC	Residential Special Training Centre
SBM	Swachh Bharat Mission
SHG	Self Help Group
SSA	Sarva Shiksha Abhiyan

Executive Summary

The project 'Creating a Women's Health Movement' funded by Hand in Hand Sweden through the Swedish Postcode Lottery was implemented by Hand in Hand (HIH) India in Dhar block of Dhar district in the state of Madhya Pradesh. The project aimed to improve the health and wellbeing of 25,000 women aged 18 to 49 years in 50 villages with tribal communities by empowering women with health related knowledge which they could use to improve their own and their children's health; raising their status within the family and in the community; and improve access to medical services for women and their families. In order to achieve strategic results, the project aimed to work with women in 200 self-help groups (SHGs) and train them on various aspects of nutrition, sanitation, menstrual health and hygiene. At the community level, 60 community mobilisers and organisers were hired from among community members themselves to act as local trainers and counselors for the women; organise community events and coordinate with the government health system. Training was a targeted intervention in the project and SHG women, government frontline workers and community mobilisers and organisers were trained on relevant aspects of the project. Mass awareness programmes were held periodically at the block and *panchayat* levels. A quantitative baseline and qualitative midline were conducted as part of project monitoring and evaluation. Specific interventions of identifying women suffering from anaemia and providing them with ferrous sulfate tablets (FST) and identifying children suffering from malnutrition and providing them with protein powder and/or referring them to the local government Nutrition Rehabilitation Centre (NRC) were also implemented. Institutional support was provided to government health centres and many information, education and communication (IEC) materials were developed and disseminated during the project such as posters, wall paintings, leaflets and take-home materials. The project period was July 2015-July 2018.

The third party evaluation of the project was conducted by New Concept Information Systems using the Organization for Economic Co-operation and Development-Development Assistance Committee (OECD-DAC) criteria of relevance, effectiveness, efficiency, impact and sustainability. Qualitative and quantitative data were collected from respondents at Sweden, India, state, program, district, block and community levels and analysed to present findings. A sample of 568 women, 539 men, 461 adolescents, 150 lactating mothers, 85 pregnant women, 141 anaemic women and 115 mothers of children with malnutrition were interviewed in a random sample of 20 intervention villages using quantitative questionnaires. In the qualitative field work, in the same villages, focus group discussions (FGDs) were conducted with 20 SHG member groups and interviews were conducted with one-two frontline workers/community leaders, with staff from government health facilities and with program staff from HIH India and HIH Sweden.

Within the broad project outcome of "Poor and marginalised women in 50 tribal villages in Madhya Pradesh (India) are empowered with better health related knowledge and power to exercise their right to health, and their families and the wider public are aware of the importance of women's health and wellbeing.", the project had various outputs and the findings have been presented broadly under the outputs as follows. Within the report, the findings have been presented under an analysis of relevance, effectiveness, efficiency, sustainability and impact. In this framework, the findings related to Output 1 have been discussed in the chapter on Relevance while the findings related to Outputs 2, 3 and 4 have been discussed in the chapter on Effectiveness. The output-wise summaries have been presented in the executive summary as follows:

OUTPUT 1 - HIH India has improved knowledge in women's health and wellbeing, and a better developed approach to advocate and train on this matter.

Training was an important aspect of the project and community mobilisers and organisers, SHG women and government health workers were trained separately in a contextual and culturally specific manner. The baseline survey that was conducted at the start of the project helped the project team to tailor interventions (especially related to anaemia and malnutrition) for the project. The project also linked people with government schemes and converged with the public health system.

OUTPUT 2 - Women have better knowledge of sanitation, personal hygiene, child and maternal health and how to maintain a balanced diet.

Both qualitative and quantitative findings showed that women and adolescents had begun to practice positive health behaviours. A majority of pregnant women had registered for antenatal care services, were consuming FST tablets and were immunized. More than half of lactating mothers said that they had delivered at a government health facility and a majority of lactating mothers had their children's births registered and their children immunized. All SHG members said that they had understood key messages related to handwashing with soap, maintaining hygiene and eating a balanced and iron-rich diet. They also understood that colostrum is good for the baby and began to opt for institutional delivery. All community members reported that the HIH mobiliser/organiser was a recognised influencer in the village and provided counseling on health and sanitation.

OUTPUT 3 - The women's health movement is a formally recognised actor within the 50 villages with the ability to inform and influence women and their families and the wider public in health and how to promote women's wellbeing.

In the time span of three years, the project achieved creation of a discussion on health in the project villages among women and their families. The women's health movement was started and SHG members were more aware of key messages related to health and had begun to put them into practice. They were able to discuss these messages with other women in their local communities to an extent. However, sustained support and mentoring is needed for women to further enhance their knowledge and build the confidence needed to take the movement forward, considering their extreme marginalisation. A trained cadre of community mobilisers and SHG women had been created.

OUTPUT 4 – Women and their families have access to better quality of health care

The project has provided supplies to local Primary Health Centres (PHCs) and also linked with staff to provide health services in community and cluster-level health camps. When the quality of health services provided was lesser than expected, the project team also linked with doctors from a private hospital to ensure that women and their families were given better health services in the camps. Community frontline workers from the health system were also mobilised and trained in the project to provide better counseling and referral services.

Conclusion

Overall, the project created a positive impact in communities across the 50 villages and the activities and camps conducted in the project were found useful by community members. Access to toilets, consumption of FST among adolescents, immunization of pregnant women and institutional delivery among lactating mothers were the crucial indicators that showed significant improvement from baseline to endline, proving that the project had a tangibly positive effect on community health. It was also found that trained SHG members showed better results in terms of participation in health

camps and increased awareness and participation in local self-governance meetings of community leaders, as compared to women who had not been trained.

The recommendations by the evaluation team are:

- Through the project experience, it will be advantageous for future projects to develop a trained cadre of women in the community who will contribute to women's empowerment.
- Targeted interventions such as those conducted in the project on tackling anaemia and malnutrition improve outcomes and efficiency.
- Building capacities of local community mobilisers and organisers contributes to sustainability.
- Conducting a project for a longer duration (minimum five years) would be conducive to generating an impact while working with vulnerable and marginalised communities.
- Building in a livelihood or education component into project design would be strategic to achieve health outcomes.
- Creating a theory of change and clearly outlining the assumptions at the start of project will help to monitor progress of the project and make mid-course corrections in a measurable and organised manner.

1. Introduction and Background

1.1 Introduction

Hand in Hand (HIH) India implemented a three-year project called ‘Creating a ‘Women’s Health Movement’ in India to improve the lives of poor women and their families funded by Hand in Hand Sweden, through the Swedish Postcode Lottery. The project had a budget of 31,459,353 INR. The program set the goal of improving the health and wellbeing of women in 50 tribal areas in Madhya Pradesh (India), and thereby their ability to work and look after their families, by:

- Empowering women with health related knowledge so they take better care of their health as well as the health of their children
- Raising women’s status within the family and improving the treatment of women at both family and societal level
- Improving access to medical services for women and their families

New Concept Information Systems, a private social development agency based in New Delhi, India, conducted the third-party evaluation of the project after completion of its three-year period. The purpose of the evaluation was to understand the **relevance, effectiveness, efficiency, sustainability and impact/potential for impact** of the project. The evaluation was carried out at two levels:

- Evaluation of project design with respect to needs and expectations of primary target audience, community and other stakeholders including the government
- Evaluation of output and outcomes with respect to project design

The evaluation was conducted by collecting qualitative and quantitative data from respondents at the program level, district and block levels, and the beneficiary level. Data collection for the evaluation was conducted largely during July 2018, with qualitative field work at district, block and beneficiary levels being conducted during 17-23 July, 2018 and telephonic interviews and in-person interviews conducted with HIH Sweden and India representatives conducted through July and August, 2018. The quantitative field work was conducted during 18-31 July, 2018.

1.1. The project geography

MADHYA PRADESH STATE

Madhya Pradesh is the second largest state in India with a sub-tropical climate and rich mineral resources. It is the sixth most populous state in India. The sex ratio in the state is 930 females per 1,000 males. Madhya Pradesh has the highest Scheduled Tribe (ST) population in the country at 15.3 million. The ST population constitutes 21.1% of the total population of the state. The Gonds are the largest tribe in Madhya Pradesh followed by the Bhils who are concentrated in the districts of Jhabua, Khargone, Dhar and Ratlam. Poverty levels are very high in the state with a poverty headcount ratio (HCR) of 31.65% in 2011-12 and 234.06 lakh people living below the poverty line (i.e. those with a monthly per capita income below INR 771¹ (14.5 USD at the exchange rate in 2011)).² The maternal mortality ratio (MMR) of the country is 173 as per National Institute for Transforming India (NITI) Aayog estimates in 2014-15³ while the infant mortality rate (IMR) is 47⁴.

¹ http://planningcommission.nic.in/news/pre_pov2307.pdf

² <http://shodhganga.inflibnet.ac.in/bitstream/10603/111767/6/chapter-4.pdf>

³ <http://niti.gov.in/content/maternal-mortality-ratio-mmr-100000-live-births>

The proportion of government institutional deliveries according to Annual Health Survey (AHS) 2011-12 was 71.3%.

DHAR DISTRICT

Dhar is the seventh most populous district in Madhya Pradesh. According to the 2011 census, female literacy in the district stands at 48.8%. It is a district with low performance in socio-economic indicators and a significantly tribal population (55.94%) consisting of the Bhil and Bhilal tribal communities. Most communities have poor access to health care and home deliveries are also prevalent. According to NITI Aayog figures, in 2015 only 41.9% of deliveries conducted at home were supervised by skilled personnel. In rural areas, only 13.51% of households had access to drinking water within their premises. Connectivity was poor-moderate with only 33.1% households having mobile phone connectivity.⁵ Only 19.2% of households had latrine facilities available at home.⁶ The rural sex ratio is 980 females per 1,000 males.



1.2. Broad scope of the project

The project commenced from July 2015 with the ultimate objective of improving women's wellbeing and thereby their ability to work and take care of their families. The project was implemented in **50 tribal villages under 10 clusters in Nalchha block in Dhar district of Madhya Pradesh** by impacting 25,000 women aged 18 to 49 years, their family members, local decision makers and public health service providers.

The core activities envisaged in the project were:

- Train 1,000 women on sanitation, personal hygiene, child and maternal health and how to maintain a balanced diet
- Train 200 women's self-help groups (SHG) in health related issues and train them on how to promote women's wellbeing in their respective villages. 200 SHGs were to be formed on the basis of the women's health movement
- Recruit 60 women from local villages as Mobilisers and Organisers to support in project implementing process
- Provide one-to-one counseling to 15,000 male family members, mothers-in-law and sisters-in-law

⁴ <http://niti.gov.in/content/infant-mortality-rate-imr-1000-live-births>

⁵ <http://niti.gov.in/best-practices/district-wise-statistics>. Retrieved on 27 July, 2018.

⁶ <http://dhar.nic.in/notifications/profile.pdf>. Retrieved on 31 July, 2018.

- Conduct mass awareness programme on women's health and well-being, information days at school, meetings, public demonstrations and theatre plays
- Partner with elected representatives and government health service providers to ensure that medical services reach out to villages
- Renovate run-down health care facilities (when and where possible and needed)
- Track women's access to health care through a special monitoring system

For the list of 50 project villages, please refer to Annexure 1.

1.3. Project outcomes

As outlined in the project logframe, the overall objective/impact of the project envisaged was that **“Poor and marginalised women and their families living in 50 tribal villages in Madhya Pradesh (India) have improved their health and wellbeing and thereby have better ability to work and look after their families, and children can develop their full potential and go to school.”**

The broad expected **outcome** of the project was that “Poor and marginalised women in 50 tribal villages in Madhya Pradesh (India) are empowered with better health related knowledge and power to exercise their right to health, and their families and the wider public are aware of the importance of women's health and wellbeing.” The three outcome indicators for the outcome were:

1. Women in 50 tribal villages feel empowered with better health related knowledge and better self-confidence.
2. Attitudes towards women's health and well-being at both family level and societal level has changed.
3. Number of reduced cases of common diseases among women and in malnutrition amongst young children.

The target groups of the intervention were:

1. 1,000 women aged 18-49 years and their families
2. 200 SHGs
3. 60 mobilisers and organisers
4. 15,000 male family members and mothers-in-law and sisters-in-law
5. Children in schools
6. Local decision makers (duty-bearers) in 50 village areas
7. Wider public in 50 village areas

Risks were identified and their management was broadly planned. One risk was that local decision-makers might feel threatened by the project and therefore object to its implementation. To manage this risk, HIH India aimed to select *panchayats* where they already had a good reputation and relationship with the duty-bearers. It was also planned to involve these duty-bearers throughout the project cycle. Another identified risk was that local decision-makers might expect bribes in return for supporting the project. This was to be countered by HIH Sweden and India's zero-tolerance policy against corruption which was complemented by internal and external financial audits. The geographical risk was the difficult terrain and the need to cover large distances to reach the target villages. The HIH India staff were confident of working in remote areas and also planned to select target areas while considering both challenges and opportunities.

Under this umbrella, the four outputs and their activities outlined in the project were:

Output 1: HIH India has improved knowledge in women's health and wellbeing, and a better developed approach to advocate and train on this matter.

Activity 1.1 Recruit and train project staff from HIH India in methods for advocating for women's health and wellbeing among women, men, local decision makers and relevant stakeholders.

Activity 1.2 Conduct a baseline survey of all 50 village areas.

Activity 1.3 Conduct meetings with decision makers at local authorities to introduce the project.

Activity 1.4 Conduct local awareness programmes to inform villagers and other local stakeholders of the project.

Output 2: Women have better knowledge of sanitation, personal hygiene, child and maternal health and how to maintain a balanced diet.

Activity 2.1 Identify and mobilise 1,000 women between 18-49 years old for health trainings.

Activity 2.1 Train women on sanitation, personal hygiene, child and maternal health, and nutrition.

Output 3: The Women's Health Movement is a formally recognised actor within the 50 villages with the ability to inform and influence women and their families and the wider public in health and how to promote women's wellbeing.

Activity 3.1 Identify 200 SHGs for the purpose of becoming part of the Women's Health Movement.

Activity 3.2 Train 200 SHGs in health and how to promote women's wellbeing within their respective villages.

Activity 3.3 Recruit 60 poor women from the 50 villages as 'Mobilisers' and 'Organisers' to help spread awareness of women's health and wellbeing.

Activity 3.4 Strengthen the Women's Health Movement by an exchange of experiences and knowledge sharing with the Swedish women's health lobby called the "2.6 Million Club".

Activity 3.5 The Women's Health Movement together with the 'Mobilisers' and 'Organisers' conduct awareness programmes to inform people about women's health and wellbeing.

Output 4: Women and their families have better access to quality health care.

Activity 4.1 Connect with public health service providers to make sure that they reach out to the 50 target village areas.

Activity 4.2 Women Health Movement, Mobilisers and Organisers are lobbying for improved access to health care for the poor and marginalised women and their families.

Activity 4.3 Improve services and infrastructure standard of village health care facilities.

Activity 4.4 Carry out health screening for women and children.

For the detailed logframe with output indicators and sources of verification, please refer to Annexure 2.

1.4. Key project activities

Multiple activities were undertaken in the course of the three-year project. These have been briefly described as follows:

1.4.1. PROJECT ACTIVITIES

1. Induction training of project staff and baseline survey

An induction training was held for all project staff to clarify project duration, objectives, deliverables, target groups, outputs, risks and risk management. After the training, a baseline survey was undertaken in the 50 selected villages. Staff were trained on using the household questionnaire for the baseline. Community mobilisers collected the data which was verified by community organisers to ensure complete coverage.

The baseline questionnaire was developed jointly by representatives of Hand in Hand India and Hand in Hand Sweden and covered the themes of women's health practices, maternal health and sanitation. Joint development of the questionnaire by both the in-country and international teams served to ensure that both the global vision for the project and the local need as understood by the in-country team could be harmonised. The baseline served to align the project to the needs of community members since it provided the project team with current data about the status of health and sanitation within the targeted villages and about potential challenges that could be faced in the field during project implementation. The enumerators chosen for the baseline survey were from the intervention villages which adds to the authenticity of data since respondents would have been able to communicate with them easily because of their understanding of the local language and milieu.

2. Periodic training of project staff

In order to build the capacities of project staff, periodic trainings were conducted in response to the training needs of staff. The purpose of training was to increase their health-related knowledge and skills and upgrade their communication and documentation skills so that they could ably fulfil their roles and responsibilities in the field. Interactive and participatory methods were used during training such as lectures, question and answer sessions and role plays. Job aids like banners, chart papers, IEC materials, hand wash kits, snake and ladder games and film shows were used. Demonstrations were held on personal hygiene (right and wrong), handwashing and use of IEC materials. Pre post tests were administered to participants to assess uptake of training content by them. The training details are provided in the table below:

S. No.	Training session topic	No. of sessions
1	Project induction	1
2	Baseline survey	1
3	Mobiliser's register (daily diary)	1
4	4 health modules	1
5	Health issues	1
6	Refresher training on 4 health modules	1
7	Communication skills	1
8	Immunization and breastfeeding	1
9	Nutrition and weighing	1
10	Menstrual hygiene	1
11	Vitamin A*	1

S. No.	Training session topic	No. of sessions
12	Behaviour change communication (BCC) and gender discrimination	1
13	Data collection and validation	1
TOTAL		13

**Training on Vitamin A was conducted by a nutrition specialist who explained the need for sufficient Vitamin A intake, the presence of Vitamin A in colostrum and the subsequent need for breastfeeding immediately after delivery, and the plant and animal sources of Vitamin A. She also showed a film to participants and held a group discussion afterwards.*

3. Midline survey

A midline survey was conducted in April, 2017 with the support of the monitoring and evaluation (M&E) team of HIH India. The survey team visited various intervention areas and interacted with beneficiaries. They adopted primarily qualitative methods (focus group discussions (FGD)) and case studies) and developed 40 case studies through direct interaction with beneficiaries. They visited Primary Health Centre (PHC) Bagdi and attended meetings with SHG members at Lamba Talab, Ward-1. They also interacted separately with the project manager, block manager, community organisers and all mobilisers to understand the gaps and challenges in implementation on the ground and the strategy for the next year. They gave guidance to the field team on how to perform better.

1.4.2. TRAINING OF SHGS & GOVERNMENT HEALTH WORKERS

1. Training of SHG members for creating Women’s Health Movement

The HIH team selected 25 SHG members from each of the 50 villages to set in motion the process of creating a Women’s Health Movement. Thus, a total of **1,250 SHG members** were selected. These SHG members were trained on using health modules for the community on the topics of personal hygiene, maternal and child health (MCH), nutrition and anaemia and community health. Participatory training methods were used such as lectures-cum-discussion, group discussion, interaction with participants, question-answer sessions and role plays. Training aids like video clips, flipcharts, IEC materials, handwashing kits and snakes and ladder game were used.

2. Training of government health workers

Training sessions were organised for health workers like Accredited Social Health Activist (ASHA) facilitators, Auxiliary Nurse Midwives (ANM), *Anganwadi* Workers (AWW) and Multi Purpose Workers (MPW) at the cluster level. The main purpose of the trainings was to introduce them to Hand in Hand India, the project objectives, build rapport between them and train them on the health modules. After training sessions, health workers participated in all village level events and activities. Through the project, **104 health workers, elected representatives and representatives of local institutions were trained.**

1.4.3. COMMUNITY LEVEL MEETINGS

1. Stakeholder meetings

To develop a rapport with stakeholders on the ground, stakeholder meetings were conducted at the community level in 94 villages and these meetings were attended by 739 men and 1,318 women – a **total of 2,057 community members participated in the meetings.** Community influencers such as AWWs, teachers, PRI members, *Panchayat* Secretaries, SHG members, decision makers, ASHAs and

ANMs also participated in these meetings. During these meetings, HIH India's project purpose, activities, aim, duration and expectations were discussed and an appeal was made to all stakeholders for their support.

2. Meetings with adolescent girls

Adolescent girls were key stakeholders in the project interventions. It was recognised that educating them on health-related issues has long-term benefits and ensures positive health behaviours not just at an individual level but also within their families. Hence, meetings were conducted with adolescent girls in the project intervention area and the following topics were discussed:

- Personal hygiene
- Importance of handwashing – 6 steps method
- Anaemia – identification, causes, preventive measures
- Menstrual hygiene
- Delayed age of marriage and appropriate diet for adolescent girls
- Removal of myths and misconceptions and provision of scientific information on health-related issues

Awareness was generated among 500 adolescent girls about menstrual hygiene and personal hygiene practices.

3. Meetings with decision makers

The project recognised that decision makers wield significant influence in their families and communities and it is important to broaden their perspective. Hence, meetings with decision makers were held in all clusters. The topics discussed during meetings included gender equality, support and respect to women, bad effects of child marriage, proper care of girl child during adolescence and family planning. The sessions encouraged participation and all participants openly shared their views. Multiple methods were used to engage them including group sessions, street plays, meetings and film shows.

1.4.4. COMMUNITY LEVEL EVENTS & CAMPS

1. Mass awareness programmes

Street plays were held as part of mass awareness activities at the village level in order to create a buzz around health awareness. The plays were held on themes such as HIH India, project introduction, project purpose and the four health modules of personal hygiene, mother and child health, nutrition and anaemia, and community health. A total of five rounds of street plays were held and **500 mass awareness programmes** were held upto March 2018. A total of **20,455 people were reached** through street plays. The street theatre groups performed in the local language with folk songs, dance and music and used satire to enact key messages.

2. Health camps



Under the project, health camps were organised as a major community-level activity. **200 such health camps** were organised through the project duration – 100 pediatric and 100 gynaecological camps. In the pediatric camps, children between 0-14 years of age were checked and treated and in the gynaecological camp, women between 14-49 years of age were treated. Project staff mobilised community members to attend the camps. The camps were supported by government health workers such as ASHAs, AWWs, ANMs, teachers and local volunteers. A total of **4,698 children were**

diagnosed in pediatric camps while **4,374 women were diagnosed** in gynaecological camps. The services provided during these camps included:

- Mid upper arm circumference (MUAC) measurement to determine whether children were malnourished, especially those between 0-5 years of age
- Weight measurement
- Diagnosis of patients and distribution of free medicines as prescribed by doctors
- Identification of referral cases
- Counseling to patients



3. Anaemia screening

A major thematic focus area of the project was treatment of anaemia among women and adolescent girls. A majority of women (60-65%) are found to be anaemic in rural areas of the state. Consequently, anaemia screening camps were conducted in two phases - pre and post.

In the pre-test, the haemoglobin levels of women in age group 14-40 years of age were tested. Those women who were found anaemic were given FST tablets under the project through the ASHA and ANM and were also counseled on proper diet including green vegetables and other iron-rich foods.

The post-test was conducted after six months of follow up of anaemic women. Those women whose Hb levels were 11 and above were declared to have come out of anaemia. Till March 2018, 1,753 women were found to be anaemic out of 3,092 screened women. During post-test, **out of 1,377 screened women, 766 (56%) were brought out of anaemia.**

4. Nutrition programme

The project also aimed to treat malnutrition among children between 0-5 years of age. Children found to be malnourished in the categories of Grade 1 and Grade 2 were treated under the project. Children falling in the Grade 2 status of malnutrition were provided with protein powder supplement and their families were counseled. Mothers of children falling in Grade 1 status of malnutrition were counseled.

In the pre-test, a total of 2,762 children were weighed and their dates of birth were recorded. Their malnutrition status was determined for those with low weight as per the norms specified in the Integrated Child Development Services (ICDS), Government of Madhya Pradesh. Out of the weighed children, 1,713 were found to be malnourished. About 56% of the children were found to be severely malnourished (Grade 2).

In the post-test, 1,158 children were weighed after three months of providing them with protein supplement and counseling. It was found that **605 children had been brought out of malnutrition.**

5. Special days

Under the project, certain days related to health issues were consciously celebrated at the community level by holding events so that key messages related to that particular issue could be disseminated among community members. Some of the days were:

a) Gram Sabha

Field staff participated in *gram sabhas*⁷ to disseminate information about the project and its activities. *Gram sabha* meetings were held as per the agenda outlined by the Government of Madhya Pradesh in which communities are meant to raise their problems, provide their experiences and voice their needs from different Departments. The project team also discussed the following points in the meetings:



Participation in *Gram Sabha* meetings

- Women’s participation should be increased in every *gram sabha*
- Vacancies in government health positions (ASHA, AWW) should be filled as early as possible
- Government infrastructure like AWCs, *Arogya Kendras* and school buildings should be renovated while buildings should be sanctioned for those operating out of rented spaces.
- Safe drinking water facilities should be provided in each village.
- Toilets should be constructed in each home through the government scheme.

b) Global Handwashing Day (15 October)

15 October is Global Handwashing Day, a global advocacy day dedicated to increasing awareness and understanding the importance of hand washing with soap and water. Handwashing is an affordable, effective way to reduce the incidence of diseases.



Keeping this in mind, Global Handwashing Day events were held in the intervention area. All 50 intervention villages were covered with the support of community mobilisers, organisers, *panch-sarpanches*⁸ and stakeholders. The project team explained the benefits of handwashing, its six steps and how children can be protected from many diseases through the practice. Students and teachers were oriented about handwashing methods and critical timings of handwashing like before eating and after using the toilet. Key stakeholders like the ASHA, ANM, *panch-sarpanch*, teacher, AWW participated in the event and explained the benefits of handwashing to the community.

c) World Toilet Day (19 November)

Events were held to observe World Toilet Day on 19 November. The purpose of this day is to raise awareness about sanitation among rural communities and explain how open defecation affects them (especially children) and how diseases spread through open defecation. Project staff explained to the community and schoolchildren about the importance of using toilets, sanitation, personal hygiene and the bad effects of open defecation. They explained to the community that places where open defecation is most widely practiced are the same places with the highest number of deaths of children in the under-five age group.

⁷ *Gram sabha* is a body consisting of all adults whose names are included in the electoral rolls of the *panchayat* (which is the institution of self-government at the village level) as defined in the Constitution of India under Article 243 (b).

⁸ The *sarpanch* is the village head. S/he is the head of the five decision makers (called *panches* since *panch* means five in Hindi) of the village *gram panchayat*.

d) International Women's Day (8 March)

International Women's Day was celebrated on 8 March at the block level in Nalchha as a block mass awareness programme. Many activities conducted on this day like mass *rangoli*, awareness rally, stalls, multi-special medical camps, public meetings, cultural and awareness programmes, signature campaigns, meetings, felicitation ceremonies for women (with medals) and chief guests (with mementos). This event saw a total of **1,937 participants**. The event was addressed by a representative from the HIH Sweden team.

e) World Health Day (7 April)

World Health Day was celebrated on 7 April in 10 clusters. On this day, project staff explained to the community about the importance of taking care of one's and one's families' health, availing of the benefits of health centres, and maintaining personal hygiene etc. A total of **290 people participated** in these meetings.

f) De-worming Day

De-worming Day was conducted by the Government of Madhya Pradesh as an event throughout the state in the month of February 2017. The project mobilisers and community organisers supported ASHAs and ANMs to provide albendazole tablet to school children. A total of **2,456 children were covered** during the programme in 2017.

g) World Breastfeeding Week (1-7 August)

In intervention villages, World Breastfeeding Week was conducted in the week of 1-7 August. The objectives of holding this week were as follows:

- To create awareness among mothers undergoing ante-natal care (ANC) and post-natal care (PNC) about the importance of sustainable and exclusive breastfeeding
- To impart knowledge about the importance of early breastfeeding (colostrum) and the right method
- To dispel myths and misconceptions related to breastfeeding practices

Major activities

- Meeting with ANC/PNC women to create awareness among them about the importance of breastfeeding
- Discussing myths and misconceptions with them and trying to remove them
- Healthy baby competition
- Competition on 'Preparation of nutritious food'
- Competition on 'Preparation of variety of food'
- Video show and counseling at PHCs/villages

h) National Nutrition Week (1-7 September)

National Nutrition Week was used to make people gain knowledge about nutrition and its importance for the human body. The event was conducted by the project team with different themes in every year. Its objectives were as follows:

- To provide knowledge to community members about the importance of nutritious diet
- To discuss sources of nutritious food with them



National Nutrition Week

- To make people aware of how nutrition can help them to carry out their work well
- To help them understand how nutritious food is important for growth and development of children
- To create interest among women to prepare various types of nutritious food using local resources

1.4.5. INSTITUTIONAL SUPPORT

1. Renovation of AWCs

In the villages of Lamba Talab, Mevas Jamaniya and Kakalpura, three *Anganwadi Centres* (AWC) were renovated. The AWC premises were beautified using paintings, portraiture and moral educational messages and maintenance work such as fencing and repairs was also done. The main purpose of this renovation was to create a recreational environment for children to motivate them to regularly come to the AWC. In all the intervention villages, a total of **13 AWCs were renovated**.

Renovated AWC in Lamba Talab village



2. Support to PHCs

The project supported 2 Primary Health Centres (PHC) – PHC Bagdi and PHC Nalchha in the intervention area. After an assessment and discussion with Medical Officers (MO), the project team finalised a need-based checklist required for PHCs. After this step, equipment and supplies were provided to upgrade the PHCs such as baby warmers, labour tables, OPD multi chairs, LED TVs, needle destroyer machines, cots, blankets, oxygen cylinders and water coolers. This institutional support was part of improving the quality of health facilities available and create model PHCs to comfort patients and increase their confidence in availing of government health services.

1.4.6. DEVELOPMENT OF IEC MATERIALS

Many information, education and communication (IEC) materials were developed for the community members. These included:

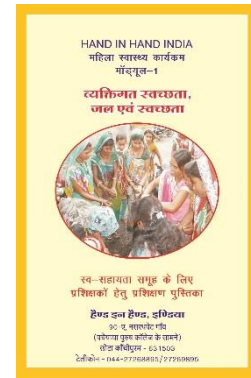
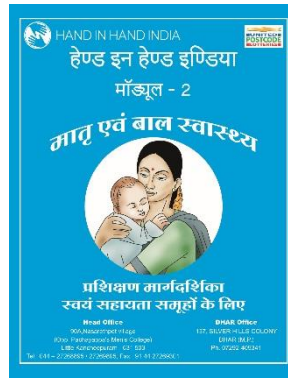
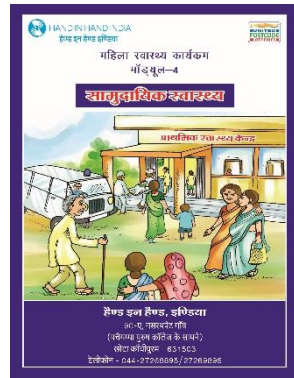
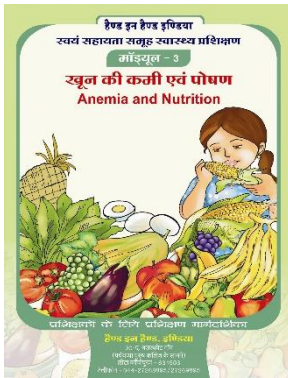
Leaflet on dos and don'ts of personal hygiene, water and sanitation



Pamphlet for meeting with decision makers



Four modules on personal hygiene, mother and child health, nutrition and anaemia, and community health



Tracker sheets on anaemia tracking and nutrition tracking

पोषण निगरानी - कार्ड धार जिला म.प्र.
कुटीयम समायो - वर्कों के स्वस्थ बनाने

वर्क का नाम	वर्क का पता	वर्क के स्वस्थ बनाने	वर्क के स्वस्थ बनाने
वर्क का नाम	वर्क का पता	वर्क के स्वस्थ बनाने	वर्क के स्वस्थ बनाने
वर्क का नाम	वर्क का पता	वर्क के स्वस्थ बनाने	वर्क के स्वस्थ बनाने
वर्क का नाम	वर्क का पता	वर्क के स्वस्थ बनाने	वर्क के स्वस्थ बनाने
वर्क का नाम	वर्क का पता	वर्क के स्वस्थ बनाने	वर्क के स्वस्थ बनाने

केसे दूर करे खून की कमी ?
खून की कमी से खून तैलक बढ़े संव

खून बढ़ाने के उपाय

1. खून की कमी को दूर करने के लिए खून बढ़ाने वाले खाद्य पदार्थों का सेवन करें।
2. खून बढ़ाने वाले खाद्य पदार्थों का सेवन करें।
3. खून बढ़ाने वाले खाद्य पदार्थों का सेवन करें।
4. खून बढ़ाने वाले खाद्य पदार्थों का सेवन करें।

हरी सचियाँ / गुड खाएं खून की कमी को दूर बनाएं

Take-home materials for SHG members

विश्व स्वच्छता सप्ताह हेतु नतिचियाँ
1-7 अगस्त 2016

UNITECODE POSTCODE BROTHERS

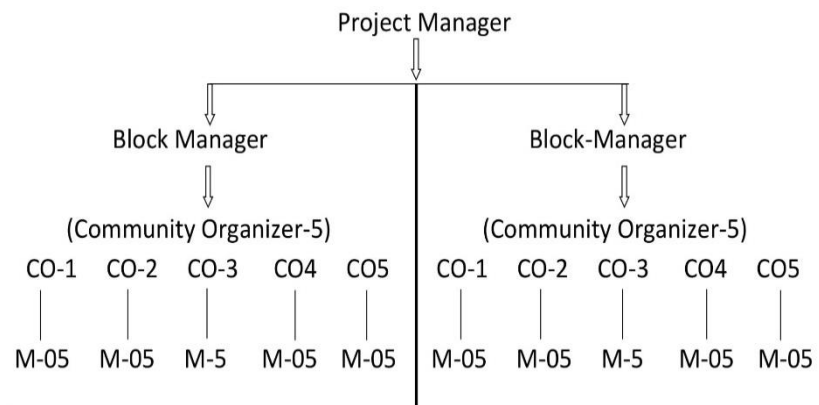
1. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।
2. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।
3. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।
4. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।
5. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।
6. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।
7. विश्व स्वच्छता सप्ताह 2016 का उद्देश्य है कि स्वच्छता और स्वस्थता को बढ़ावा देना।



Wall paintings with key messages on health, nutrition and sanitation

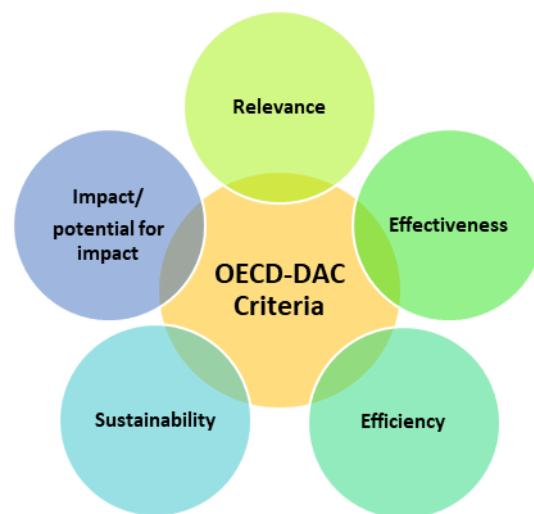
1.5. Project organigram

The project team had one overall project manager, two block managers, 10 community organisers (CO) and 50 community mobilisers (M). The organogram has been illustrated below:



2. Evaluation Purpose and Scope

The evaluation was carried out in order to assess the **relevance, effectiveness, efficiency, sustainability and impact/potential for impact** of the project. These five criteria are promoted by the Organisation for Economic Cooperation and Development’s Development Assistance Committee (OECD-DAC) and commonly used in the evaluation of development cooperation. Considering that a quantitative baseline survey and a qualitative midline survey were previously carried out, the aim of the current end of project impact evaluation is to further inform findings from the perspective of experiences related to the evaluation questions and provide more data to assess achievements, share lessons learnt, guide recommendations and determine whether key strategies and activities in the project are replicable and sustainable.



It is a **360-degree approach** focusing not only on the immediate and direct beneficiary – the women but the entire eco-system of beneficiaries and stakeholders who played/are likely to play a definite role in institutionalising the model and ensuring sustainability of the programme/model envisaged by HIH. A partnership approach was adopted for the evaluation in which relevant government and community-level

stakeholders were considered partners in the consultative evaluation process rather than adopting a clinical/isolated approach to the evaluation.

The evaluation was conducted in line with the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation. The 14 norms of evaluation cover aspects such as:

- adhering to internationally agreed principles, goals and targets
- making relevant and timely contributions to organisational learning and processes
- using reliable and valid data to present findings and develop recommendations
- maintaining behavioural and organisational independence during the evaluation
- maintaining objectivity, professional integrity and absence of bias
- following ethical guidelines
- maintaining transparency
- protecting human rights and gender equality
- contributing to strengthen national evaluation capacities
- conducting evaluation with professionalism and integrity
- creating an enabling environment
- adhering to an evaluation policy
- being responsible for the evaluation function
- using results of the evaluation and following up

For the detailed evaluation terms of reference, please refer to Annexure 3.

3. Methodology and Limitations

The evaluation methodology adopted a mixed methods approach (comparison with baseline findings) in the 10 clusters. Further, since there was no comparison group (control group), the evaluation reviewed the project logframe, baseline report, midline report, annual and biennial reports, quarterly reports, status updates and field case studies along with primary quantitative and qualitative endline data to assess the project based on the OECD-DAC criteria. The mixed methods approach included use of quantitative and qualitative tools including:

- literature/document review
- endline survey using household questionnaire with primary and secondary stakeholders
- focus group discussions with primary stakeholders
- semi-structured interviews with secondary stakeholders
- Case studies and good/best practices

Detailed stakeholder-wise tools are provided in Annexure 4.

Fig. Evaluation Universe



Sampling methodology

The baseline survey covered the entire population in the project area divided into 10 clusters consisting of 4,105 households with a population of 22,800 persons. Each cluster consists of five villages. The average size of the household is 5.6 persons per household, which is relatively large compared to the national average.

QUANTITATIVE SAMPLING

A. Households

Based on project documents and considering the different stakeholders that needed to be covered in the evaluation, a **stratified sampling methodology** was applied with the village as the primary sampling unit and women in the household as primary respondents. A simple random sampling of 4,105 populations gives a sample of 352 households at 95% confidence level, response distribution of 50% (normal) and error margin of 5%. However the evaluation required that a representative sample of the following respondents be included:

- A randomly selected sample of targeted beneficiaries representative of the target population including women with different economic status and from different geographical locations
- At least half of interviewees/respondents from year one (2015) in order to assess impact on members over a “longer” period of time
- A representative sample of participants who are part of the health movement
- A representative sample of male family members who are direct beneficiaries

To account for this, a design factor of 1.5 was applied for the primary sample thus bringing the target sample size to 525 households. The survey covered **568 households** wherein women were interviewed first. An attempt was made to cover adolescents and men in the same household. However, when this was not possible due to non-availability of concerned respondents, adolescents and men from neighboring households were selected randomly. Thus a total of **539 men** and **461 adolescents** were interviewed.

B. Pregnant women and lactating mothers

Adolescent girls, pregnant women and lactating mothers are the most important stakeholders in the project. One of the specific project deliverables was to track women’s health and access to health care through a special monitoring system. Data from this monitoring system was used for selecting the sample.

A separate sample for pregnant women and lactating mothers was selected through semi-purposive sampling, to understand their knowledge, attitude and practices with respect to antenatal care (ANC) and postnatal care (PNC). They were identified by the HIH mobiliser. Lactating mothers were interviewed to understand their knowledge and behaviours during the ANC period. All pregnant women and lactating mothers available at the time of the evaluation visit were identified and interviewed. The final sample covered 235 women – **150 lactating mothers** and **85 pregnant women**.

C. Women with malnourished children and anaemic women

The project had two specific interventions related to malnutrition in children and anemia. Malnourished children and anaemic women were identified through targeted health camps and

steps were taken to improve their condition through counseling, provision of Ferrous Sulphate Tablets (FSTs) for anaemic women and nutrition powder for malnourished children, and health and nutrition services through linkage with the Nutrition Rehabilitation Centre (NRC) for malnourished children, a private hospital and empanelled local doctors. To understand the impact of these two interventions, a semi-purposive sampling method was adopted in sampled villages to reach out to 100 respondents in each category from the monitoring data maintained by HIH. The final sample consisted of **141 women identified as anaemic** and **115 mothers of children who were identified as malnourished** and provided with nutritional and medical support.

Quantitative evaluation sample break-up

Respondent type	Design sample	Actual sample
Women	525	568
<i>SHG members as subset of 568 women</i>	<i>525</i>	<i>124</i>
Adolescents	525	461
Men	525	539
Pregnant women (undergoing ANC)	170	82
Lactating mothers (undergoing PNC)	260	235
Anaemic women	100	141
Women with malnourished children	100	115
Villages	20	26
TOTAL	2,205	2,141

Reasons for difference in actual sample from design sample:

- Two villages were to be selected from each cluster to give a final sample of 20 villages in total. But to reach out to a sufficient number of anaemic women and mothers of malnourished children, the survey covered 26 villages (more than 50% of the total 50 intervention villages) and thus also ensured greater spread of the overall sample.
- The design sample of women as primary respondents was covered. However not all of these women were part of SHGs as was expected and so 124 SHG women (all those who were present in the household on the day of the visit were covered.
- The number of adolescents and men interviewed was slightly less than the intended design sample since it was found that adolescents were often at school and men were either away from the village for work or in the fields on the days of the evaluation visit.
- The number of pregnant women and lactating mothers interviewed was slightly less than the intended design sample since less of these respondents were found on the days of visits to villages. All of those respondents from these groups who were present on the days of the evaluation visit were covered.

QUALITATIVE SAMPLING

Besides the abovementioned samples for administering the quantitative questionnaires, the evaluation included the following respondents for qualitative interactions through IDIs and FGDs:

A. FGDs

- Randomly selected sample of SHGs in 20 villages
- Community mobilisers
- Community organisers

B. IDIs

- Representative sample of community representatives (PRI members) and health workers (ASHA/ANM/AWW at village level)
- Block and district officials
- HIH India managers from field office and head office
- HIH Sweden project/evaluation managers

Interaction & respondent type	Design sample	Actual sample
FGDs with SHG women	20	20
IDIs with frontline workers	20	25
IDIs with PRI members	20	9
FGD with mobilisers	1	1
FGD with organisers	1	1
IDIs with government representatives	8	8
IDIs with private hospital representatives	0	2
Case stories	5-6	11
IDIs with HIH India team	2	2
IDIs with HIH Sweden team	2	2
TOTAL	74	79

Reasons for difference in actual sample from design sample:

- More frontline workers were met than the design sample number since they were present in almost all villages at the time of the evaluation visit.
- Less PRI members were present at the time of the evaluation visit and hence their actual sample is less than the design sample.
- Since close networks were built with the private hospital, Vyankatesh Nursing Home and Research Centre, hospital representatives were interviewed even though they were not part of the original sample.

List of documents reviewed and list of stakeholders consulted during the evaluation are provided in Annexures 5 and 6. Profile of respondents interviewed using household questionnaire at endline is provided in Annexure 7.

NOTE: Presentation of findings

The following chapters present the findings of the end of project evaluation under the five DAC criteria of relevance, effectiveness, efficiency, sustainability and impact. In this framework, the findings related to Output 1 have been discussed in the chapter on Relevance while the findings related to Outputs 2, 3 and 4 have been discussed in the chapter on Effectiveness.

5. Assessment

5.1. Relevance and design

This section discusses the relevance of the project.

Please refer to Annexure 8 for a detailed list of the evaluation questions related to Relevance.

5.1.1. OUTPUT 1 - HIH INDIA HAS IMPROVED KNOWLEDGE IN WOMEN'S HEALTH AND WELLBEING, AND A BETTER DEVELOPED APPROACH TO ADVOCATE AND TRAIN ON THIS MATTER.

The HIH Sweden and India representatives informed that the project was entirely in line with the mandate of HIH which is to help vulnerable and marginalised women in any possible way. While HIH has been working consistently on livelihood interventions, its work in India has evolved in a different way with a greater focus on empowerment and a five pillar approach to poverty alleviation - Self-Help Groups and Microfinance, Child Labour Elimination Programme, Skills Development and Technology Centre, Health, and Environment. Within this framework, the Health pillar has been the focus of the current project.

Baseline survey

The baseline results showed that more than half the community members in intervention villages were not educated and 90% of community members lived in extreme poverty in mud houses. Around one third of them still went to informal/traditional healers for health care and only 7.6% had access to improved sanitation. Around 40% of ANC mothers had not received full immunization and a third of mothers did not want to disclose their place of delivery (which could mean that they delivered at home and were not comfortable with saying so) along with 10% stating that they delivered at home. The situation shows that the levels of poverty and marginalisation from basic services of health, sanitation and education was high in the target villages. The proxy indicator for empowerment of women i.e. their membership in SHGs also showed a low level of 37.7% at baseline.

For more details about baseline survey, please refer to Annexure 9.

Project design

The project team thus identified the broad needs among populations in the target villages and designed the project interventions to focus on those needs. Interviews with frontline workers, PRI members and FGDs with SHG members confirmed that project interventions were relevant to the needs of community members. These community-level stakeholders highlighted that lack of sanitation and low-average rates of toilet construction, poor diet of women and adolescent girls and malnutrition among children between 0-5 years of age are significant problems in the villages. Most of them said that the project activities such as meetings with SHG women and provision of counseling, organising health camps and ANC/PNC checkups for pregnant women and mothers were beneficial for community members.

The project had also kept anaemia treatment and treatment of severe acute malnutrition as prime goals. Frontline workers and community members, including SHG members, alike both unanimously reported that FST tablets had been distributed to women and girls who were found to be anaemic

and protein supplement powders had been provided to mothers of severely malnourished children. They also said that adolescent girls had been counseled on menstrual hygiene.

A key intervention was related to empowerment of SHG women which contributed to the relevance of the project intervention. It can be considered relevant because empowering SHG women was expected to increase their chances of adopting health seeking behaviors. Even though the proportion of membership of women in SHGs was less than half, the project made a relevant decision to work with SHGs as the likelihood of bringing about change is more with women who are already familiar to some extent with meeting and discussing issues, albeit to varying extents. Identification and training of SHGs was done to promote the Women's Health Movement.

"Earlier, poor hygiene and open defecation were problems in our village. Hand in Hand addressed these needs by encouraging us to construct toilets in our homes. Now, almost all houses in the village have toilets and only five houses are yet to construct toilets. After they do so, our panchayat will be declared open defecation-free (ODF)."

Mamta Bai, Sarpanch, Kalyadeh village, Nalchha cluster

Skill building of women and youth and livelihood generation was a definite and specific need that was identified in the baseline survey. The project did not have a specific and direct component that addressed these aspects. The intervention of empowering women and creating a women's health movement was indirectly linked to these aspects. It was envisaged that if women were empowered to voice their aspirations and begin to contribute their voice to decision making, then their ability to seek out livelihood opportunities would increase.

5.1.2. USEFULNESS FOR COMMUNITY & EXTENT TO WHICH PROJECT RESPONDED TO IDENTIFIED PROBLEMS AND WHETHER DESIGN WAS ADEQUATE TO ADDRESS THESE PROBLEMS

During the evaluation, it was observed that the living conditions of people in most villages were very poor with many houses being *kutchra*, barely furnished and lacking electricity connection or having power cuts. The water sources in the village were usually found to be hand pumps or wells. In some of the villages, the sole hand pump in the village was broken and the community members had yet been unable to mobilise government funds to repair them. Most households were engaged in subsistence farming of soyabean along with corn etc. Literacy levels were low and mobile connectivity was poor to non-existent. It was evident from the interactions with community members during the evaluation visit that they lived in extremely marginalised conditions.

Across the villages reached during the evaluation, community members said that they had found the project interventions to be useful. The project interventions focused on sanitation, hygiene, balanced diet and tackling anaemia and malnutrition were perceived by community members to be directly useful to them.

"We have started to wash our hands with soap instead of ash."

SHG women, Haidari village, Bheeltalwada cluster

The project intervention focused on constant interaction with SHG women to provide them with key messages and thereby have a greater chance of indirectly influencing the larger community. These discussions were also aimed at broadening the perspective of women and helping them realise their

own rights and raise their voices for them, within the family and the community. Engagement with SHG women also helped in creating the nucleus for women's health movements in the intervention villages.

5.1.3 ASPECTS OF PROJECT IN LINE WITH GOVERNMENT'S POLICIES AND PROGRAMMES

Overall, the project interventions were aligned with government policies and programmes and its interventions spread awareness about government schemes and programmes. The interventions were implemented with awareness of and support from government frontline workers. Government officials corroborated that the work done over the duration of the project was in convergence with the government service delivery system.

The project team consciously and deliberately provided information about government schemes in the course of meetings and during health camps and street plays. In line with the mission of the government's sanitation scheme of SBM which promotes construction of IHHLs, community members were counseled on using government funds for toilet construction and almost all community members who had constructed toilets reported having used the 12,000 rupees incentive allotted under the SBM for construction of IHHLs. However, they reported that the allotted incentive was not sufficient and that they had to take loans or use their own savings to cover the entire cost of toilet construction.

The Project also utilised the AWC, the government nutrition and childcare center at the village level, set up under ICDS, as a critical delivery site for its interventions. Out of 20 frontline workers interviewed, 12 reported that they had been given information about the Janani Suraksha Yojana (JSY)⁹ and 108 helpline number under the Janani Express Yojana (JEY)¹⁰ to call the van for taking expectant mothers to the nearest health centre for institutional delivery. In many villages, SHG women reported that more women in the village had begun to opt for institutional delivery but it had already been a practice in most villages before the project started. On being prompted, most SHG women showed high recall of the 108 helpline number.

A few SHG members and PRI members also reported having been informed about the Ladli Laxmi Yojana¹¹ which aims to encourage empowerment of girls by financing their education.

5.1.4 CLARITY OF INTERVENTION LOGIC AND MATRIX

The project logframe was clearly defined with four key outputs, activities under each output, their target groups, the indicators for measurement of each output, the source of verification and the

⁹ Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM) of the GoI. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. (<http://www.nhm.gov.in/nrhm-components/rmnc-h-a/maternal-health/janani-suraksha-yojana/background.html>)

¹⁰ The Janani Express Yojana is a scheme launched by the Government of Madhya Pradesh (state government). It provides emergency transportation facilities to expectant mothers, sick infants and below poverty line (BPL) families in rural Madhya Pradesh so as to enable them to avail adequate healthcare facilities on time. (<http://indiagovernance.gov.in/bestpractices.php?id=1410>)

¹¹ Ladli Laxmi Yojana is another scheme launched by the Madhya Pradesh state government. It is aimed at empowerment of girls and is an incentive paid to families with girl children. In the first 5 years of age, the girl's family is paid 5,000 rupees every year. Then the family is paid 2,000 rupees if the girl child starts grade 6, 4,000 rupees if the child starts grade 9 and 7,500 if the child starts grade 11. (<http://www.mp.gov.in/web/wcd/we-ily>)

timeline for each activity. The outputs were related to each other and complementary both in their activities and target groups. The project team had also identified the potential risks that could be encountered during each activity and defined them as well as identified methods for risk management.

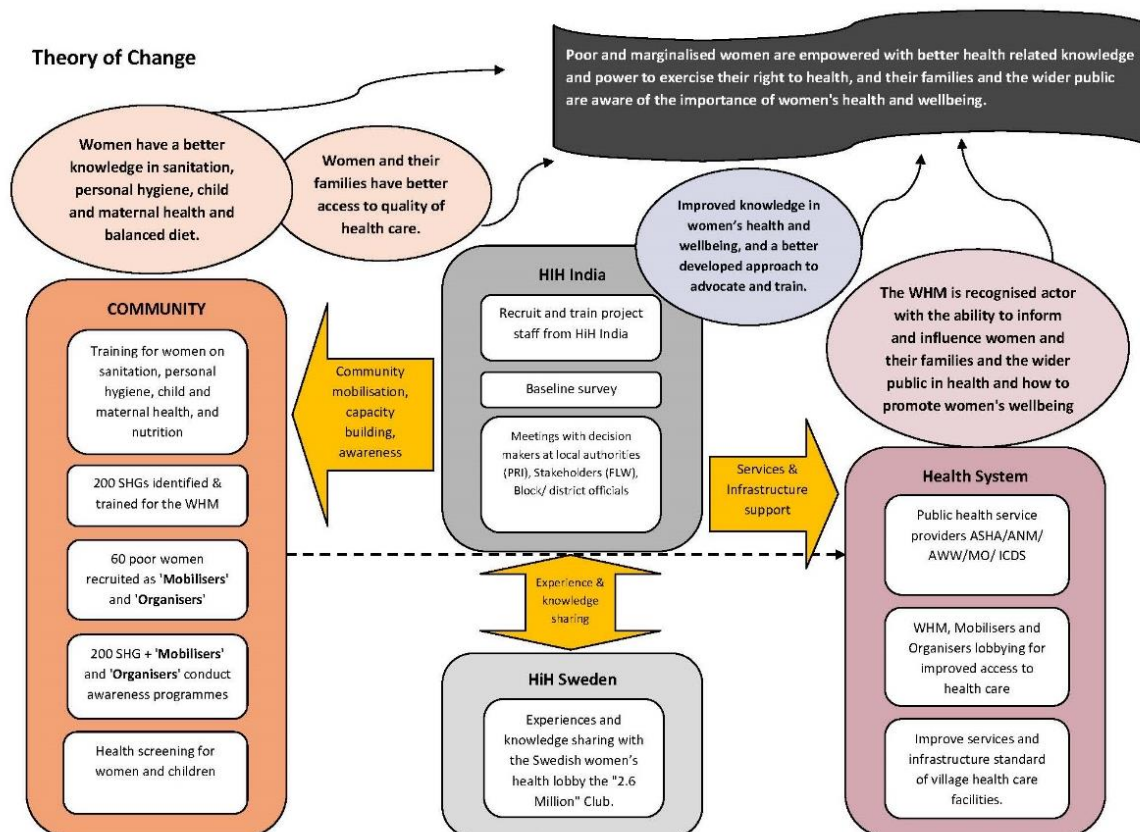
The Theory of Change (ToC) defined indicators that were primarily output-based like ‘number of SHGs trained’ and ‘number of mobilisers recruited’ etc. These indicators and the set targets for each of them were clearly defined.

5.1.5 USE OF APPROPRIATE INDICATORS TO ASSESS ACHIEVEMENT OF OBJECTIVES

The indicators used to measure achievement of objectives were primarily quantitative in nature and output-based rather than process-based. Here, the evaluation found a lack of indicators that would have measured the extent of qualitative uptake of the interventions. This was compensated to some extent by documentation of case studies throughout the project and identification of challenges and lessons learnt on a quarterly and annual basis. However, a focus on measuring the quality of interventions would have improved the rigour of the project’s internal monitoring and evaluation (M&E).

5.1.6 THEORY OF CHANGE

The evaluation team has developed a Theory of Change (ToC) of the project. The ToC supposed that various activities undertaken by HIH in collaboration with stakeholders would result in an increase in knowledge and change in attitude, behaviour and practices with respect to health amongst poor and marginalised women and their families living in 50 tribal villages of Madhya Pradesh leading to improved health and wellbeing and thereby would have better ability to work and look after their



families and children can develop their full potential and go to school. The ToC has been illustrated below:

The project activities have largely been carried out as per the ToC. Some of the assumptions had to be reconsidered and adapted to the field situation. A discussion of the assumptions is described as follows:

Assumption	Correctness
Usefulness of baseline survey	✓
Convergence with health system	✓
Enhanced knowledge among women about sanitation, personal hygiene, balanced diet	Largely correct (Women require constant engagement)
Recruitment of 60 poor women as mobilisers and organisers	Largely correct (Women hired as mobilisers but could not take on organiser role because of lack of confidence and so men were hired)
Women’s health movement would become recognised actor by project end	Partially correct (Women’s health movement is in nascent stages and requires nurturing)

Conducting baseline survey

The assumption that a baseline survey would prove useful is proven correct since the project team was able to define its outputs and key output indicators based on the results of the baseline and the understanding of field challenges gained through the baseline field work. The evidence-based aspect of project design was strengthened through this step. The baseline survey also served to aggregate information and data about key outcome indicators before the start of the project so that progress against the baseline status could be assessed through the course of and at end of the project.

Women have better knowledge of sanitation, personal hygiene, child and maternal health and a balanced diet

The assumption that women’s knowledge related to health and sanitation would improve has been largely correct. A majority of SHG members said that they remembered the key messages imparted to them during the meetings and community events. The detailed discussion is provided in the Effectiveness section.

“We understood what was being taught in the training for SHGs and the information that was imparted was very useful.”

SHG members, Jamanya village, Jamanya cluster

Women and their families have better access to quality health care

The project enhanced the knowledge about government health facilities among women and their families. In a majority of discussions, SHG members reported that the rate of visiting local quacks for treatment and advice had reduced and that of visiting government health facilities had increased. AWWs also reported that their capacities for counseling women had been increased and that they regularly participated in the community events. The detailed discussion is provided in the Effectiveness section.

Recruitment of 60 poor women as ‘Mobilisers’ and ‘Organisers’

The assumption that 60 poor women could be recruited as ‘Mobilisers’ and ‘Organisers’ was not accurate as developments in the field showed. Women were hesitant to take up these positions as they were not used to such a great degree of social interaction that would be required for these mobilisation roles. Hence, the project hired men from the intervention villages as mobilisers and experienced field workers who had worked previously in development organisations as organisers. The evaluation team found that these staff were capable and fully informed about the project status in their work areas and also shared a strong rapport with community members and between themselves.

Women’s health movement would become a recognised actor by the end of the project with the ability to inform and influence women and their families and the wider public in health and how to promote women’s wellbeing

The assumption that the women’s health movement would become a recognised actor by the end of the project with the ability to inform and influence women was ambitious given the project duration and scope. The project hoped that a ‘movement’ in terms of beginning a discourse around women’s health in local communities would be set in motion through the project interventions and that the topic would be given importance by community leaders and PRI members. It was also intended that through this ‘movement’, women would become trainers for their peers and family members and spread key messages related to health and sanitation while also demand their right to health care and question local duty-bearers of the same.

The evaluation team found that the women’s health movement had been initiated and showed positive signs of becoming stronger provided that the community level activities were kept alive by the community mobiliser. But the movement had not yet become a recognised actor since in 9 out of 20 FGDs with SHG members, they themselves were not able to say that such a movement had been started in their village. The evaluation team considers that even among the 11 FGDs where SHG women gave a positive response about the movement, their overall levels of awareness were still nascent and would not be able to sustain a movement without external support. However, a trained pool has been created of community mobilisers and frontline workers and IEC materials related to the thematic area of health have been produced which can be considered as systems strengthening support provided by the project towards institutionalising the work.

5.1.7 REACHING APPROPRIATE BENEFICIARIES

The project targeted vulnerable tribal populations living in the 50 intervention villages after conducting a baseline survey. Within these vulnerable populations, it was correctly identified that women and adolescent girls are even more marginalised and therefore, they became primary stakeholders in the interventions and the central doers to be energised for creating a women’s health movement. The project has therefore, correctly targeted appropriate beneficiaries.

5.2. Effectiveness

This section discusses the effectiveness of the project.

Please refer to Annexure 8 for a detailed list of the evaluation questions related to Effectiveness.

5.2.1 MAIN RESULTS OF PROJECT

The third annual report of the project mapped the latest status of results in the project against the set targets at project inception. The project head at the district level provided final figures for the project results over its duration. During the evaluation visit, community members and frontline workers were able to qualitatively validate that the stated activities and events had been conducted. The project results have been presented below. The evaluation aimed to understand qualitative experiences of stakeholders and collect quantitative information about individual and family adoption of behaviors from a sample.

a. Results as reported by project

Outputs against set targets

S. No.	Key project outputs/deliverables	Project target	Achieved	%
1	Health camps – Pediatric	150	150	100
2	Health camps for women	150	150	100
3	Midline survey			100
4	Anemia screening	3,000	3,055	102
5	Women and girls found to be anemic	1,500	1,653	110
6	Women and girls brought out of anemia	500	766	153
7	Identification of children suffering from malnutrition	1,000	1,713	171
8	Children brought out of malnutrition	300	639	213
9	Health workers training	72	51	71
10	Elected representative and local institution training	60	53	88
11	Staff training on different topics	-	16	-
12	Awareness programs - Mass – Panchayat	600	500	83
13	Awareness programs - Mass – Block	6	6	100
14	Awareness programs - Mass - Project	3	2	67
15	Wall painting in villages	100	100	100
16	Institutional support to PHCs (Bagadi & Nalchha)	2	2	100

Out of the 16 key project outputs, the project reported that targets were completed/exceeded in 8 indicators. Significant achievements reported include bringing **167 women out of anaemia** and **bringing 385 children out of malnutrition from among 550 children.**

Apart from the key outputs of the project, other activities were also undertaken and their results are detailed in the following table:

S. No.	Activity	Number
1	Women referred to government hospitals through field staff	372
2	People benefited through health camps (approximate)	11,759

S. No.	Activity	Number
3	Referred gynaecological and pediatric patients for special treatment at Vyankatesh Nursing Home and Research Centre in Dhamnod	226
4	Total patients referred for special treatment	428
5	School awareness programme on handwashing with soap and use of toilets; distribution of books on personal hygiene in each school	67
6	Awareness generation among adolescent girls on menstrual hygiene	500
7	Conducted eye camp with support of Choithram Netralaya, Indore (screened 227 patients and 53 among them referred for cataract)	1
8	Conducted dental camp with support of Pooja Dental Care, Dhar (screened 51 patients and 14 among them referred)	1
9	Number of family members (men, mother and sisters-in-law) counseled on women's health and wellbeing.	24,777
10	Number of community members reached through mass awareness generation programmes	37,258

b. As documented during the evaluation

During the evaluation visit, SHG members, PRI members and frontline workers confirmed that all the stated project activities had been conducted in their villages. Quantitative data from the endline household questionnaire used also indicates that the project generated a positive buzz in the community and women and their families participated to a large degree in project health camps.

Recall of key messages related to nutrition

SHG members had to be prompted to recall the exact nature of each event but they clearly remembered being given FST tablets and protein powders to treat anaemia and malnutrition respectively. Wall paintings with key health and sanitation messages could also be seen in prominent locations such as the *panchayat bhavan*, AWC and school in every village. Case studies of positive deviance were encountered in many villages by the evaluation team during the field visit. Women showed high recall for the message of eating green leafy vegetables. However, in a few villages, women said that they were unable to afford purchasing vegetables.

"We have begun to regularly eat green, leafy vegetables like palak (spinach) and methi (fenugreek). We have also started to take our children for routine immunization."

SHG women, Kunjara Kaodara village, Kakalpura cluster

Provision of health services

The project also had positive effects on provision of health services in the intervention villages. Community mobilisers reported that AWCs would not open on time earlier but now government staff open AWCs on time because of continued engagement with the project staff.

Case study on malnutrition (from evaluation visit)

Sunita Maliwadh; 30 years; Anganwadi Helper (AWH)

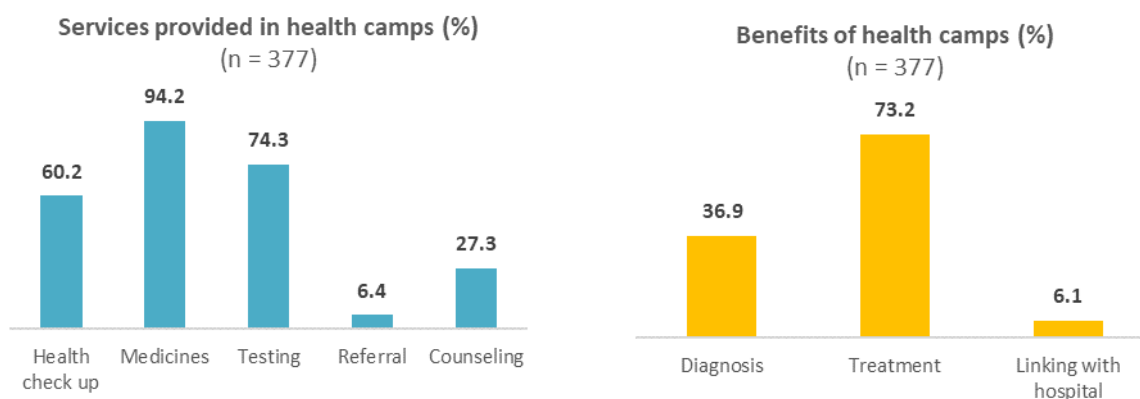
Sunita narrated that she was informed by a community mobiliser that women's groups would be formed in the village and would be trained on maternal and child health and malnutrition. During these meetings, she was told about various symptoms of malnutrition among children such as

change in hair colour, paleness on face and skinny appearance. She suspected that her children were quite weak and could be suffering from malnutrition.

When the AWW, ASHA and community mobiliser were weighing children to check whether they were malnourished she got both her children, Pinky and Sawan weighed. Pinky weighed about seven kgs while Sawan weighed about five-six kgs. Both children were identified as malnourished for their ages. She was then given protein powder for both children. The mobiliser also counseled her on the process and daily frequency of giving them protein powder. She followed the mobiliser’s advice and the children were periodically weighed by the mobiliser. But the children were not gaining weight even after intake of protein powder. Hence, it was decided that they would be referred to the Nutrition Rehabilitation Centre (NRC). They were admitted in the NRC for 15 days. After being discharged, they had gained weight and looked healthier. Pinky weighed about nine kgs and Sawan weighed seven kgs. Sunita was also counseled to give her children milk, cereals and pulses. She followed the advice and her children's nutritional status steadily improved.

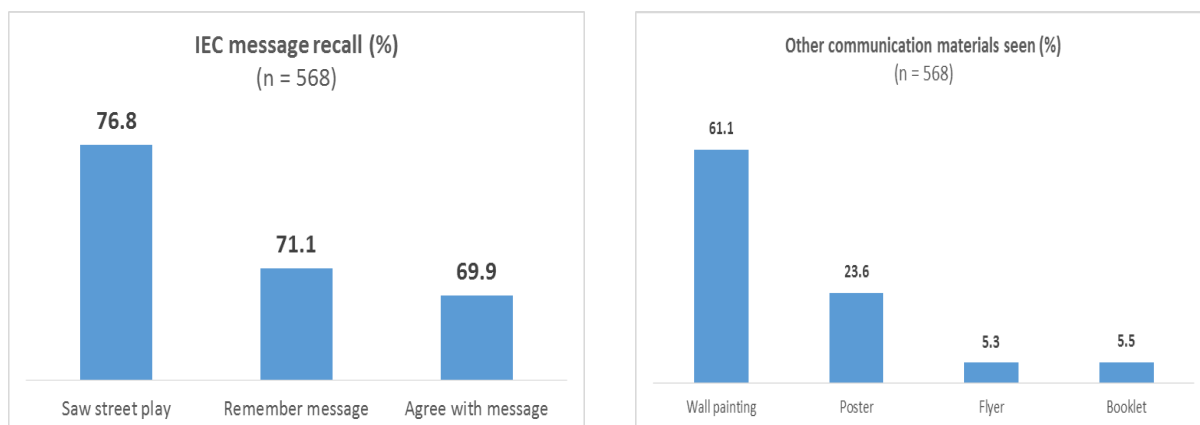
Health camps

83.5% women out of 568 respondents were aware of health camps conducted by HIH while 66.4% (377) of them had participated in the health camps. This shows that the project was effective in mobilising a majority of women to access services in health camps. Out of the 377 women who had participated in health camps, 94.2% said that they had been provided medicines, 74.3% said that they had been tested for various deficiencies and ailments and 60.2% had undergone health check-ups. Further, 73.2% of the women said that the treatment they received in health camps had benefited them.



IEC materials and events

The information, education and communication (IEC) materials and events developed and disseminated in the project were also found to be very visible in the community. 76.8% of the women said that they had watched street plays and 71.1% of the women remembered the message. 61.1% of the women said that they had seen wall paintings in the community while 23.6% said that they had seen posters. Out of those who had seen the IEC materials/events, 59.9% said that they had adopted the behaviour, 57.9% said that they had told others in the family to adopt the behaviour while 14.3% had told others in the community to adopt the behaviour. This shows that the key messages related to health were understood by a majority of the women and were also found to be useful as they were practicing the behaviours.



5.2.2. OUTPUT 2 - WOMEN HAVE BETTER KNOWLEDGE OF SANITATION, PERSONAL HYGIENE, CHILD AND MATERNAL HEALTH AND HOW TO MAINTAIN A BALANCED DIET.

KAP improvements in SHG women

Knowledge

During qualitative interactions, all SHG members interviewed said that the training they had been given had been of use to them and their main takeaways in terms of improved knowledge were about handwashing with soap, maintaining hygiene and eating green and leafy vegetables.

“We learned how to wash our hands properly with soap through the project. We know now that diseases spread through flies when people defecate in the open.”

SHG members, Lamba Talab village, Mandav cluster

PRI members and frontline workers confirmed that knowledge levels among women have improved because of the project.

“The project has brought about a change among women. They have become more aware and now they wash their hands and use toilets. More and more women go to government hospitals for institutional delivery and other check-ups.”

Amar Singh Grewal, Sarpanch, Bedvapura village, Bedvapura cluster

Attitude

Many SHG members reported that the myths and misconceptions they harbor had been dispelled because of gaining a better understanding of these issues through the project. Out of 20 FGDs conducted with SHG members, in three FGDs, SHG members reported that they go to doctors in hospitals/clinics instead of going to local quacks (called *badvas* or *ojhas* in the local dialect). In one FGD, SHG members said that some village members still go to *badvas/ojhas* but they also go to hospitals. In two FGDs, SHG members spoke about the previous misconception of colostrum (first milk) being harmful for the baby having been cleared. They understand that colostrum is full of nutrition and now give it to the newborn baby. This is corroborated by the quantitative findings. Out of 150 lactating mothers, **42.7%** reported that they were able to follow the counseling advice of feeding colostrum to the newborn and **54.8%** of mothers said they had benefited overall from counseling and were able to change their practices (practices on the whole of which feeding colostrum is one practice).

“Colostrum looks like water and hence we used to throw it. But now through the project, we understand that it is full of nutrition.”

SHG members, Jamanya village, Jamanya cluster

Frontline workers corroborated that the attitudes among women related to health are improving which is leading to better health practices. Seven out of 22 frontline workers interviewed said that the belief in quacks has gone down and women take their health more seriously and visit government health facilities for getting checkups. Five frontline workers said that women have begun to discuss the health issues they face more openly and also proactively participate in the monthly meetings.

“Now women themselves call us up and ask us when to meet next. They also call us to ask for advice.”

ANMs, Banjari and Chorbawadi clusters

KAP improvements in pregnant women and lactating mothers

Counseling

65.9% pregnant women (n = 85) and **66.2%** lactating mothers (n = 150) interviewed purposively reported that they had been counseled by the HIH volunteer. The next highest frequency of counseling was provided by the ASHA followed by the AWW and ANM. Among those who had been counseled, **94.5%** reported that they had been specifically counseled for institutional delivery. **63.2%** pregnant women (n = 85) and **69.2%** lactating mothers (n = 150) reported that they had been specifically counseled for institutional delivery by the HIH volunteer. The next highest frequency of counseling for institutional delivery was provided by the ASHA followed by the AWW and ANM. Both sets of results show that the HIH volunteer acted as a useful communication bridge between the health system and the community.

Knowledge

The messages imparted to women during counseling that they remembered included complete immunisation (**85%**), benefits of institutional delivery (**77.9%**), consumption of FST tablets (**71.1%**) and nutrition of women (**61.7%**).

Practice

The counseling of women was also shown to have translated into action. Out of 235 pregnant women and lactating mothers, **98.7%** had registered for ANC services. Most women had registered in their first trimester (45.3%) and in the fourth month of conception (**27.6%**). It was also found that 57.9% of pregnant women and lactating mothers consumed the same amount of food or more than usual during pregnancy. This shows that significant number of women (**42.1%**) still consume less food than usual during pregnancy which is at odds with the qualitative findings wherein women said that they were aware about the components of a healthy diet and also consumed a healthy diet in adequate amounts.

Additionally, it was found that there were 66 pregnant women in the sample of 568 women interviewed separately. Out of these 66 pregnant women, **77.3%** reported that they consumed FST tablets and **86.4%** had immunisation done.

Out of 150 lactating mothers interviewed purposively, **57.3%** said that they had planned to go for delivery to the sub centre/PHC and 25.3% to the CHC. Encouragingly, **56.7%** said that they had

delivered at the sub centre/PHC and **24.7%** said that they had delivered at the CHC. This finding is in agreement with the qualitative findings wherein most women said that they opt for institutional delivery. Additionally, there were 158 lactating mothers in the sample of 568 women interviewed out of which **90.5%** had had institutional deliveries, **96.2%** had their children immunised while **92.4%** had their births registered.

94.5% pregnant women and lactating mothers reported that they knew about the benefits of JSY while 56.6% of them had availed of JSY benefits. The most common benefit reported was that of the Janani Express transport facility available (**40.9%**) followed by the cash incentive that is given after 90 days of delivery (**27.2%**).

Overall, the endline points to a positive situation wherein both women and adolescents began to practice health behaviours to a great extent. A majority of pregnant women had registered for antenatal care services, were consuming FST tablets and had had immunization. More than half of lactating mothers said that they had delivered at a government health facility and a majority of lactating mothers had had their children’s births registered and their children immunized. These improvements were confirmed both by qualitative and quantitative findings.

KAP improvements specifically in lactating mothers

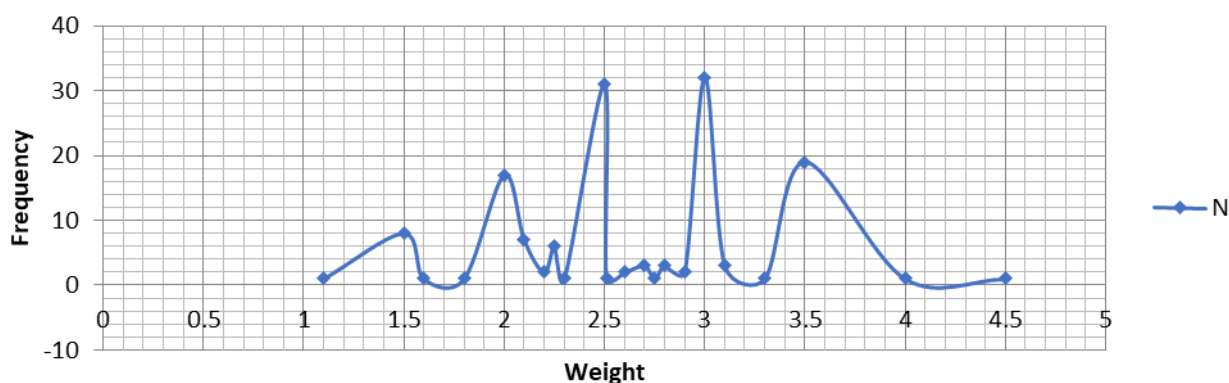
Knowledge and attitudes

Out of those mothers who said that they had benefited, almost all (**92.3%**) reported an increase in their knowledge and more than half (**54.8%**) reported that their health-related practices had improved. **16.3%** said that the myths and misconceptions that they used to harbour had been dispelled.

Practices

In relation to practice of health seeking behaviours by lactating mothers, the quantitative data was positive. **91.9%** out of 150 lactating mothers said that they had planned to undergo institutional delivery and an even higher proportion (**93.4%**) said that they had actually undergone institutional delivery. **44.7%** of them had got checkups after delivery and **69.3%** (104) of them said that they benefited from counseling during the postnatal period.

A histogram of the weights of children at birth plotted against frequency showed that **2.5 kgs** was the most common weight for newborns and the frequency of weight of children was normally distributed. There were a few outliers at 0.5 kgs and 4 kgs. The most frequent weight of 2.5 kgs (which is considered to be a healthy weight) showed that women were delivering healthy babies and indicates that the mother had been undergoing proper ANC.



Effectiveness of malnutrition intervention

Out of 115 women with malnourished children who were interviewed, 46% had three children while 35% had two children and 13% had four children. **86.1%** of women with malnourished children reported having been counseled by an HIH volunteer. The most common message imparted to these women was to give their children a balanced diet of milk, green leafy vegetables and fruits. More than half the number of women (**53%**) said that the HIH mobiliser had linked them with the AWW/ASHA while **67%** said that the mobiliser had helped them to get nutrition powder from the AWC and **48.7%** said that the mobiliser had referred their children to the Nutrition Rehabilitation Centre (NRC). These findings show that mobilisers played a very significant role in implementing the malnutrition treatment arm of the project and had provided concrete assistance to women in helping their malnourished children along with counseling.

43.5% of the women said that their children had fully recovered while **41.7%** said that their children were recovering from malnutrition which shows that the intervention was effective and contributing to reduce the prevalence of malnutrition in the intervention villages.

Effectiveness of anaemia related intervention

Data showed that around 64% of 141 women with anaemia interviewed had between two-four children. Undergoing multiple births with poor diet is a typical factor contributing to anaemia. **92.2%** women with anaemia said that they were aware of HIH anaemia camps. Out of these women, **90.1% (127)** had been tested in the camps. Out of the 127 women who had been tested, **92.9% women** had been counseled by the HIH volunteer. The most recalled message among these women was about consumption of green, leafy vegetables, jaggery, *chana* and soyabean and consumption of FST tablets. The results show that the anaemia intervention produced positive results in the community in terms of providing testing and counseling services to community members and was useful as a targeted intervention to improve health outcomes since anaemia is a significant health issue among women.

Menstrual hygiene and lifeskills for adolescents

58.4% of 461 adolescents interviewed said that they had participated in HIH events/meetings/camps and benefited from these. The two most common knowledge benefits that they gained were about using clean cloth during menstruation, properly washing it and drying it in the sun; and about use of sanitary pads.

21.3% adolescents were members of adolescent groups and the most common topics they discussed during their group meetings included menstrual hygiene, delayed marriage, girls' education and balanced diet and nutrition. **96.9%** adolescents in HIH groups (n = 98) said that they had benefited from group discussions while **65.2%** said that their knowledge and awareness had increased. **42.8%** said that their practices around empowerment, health and hygiene had improved. The data shows that most adolescents felt benefited by the project in terms of increased knowledge and awareness while some of them had also begun to practice positive health behaviours, such as maintaining menstrual hygiene and intake of a balanced and nutritious diet, and life skills such as continuing education for girls and delaying marriage.

Out of 568 women interviewed, 256 reported that they had adolescents at home. Out of these 256 adolescents, 114 (**44.5%**) were reported by women in the sample to be consuming FST tablets at endline. Both these sets of findings (from 461 adolescents and 256 women with adolescents) show that the interventions in the project related to improving lifeskills of adolescents and providing them

with information and resources to practice better menstrual hygiene were well received and found useful by adolescents, the primary stakeholders and their parents as well. Out of the 22 frontline workers interviewed, 13 reported that adolescent girls have started using sanitary pads after being counseled in the project.

Participation of men in project activities

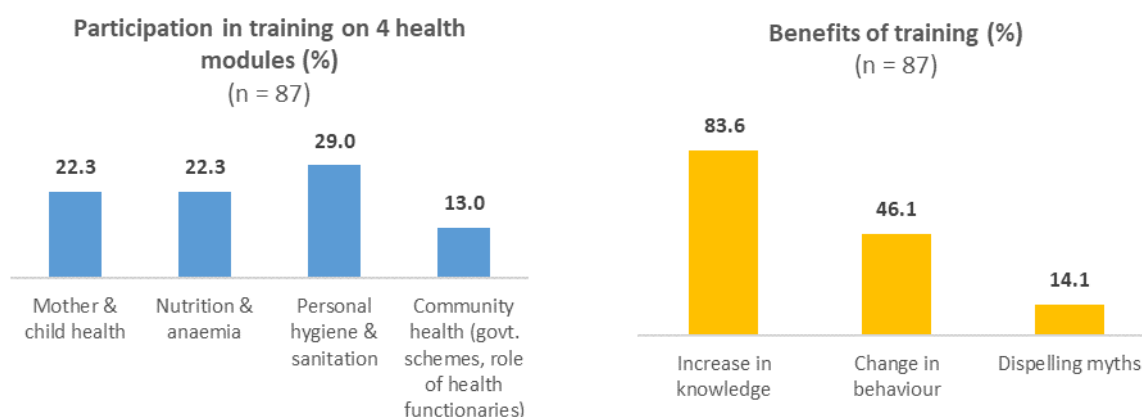
36.7% (198) out of 539 men said that their perceptions about women had changed. Out of these 198 men, **80.8%** said their perceptions about early marriage had changed while **76.8%** said that their perceptions about education of girls and women had changed.

Out of the total number of men (539), **66.6%** said that they had participated in IEC activities. Out of these, **99.7%** had watched street plays. **44.9%** of the men were aware of the eye camp held by HIH and out of these, **10.4%** had availed of services during the eye camp. The services they had availed of included eye checkups, cataract operations and referral.

5.2.3. OUTPUT 3 - THE WOMEN'S HEALTH MOVEMENT IS A FORMALLY RECOGNISED ACTOR WITHIN THE 50 VILLAGES WITH THE ABILITY TO INFORM AND INFLUENCE WOMEN AND THEIR FAMILIES AND THE WIDER PUBLIC IN HEALTH AND HOW TO PROMOTE WOMEN'S WELLBEING.

The general consensus arising from discussions with stakeholders at the community and block levels showed that the project had set women on the path to empowerment as they had begun to gain confidence through increasing social interaction and discussion during meetings. This is a significant achievement considering the extreme marginalisation and low exposure of women in intervention villages to avenues for voicing their opinions and needs related to health and development. The project interventions were primarily focused on women and involved a high degree of social interaction through mass awareness programmes and health camps.

Out of 568 women interviewed using the quantitative household questionnaire, only 124 were SHG members while 87 of these 128 women (**70%**) had participated in training on the four health modules. Out of these 87 women, **29%** had participated in training on personal hygiene and nutrition and **22.3%** each had participated in training on mother and child health and on nutrition and anaemia. **83.6%** said that their knowledge about health had increased while **46.1%** said that their behaviours had changed. These findings corroborate with the qualitative findings related to KAP improvements (in the earlier sub-section) and confirm that SHG women had experienced an overall increase in their knowledge levels and improved their practice of health-seeking behaviours. Training is a crucial step towards increasing the effectiveness of interventions, i.e. it enhances the knowledge of community members thereby improving their attitudes and practices. It also contributed to setting the stage for the women's health movement, whereby trained SHG women gained knowledge and began to implement the practices to create the beginning of a ripple effect.



Out of nine PRI members, five felt that the project had contributed to improving the status of girls and women in the community. They said that women had begun to talk more freely and also participate in SHG meetings on their own. They discuss their need to visit health facilities for checkups. Five PRI members also felt that women are more aware about availing services from government health facilities and are more concerned about their health. The larger community is also more aware about not defecating in the open and using toilets instead.

“Women’s health is now discussed in gram sabha meetings. This practice was introduced by community mobilisers during the project.”

Amar Singh Maliwal, Panch, Kunjara Khaodara village, Kakalpura cluster

Out of 22 frontline workers, 18 agreed with this view and said that women have become confident and express themselves more freely now. They avail of government health facilities and also open up about their health concerns. They felt that the project had been successful in initiating a health movement among women as women are now more informed about the importance of not defecating in the open, maintaining cleanliness, eating a balanced diet and visiting health facilities for checkups. The MO confirmed that patients are more aware now and visit the OPD for checkups and the number of institutional deliveries have also increased.

The gynaecologist and obstetrician in Vyankatesh Nursing Home and Research Centre, Dhamnod, said that women needed more counseling and that they needed to be provided more support as she observed that women visit the health centre for checkups only when accompanied by community mobilisers.

Quantitative data also showed that participation of women in *gram sabha* meetings was low (18.3%) and out of those women, only 5.6% raised queries in the meetings. The predominant reason women gave for not raising queries was that men dominated meetings. They also felt uncomfortable/scared to raise their voices and they felt that they may not be heard. Some women felt that other women raised queries so they did not have to. However, 51% of the women said that their *gram sabha* meetings took up women’s issues. Within that, the two main topics taken up included personal hygiene and sanitation and mother and child health.

5.2.4. OUTPUT 4 – WOMEN AND THEIR FAMILIES HAVE ACCESS TO BETTER QUALITY OF HEALTH CARE

The project has been able to mobilise the health system in the intervention villages. Frontline workers including ASHAs, AWWs and ANMs all confirmed that they had participated in the community level activities and the training conducted for them. Mobilisers and organisers both reported that they had continuously interacted with health workers and worked together in various capacities. Infrastructure improvement of AWCs and PHCs was also undertaken as was corroborated by frontline workers during the evaluation visit. The project even mobilised doctors from private hospitals to provide treatment in health camps when it was found that the quality of care provided by government health providers was low.

“We regularly visit AWCs in our villages and spend a minimum of two hours there during each visit. Supplies such as salter scale, toys and paintings have been provided to AWCs.”
Community mobilisers, HIH block office, Nalchha

Detailed quantitative data for all indicators captured during evaluation is provided in Annexure 10.

5.2.5. EXTERNAL FACTORS THAT HINDERED OR FACILITATED PROJECT

Out of 22 frontline workers, six said that attendance and participation of women in meetings had been low at the start of the project as they were hesitant to step out of their homes or voice their concerns. Some women also felt that the meetings would be a waste of time. But with time and continued engagement with the project team, they began to participate to a greater extent. The project team had also identified the following challenges during the course of the project:

- Availability constraints - Community members are always busy in sowing, ploughing and crop cutting. They are also preoccupied during marriage season and a large number of festivals.
- Community members did not feel that health issues were a big concern for them.
- Many myths and misconceptions were prevalent around health and sanitation.
- High levels of migration to cities and other states in search of livelihood.
- Lack of community participation and ownership
- Low levels of literacy among women
- Availability of mid day meal (MDM)¹² was poor during school vacations
- In some villages, AWCs are not convenient to access since they are located far away from the main village
- Ultrasound facilities were not available at the block level for ANC/PNC checkups
- Child marriage was prevalent which could prove to be a negative social norm that restricted the agency of adolescent girls
- Insufficient water supply facilities made it difficult to use toilets.

Some of these challenges were overcome during the project through the interventions themselves. Community members began to see the usefulness of the project activities and began to regard health as an important issue, especially the health of women and girls. Through provision of information and counseling, many myths and misconceptions related to health and sanitation were

¹² Mid Day Meal (MDM) Scheme is a Central scheme of the Department of School Education and Literacy, Ministry of Human Resource Development, GoI. Under the scheme, schoolgoing children are provided hot, cooked nutritious food as part of their school meal to improve their nutritional status.

cleared and community engagement and ownership around issues of women’s health began to increase steadily. The project also provided ultrasound equipment to PHCs for ANC and PNC checkups. Other aspects such as insufficient water supply, poor availability of MDM, distant location of AWCs were navigated by the project team as conditions on the ground and were not specifically tackled in the project.

5.2.6. EXTENT TO WHICH RESULTS CAN BE ATTRIBUTED TO PROJECT

The project research framework did not include a control sample at baseline because of which it is difficult to isolate the impact of the project from that of other interventions in the area. However, stakeholders interviewed qualitatively attributed their increased knowledge, improved attitudes and positive uptake of health behaviours to the project. Almost all community members identified the project through the presence of the community mobiliser and organiser and many were also familiar with the health camps and other events conducted in the project. While these aspects point to the project having been effective, the absence of a control group makes it difficult to empirically attribute results to the project. Most of the behavioural aspects studied at endline were not measured at baseline and hence it is not possible to do a before-after analysis of the project. These are the limitations faced by the project evaluation. A comparison of groups of beneficiaries who have been trained versus those beneficiaries who have not been trained shows that training is an aspect of the project which brought significant dividends.

Analysing significance of improvement in indicators

Certain parameters such as access to toilets, consumption of FST tablets among adolescents and pregnant women, immunization for pregnant women, and opting for institutional delivery were compared (baseline to endline) and a significance testing was done to check whether the improvement in each indicator was significant. The results are provided as follows:

S. No.	Parameter	Baseline		Endline		Tool	P value*
		N	%	N	%		
1	Access to toilets	4,105	7.6	568	72	HH	P < .0001
2	Consumption of FST among adolescents	2,063	56.5	256	44.5	HH	P = 0.0003
3	Consumption of FST among pregnant women	291	62.2	66	77.3	HH	P = 0.0204
4	Immunization of pregnant women	291	51.9	66	86.4	HH	P < 0.0001
5	Institutional delivery among lactating mothers (as reported in the household questionnaire)	764	57.07	158	90.5	HH	P < 0.0001
6	Institutional delivery among lactating mothers (as reported in the ANC/PNC tool)	764	57.07	150	93.3	ANC/PNC	P < 0.0001
7	Consulting informal health providers	4,105	31.8	568	34.1	HH	P = 0.2711

*There is a significant difference between baseline and endline values for parameters where P value is less than 0.01.

These parameters are access to toilets, consumption of FST among adolescents, immunization of pregnant women and institutional delivery among lactating mothers. These findings prove that the project has had an impact on the health and sanitation of women and adolescents and ultimately on their families. However, while the rate of institutional delivery has gone up significantly, women and their families still continue to access informal health providers.

Analysis of trained vs untrained beneficiaries (SHG members)¹³

In the absence of baseline or control data or any other counterfactual, we used the chi square statistic to examine the relationship between trained and untrained beneficiaries. The null hypothesis is that training does not make a difference to knowledge and behaviours among project beneficiaries. We considered four independent variables: i) consumption of FST by adolescents, ii) awareness about health camps; iii) participation in health camps; and iv) participation in *gram sabha* meetings. **The analysis revealed that trained beneficiaries performed better in all these project outcomes thus proving that training had a significantly positive impact in this respect.** The findings have been outlined in the following tables:

Consumption of FST tablets by adolescents

	Trained	Not trained	Row Totals
Yes	65 (53.99) [2.25]	49 (60.01) [2.02]	114
No	204 (215.01) [0.56]	250 (238.99) [0.51]	454
Column Totals	269	299	568 (Grand Total)

The chi-square statistic is 5.3368. The p-value is .02088. The result is significant at $p < .05$.

Health camp awareness

	Trained	Not trained	Row Totals
Aware	248 (231.22) [1.22]	226 (242.78) [1.16]	474
Not aware	12 (28.78) [9.78]	47 (30.22) [9.32]	59
Column Totals	260	273	533 (Grand Total)

The chi-square statistic is 21.4795. The p-value is $< .00001$. The result is significant at $p < .05$.

Health camp participation

	Trained	Not trained	Row Totals
Participated	220 (197.29) [2.62]	157 (179.71) [2.87]	377
Did not participate	27 (49.71) [10.38]	68 (45.29) [11.39]	95
Column Totals	247	225	472 (Grand Total)

The chi-square statistic is 27.2564. The p-value is $< .00001$. The result is significant at $p < .05$.

Participation in Gram Sabha

	Trained	Not trained	Row Totals
Participated	64 (49.34) [4.36]	40 (54.66) [3.93]	104
Did not Participate	205 (219.66) [0.98]	258 (243.34) [0.88]	463
Column Totals	269	298	567 (Grand Total)

The chi-square statistic is 10.1487. The p-value is .001444. The result is significant at $p < .05$.

¹³ The evaluation team used an online chi square calculator available at <https://www.socscistatistics.com/tests/chisquare2/default2.aspx>

Estimating population parameters from sample proportion¹⁴

S. No.	Parameter	Approx. population size (Baseline)	Endline sample size and percentage response		Population estimate (%) for 95% confidence level
		N	N	%	
1	Access to toilets	4,105	568	72	(68.57, 75.43)
2	Consumption of FST among adolescents	2,063	256	44.5	(38.8, 50.2)
3	Consumption of FST among pregnant women	291	66	77.3	(68.4, 86.2)
4	Immunization of pregnant women	291	66	86.4	(79.12, 93.68)
5	Institutional delivery among lactating mothers (as reported in household questionnaire)	764	158	90.5	(86.43, 94.57)
6	Institutional delivery among lactating mothers (as reported in ANC/PNC tool)	764	150	93.3	(89.71, 96.89)

The above table explains the range within which the percentage response for each indicator can be extrapolated. For example, it shows that within a 95% confidence level, access to toilets can be assumed to be within 68.57-75.43% or approximately 68-75% for the entire intervention population in the 50 villages. The survey results thus show that there has been a significant improvement in all indicators within the larger intervention population.

¹⁴ Estimated using <https://select-statistics.co.uk/calculators/confidence-interval-calculator-population-proportion/>

5.3. Efficiency

This section discusses the efficiency of the project.

Please refer to Annexure 8 for a detailed list of the evaluation questions related to Efficiency.

5.3.1 TIMEFRAME AND BUDGET ANALYSIS

The HIH India project manager informed the evaluation team that there is no previously calculated unit cost per beneficiary for comparison since the current project requirements were unique. This was confirmed by the HIH Sweden project manager. They informed that the actual expenses incurred in the project will be used to calculate the unit cost actually spent and serve as a benchmark for budgeting in future projects.

The unit cost that was incurred for health camps in the project amounted to approximately 400-500 rupees per beneficiary which is a larger amount than that in previous HIH projects in Tamil Nadu (300 rupees). The reason for the higher unit cost in health camps was that initially, doctors from the district hospital provided unsatisfactory health care. Hence, doctors from the private Vyankatesh Nursing Home and Research Centre were mobilised which added to the unit cost. The project utilised most of the funds allocated and the unspent funds were directed towards conducting the current evaluation study to provide learnings for future project planning.

The project was planned for three years because donor funding was specified for that duration. The project was completed within the timeframe and there were no issues with the fund flow.

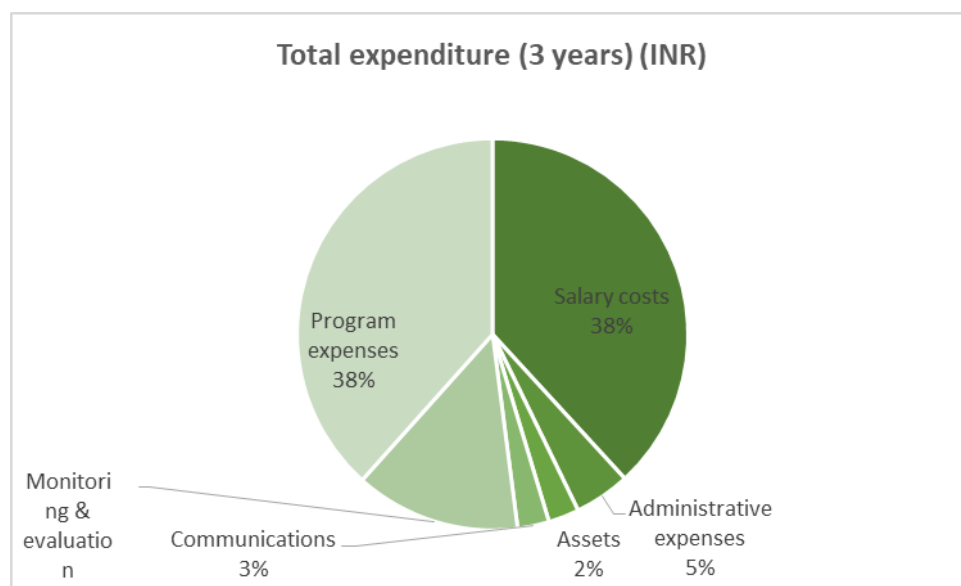
Project budget vs. expenditure over three-year duration

Project budget head	Total budget (3 years) (INR)	Total expenditure (3 years) (INR)	% spent	Balance (INR)	% balance
Salary costs	11,933,931	11,999,948	100.6	-66,017	-0.6
Administrative expenses	1,456,344	1,451,400	99.7	4,944	0.3
Assets	823,817	801,539	97.3	22,278	2.7
Communications	826,124	819,493	99.2	6,631	0.8
Monitoring & evaluation	4,355,886	4,301,373	98.75	54,513	1.3
Program expenses	12,063,251	12,058,714	99.96	4,537	0.0
Total program budget	31,459,353	31,432,467	99.9	26,886	0.1

From the budget vs. expenditure details, the following observations can be made:

- Almost the entire allotted amount was spent under each head. Expenses incurred on salary costs were slightly more than the budgeted amount.
- The balance unspent amount remaining under each head was very negligible. The balance unspent amount was maximum in case of assets. The total balance unspent amount as a percentage of the total budgeted amount was 0.1%.

A breakup of the amount spent in the project has been provided in a pie diagram below. The maximum expenditures incurred were on program expenses (38%) and salary costs (38%).



5.3.2 INVOLVEMENT OF COMMUNITY/GOVERNMENT/IMPLEMENTATION PARTNERS

The project effectively created linkages with a private institution, Vyankatesh Nursing Home and Research Centre to provide health care to community members. Government officials such as the Block Medical Officer (BMO), the Chief Medical Officer (CMO), the Child Development Project Officer (CDPO) and the ICDS Supervisor were also mobilised to support the project. The work of HIH was commended by the Member of Parliament, Ms. Savitri Thakur who went on record saying:

“I appreciate Hand in Hand India for their work done in villages in recent years and their role in motivating women on aspects of personal and menstrual hygiene. The role they played in changing women’s health seeking behaviours is commendable. Visible changes have occurred and women are more aware now.”

“The HIH team kept in regular touch with me. They took approval from me before organising health camps and regularly updated me about health activities. They worked well with the district health system.”

Dr. RC Panikar, CMO, Dhar

“The HIH team worked together with the ASHA, ANM and AWW in a collaborative manner. Together, they were able to reach more women and children.”

Selila Minz, CDPO, Nalchha block

Another key aspect of linkages was the deployment of community mobilisers. They acted as a bridge between the community and the health system by counseling community members to avail of government health services and opt for institutional delivery while simultaneously supporting frontline workers like the ASHA, ANM and AWW and improving their ability to provide health services. Their involvement contributed to improving the mechanism of health care service delivery.

5.3.3 COMPLEMENTING OTHER INTERVENTIONS & SCHEMES

The project has increased awareness among women in the intervention area about the benefits of JSY and JEY which are Central government schemes and there is increased use among women of the JSY van for transport to institutions. The project has also increased awareness among families in the intervention area about the Ladli Laxmi Yojana.

5.3.4 INPUTS FROM DONOR, HIH INDIA, HIH SWEDEN & GOVERNMENT AGENCIES

The donor did not provide specific inputs to the project, except for financial inputs. There were also no inputs from government agencies on the project design. The HIH India and Sweden teams worked closely together to develop the project design. Complete budgeting for the project was done by the HIH India team. The entire project amount had been given to HIH Sweden by Swedish Postcode Lottery at the start of the project and was disbursed on a quarterly basis to the India team as per the agreed upon plan of disbursement.

5.4. Sustainability

This section describes the sustainability of the project.

Please refer to Annexure 8 for a detailed list of the evaluation questions related to Effectiveness.

5.4.1. INFRASTRUCTURE SUPPORT & MAINTENANCE

Equipment was provided to Arogya Kendra and two PHCs during the course of the project as part of institutional support. An examination table was donated to the Arogya Kendra at Patadapura while salter scale weighing machines were given to the PHCs at Bagdi and Nalchha along with other equipment and supplies. Further, the AWCs in Kakalpura, Mewas Jamniya and Lamba Talab were renovated and many AWCs were provided with salter scale weighing machines. The MO, Dr. Jayprakash Makhwani said that that PHCs had been provided with beds, labour table, sanitary pad dispenser, water cooler, baby warmer, mattresses, LED TV and a BP measurement instrument.

The details of equipment given to PHCs are provided in the following table:

Equipment given to PHC Bagdi

S. No.	Particulars	Quantity
1	BP machine	1
	Delivery table	1
3	Water cooler	1
4	Mattress	7
5	Stethoscope	1
6	3-seater chairs for OPD patients	2
7	Blanket	10
8	Baby warmer	1
9	Needle destroyer	1
10	Cots	6
12	Oxygen cylinder	2
13	LED TV (40") (to be donated)	1
14	Sanitary disposal machine (to be donated)	1
15	Fly catcher	1

Equipment given to PHC Nalchha

S. No.	Particulars	Quantity
01	Blanket	10
02	Oxygen cylinder kit	2
03	Sanitary disposal machine	1
04	LED TV (40") (to be donated)	
05	Sanitary disposal machine (to be donated)	

Out of 22 frontline workers, eight said that they would maintain the weighing machines given to AWCs or share the responsibility between them (ASHA, AWW and ANM).

5.4.2 STAKEHOLDER OWNERSHIP AND SURVIVAL OF WOMEN'S HEALTH MOVEMENT

SHG members expressed that they would continue to implement the good practices they had learnt and also tell other women about them. They felt that the women's health movement would survive since women had understood the importance of taking care of their health and visiting facilities for check-ups. They would also advocate for use of toilets in households. In Jamanya village of Jamanya cluster, SHG women said that a health committee (*swasthya samiti*) had been formed which would sustain the changes initiated by the project. By and large, the women said they would try to keep mobilising community members and organise meetings themselves. The *sarpanch* of Bedvapura village in Bedvapura cluster also confirmed that a health committee had been made in the village. On the whole, since the formation of health committees was a recent event, it did not have very high recall among most SHG women. The evaluation team observed that women in these villages require regular contact and support to be strengthened and empowered. They have been consistently mobilised through the course of the project which is why they are able to recall key messages related to health and sanitation and also speak to the evaluation team. Even then, it was observed that many women are still shy/timid and hesitate to speak freely.

Majority of frontline workers felt that the changes set in motion by the project would sustain and also expressed that they themselves would reach out to women and girls and disseminate the key messages of health and sanitation. Two frontline workers mentioned that the health committees which had been formed in the village would help to sustain the movement. One frontline worker felt that women need to be mobilised for meetings and would not be able to come together for meetings on their own. The community mobilisers and organisers who had been recruited specifically for the project and trained will also form a resource pool at the community level for community members to seek advice and counseling from. Although they are not formally mandated to perform their tasks as mobilisers and organisers and many of them have been absorbed into other projects and work, their presence in the local community as influencers will act as a catalyst to promote health-seeking behaviors and a majority of them said that they would continue to spread the key messages they had learnt and to counsel community members on women's health and sanitation.

5.4.3 EXIT STRATEGY OF PROJECT

HIH intended that involvement of key community influencers from the very start in the project and also training SHG women would generate enough social capital to propel the movement forward. The exit strategy was that trained SHG women, community mobilisers and organisers would act as community leaders in spreading the practice. Some frontline workers raised the fact that extended support would be required for the gains from the project to be sustained. This was also echoed by the community mobilisers and organisers themselves and by some SHG members. This indicates that the project duration of three years was not entirely sufficient for the project outcomes to create a lasting and broad-based impact at the community level and for extended sustainability.

According to the HIH India representative at the district level, at the close of the project, most community members felt that the project would be sustainable while frontline workers felt that extended support by HIH mobilisers would be essential. This was corroborated by Health and ICDS Department officials who commended the project for facilitating convergence. After interacting with stakeholders at all levels, the evaluation team also puts forth that extended presence in the community and constant engagement and counseling is required to dispel myths and

misconceptions around health, create an enabling environment for women to continually develop confidence about taking their health into their hands and demanding services and to ensure that the women's health movement continues.

Another component of the exit strategy was to form women's health committees in all intervention villages. To that end, some committees have been formed to encourage women to play an active role in these committees and themselves demand health services. Gauging the effectiveness of the exit strategy is out of the scope of the current evaluation since achieving a critical mass may take some more time. Additionally, the exit strategy was not outlined in project documents but was instead understood by the evaluation team through discussions with project representatives. It is recommended that projects should be planned with a definite exit strategy so as to ensure project closure in a planned and coordinated manner and accordingly also prepare the primary and secondary stakeholders of the project. However, these two aspects of the broad exit strategy seemed to be grounded in local context and brought in participation of community women themselves.

"They were able to create a cadre of local people in the form of community mobilisers and organisers who worked with ASHAs and ANMs to increase immunisation. This was an effective strategy. On the whole the program was good and HIH must continue to work in Dhar."

Dr. RC Panikar, CMO, Dhar

5.4.4 EXTENT OF CONDUCIVENESS OF GOVERNMENT STRUCTURES AND SCHEMES AND LEGAL POLICIES FOR SUSTAINING THE MOVEMENT

The project focused on creating awareness among community members about health facilities. Its aim was to empower women to demand their health rights and access government services by setting in motion a women's health movement while at the same time, giving an impetus to health service delivery. Ultimately, the government is the main duty-bearer for provision of health and the project was relevant in addressing the barriers to health service uptake by marginalised women and empowering them. It can be said that the health movement was conducive for women to access government schemes rather than government schemes being conducive for the movement since accessing schemes was an output of the project rather than an input.

5.5 Impact

This section discusses the impact of the project.

Please refer to Annexure 8 for a detailed list of the evaluation questions related to Effectiveness.

5.5.1 EXTENT TO WHICH LIVES OF POOR WOMEN & THEIR FAMILIES HAVE IMPROVED & CAN BE EXPECTED TO IMPROVE

The project has been able to create a positive environment and a dialogue around women's health in the intervention villages. Women remember key messages related to health and sanitation and are likely to pass on these messages to their families, friends and neighbors. The presence of the local community mobiliser from the village has proven to be useful for creating a permanent presence of the project in each of the 50 villages. They will be able to provide counseling and act as leaders in their communities, although on a voluntary and informal basis. Most community members were immediately able to identify the community mobilisers and were familiar with the project through continued interaction with them.



The documented outcomes of the project are significant and show that the project brought a tangible improvement in the lives of women and their families with potential for lasting impact given continued support and encouragement. The project has created a feeling of empowerment among women to practice health-seeking behaviours and demand their rights for better health services. SHG women said that they are opting for institutional deliveries and going to doctors in government health facilities for diagnosis and treatment rather than to quacks.

These women are in turn beginning to mobilise other women and clarify their doubts and issues related to health and agency, thus acting as change agents in their communities. The women's health movement has initiated a definite discourse around women's health in communities.

5.5.2 PROSPECTS FOR UPSCALING, REPLICATION OR MULTIPLIER EFFECTS

The evaluation findings will be taken into account while designing future projects with a health component. HIH Sweden informed that HIH has begun new projects related to health in Tamil Nadu. Taking into consideration the diverse and rich experience gained in the project, the takeaway for the HIH team has been that instead of focusing only on health in future projects, entrepreneurship and literacy could be tackled first since an improvement in indicators related to these leads to greater likelihood of better health. During the evaluation, respondents at the community level expressed that they would have appreciated opportunities for livelihood through the project. These are also

areas where HIH has significant expertise and therefore dovetail better into their overall vision of empowering vulnerable women. Hence the evaluation team recommends that building in a livelihood or education component while working in areas with extremely poor performance across socio-economic indicators improves the acceptability of the project and its chances of success or 'sticking' with the community.

Strengths and weaknesses of project

STRENGTHS

- The project converged with public health services at the community, block and district levels. At the community level, government frontline workers such as ASHAs and ANMs were engaged with. At the block level, it engaged with two PHCs and provided essential supplies to them as well. Children who were found to be suffering from malnutrition were referred to the NRC and followed up during the course of the project.
- Linkages were built with a private health centre and thereby expanded the ambit of health care provision in the area by making better quality health care affordable for community members. Simultaneously, it also contributed to improving infrastructure of government health facilities.
- Local women were recruited as community mobilisers thereby creating a local resource in every village which community women could tap into and also enhancing the credibility and recall of project interventions.
- SHG women were chosen as primary stakeholders since they were already used to a greater level of social engagement through SHG meetings and were therefore more likely to participate effectively in the training.
- Government frontline workers such as AWWs, ASHAs and ANMs were involved at every stage of implementation. Their own skills and knowledge were refreshed in the trainings on four health modules and they were able to work with the community mobilisers and organisers in a synergistic manner.
- The mentor-doer pairing of community mobiliser and organiser worked very well and is a definite strength as it combined the local know-how of the community mobiliser with the skills and experience of the community organiser to help the community mobiliser perform their tasks effectively.

WEAKNESSES

- A livelihoods component was absent from the project. It could have complemented the health interventions and provided added incentive to women to avail of health services.
- Men were not engaged to a great degree in the project. But as key decision makers in the family, their involvement could have further improved the outputs related to women's access to health.
- The project duration was too short for the stated outcomes to begin unfolding. Hence for the given duration, it would have been feasible to set more realistic outcomes. While the women's health movement has begun and a positive atmosphere has been created around the subject, continued engagement with key stakeholders at the community level would have deepened the effect of the movement on women's knowledge and ultimately their lives. The evaluation team recommends a follow up project for a minimum duration of two

years so as to build on the positive results that have already been achieved and work to create a deeper imprint about positive health seeking behaviors in the community.

- Women's health committees were introduced towards the very end of the project. As a result, they have not yet caught a firm foothold in the intervention villages and a considerable number could dwindle in some time after the project has ended.

6. Conclusions

The project has been successful in implementing its set targets to a high degree of satisfaction in terms of quantitative outputs. Qualitatively as well, many women have begun taking care of their diet including consuming iron-rich foods, going for institutional deliveries, getting regular health check ups, immunizing their children and giving them nutritious food. They have begun to put forth their opinions and voice their concerns in the family and also in the community through SHG meetings and participation in *gram sabha* meetings. The women's health movement is tangible in terms of having created an environment of dialogue about women's health and imparted concrete knowledge to women that they can use to change their behaviours and improve their health. The movement will need to be nurtured and supported as it is still quite new and the women's health committees have been formed very recently.

There is a favourable attitude among community members about the project since many health camps, awareness days and street plays were held through the course of the project which contributed to the dynamics of community life and provided health services to all community members. They found the community mobilisers to be consistent figures in the community who were available for counseling and support and also worked closely with frontline workers. They repeatedly said that they wanted the project to continue and many also asked for a livelihood project to be started locally.

7. Recommendations

Considering the diverse experiences and perspectives gathered during the course of the evaluation and taking the local context into account, some broad recommendations can be made based on the project's overall experience:

- Through the project experience, it will be advantageous for future projects to develop a trained cadre of women in the community who will contribute to women's empowerment.
- Targeted interventions such as those conducted in the project on tackling anaemia and malnutrition improve outcomes and efficiency.
- Building capacities of local community mobilisers and organisers contributes to sustainability.
- Conducting a project for a longer duration (minimum five years) would be conducive to generating an impact while working with vulnerable and marginalised communities.
- Building in a livelihood or education component into project design would be strategic to achieve health outcomes.
- Creating a theory of change and clearly outlining the assumptions at the start of project will help to monitor progress of the project and make mid-course corrections in a measurable and organised manner.

8. Lessons Learned

The project has been a unique one for Hand in Hand and was implemented as a pilot intervention in a challenging setting with marginalised tribal women as the primary stakeholders for the intervention. The key lessons learned from implementing the pilot intervention are:

- SHGs are viable platforms wherein to engage with marginalised women. However, considering their marginalisation, a very high level of interaction with them is required along with mobilising their family members and community leaders for them to be able to better practice health behaviours and access health services in a sustained manner.
- Helping families in the community create a concrete asset for the home such as a toilet which can be used by all family members proved useful to mobilise family members as well as improve the status of sanitation in the community.
- Adding a livelihood component to the project when working with marginalised communities is important so as to provide them with the tools to earn an income and thereby access more services.

Snapshots of field work

QUANTITATIVE DATA COLLECTION



Household questionnaire with women



Administering men's tool

QUALITATIVE DATA COLLECTION



IDI with Dr. Jay Prakash Makhwani, MO



SHG women, Dukani Mafi village, Meghapura cluster



FGD with SHG women, Kalyadeh village, Shikarpura



FGD with SHG women, Bhojapura village, Banjari



Feeding demonstrator counseling mother in NRC



Conducting participatory exercise during FGD with SHG women in Kakalpura village, Kakalpura cluster

