MID TERM EVALUATION

OF

MEMISA - BELGIUM

INDIA

Project

IMPLEMENTED BY: WEST BENGAL VOLUNTARY HEALTH ASSOCIATION (WBVHA)

August - December 2019

Evaluated by :

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LIST OF ABBREVIATIONS

A-DEEP	-	*IAD*
ANC	-	*Antenatal Care*
ASHA	-	*Accredited Social Health Activist*
BMOH	-	*Block Medical Officer of Health*
BPHC	-	*Block Primary Health Centre*
CBO	-	*Community Based Organisation*
CHC	-	*Community Health Centre*
CMOH	-	*Chief Medical Officer of Health*
HDC	-	*Human Development Centre*
HSWS	-	*Hill Social Welfare Society*
IIMC	-	*Institute for Indian Mother & Child*
INSS	-	*Indranarayanpur Nazrul Smriti Sangha*
MIS	-	*Management Information System*
NGO	-	*Non Governmental Organization*
NGSSC	-	*Nepali Girls Social Service Centre*
PO	-	*Partner Organization*
SEVA	-	*Seva Amdanga*
SKL	-	*Seva Karya Lamhatta*
SKT	-	*Seva Karya Takdah*
SSDC	-	*Sunderban Social Development Centre*
WBVHA	-	*West Bengal Voluntary Health Association*

CONTENTS

OVERVIEW

PROJECT BACKGROUND:

The Basic Health Care Support program implemented by WBVHA coordinates the functioning of 4 NGO-forums in 4 different districts, all together bringing together 29 local NGO's. They work with a network of Village Health Workers in different villages. The program aims at: ***Closing the gaps****;* ***Influence policy and Stimulating strategic and functional partnerships****. The* ***Project Time Frame is 60 months i.e. from 2017 to 2021.*** *The* ***Project Objective*** *is to improve access to affordable, sustainable and equitable quality health services. The planned Project Activities include: Capacity Building, Quality of care issues in the local health system and Community empowerment leading to a more equitable society.*

*The 5 year project is in its mid phase and a mid term evaluation was carried out. The Key issues addressed by this evaluation include -****Relevance of the project; Outcomes and impacts; Effectiveness; Efficiency; Sustainability and Cooperation with local government. The Evaluation Methodology was both quantitative and qualitative (participatory) and involved a 2 stage assessment.***

Under Basic Health Care Support programme West Bengal Voluntary Health Association works on strengthening the health systems governance covering all the basic health services offered by Government of India under National health policy. They strengthen all the hierarchies of health governance from village, panchayat, Block to District level. Several community groups (viz. Geriagric, mothers, adolescent groups etc) were formed to solve issues related to health problems and healthcare seeking of various age-groups cross-cutting gender, environment etc. Side by side, they build forum in each intervention district comprising of demand and supply side stakeholders and resolve the issues very well through this method.

The target area comprises of 25 blocks under 4 districts of West Bengal, India. WBVHA coordinates the functioning of 4 NGO-forums in 4 different districts, all together bringing together 29 local NGO's. The duration of Phase V of the programme is 60 months following a people centred partnership process with involvement of all stakeholders and policy makers. The mid-term process evaluation followed DAC framework and explored the relevance of the programme, progress towards impact, efficiency and effectiveness of the implementation process and how far the sustainability dimension is inclusive in the implementation. Evaluation collected information from stakeholders at different levels, implementing

partners and beneficiaries through mixed method approach and recommended some directives to accelerate the progress.

EXECUTIVE SUMMARY

WBVHA has taken into consideration location specific needs of the communities of the operational area through the partner NGOs working at the grassroot level. District and block level health officials mentioned that BHCSP improves health seeking behavior through building different target groups by categories like geriatric, mother and adolescents. It reduced the level of catastrophic health expenditure and contributing to reduce health poverty through conducting awareness programme on government schemes those are offering different social entitlements like insurance. They initiated and now successfully run community level fund as one social protection mechanism. The ground level field workers help them in maternal care, ASHA co-ordination, advocacy for immunization where social challenges are there.

At implementing partner level, it is evident that during the phase V of the project the coverage of the target beneficiaries increased. Partners and gram panchayat level stakeholders reported that accessibility is increased by 60 to 80 per cent, 60 to 80 per cent accountability of stakeholders to higher level of governance community is increased from 15 to 50 per cent of the implementation area. However, improvement in data collection process for monitoring by partners and following of compliance by stakeholders improved by 30 to 60 per cent.

There has been change in the partners of WBVHA in the districts with a few exclusions owing to legal or statutory problems. In lieu of this new partners have added. BHCSP highly successful towards reducing catastrophic health expenditure by 72.4 per cent and more than 60 per cent of users' satisfaction indicates good progress towards outcome achievement with respect to increasing accessibility.

Coverage of stakeholders is in different capacity building activities are achieved by 80 to 85 per cent. In 80 per cent of implementation area monitoring activities are done on quarterly basis Monthly analysis is done in 65 per cent of the area which is to be increased by 35 per cent.

WBVHA conducts dissemination and sharing of learning in periodic manner through attending in national and international conferences. Degree of integration between BHCS and stakeholders increased from 30 – 60 per cent to 60 – 80 per cent from 2017 to 2019 by 45 percentage points.

Efficient utilisation of resources (allotted under health service delivery) by 30 to 60 per cent of stakeholders is increased from 35 to 85 per cent. Partners and stakeholders perceive that outsourcing of M&E will enhance the quality and quantity of output (75 per cent perceive), time efficiency (25 per cent thinks), save cost related to human resource and their capacity building (50 per cent perceives). Digitised M&E will accelerate progress towards outcome achievement - 90 to 100 per cent perceives. There is good collaboration with local self government and the block government health system.

Both the visionary leadership of WBVHA as well as the project leadership has decades of experience in the health and NGO sector in the state of West Bengal by which it is successful in generating awareness among community members to raise demand about healthcare, access healthcare without financial catastrophe and health seeking in timely fashion to reduce the morbidity within community across different age group.

CHAPTER RECOMMENDATION

The processes are to be enhanced to boost progress towards outcome within shorter duration leading to providing space for sharing lessons learnt and success stories towards universal health coverage – presenting BHCS as a ***Model Intervention****.*

RELEVANCE

a. *WBVHA in future could adopt a process of formal assessment and ranking in the selection of NGO partner in the districts so as to avoid any bias.*
b. *The Adolescent girl groups promoted by the partners of WBVHA should link up with the government scheme wherever possible.*

OUTCOMES AND IMPACTS

1. *Demand Side Social & Behaviour Change*
    a. *Beneficiaries are to be made aware about actual amount of contribution made by BHCS through periodic workshops.*
    b. *Attendance in awareness programmes are to be increased for at least 90 per cent programmes and it is to be by more than 80 per cent of target population. Though more than 60 per cent of user satisfaction rate indicates good progress towards outcome achievement, however, some improvements in process effectiveness and efficiency will improve the pace of progress further.*
    c. *Following the National model the West Bengal Government has introduced the Swasthya Sathi – health insurance scheme and some partners have already assisted communities in enrolling them under the scheme. The project should align the partners so that the Basic Health Care Support Project is tuned with current state and district level programmes and if necessary WBVHA can further train the field NGO partners on the schemes.*
2. ***Partner strengthening***
    a. *WBVHA could consider in future formal assessment process along with ranking of partner NGOs in the districts prior to induction to avoid any bias.*

EFFECTIVENESS

3. ***Specific at the Partner level***

a. *INSS in South 24 Parganas may consider change in the operational area after the current phase of the project is over. If agreed to, then INSS need to develop Exit Strategy prior to closure of the current phase of the project.*

b. *INSS may consider inclusion of geriatric programme with support from the other partners.*

c. *In future WBVHA could consider selection of district based common health issues for joint action by partners to enhance effectiveness and visibility.*

d. *In Darjeeling district should continue focusing on developing health seeking behavior of local communities from local health systems.*

4. Institutional strengthening

a. *Process effectiveness to achieve good governance require assessing the scopes remaining to increase stakeholders' capacity – particular aspects and accordingly sub-components can be incorporated.*
b. *Though there is significant coverage of heterogeneous target groups comprising of BHCS team members and healthcare providers; coverage is to be increased for other local CBOs, PRIs, private providers and policy makers in the post-mid-term phase of the programme.*
c. *Knowledge of stakeholders on the execution process of programme components is to be increased through forum meetings and workshops. The process of feedback collection is to be done in written format to increase the understanding of stakeholders to increase acceptance of the capacity building activity. Consistent sharing of training reports with stakeholders is to be conducted.*
d. *Stakeholder inclusiveness will be increased by sharing the reports with stakeholders in review and dissemination workshops with their acknowledgements during the workshops.*

EFFICIENCY

5. Policy Advocacy

a. *Documentation and sharing of policy briefs are to be done periodically following similar methods at higher levels of governance.*
b. *More importance is to be given to increase the capacity of partners in North 24 Parganas and Darjeeling to improve the quality parameters ensuring effectiveness followed by regular monitoring and reviews.*

c. *More emphasis is to be given on capacity building for comprehensive documentation of progress and good practices, success stories and lessons learnt towards achievements to increase efficiency in the direction of effectiveness.*

6. ***Efficiency in M&E System***

1. *More emphasis is to be given on capacity building for M&E in partners. 2 or 3 review meetings per quarter with the stakeholders is to be conducted to assess the challenges faced in the process of* ***compliance*** *and* ***monitoring*** *so that strategies to achieve it can be formulated.*
2. *Outsourcing of M&E system with digitisation will help to enhance the quality and quantity of output, ensure JIT (Just In Time), save cost related to human resource and their capacity building.*
3. *The application software should be complemented by baseline, mid-line and end-line evaluations, periodic participation of the evaluators in action plan reviews, and the MIS should be linked with a dashboard to display monthly, quarterly and annual results.*

7. ***Efficiency at specific Partner level***

a. *In IAD, Howrah District consider small amount as untied fund to enable the organization to undertake unforeseen collaborative activities.*

b. *In SEVA Amdanga, North 24 Parganas district set up small project office in preferably central operational location otherwise bias issue between communities may arise.*

SUSTAINABILITY

a. *In A-DEEP, Howrah District consider involvement of elders in small scale part time income generation activities utilizing existing skills.This should be tried out as an experiment in a relatively small scale.*

COOPERATION

a. *The partner organizations in Darjeeling district should continue to focus on creating awareness and assisting communities in developing health seeking behavior from local agencies.*

CHAPTER I BACKGROUND

INTRODUCTION

Under Basic Health Care Support programme West Bengal Voluntary Health Association work on strengthening the health systems governance covering all the basic health services offered by Government of India under National health policies and programmes consist of

- ***Reproductive, Maternal, Neonatal, Child and Adolescent health***
- ***National Nutritional Programmes***
- ***Communicable diseases***
- ***Non-communicable diseases***
- ***Health system strengthening program***
- ***Programme targeted to Adolescent Girls***

India health insurance - Ayushman Bharat Yojana (PMJAY) scheme

West Bengal – Health insurance scheme

Swasthya Sathi scheme was launched on 30th December 2016. The scheme has basic health cover for secondary and tertiary care up to Rs. 5 lakh per annum per family with up to Rs 1.5 Lakh through Insurance Mode and beyond 1.5 lakh to 5 Lakh through Assurance Mode. Insurance Companies are partners in the assigned districts. Entire premium is borne by the State Government and the scheme is paperless, cashless and smart card based. Transport allowance is also provided after discharge. There is no ceiling on family size and parents from both the husband and wife are included. All dependent physically challenged persons within the family are included and all pre-existing diseases are covered. There is also an Android based Swasthya Sathi Mobile app for the beneficiaries

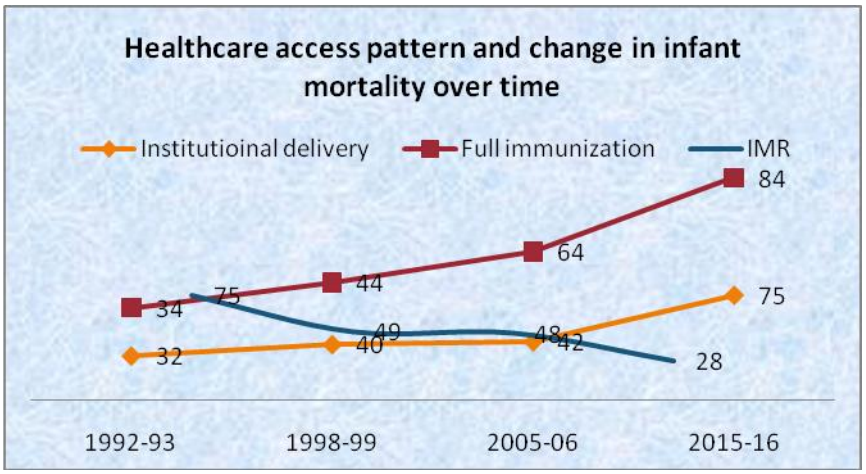
Maternal and child health programmes are components of National health programmes in India as per National Health Policy. For better administrative control in Indian states like West Bengal, the bigger districts (except Murshidabad) have been separated into health districts and the state has 20 revenue districts and 27 health districts[1]. However, the level of awareness among general population and utilization of health services still shows suboptimal and requires improvement in West Bengal. To combat the situation, different donor organization is investing to improve population health and strengthening communities through different programmes. Hence, Infant and Maternal Mortality rates are improving than the national average. Improving

[1]SITAN Paper, UNCEF, 2017

the health status and access to healthcare services has been two focus areas which are monitored by the organizations.

Chart 1.1: Temporal variation in healthcare access and child health status in West Bengal

Infant Mortality Rate has fallen from 75 to 28 (below the age of 1 year per 1000 live births). The percentage of institutional delivery has been increased from 32 Per Cent to 75 Per Cent. Full immunization increased from 34 to 84 Per Cent[2].



Another initiative is improvement of geriatric health in India which shows that the projected increase in elderly population is 198 million in 2030 and currently 80 per cent of them stay in rural area, 51 per cent of them are female one third live below poverty line. According to Census of India, 8.5 per cent of the total population was elderly population which may be 10 per cent now given the decadal growth rate of 21 per cent. Life expectancy at 60 years of male is 16.9 and female is 18.7 in West Bengal[3]*. Old age dependency ratio is higher in urban area (14.5) and among females (13.7). Among elderly population, 41 per cent are suffering from any ailment as per reported illness and 47 per cent have poor health according to self reported morbidity*[4]*.*

According Census of India (2011), 20.9 per cent of population is adolescent and the number is increasing to approximately 253.2 million[5]*. Adolescent population in West Bengal is 20 per cent and with respect to adolescent health and nutrition status in West Bengal, Underweight among*

[2]NFHS 1(1992-93), NFHS 2(1998-99), NFHS 3(2005-06), NFHS 4(2015-16)

[3] Sample Registration System 2013

[4] National Sample Survey Office, 60th Round 2004

[5] Bej P. Adolescent health problems in India: A review from 2001 to 2015. Indian J Comm Health. 2015; 27, 4: 418-428

adolescent girls is also higher within STs (53.6 per cent) compared to the state average (34.5 per cent)[6].

Table 1.1: Demographic and Health status in intervention districts

	South 24 Parganas	North 24 Parganas	Howrah	Darjeeling	West Bengal
Population (%)	81,61,961	1,00,09,781	48,50,029	18,46,823	9,12,76,115
Sex ratio of the total population (females per 1,000 males)	1036	981	1001	992	1011
Female literacy rate (%)	74.6	82.9	78.4	78.0	70.9
Women age 20-24 years married before age 18 years(%)	48.8	36.5	25.6	21.9	41.6
Mothers who had at least 4 antenatal care visits (%)	75.6	79.3	86.6	65.9	76.5
Institutional birth (%)	52.2	86.9	86.6	94.5	75.2
Institutional births in public facility (%)	35.8	64.3	37.5	76.3	56.6
Children age 12-23 months fully immunized (%)	94.8	88.7	73.8	84.2	84.4
Children under age 3 years breastfed within one hour of birth (%)	59.3	33.3	46.3	37.7	47.5
Children under 5 years who are underweight (%)	27.8	18.3	28.4	25.7	31.6

Source: NFHS 4 (2015 – 16)

Table 1.2: Gender Inequity and social exclusion in healthcare access – by gender and caste in West Bengal

	All basic vaccinations	Percentage for whom treatment was sought for fever from a health provider	Percentage of children with diarrhoea taken to a health facility or provider	Percentage of children age 0 - 71 months who received service from AWC		Percentage of children age 0 -59 months who were weighed at AWC	Percentage who started breastfeeding after 1 hour of birth	Percentage of children age 6 - 59 months given iron supplements in past 7 days preceding the survey
Sex				Any Benefit	Supplementary food			
Male	85.6	73.0	77.0	73.3	71.8	69.4	49.2	28.3
Female	83.3	72.8	72.2	75.5	73.7	69.6	46.2	27.4
Caste/tribe								
Scheduled caste	86.0	83.5	75.8	80.2	78.1	75.1	48.8	28.4

[6] Rapid Survey On Children 2013-14

Scheduled tribe	*91.0*	-	-	*81.2*	*79.8*	*77.4*	*51.8*	*24.6*
Other backward class	*76.8*	*65.2*	-	*74.3*	*72.7*	*70.4*	*46.2*	*22.5*
Other	*84.7*	*68.5*	*72.0*	*70.1*	*68.6*	*65*	*46.7*	*29.3*

Source: NFHS 4 (2015 – 16)

Despite these achievements, bottlenecks in implementation and management systems affect the health service delivery.

WBVHA is implementing different programmes to strengthen primary health care and preventive and promotive health care at community level. It is trying to move beyond conventional areas of health engagement, enhancing convergent interventions like health, nutrition, water-sanitation & hygiene etc. Resource planning and management remains a part to ensure Indian Public Health Standards norms in facilities, so that services can be provisioned to reach target audiences or are sought by them. They are implementing several programme components to

- *Improve community health system to reduce structural and systemic gaps through effective policy design;*
- *Case Building to ensure social welfare and justice in access to healthcare delivery system;*
- *Ensure service provider's accountability in this aspect.*

MEMISA wants to conduct two independent evaluations of this programme in two different timeframe – Mid-Term (Process) evaluation and End-Line (Impact) Evaluation – to assess the Relevance, Efficiency, Effectiveness, Impact and Sustainability of the programme.

1. *What studies exist in developing world, India, West Bengal and respective districts on access to healthcare in poor and marginalized population*
2. *Analyze the Theory of Change underlying the intervention, examine its feasibility, the relevance of the hypotheses and propose recommendations for improvement.*
3. *Verify globally and independently the results of the project/programme (outputs, outcomes, impact) and assess the effectiveness, efficiency, and sustainability of the programme in terms of development.*
4. *Draw key lessons and make practical recommendations for monitoring interventions,*

CHAPTER II THE EVALUATION PROCESS

The 5 year project is in its mid phase and as per plan a mid-term evaluation was carried out. The Terms of Reference, evaluation framework and the Experts were finalized by MEMISA in consultation with WBVHA.

Key issues addressed by the evaluation:

1. Relevance *of the project [Outcome and impact focus on project partners and thereby households or communities in order to see how they affect and help the population and individuals in health sector activities.]* ***Relevance of programme Logical Framework*** *– Assessment of the hypothesis, the Outcome – Input – Output Matrix, current execution of Roles and Responsibilities as per activities in parity with framework, revisiting Assumptions/ Risks.*

2. Outcomes and impacts *measure if possible which activities at partner level achieve the greatest impact and in which areas, (training, community mobilization and use of health services) in order to focus onthe future work.*

Impact of the programme – Assessment through collection of quantitative data *– How far the programme is successful in supporting communities and healthcare delivery to reduce structural and systemic gaps through effective policy design; contributed to increase physical, social and economic accessibility of healthcare through engaging them in programme activities; accountability of service providers and other stakeholders has been ensured through the programme implementation.*

3. Effectiveness – Monitoring led process change *- How frequently Program Activity data has been collected and how far quality has been maintained, What techniques are followed to ensure process monitoring, How far modification of content and / or methodology of respective components has been done, How far all these factors are contributing to achievement towards outcome, Analyze the collaboration and synergy in the field between Memisa and other actors through WBVHA to achieve its objectives.*

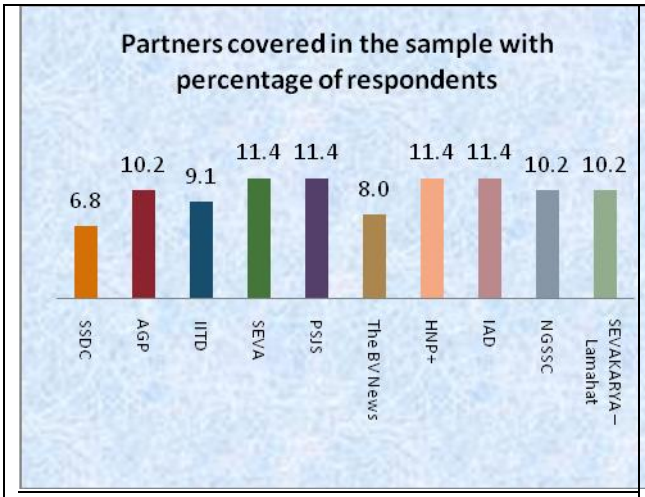
4. Efficiency – Mixed Method Approach *through* ***In depth*** *and* ***Structured interviews*** *with Stakeholders to assess the degree of resource utilization under the programme, Lessons learnt from the project, Risk and Bottleneck analysis,*

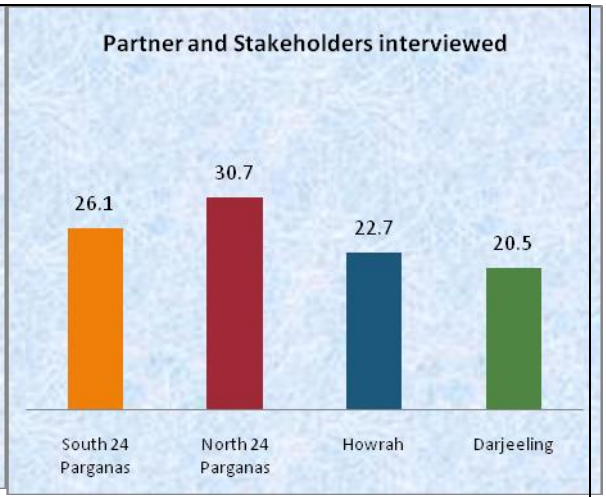
5. *Assess* ***organizational learning*** *to estimate the degree of* ***Sustainability*** *achieved by Secondary research on* ***Reports*** *on* ***Baseline Study, Documents*** *on* ***Review Meetings*** *with service providers, implementing partners and communities,* ***Documents on success stories and cases built, Focus Group Discussion*** *with community to assess how far they are well equipped to independently demand their health rights.*

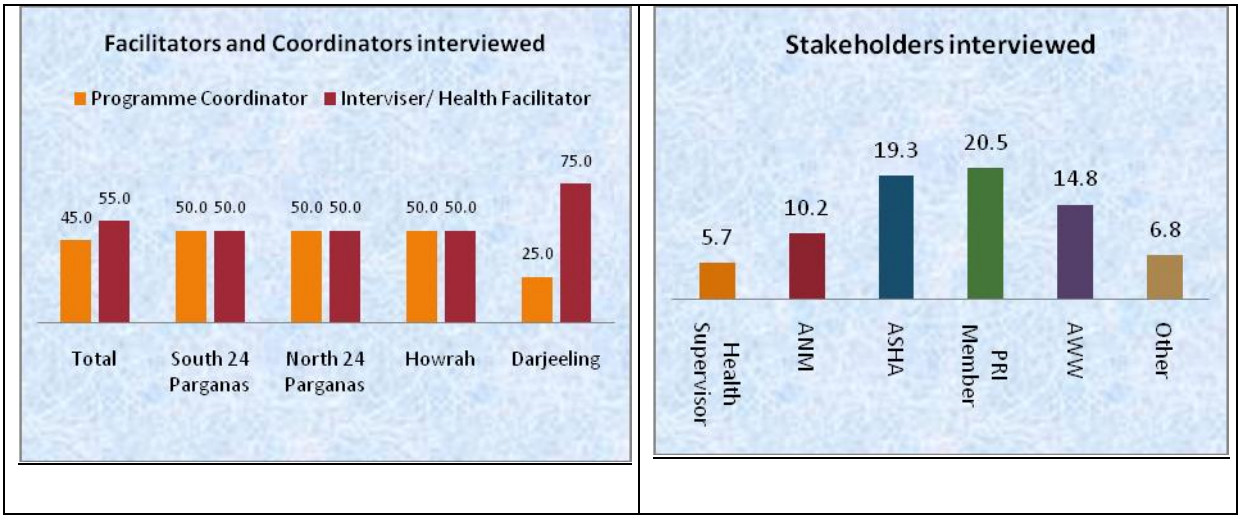
Recommendations *will be based on what the programme implementing partner and the district level authorities perceive about the success of the intervention – whether to modify the planning process to increase the success rate, what innovative techniques can be used to accelerate the process, how the programme activities have overcome challenges they faced, how far different social entitlements are ensured through the intervention – with cross-cutting focus on gender and environment.*

Interviews completed given the sample size for the evaluation *- The evaluation has taken 10 partner NGOs among ---- NGOs of WBVHA to assess the relevance, effectiveness, efficiency of the implementation processes followed to achieve improvement towards impact and sustainability. Number of respondents in the sample was selected based on the size and coverage of the organizations and therefore the sample is comparatively larger in South and North 24 Parganas compared to Howrah and Darjeeling. Availability of programme coordinators and health facilitators was almost 50-50 as respondents. Among stakeholders PRI members, AWW, ANM and ASHA were higher given their availability in a jurisdiction and their knowledge about process followed by BHCS programme towards establishing good governance as well as progress towards improving health and nutrition service delivery.*

Table 2.1: Sampling distribution for quantitative study







***6. Cooperation** and views of local government about the project*

EVALUATION METHODOLOGY

The mid-term evaluation contains data collection at five levels -

1. *District level governance*
2. *Implementing partner level*
3. *GP level local self governance and frontline service providers*
4. *Community level*
5. *Beneficiary level*

SELECTION OF STAKEHOLDERS AT VARIOUS LEVELS

IDI AT DISTRICT AND BLOCK LEVEL

At district level, stakeholders' selection for semi structured interviews followed purposive sampling procedure. District and Block level officials in South 24 parganas, North 24 parganas, Haora and Darjeeling were selected for face to face in depth interview – The officials are CMOH, DPHC, ACMOH, BMOH, BPHN, etc.

STRUCTURED INTERVIEW AT IMPLEMENTING PARTNER LEVEL

Purposive sampling method is used to collect information. In each of the 4 districts the main programme implementation partner of WBVHA was selected for conducting face to face interviews with health facilitator and interviser.

STRUCTURED INTERVIEWS AT GP LEVEL

Structured interviews to assess impact of the intervention, degree of knowledge and inclusiveness of stakeholders created at the ground level have been conducted among frontline service providers in supplying health and nutrition services to the population. Here also purposive sampling procedure was adopted to select PRI member, Health Supervisor, ANM, ASHA, AWW who actively provide service to community people, women, adolescent and children in the selected gram panchayats.

Total 88 interviews were conducted covering partners and ground level stakeholders.

FGD AT COMMUNITY LEVEL

For conducting focus group discussion with community people, 8 FGDs are decided to be conducted in most vulnerable gram panchayats in the selected intervention districts. In relation to FGD, purposively we selected 10 to 20 community members (elderly people, mothers of children or adolescents).

Focus group discussion interview had been conducted in Bara Mangwa MSK, under Rangli rangliet block and lamahatta of Darjeeling district. In one FGD there were 13 adolescence boys and girls and in Lamahatta, 11 from the school participated in the FGD regarding Basic Health Care and Support Programme. 10 to 15 mothers were present from Mothers' Group. There the BHCS programme has been facilitated by WBVHA and implemented by NGSSC and Seva Karya Lamahatta respectively. In North 24 Parganas 2 FGD with Mothers' group (10 respondents in each group) and 2 adolescent groups (10 respondents in each group) were met for discussion in PSJS field area. In the IAD field area of Howrah district, 1 FGD with Mothers' Group (11 respondents in group) and 1 FGD with Geriatric Group ((13 respondents in group) were conducted. In South 24 Parganas 2 FGDs with Mothers' Group (8 respondents in each group) and 1 FGD with adolescent Group (15 respondents in group) has been conducted.

BENEFICIARY SURVEY

SELECTION OF SAMPLE POINTS AND ADDRESSES FOR SURVEY

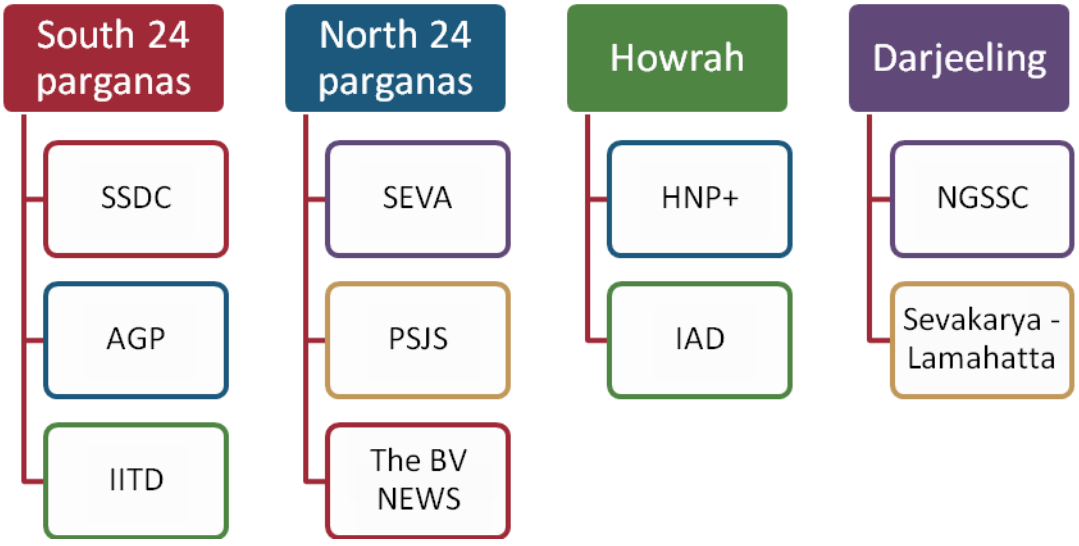
Official at partner level of each selected district helped to share the complete beneficiary lists to select them for each district. The GPs are selected based on the degree of sociopolitical

vulnerability where the BHCSP programme has been implemented facing lots of challenges. The approach taken reflects standard approaches to survey work in each district in this regard. The beneficiaries are selected from the list using systematic circular random sampling method, but the precise approach vary by districts reflecting different circumstances on the ground, the nature of sample frames available, and cultural differences.

RESPONDENT SELECTION

An interview with beneficiary belonging to a particular group has been conducted. The interview with beneficiary was conducted as s/he knows the most about the intervention and the service uptake. In around some of the cases, the respondent was interviewed, along with other member of the group, to accompany him/her. In relation to collecting retrospective data 2 years recall is used to avoid recall bias though there is a long history of BHCS programme in the state of intervention. So along with current year, questions were asked to recall the experience during the year 2017 – the baseline period of Phase V of BHCS programme. In 4 intervention districts 148 beneficiaries were interviewed with structured questionnaire.

Mixed Method Evaluation has considered the following organizations from four intervention districts



CHAPTER III OBSERVATIONS & FINDINGS

RELEVANCE OF THE PROGRAMME

WBVHA has partnerships with district level field NGOs for several years and is well aware of the needs of the populations.

- ***WBVHA has taken into consideration location specific needs of the communities of the operational area through the partner NGOs working at the grassroot level.***

Relevance of the programme is assessed by developing Activity – Output Matrix.

Sl. No.	***ACTIVITIES***	***OUTPUTS***
RESULT: 1	*Capacity Building, promotion of good governance and developing strong network and linkage among communities, CBOs/CSOs, PRI, Public-Private Health actors, policy makers and BHCS team which leads to better health governance and real democratization .*	
1	*Assessment of National health plans, programs and strategies and assessing health system performance in collaboration with AIIH & PH*	*Critical analysis of National Health Policy 2017 completed in collaboration of All India Institute of Hygiene and Public Health (AIIH&PH)*
		Questionnaire developed for Community level and Facility level
		Three villages from each block (22+29)were selected randomly from both North & South 24 Parganas Districts
		2000 HHs were selected randomly for interview
		*Data collection: * Community level survey & data analysis completed * Facility Survey in the progress*
2	*Building institutional capacity for analytical work and policy dialogue/advocacy in collaboration with AIIH & PH*	** 3 days Capacity Building training and 1 refresher training for Coordinators (26) were held In collaboration with AIIH & PH, Kolkata .*
		**2 days Capacity Building training for NGO managements/Coordinators (28) were held In collaboration with Centre for Health and Social Justice, New Delhi*
3	*Conduct (action) research on the role of DHF in stewardship*	*2 days Capacity Building training on Stewardship for Coordinators (28) were organised by WBVHA*

	of the local health system in collaboration with national and international research institute (ITM, Antwerp) and publish the results (expenses for Bart and Karel)	*2 days Capacity Building trainings on Stewardship for Coordinators (27) were held In collaboration with Indian Institute of Health Management & Research (IIHMR), Jaipur.*
		Identified the potential Leaders/Stewards
4	*Improve stewardship in human resources for health systems*	*Capacity building training on stakeholder analysis, Community Score Card etc*
		28 Partners were assessed and ranked as per their leadership/stewardship quality
		Identified the potential Leaders/Stewards from the BHCSP team
		Selection of potential steward at GP, block and district level
5	*Collection and analysis of health evidence to support policy influence*	*Sharing of health evidences at selected GP, Block and District level*
6	*Capacity building of civil society and private sector for better advocacy to increase transparency and accountability*	*14 Capacity building training were held of RMPs (363) were held in collaboration with Block authorities*
		1 Training Module developed
7	*Establishing peer learning network to facilitate cross dissemination and mentoring good practices and policy (like knowledge, experience and expertise)*	*Potential peer at GP/ block/District identified by partners*
		Identification/follow up of issues and gaps at the local level by the partners
		Action plan prepared
8	*Organising State/National level consultation and Conference*	*Organised 1 International Conference in Kolkata*
9	*Action research on operational and policy gaps*	*Action research on Community Health Fund and VHSNC are in progress*
10	*Capacity building of project team on Action Research and Methodology of Data Collection*	*3 days Capacity building training were held for the coordinators, research fellows & WBVHA Staffs by exerts of Be-Cause health*
11	*Annual workshop with friends of the forum (combined with annual mission/external evaluation)*	*Annual mission (3) held in every year*
Result 2	*Quality of care issues in the local health system have been identified & properly addressed and appropriate policy changes at different levels in partnership with the District Health Forums and other stake holders have been proposed and the evidence-based, people centred inclusive BHCS programme is acknowledged by International Health Organisations.*	
11	*Capacity building of BHCS Team*	*Yearly Capacity building of BHCSP Team & Health workers*
12	*Process Documentation*	*South 24 Parganas Brochure developed*
13	*Workshops on Case Building, good practices and experiences*	*Case stories and good practices were shared at GP, Block and District level shared*

14	*Capacity building of PRI (Public Health Planning (ISGP), Health actors **ANM**, AWW*	*Capacity building of ANMs (529) at North & South 24 Parganas*
		1 training module was developed
15	*Strengthening forums at multiple levels with multiple actors / Workshop with partners*	*7 cluster meetings organised in every quarter*
16	*Review of the government health charter on the health services*	*Adolescent and elderly group created their demand*
17	*Publication on community participation, networking, stewardship etc (Book publication)*	*—Essay on **Stewardship Role Of Health Forum In Strengthening Local Health System, West Bengal, India was selected** by for Short Online Publication Effective Health Cooperation of the Medicus Mundi International Network (MMIEHC) **a**t the 10th European Congress on Tropical Medicine and International Health (ECTMIH 2017) taking place in Antwerp, Belgium, October 2017*
18	*Participation in National and International conferences*	*Participated in 12 National and 2 International conferences*
19	*Promotion of health and wellbeing in community settings*	*Identification of gaps in Health Care provision for the use of the untied funds for improvement of the different health facilities*
		Partners participated in 4th Saturday/BTF meeting
20	*Promote equity in health and healthcare by working in partnership & consensus building – between individual/groups that face barriers to quality and equity of health*	*Review and analysis of ANC, PNC and Institutional delivery status for effective intervention*
		Participated in health planning
		Advocacy at GP/Block and district level
21	*Facilitate the active involvement of members of the public through participatory methods*	*Stakeholder analysis*
		Questionnaire developed for IDI and FGD
		Identification of Indicators
		Scoring by Community & Service providers
		Organized interface meeting at GP level by partners and at State level by South 24 Parganas Health Forum
22	*Strengthening communities for taking action on health and health determinants*	*Capacity building of peoples forum at GP level*
23	*Promotion of health fund (HF)*	** Total No. HF groups : 460 * Total savings in HF : 1,678,138/- * Benefit received 1044 individuals from 823 families from HF*
24	*Promotion of Medical insurance (UHC)*	*494 SHGs were linked with Swasthya Sathi*

25	Linkage with academic institutions and creation of practical research field for MPH/PHD students	* 7 MPH Students under Internship programme from various Institutions like TISS, SPJIMR. IISWBM & Assam University worked in the BHCSP area
		* 1 Ph.D. student from Indian Statistical Institute is working in BHCSP project areas
26	Creation of Community hubs in selected GPs - healthy living centres, which provide multiple activities and services i.e., health or other determinants of health	1 Community Hub created in Pathar Pratima Block 4 Community Hubs under preparation
Result 3	Community empowerment leading to a more equitable society.	
27	Situation analysis of health system through system thinking approach (based on 6 building blocks) with 1.1	Data collection & analysis completed based on 6 building blocks of health system in all blocks of North & South 24 Parganas
28	Involve community members to identify problems and priority solution identification and Action (Thematic Group)	3 Thematic Groups like Adolescent, Elderly & Women were able to identify the problems and prority solution identification and action
29	Conducting evidence synthesis as systematic reviews, and focus on the various barriers in health system for effective interventions	Enhancement of local capacities for social audit team
30	Promoting accountability and transparency through Social audit, transparency boards etc (Forum level)	3 Capacity building Training were held on Social Audit
31	Supporting local initiatives	Approach road to Sub Centre (HDC, INSS) Garbage Pit (IAD, RLSK) Construction of Drain (AGP-S)
32	Organise interface between health and other sectors for planning and implementation (Forum)	1 State Level Interface meeting was held in presence of Govt. Officials, Service providers, community, researchers and Health Forum
33	Networking of Community Groups (adolescents/geriatric/women) leading to evolving a statement of charter of demands	1 adolescents and 1 geriatric network formed at district levels
		Adolescent and elderly group started advocating at GP & Block level

PROGRESS TOWARDS IMPACT AND PROCESS EFFECTIVENESS

DISTRICT LEVEL

ACMOH

At the district level, mainly ACMOH in South 24 Parganas and DCMOH in Darjeeling are interviewed. In other two districts due to sociopolitical unrest they are substituted by other

officials. They were asked about the effectiveness of the processes followed by BHCS programme for reaching its objectives. At district level they shared that – BHCS programme helps the stakeholders and ground level health workers by means of better service delivery. The programme helps different beneficiary groups of the community like Pregnant Mothers' Group, Mothers' Group, Adolescence Group, Geriatric Group. The field level workers help to spread awareness regarding the health and do advocacy about BHCS programme in the community.

Regarding ensuring quality of care with increase in affordability and physical accessibility they added that – in case of quality assurance ACMOH has limited idea because of irregular follow-ups from their busy schedule. The ground level field workers help them in maternal care, ASHA co-ordination, advocacy for immunization among Muslim communities, Full immunization, help to avoid home delivery, lead the community towards institutional delivery, adolescence counselling. Though the BHCS fund is not directed for indoor patient care, however, they are building knowledge about effectively using health insurance schemes and as a result the out of pocket expenditure has been reduced within communities as can be inferred with increase in number of RSBY beneficiaries with time.

In relation to the support in decision making process of health governance they suggested strengthening of weekly and monthly monitoring systems of BHCS programme. They also stated that the BHSC help the beneficiaries regarding their health issues. The BHCS is reaching the community and easing the access to service delivery in terms of Cost, Quality and Context perspective. It is cost effective because due to awareness the community people don't neglect their health problems now a days and go to visit doctor in early stages of any sickness.

According to them, the quality is assured by BMOH as they are much engaged with the programme than ACMOH. In relation to context in some areas, it is acceptable to the minorities and marginalised communities because of BHCS ground level workers are from the same community and they are trained for the purpose of awareness and advocacy – one ***replicable strategy*** *to use* ***inclusive approach*** *to increase health service coverage.*

Challenges and Recommendations

As per ACMOH opinion BHCS should look after in the matters like Cancer screening & care, Diabetes care with the health department. Medical waste dump yard is needed in some centres. Official letter is to be issued addressing CMOH for their direct involve in BHCS programme. Need to do 100 percent institutional deliveries and full immunization for the target population.

BMOH

At block level, BMOH of Kakdwip, South 24 Parganas, of Amdanga, North24 Parganas, Udaynarayanpur, Howrah, BPHN in Shyampur 1 in Howrah and MO of Takdah PHC in Darjeeling are interviewed. Regarding the progress towards effectiveness, they said that BHCS programme helps the department officials of the nearest health centres to improve public health status in village level mainly by providing human support for solving various Bio-Social problems regarding human health covering different groups like Geriatric group, Mother's group, Children's group, adolescence group. The program help to mobilized the beneficiaries towards the nearest health care centres like hospital, PHC, SC. As a cross-cutting agenda, the programme workers help to identify leprosy and HIV patients and lead them for Medical treatment.

According to them, BHCS programme helps to improve the health care system for the village people. By this programme the Government officials get support in case of full immunisation, it further helps in spreading awareness to the village people regarding their health. The programme workers identified the under-nourished children and mothers, advocated and linked with ICDS and Panchayat for nutrition supplementation. They do awareness campaigning programmes, they create people's forum for solving health problem, they also counselling the adolescence group to improve their health and hygiene and further deals with the non-communicable disease of the community.

The impact of BHCS is visible in different ancillary aspects too like BHCS provides handholding support to BMOH to conduct capacity building and training programme for the RMP. The BHCS programme helped to aware people and to provide human support to solve the health problems of the target population. With the BHCS community people get easier access to the health service delivery.

Block level medical officers also added that, for the Geriatric group they request BPHN to go to the community for regular health check-up and monitoring, for serious patients they arranged ambulance. They further helped to arrange cervical cancer screening camp.

It helps them in terms of Cost, Quality and Context perspective. It is cost effective because due to awareness and counselling programme the community people become aware about their health problems, so they avail medical treatments. BMOH take part in programme implementation as he is much engaged with the programme. In case of context it is acceptable to

the minorities and marginalized communities because of BHCS ground level workers are from the same community and they are trained for the purpose of awareness and advocacy.

Block level doctors are very much satisfied and pleased to get the BHCS programme help for serving the community a better health.

He suggested to provide some nutritious food to the mother's group, and to arrange transport facilities for the needed people of the community.

Challenges and Recommendations

As per opinion of BMOH, basic health care support should also look into the cervical cancer screening. The BMOH suggested for 100% immunisation for the community people and suggested for more human support to solve health care problems.

WBVHA LEVEL

In depth discussion following In Depth Interview guide is conducted with WBVHA. The discussion with project direction, public health research officer and project manager was very useful to develop insights from insiders' perspective.

Mechanism	*Effectiveness*	*Process and Method*	*Impact on Governance*
Capacity Building of community, public/private actors, CSO/CBO	– *Pool of resources created,* – *Identification of key issues of advocacy planning* – *Leadership* – *Consensus and coalition building* – *Identification of SWOT* – *Distributive learning approach* – *Cohesive and resilient community*	– *Module preparation in collaboration and consultation with public actors* – *Capacity building* – *BHCSP field coordinators are selected as district level VHSNC Trainer (South 24P and Howrah).*	– *Raised voice* – *Multi-stakeholder approach (dengue mitigation)* – *Improved accountability and transparency* – *Cooperative Ownership and Community sustainability* – *Decentralised decision making* – *Better and more integrated services* – *Responsiveness in timely service provision* – *Increased community involvement in local level committees (VHSNC, WATSAN)* – *Interactive decision*
Community mobilisation/ senstitization		– *Community awareness* – *Group meeting* – *Consensus building*	
Gap Identification		– *Need Identification/situational analysis* – *Resource mapping/fish-bone/problem tree/case building*	
Networking	– *Trust building* – *Autonomy and independence* – *Voluntary reciprocal*	– *Community Group formation and networking* – *Baby sitting/peer learning*	

	exchange for mutual benefit	– *Creation of forum at different level*	*making process* – *Minimising the gap in service delivery*
Linkage Development	– *Mutual understanding* – *Better reporting* – *Active community participation* – *Effective bottom-up approach* – *Inclusion of un-served/underserved areas/issues* – *Creation of win-win situation*	– *Stakeholder analysis* – *Rapport building* – *Sharing of report* – *Collaborative intervention*	
Demand Creation:	– *Active community scoring process* – *Improved infrastructure and services of AWCs* – *Incorporation of "nutrition" and "palliative and rehabilitative care" for rural elderly in draft state elderly policy.* – *Identifying key elements for advocacy planning* – *Framing of message for different level/issue* – *Earned ability to respond critical views* – *Capacity to prepare health evidence* –	– *Identification of issues/cases and analysis* – *Listing of demand* – *Submission to relevant authority and follow-up*	
Advocacy		– *Identifying key elements for advocacy planning* – *Framing of message for different level/issue* – *Preparing health evidence* – *Responding to critic's views*	
Interface		– *Identification and prioritization of the issues/services* – *FGD/Depth interview with beneficiaries and service providers* – *Identification of indicator* – *Scoring of indicators by beneficiaries and service providers* – *Interface meeting with beneficiaries, service providers, decision maker/higher level authorities* – *Follow up and further action plan* – *District level VHSNC Convention[7] acted as a platform of interface between VHSNC members and DPHC*	

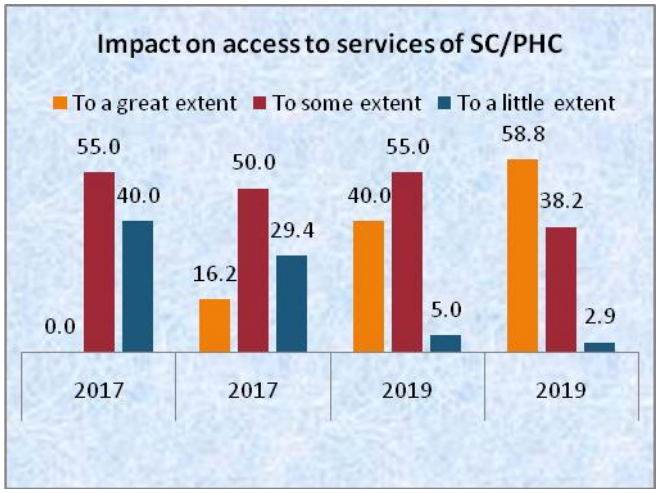
[7] District level VHSNC Convention in N24P – recognition of the role of BHCSP partners in formation and strengthening VHSNCs at their operational areas

Action Research	–	– *Learning by doing* – *Data Collection and analysis before and after intervention* – *Report writing* – *Sharing at various platform*	
Others	–	– *Experiences, feedback and suggestions are shared at GP, block and district level even at state level (viz. BHCSP conference 2019).*	–

GRAM PANCHAYAT LEVEL

PARTNER AND STAKEHOLDER EVALUATION

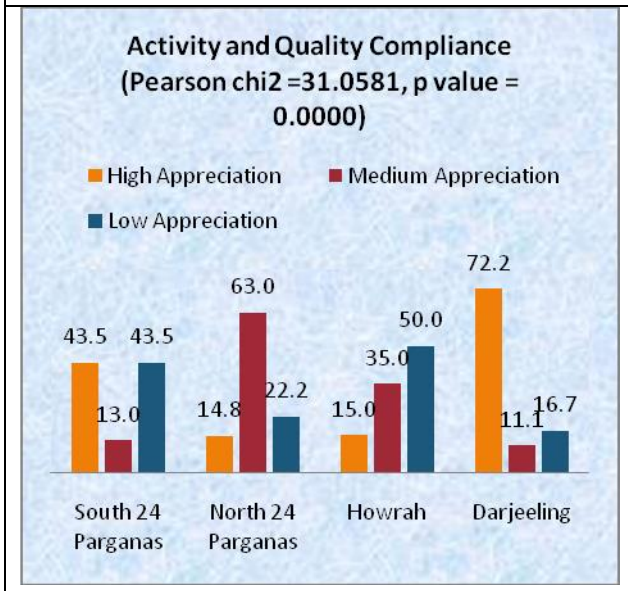
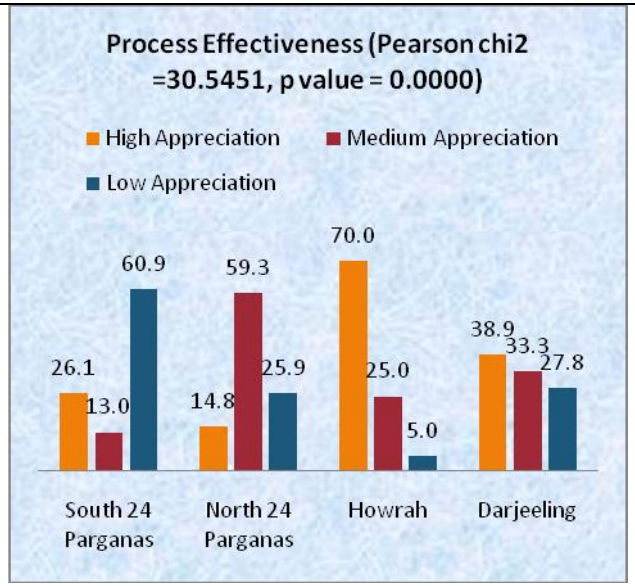
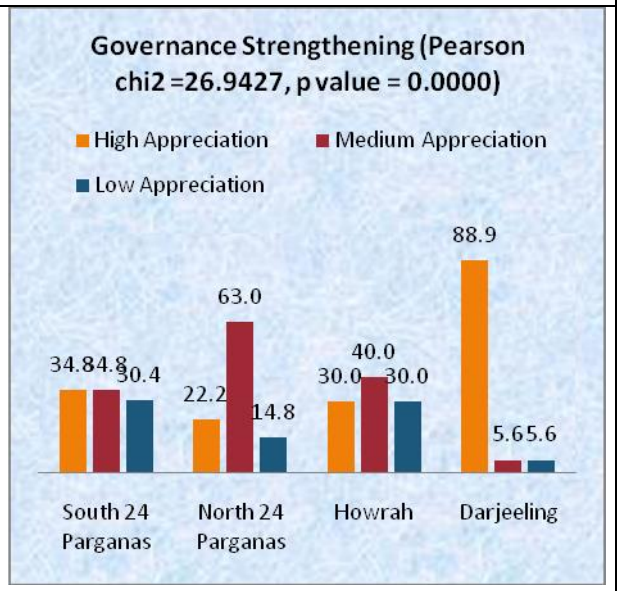
Chart 3.1.1: Impact of Phase V of BHCS programme on health service accessibility



Progress towards ***Impact*** *of the programme measured how far the programme is successful in supporting communities and healthcare delivery to reduce structural and systemic gaps in the supply side and knowledge-attitude-practice gap in the demand side through effective process design and implementation. Here '****to a great extent****' implies* ***60 to 80 per cent increase*** *and '****to some extent****' implies* ***30 to 60 per cent increase****.*

It is evident that during the phase V of the project span the coverage of the target population increased from 2017 to 2019 – average number of individuals reached per quarter in a year increased from 780 to 968 as per the information from the project staffs. ***It is an indication of better progress towards outcomes as the reach per quarter is substantive given the target population.***

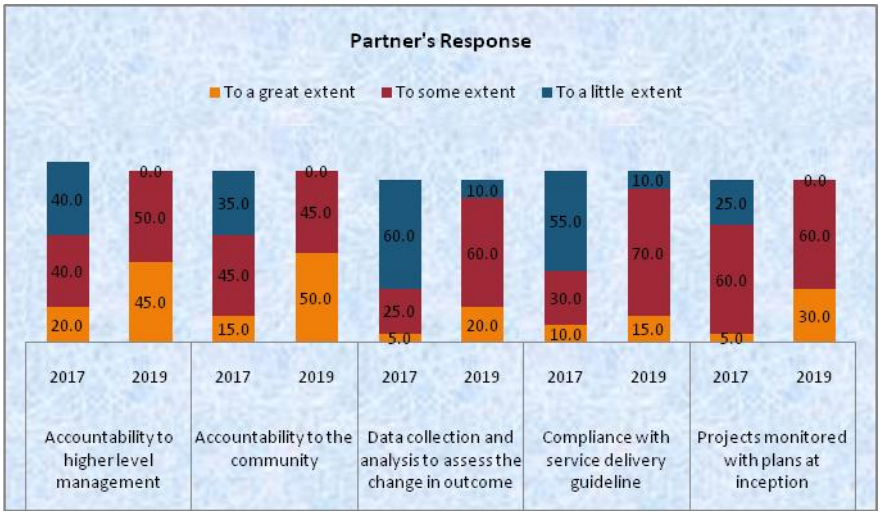
Chart 3.1.2: Degree of Stakeholder's Appreciation with respect to Activity and Quality Compliance, Process Effectiveness and Governance Strengthening

Activity and Quality Compliance	*Process Effectiveness*	*Governance Strengthening*
		

Degree of stakeholders' appreciation with respect to process implementation with quality compliance as well as activities as per plan is significantly higher in Darjeeling, moderate in South 24 Parganas and medium in North 24 Parganas. Regarding implementation process effectiveness, appreciation rate is significantly medium in North 24 Parganas and Howrah shows significantly higher rate of appreciation. Concerning the strengthening of governance, Darjeeling shows significantly higher rate of appreciation. Items used to manifest each construct are available in the questionnaire in the Appendix.

Chart 3.2 A and B: Disaggregated views of partners and stakeholders on impact towards strengthening health governance

It also measured how far the programme contributed to increase physical, social and economic accessibility of healthcare through engaging them in programme activities from programme launch to till date. From



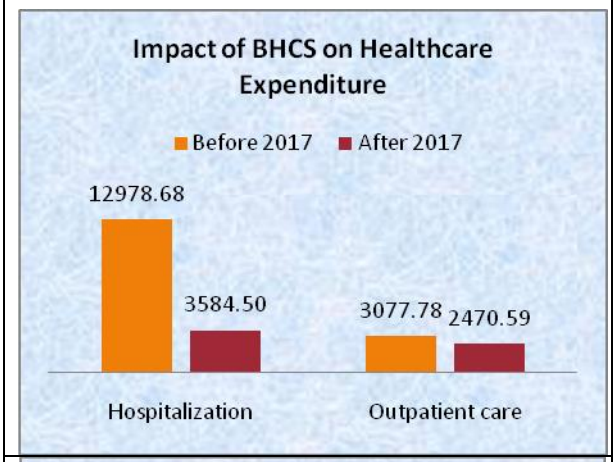
partners' and their stakeholders' response the positive impact of BHCS programme in increasing access to health service has been increased from some extent to great extent – as mentioned by 50 to 60 per cent of stakeholders and 40 to 55 per cent of programme personnel. In other words, the programme phase V is successful in increasing the healthcare access – both at demand side social and physical accessibility through community awareness and at supply side the availability of quality service through strengthening of governance. The evaluation shows that in this phase such increase in access in demand and supply side is achieved by 60 to 80 per cent in near about 50 per cent of the project area which is quite promising as the growth rate indicates. This is because; if the process can be further improved the target can be easily reached before 2021. The process acceleration will boost the achievement within shorter period leading to making space for more international and national dissemination of lessons learnt and success stories towards achieving universal health coverage as a ***Model Intervention****.*

How far the accountability of service providers and other stakeholders has been ensured through the programme implementation *– as per programme coordinators and facilitators, success to increase the accountability of ground level frontline workers to their higher level of governance is 60 to 80 per cent which increased the coverage from 20 per cent of implementation area to 45 per cent of implementation area. According to stakeholders such higher accountability resulted in 25 per cent of coverage area to 47 per cent. Moreover, success towards creating stakeholders' accountability to the community is increased by 60 to 80 per cent from 15 per cent of the implementation coverage area to the 50 per cent of the coverage area – 35 percentage point increase. Validation of its reliability from stakeholders reflects 26 percentage point increase in success.* ***Having said that, it can be inferred from the above findings that better progress is visible towards achieving the efficient ground level governance and the 100 per cent reach is not so far.*** *However, improvement in data collection process for monitoring of implementation improved by 30 to 60 per cent – from 25 per cent to 60 per cent of the implementation partners as per programme personnel and 22 to 54 per cent of the programme as per stakeholders. With respect to following of compliance with service delivery guidelines, those targets are getting fulfilled by 30 to 60 per cent in 30 to 70 per cent of the implementation coverage areas as per partners which is somewhat less successful as per stakeholders. Whereas, success towards increasing the execution of monitoring from plan at inception – positive change by 60 to 80 per cent is reflected in 5 per cent (2017) to 30 per cent (2019) of coverage area as per partners but less according to stakeholders.****This can be easily rectified by 2 or 3 review meetings with the stakeholders in respective places in order to assess the challenges faced in the process of compliance and monitoring so that strategies to achieve it can be formulated.*

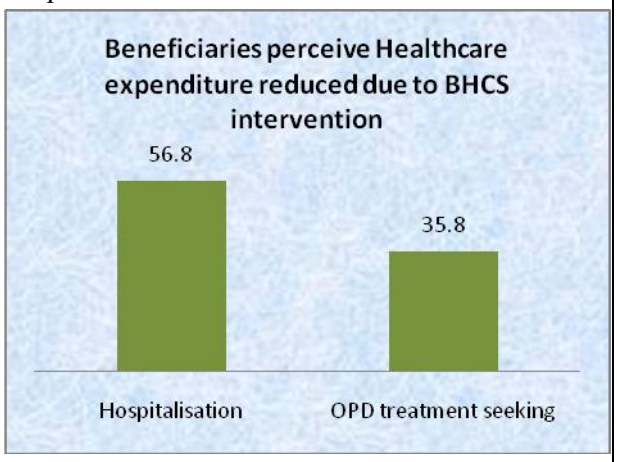
BENEFICIARY LEVEL – THE DEGREE OF USER SATISFACTION – PROGRESS TOWARDS IMPACT

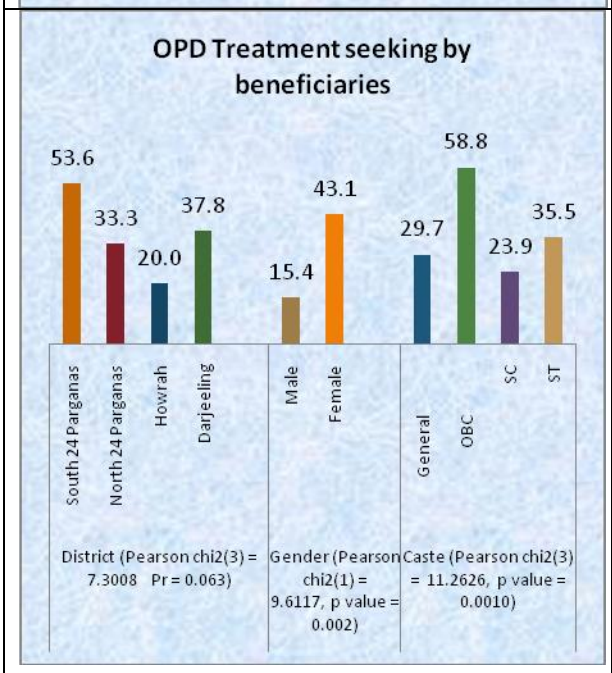
Chart 3.3: Actual (Graph 1) and perceived (Graph 2) change in out of pocket expenditure on healthcare due to BHCS intervention and distribution of beneficiaries' attendance in awareness programme

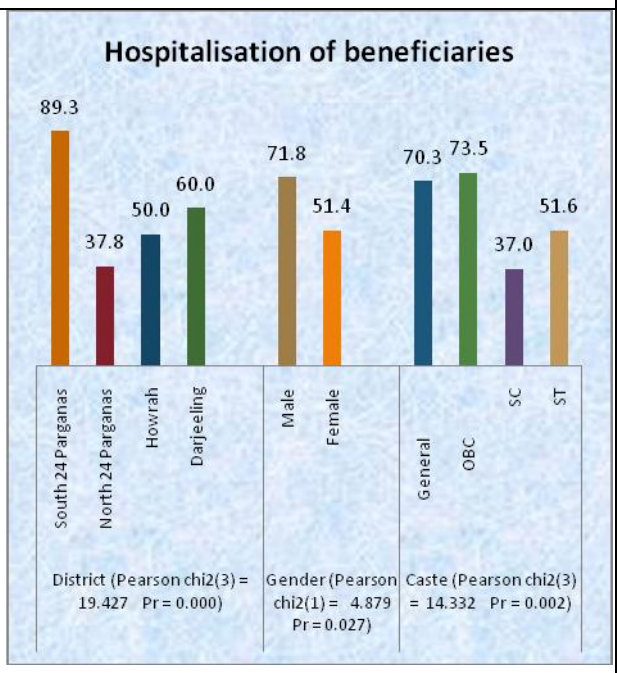
Graph 1

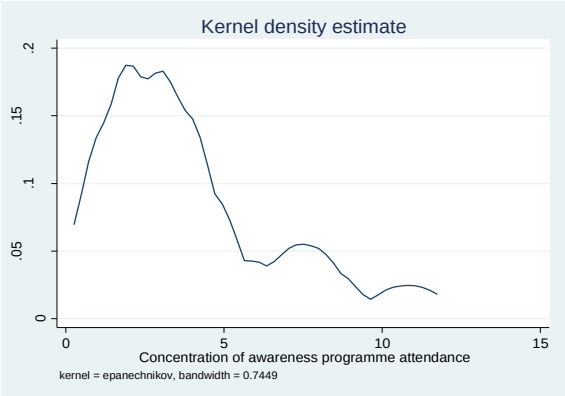


Graph 2







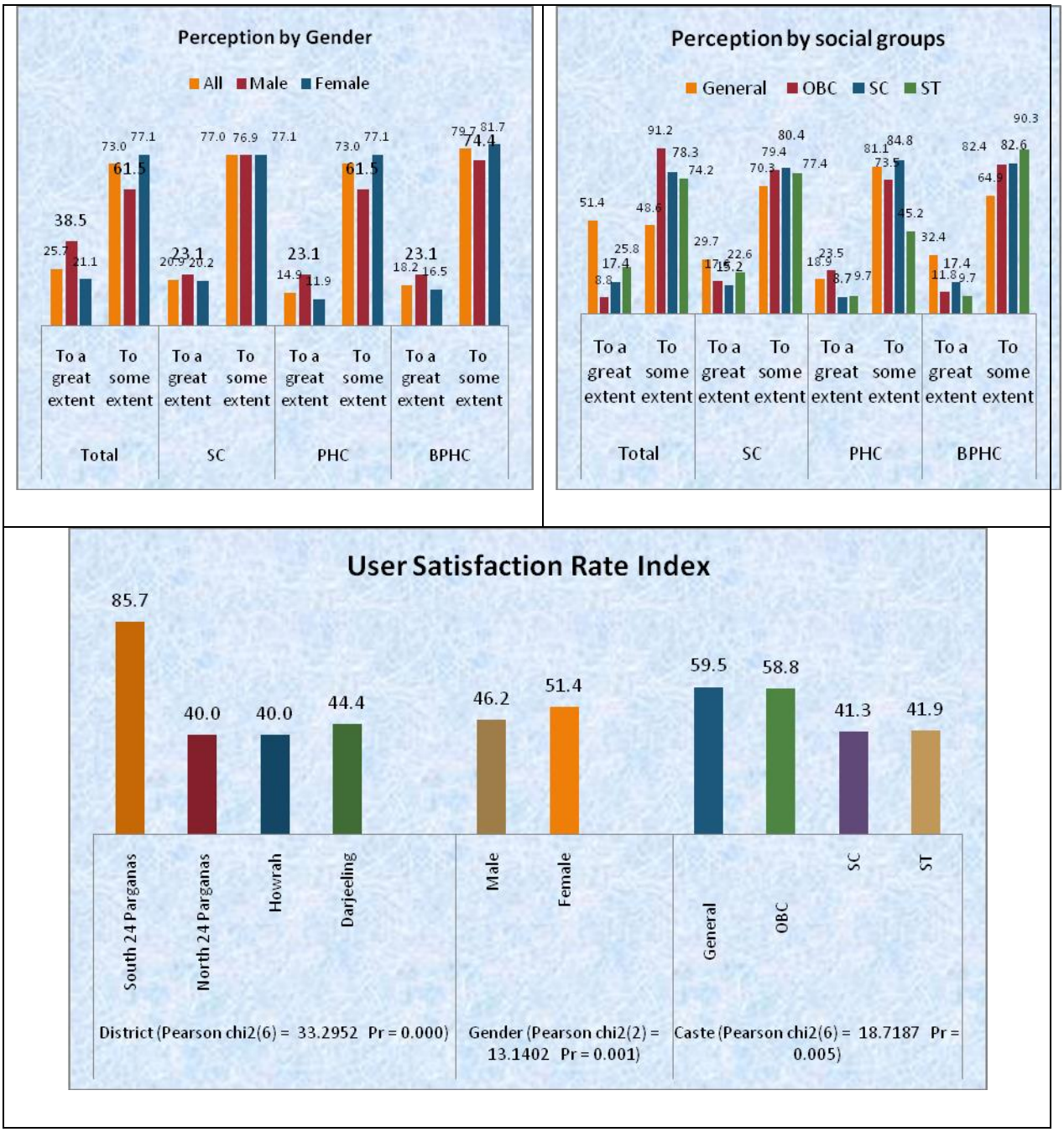


It is evident that the success of BHCS towards reducing catastrophic health expenditure is 72.4 per cent (Graph 1) as reported by respondents ***implying a huge success towards reduction of health poverty – a crucial contributor to the overall poverty in Indian economy.*** *However, among the respondents, 57 per cent and 36 per cent perceives the expenditure on hospitalization and outpatient care has been reduced respectively due to BHCS programme implementation.* ***Therefore, the actual contribution of BHCS which is higher than the perception level is to be shared with beneficiaries.*** *Concerning OPD treatment seeking the improvement is significantly visible at higher degree in South 24 Parganas (53.6 per cent and*

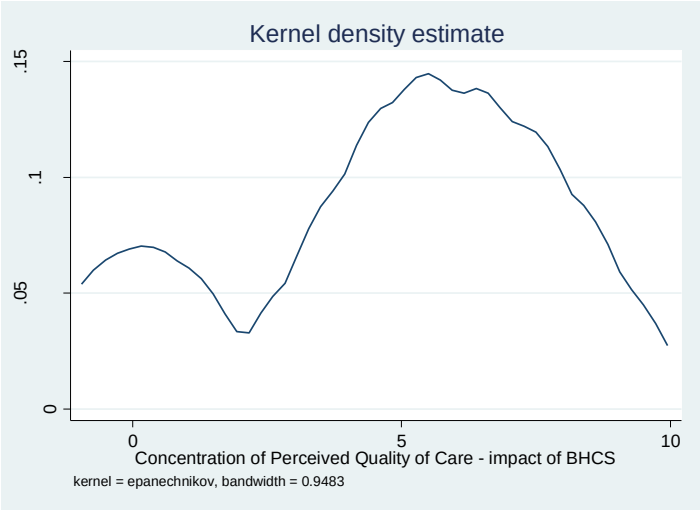
moderately in Darjeeling (37.8 per cent) whereas hospitalization is increased significantly highly in South 24 Parganas (89.3 per cent) and Darjeeling (60.0 per cent) and Howrah (50.0 per cent) districts.

Most of the beneficiaries attended 3 to 5 programmes (42.2 per cent of them) and 61 per cent attended the programme on health insurance ***which is a very good indication towards direct and indirect increase in access to health services.***

Chart 3.4: Perceived improvement in service delivery of health facilities –by gender and marginalized population and concentration of perception about BHCS' impact towards changing service quality

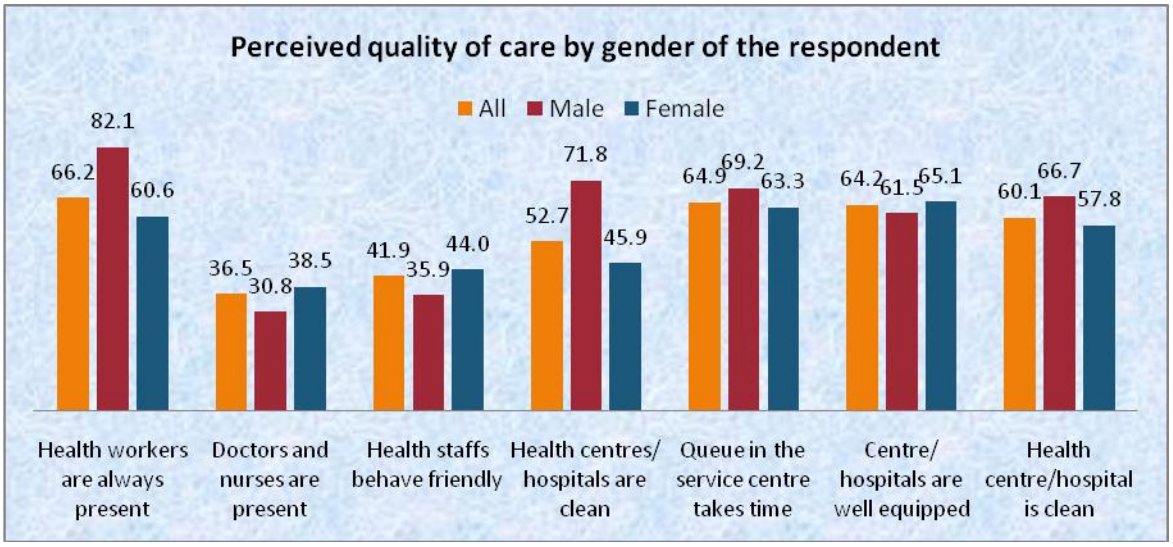


User satisfaction rate is calculated based on responses on how far the treatment seeking has been changed, OOPE has been reduced, quality of care improved and awareness programmes took place during programme implementation. It is evident that user satisfaction is significantly higher in South 24 Parganas, among female users and less among SCs and STs. The other districts need to focus on dissemination and sharing more along with implementation of the programme.



Beneficiaries were asked whether they think the service delivery of SC, PHC and BPHC are improved with respect to presence of health workers, doctors and nurses, friendly behaviour of health staffs, cleanliness of health centres/ hospitals, queue in the service centre, equipments in centre/ hospitals. It is evident that 60.8 per cent of beneficiaries feel that all these aspects are improved due to intervention of BHCS programme and some of them agree that out of pocket expenditure on healthcare has been reduced after intervention started. Therefore ***more than 60 per cent of user satisfaction rate indicates good progress towards outcome achievement****, however some improvements in process (as indicated in the effectiveness and efficiency parts) will improve the pace of progress further.*

Chart 3.5: Enhanced Perceived Quality of Care - by Gender of the beneficiary



FOCUSED GROUP DISCUSSION WITH GERIATRIC GROUP

PROGRESS TOWARDS IMPACT

- *With the help of the BHCS programme they became aware about health issues along with usefulness of exercise and yoga in older age. During the awareness programme the Geriatric group gathered clear idea about their health and fitness.*

- *The Geriatric group explained that the service deliveries of health facilities in their community have been improved than before. After the involvement of Ashadip foundation the aged people get better health care facilities on a regular basis. Due to the far distance of the hospital from the community the NGO staffs arrange health camps along with the ASHA and ANM staffs in the community. They get routine blood tests, blood pressure check-up on regular basis, and their psycho-social health also improved after getting engaged with the organisation.*
- *The nature of service delivery is good by means and behavior of health staffs improved than before, cleanliness of institutes, and maintaining separate queue for aged people. By the support of NGO workers they get transport facilities to go to the hospital or health centre. The community leaders very often help them out in health problems by issuing various certificates they need.*

SERVICE ACCESSIBILITY IMPROVEMENT- PROGRESS TOWARDS EFFECTIVENESS

- *They often go to sub centre for seeking healthcare services, usually the SC provides all the health services they can offer. If they don't get any service in hospital or health centres then they inform the members of the Ngo to help them out.*
- *The NGO staffs help them to get old age pension and widow pension by assisting them in each official procedure.*
- *As per them, all the members of their community have toilets. They have hand pumps for drinking and household works. But there is no piped water supply in the community. They clearly stated that the NGO members inform them about Basic health care services, which helped them to getting fit mentally and physically.*

FOCUSED GROUP DISCUSSION WITH MOTHERS' GROUP

PROGRESS TOWARDS IMPACT

- *There the mothers' group were very much familiar with the BHCS programme objectives as they attend three to four awareness programmes on average organized by NGO partners and*

WBVHA. With the help of the programme knowledge they were aware about institution of delivery, door to door visit, immunization and other health related issues.

- *During the awareness programme the mothers' group received clear idea about how to aware local people in respect of their health, and also get trained to resolve some other issue by their own like- identify peoples suffered by any sickness or illness of the community, door to door visit for spreading awareness, stop early marriages in the community and start to recommend for institutional delivery in place of home delivery.*
- *The service deliveries of health facilities have improved than before as the NGOs help to get doctors and nurses in the PHC, in previous days there was only a pharmacist, but from 2018 after many efforts and applications by the implementing partners NGO doctors and nurses had been appointed in the PHC. As per their opinion the health service delivery of sub-centre and primary health centre is good but the health service delivery of BPHC is not satisfactory. However, services in Baduria Rural Hospital in North 24 Parganas are improving.*
- *As per the mothers' group, the BHCS programme also helps to reduce health care expenditures by identification of old age pension, Swastha Sathi health card awareness, awareness campaign for Manabik Pension Scheme, provide Pulse Polio in inaccessible areas, and helps to build health funds. The community leaders also help them out in health problem related issues by providing money, arrange ambulance and sometimes provide human resource.*

SERVICE ACCESSIBILITY IMPROVEMENT- PROGRESS TOWARDS EFFECTIVENESS

- *The mothers' group goes to sub centre for seeking healthcare services, usually the SC provides all the health services as per their capabilities. If they don't get any service in sub centres then they inform the members of the NGOs to help them out.*

- *As per them, all the members of their community have toilets and groups in Darjeeling they get good quality spring water for drinking purpose. They clearly stated that the NGO workers inform them about Basic health care services, which helped them to identify any community problem and solved the problem by their own, to know about immunization process, to get Swastha Sathi health card.*

FOCUSED GROUP DISCUSSION WITH ADOLESCENT GROUP

PROGRESS TOWARDS IMPACT

- *With the help of the BHCS programme, they are now aware about health and hygiene issues along with cleaning the environment as well as basic human rights. During the awareness programme the adolescence group gets to know a clear idea about their health and hygiene,*

and also get trained to resolve some other issue by their own like- identify people suffered by any sickness or illness of the community, make posters for spread awareness, and inform the NGOs about early marriages in the community. Monthly meeting on adolescent health has been started.

- *The adolescent group explained that the service deliveries of health facilities in their community have been improved than before. They spread awareness among the adolescent group, helped them to get a health counselor in their school. After the awareness programmes they went to school to demand the services regarding the health counselor. They get instant tetanus injection facilities from BHCS fund. The adolescent group clearly explained that the service deliveries of health facilities in their community have been improved than before by means of adequate medicines, health staffs and infrastructures. There the new SC is very much clean and newly constructed two storied building with two health staffs.*
- *The nature of service delivery is good by means of cooperating behaviour of health staffs, cleanliness of institutes like schools, health centres and environment. By the support of NGO workers, they made plastic dump yard in the school and do plantation on regular basis in school campus. The community leaders very often help them out in health problem related issues.*

SERVICE ACCESSIBILITY IMPROVEMENT- PROGRESS TOWARDS EFFECTIVENESS

- *They often go to sub centre for demanding services of health seeking, usually the SC provide all the health services they can. If they don't get any service in sub centres then inform the members of the Ngo to help them out.*
- *As per them, all the members of their community have toilets and in Darjeeling respondents added they get good quality spring water for use and drink. They clearly stated that the NGO members inform them about Basic health care services, which helped them to identify a problem and solved the problem by their own, to achieving life goals, to get education loan for the student under below poverty line, to get Swastha Sathi health card.*

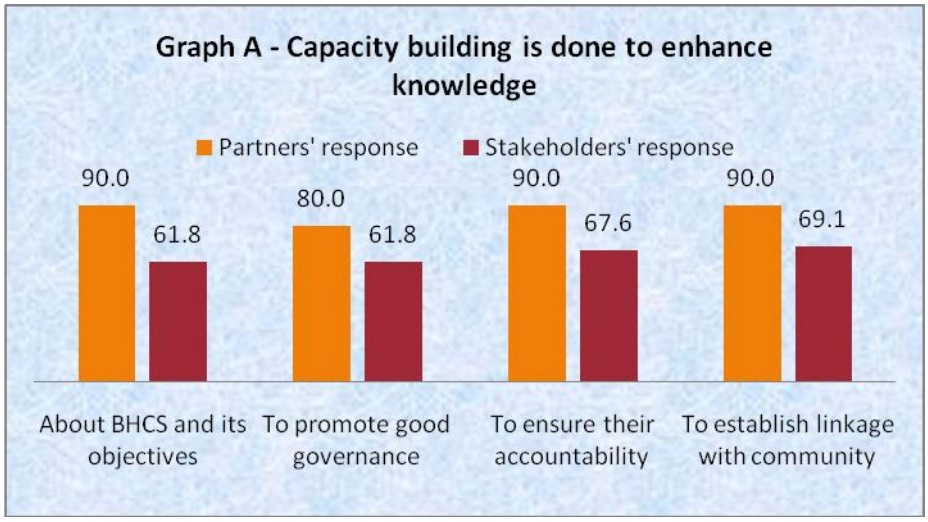
DEGREE OF PROCESS EFFECTIVENESS

PROCESS I: CAPACITY BUILDING

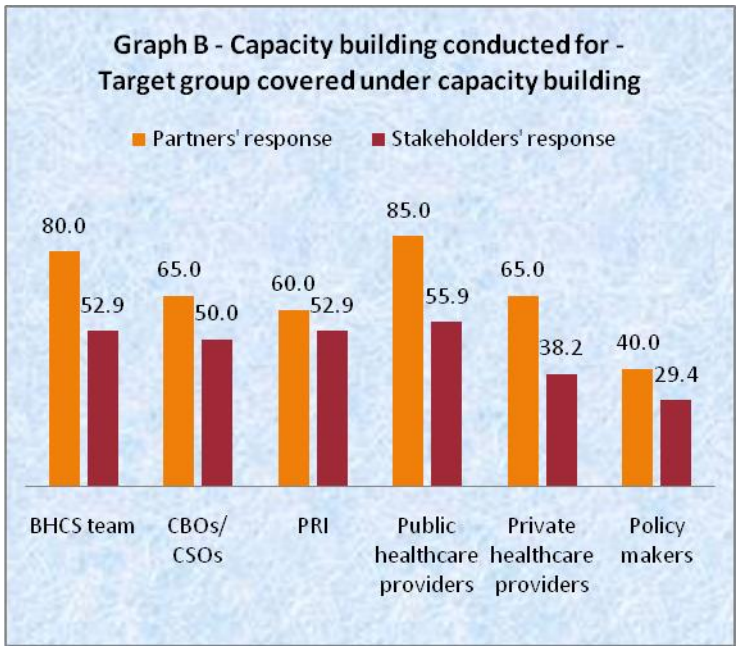
Chart 3.6: Success towards achieving efficient governance through the effectiveness of process - Capacity building

In assessing the process of Capacity building dimensions explored are –

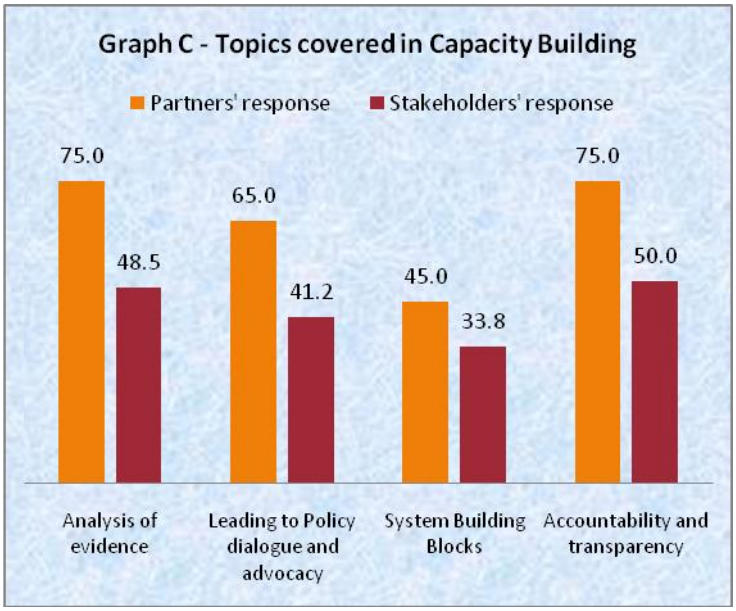
1. *Capacity building covered components of good governance (Graph A)*
2. *Target group (Graph B)*
3. *Topics designed to develop capacity on policy advocacy, systemic building blocks, accountability and analytics etc., (Graph C)*
4. *Documents maintained related to process change and reflected in advocacy(Graph D)*
5. *Documents maintained and shared with stakeholders related to capacity building(Graph E)*



Process effectiveness has been achieved by 60 to 70 per cent with respect to ground level workers knowledge enhancement. The process was implemented in 80 to 90 per cent of the project area. However, to improve service delivery further, improvement in knowledge is to be achieved through reducing the 20 to 30 per cent gap in capacity building effectiveness (in relation to BHCS overall objectives and specifically, promoting good governance, enhancing accountability and increasing linkages with community). Moreover, progress is better in Darjeeling and South 24 Parganas district and process strengthening is required in north 24 Parganas and Howrah. ***Therefore, to improve the effectiveness of the process towards good governance require conducting of review meeting with stakeholders to assess what are the scopes remaining to increase their understanding – aspects and accordingly sub-components can be incorporated.***

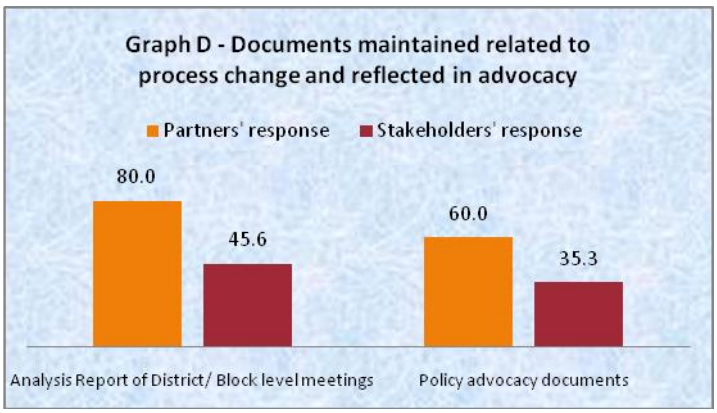


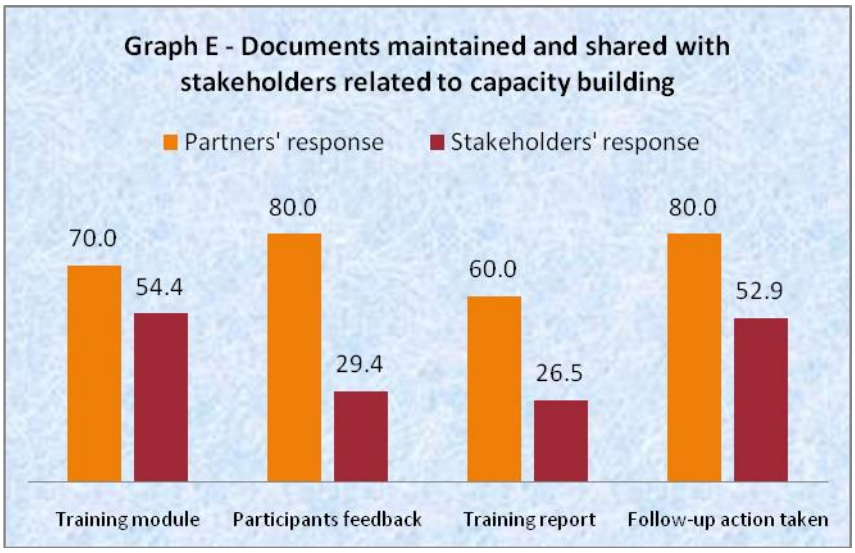
Though there is good and significant coverage of heterogeneous target groups covering 80 to 85 per cent of BHCS team members and healthcare providers, coverage is to be increased for other local CBOs, PRIs, private providers and policy makers in the post-mid-term phase of the programme. *In addition to this further, knowledge of stakeholders on the execution of programme components is to be increased comprehensively through more forum meetings and workshops as there is a gap visible in their knowledge about the actual coverage of target groups. The strategic modifications in this process are to be focused more in North 24 Parganas and Howrah and comparatively less in other two.*



Good coverage of different topics (75 per cent of partners are covering them) related to successful implementation is visible in the process, however, more stress is needed on how to conduct policy advocacy after sessions on system building blocks of the health service delivery is to be shared in capacity building of block level officials.

Sharing of training modules, participants' feedbacks and follow up actions based on feedback are evident in 70 to 80 per cent of the implementation areas. *However, the process of feedback collection is to be done in written format to reduce the gaps in stakeholders' understanding and acceptance of the capacity building activity related processes. Consistent preparation and sharing of training reports with stakeholders is to be conducted.*





Though process like sharing of training module and follow up actions after capacity building are performed in good to moderate degree in South 24 Parganas and Darjeeling; collection of documented feedbacks and sharing of training report to stakeholders are to be conducted in regular manner in all the districts.

Sharing of implementation process related changes based on district or block level meetings are done in 80 per cent of the implementation area. *Still, sharing the copies with stakeholders in sharing meetings with their acknowledgements during the meetings and workshops will increase their stakes more in bringing success of BHCS in inclusive manner. Documentation and sharing of policy briefs are to be done periodically following similar methods. The performance is well and much better in Darjeeling which may need to be shared as learning lessons for other three districts.* ***Then it can be predicted that the remaining 20 to 30 per cent increase in collection and sharing of feedback can be achieved within 2021.***

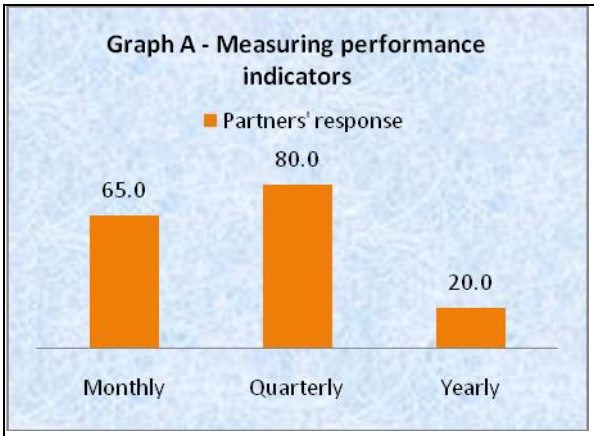
PROCESS II: MEASURING RESULT INDICATORS

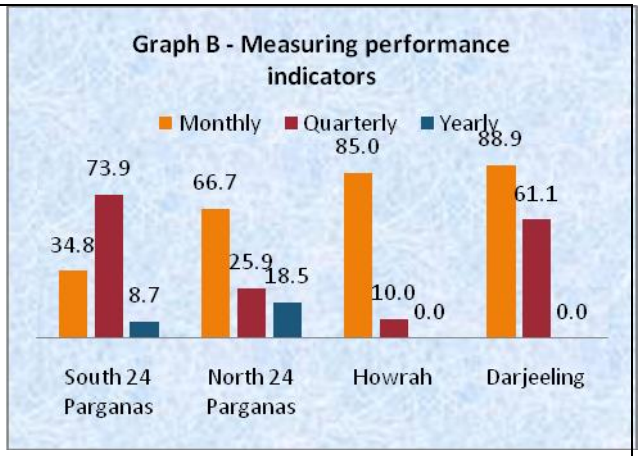
Chart 3.7: Success towards achieving efficient governance through the effectiveness of process –Output measurement process

In assessing the process of output measurement dimensions explored are –

1. *Measuring performance indicators – by period (Graph A)*
2. *Measuring performance indicators – by districts and periods (Graph B)*

80 per cent of implementation area measures activities and outputs on quarterly basis, however mostly in consistent manner in South 24 Parganas and Darjeeling. Annual cumulative estimates are to be performed also to reduce the gap of 80 per cent covering all the districts. Monthly analysis is done in 65 per cent of the area (mostly in Howrah and Darjeeling) which is to be increased in other two districts.





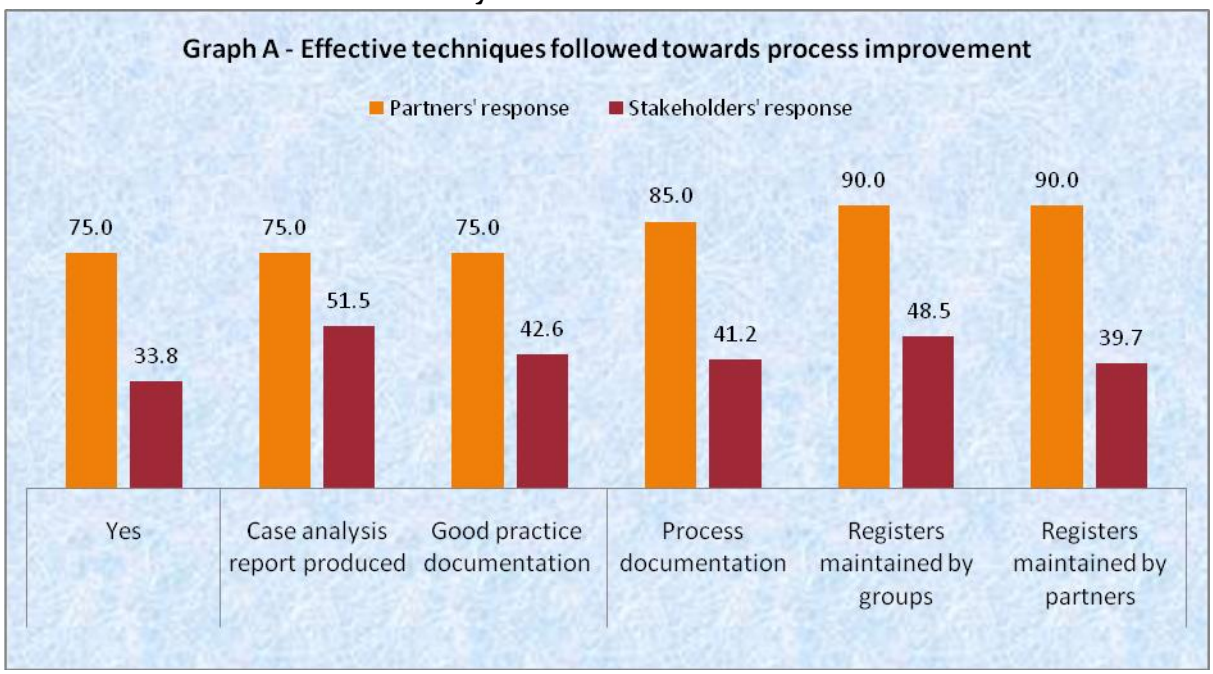
PROCESS III: SHARING OF SUCCESS THROUGH DISSEMINATION

Chart 3.8: Sharing of success through dissemination

In assessing the process of sharing success, dimension explored is –

1. *Effective techniques followed towards process improvement (Graph A)*

Sharing of success stories of BHCS implementation programme is to be done through presenting scientific papers in national and international conferences. This is to be done as a part of policy advocacy which is to be strengthened. ***Currently WBVHA conducts it in periodic manner through attending in national and international conferences. This can be further increased in collaboration with any academic institution.***



Implementing partners followed different effective techniques to improve the processes towards reaching outputs. Among 75 per cent of the implementers who adopted different techniques, ***90 per cent of such BHCS implementers maintain registers of participants in programmes, 85 per cent of them follow process documentation and 75 per cent prepare report after case by case analysis followed by good practice cases to represent the success in case building****. However, regular sharing of all such output documents is to be done in common forum with stakeholders and beneficiaries at district and block level as well as at state and national level through workshops. Much improvement is required in North 24 Parganas and Howrah.* ***Then the success rate will exceed 100 per cent before 2021.***

PROCESS IV: MONITORING TECHNIQUES

It is measured by different ways–

8. *Measuring monitoring quality by indexing (Table 3.1)*

Graph 3.9: Monitoring techniques followed and effectiveness in those processes evident

e. Increase in effectiveness in regular monitoring(Graph A)

f. Parameters to ensure quality of implementation followed (Graph B)

g. Quality assurance technique followed by Partners (Graph C)

h. Enriched financial and HR management in relation to M&E (Graph D)

i. M&E process improvement techniques followed (Graph E)

j. Improvement in Monitoring process to measure implementation activities (Graph F)

k. Improvement towards impact on governance (Graph G)

l. Improvement in process of integration between BHCS and Stakeholders (Graph H)

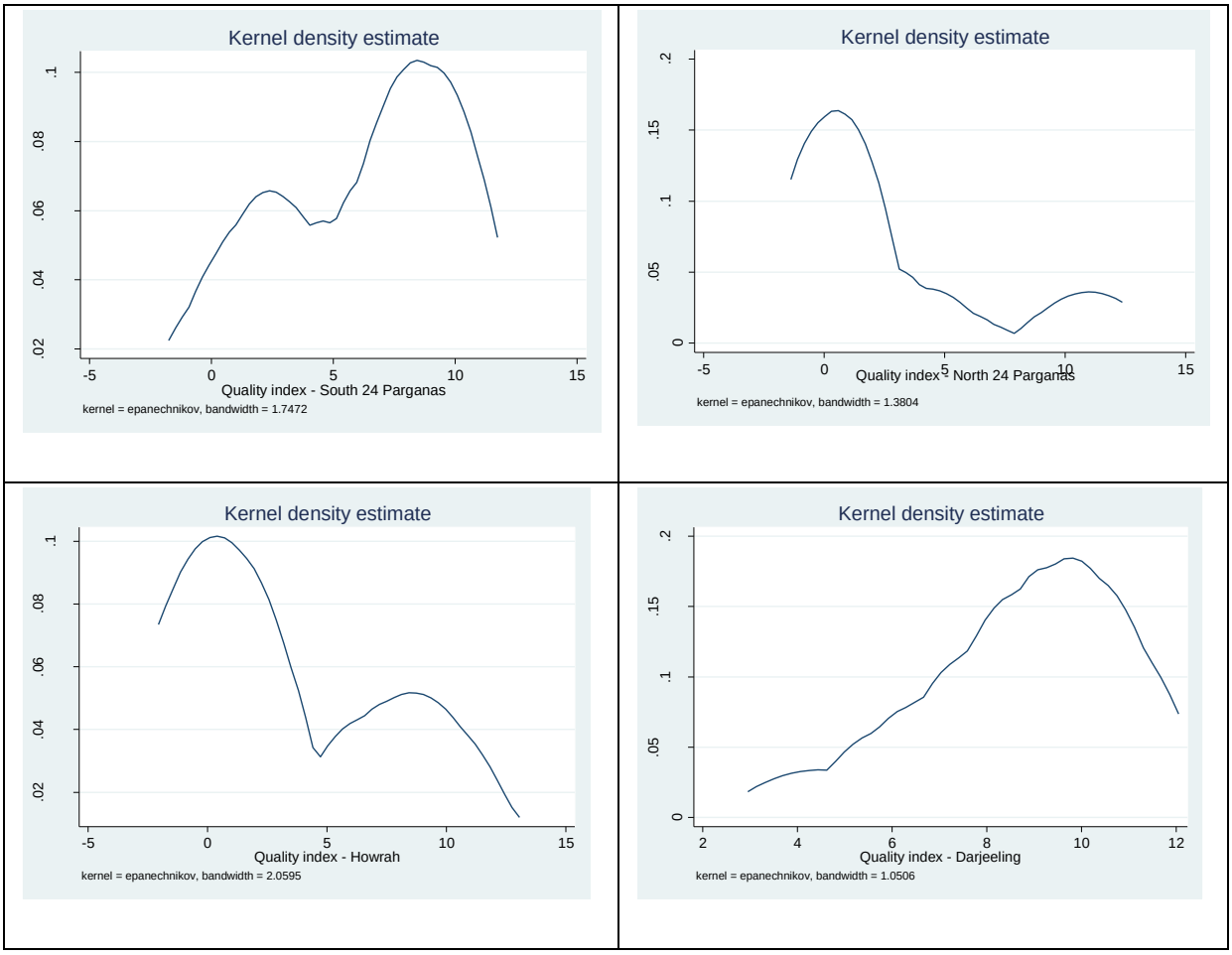
Whether budget for M&E at partner level has been increased, personnel are trained and how frequently Program Activity data has been collected as well as how far quality has been maintained in the implementation process is one way to measure effectiveness. ***Regular monitoring comprising of routine data collection and follow ups based on analysis has been increased from 80 to 100 per cent; 65 to 80 per cent of the implementers followed several parameters to ensure quality using mixed method approach and consultations in review meetings.***

A ***Quality Index*** *is created with aspects like*

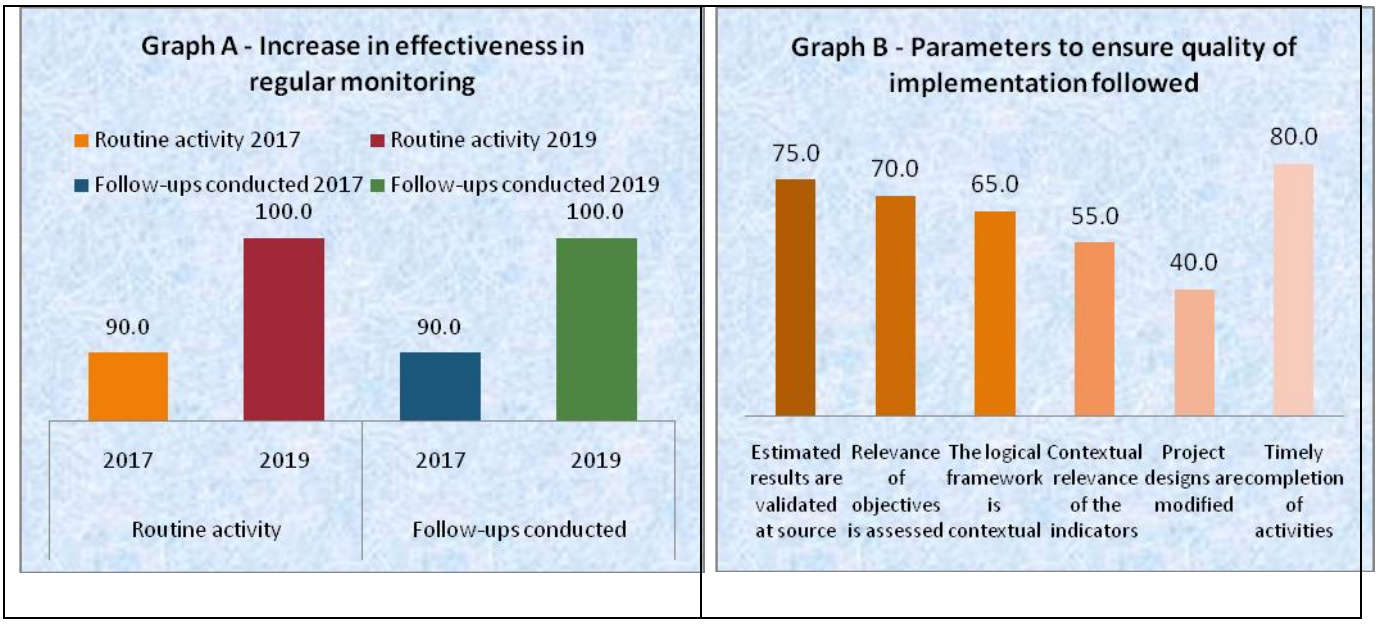
Whether estimated results are validated at source, Relevance of objectives is assessed, The logical framework is contextual, Contextual relevance of the indicators, Project designs are modified based on monitoring, Timely completion of activities, Process documentation and evaluation. In addition, also asked about techniques followed as – Consulting with implementing partners, Focus Group Discussion with community, Consulting stakeholders, Quantitative data collection, Qualitative data collection.

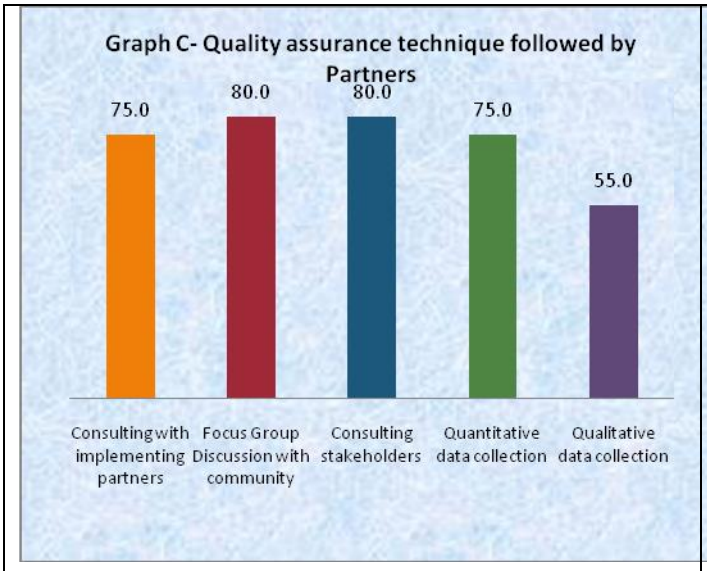
It is evident that the concentration of processes used to ensure quality in implementation is higher towards better quality in South 24 Parganas and Darjeeling whereas concentration of the same in maintaining quality in North 24 Parganas and Howrah is mostly under good to moderate scale (Table 3.1).

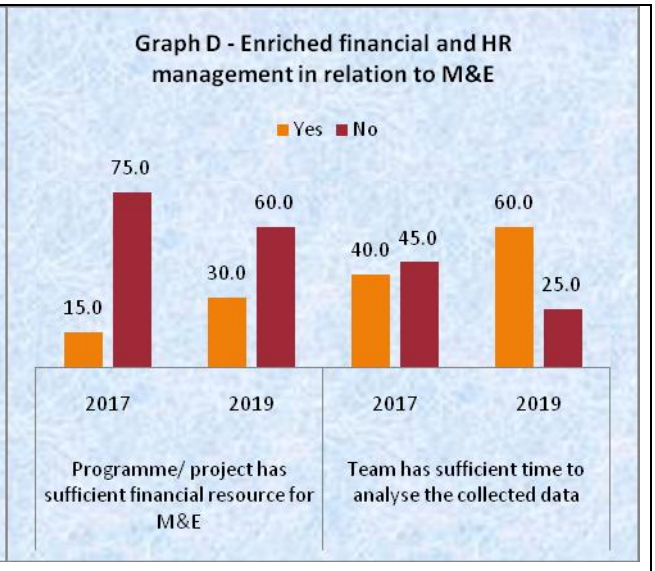
Table 3.1: Distribution of monitoring-quality index values by districts



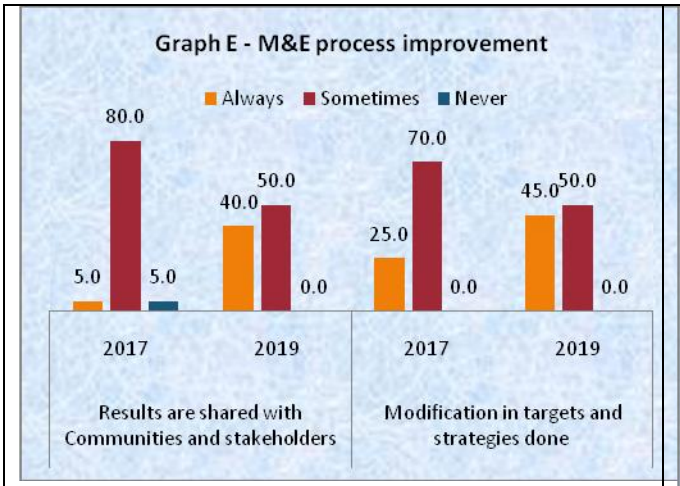
More importance is to be given to increase the capacity of partners in North 24 Parganas and Darjeeling to improve the quality parameters to ensure effectiveness. Such capacity building activities are to be followed by regular monitoring and reviews.

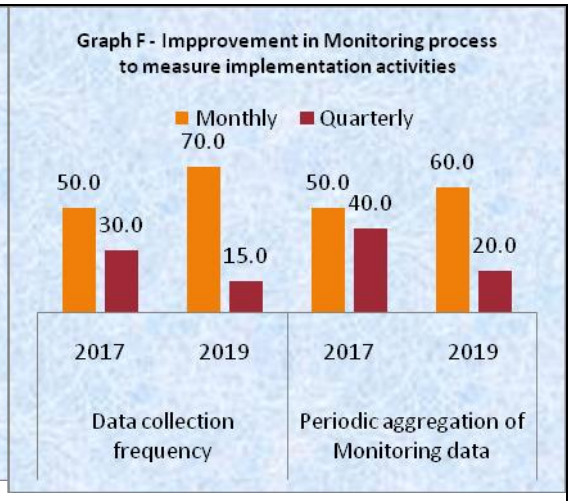


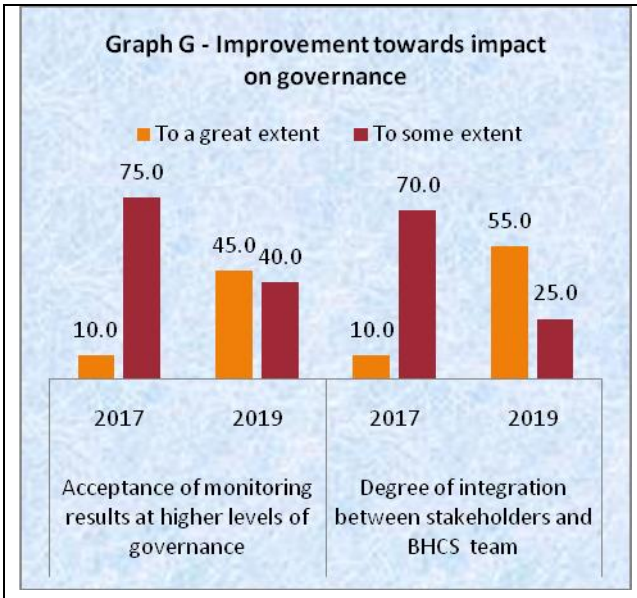


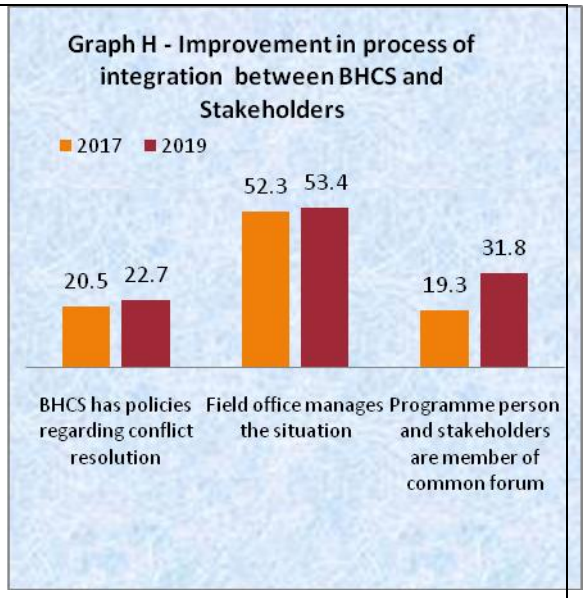


How far modification of content and / or methodology of respective components have been done and what techniques are followed to ensure process monitoring – In 2017, 70 to 80 per cent of the implementers followed result sharing and strategy modifications occasionally or in need based manner. Gradually, 2019 reflects increase in regular sharing to 40 per cent and regular modifications as per change requirements is visible among 45 per cent of them. Data collection frequency and periodic aggregation increased from quarterly to monthly from 2017 to 2019 and is followed by 60 to 70 per cent of them.









Acceptance of monitoring results has been increased from 30 – 60 per cent to 60 – 80 per cent from 2017 to 2019 by 35 percentage points. In other words, in 2017, fewer acceptances were concentrated among 75 per cent of the stakeholders. In 2019, greater acceptance (almost 60 to 80 per cent) is evident and increased from 10 per cent to 45 percent. Consequently, fewer acceptances are only visible 40 per cent in place of 75 per cent. Similarly, degree of integration between BHCS and stakeholders increased from 30 – 60 per cent to 60 – 80 per cent from 2017 to 2019 by 45 percentage points. The major process followed to bring success in integration is building a common forum of stakeholders and programme personnel which has been increased in good degree. ***Therefore, it can be predicted that the pace of progress towards acceptance and integration of M&E can be reached smoothly which can be further enhanced to ensure value for money efficiently within given time frame.***

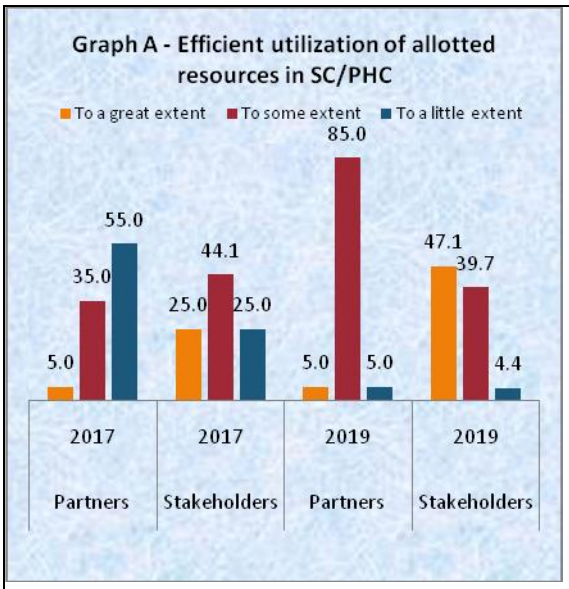
EFFICIENCY

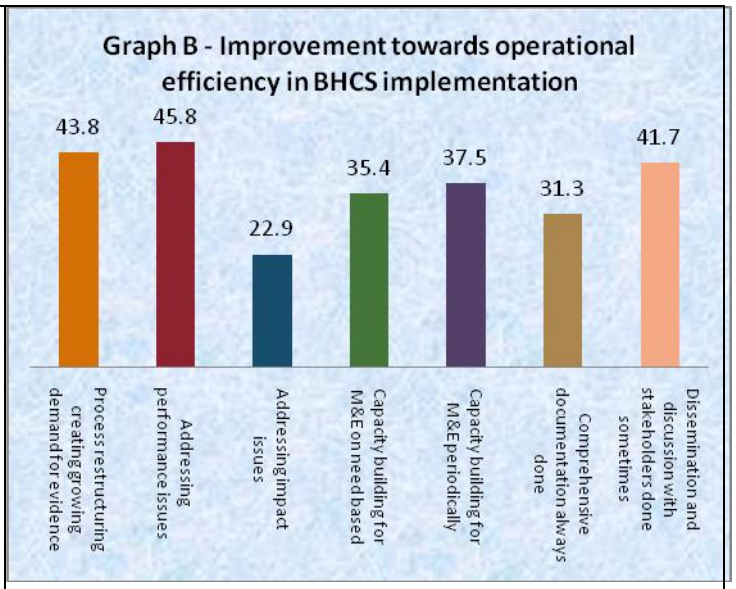
Chart 3.10: Measurement of financial, operational and risk management techniques followed to ensure efficiency

a) *Financial Efficiency (Graph A)*
b) *Operational Efficiency (Graph B)*
c) *Risk and Bottleneck analysis (Graph C)*

Supplemented by ***In depth interviews*** *with Stakeholders to assess the degree of resource utilization under the programme.*

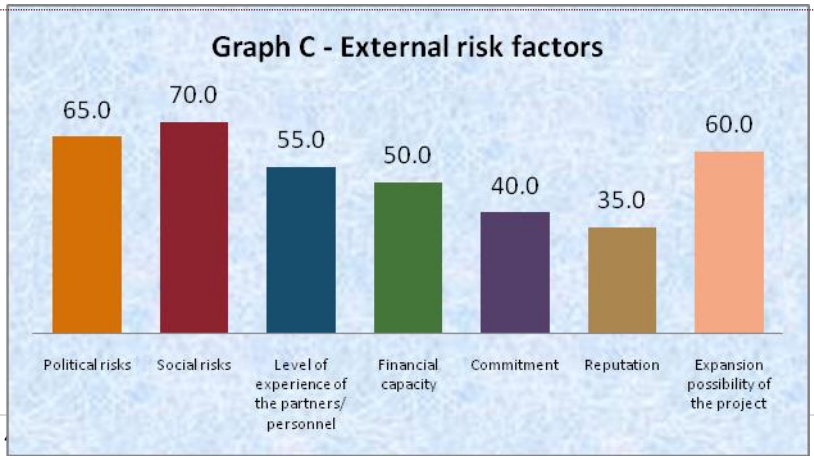
FINANCIAL AND OPERATIONAL EFFICIENCY





Through BHCS intervention, efficient utilisation of resources (allotted under health service delivery) by 30 to 60 per cent of stakeholders increased from 35 to 85 per cent as per programme partners while stakeholders reflect that efficient utilisation of resources (allotted) by 60 to 80 per cent of stakeholders is increased up to almost 50 per cent. ***Therefore, it can be inferred that the remaining efficiency gain – 15 per cent among two-third stakeholders and 50 per cent among one-fifth can be easily achieved in the rest of the programme phase.*** *Under operational aspects, efficiency is increasing in process restructuring creating periodic evidence, performance evaluation of personnel, dissemination in common forum. However, scope of improvement is evident in addressing issues affecting impact, more stress is to be given on capacity building for M&E and comprehensive documentation of progress towards achievements.*

RISK AND BOTTLENECK ANALYSIS



BHCS programme success cannot be measured only by their activities performed. In addition to activities, the nature of challenges they faced and have overcome

matters to assess their real level of success. BHCS programme selected the geographical areas of intervention which are politically (65 per cent), socially challenging (70 per cent). Through this implementation, BHCS is building partner's capacity to make the implementation sustainable – to be continued even after the end of implementation span. Among them, 60 per cent thinks project will be extended which is perceived to be required in order to accelerate the process of sustainability. ***In other words, given the time to build the mindset of communities and stakeholders an extension phase is needed to increase the pace of smooth implementation – will help to achieve the outcomes in sustainable manner further.*** *With respect to bottleneck analysis, though the programme is receiving active support and involvement from stakeholders, there is scope to increase the technical support from them. More involvement with policymakers is to be established to be increased by almost 50 per cent. The contextual relevance of the programme is good – more than 50 per cent of the implementation area found it highly relevant whereas 43 per cent found it moderately relevant. However, one third of the implementers perceive that more implementation process related change is needed to increase the efficiency of the intervention.*

COLLABORATION AND SYNERGY

Itarai Asha Deep in Howrah District :

In IAD there is good collaboration with the local self government (Gram Panchayat). Also there is synergy and cooperation with the block health system. They have suggested food support for the elders who need. There is good collaboration with the Debipur Block Primary Health Centre and the BMOH has requested some transport and food support for the Tuberculosis patients.

- *There is good collaboration with local self government and the block government health system*

NGSSC, Darjeeling District :

As per opinion of BMOH, basic health care support should also look into the cervical cancer screening. The BMOH suggested for 100% immunisation for the community people and suggested for more human support to solve health care problems. Sustainability

BHCS' approach towards Sustainability is assessed by

a) *Success Stories of the programme and secondary study of the programme documents*
b) *Outsourcing of M&E to improve programme performance towards sustainability.*

c) *These methods are supplemented by focused group discussion with communities.*

EVOLVED SUCCESS OF BHCSP

1. *People-centred health governance – Memisa programme is gaining success towards achieving that where people do not only 'participate' but involve themselves to commit towards their own health and collectively on community health to ensure their health rights. The sustainability indicator is that people become in charge and not the implementing partner ('from Forum to movement').*

2. *Tackling the structural changes - The focus on structural transformation is successful in retarding the shifts of healthcare from a public to a private good. BHCS is gaining success in ensuring access of quality service with trust on doctors, strengthening the following of health regulation, decentralised policy decisions, and expanding space for civil society to provide handholding support. Implementing partners are getting systematically connected with the broader global policies objectives (e.g. Universal Health Coverage with reduced out of pocket spending).*

3. *BHCS being an exceptional programme with Memisa support of continuous 15 years able to bring sustainable change at the level of the communities at micro level. They strengthened in-house capacity to prepare policy documents and decisions taken in scientific and systematic manner. This documentation involves the evolution process of people-centred health governance over 15 years and its contribution to the society (e.g. regarding roles and their relations; social cohesion between health professionals and communities).*

4. *BHCS is also focusing on mitigating the challenge of mind-shifts which is the central point of daily activity at all levels concerning all stakeholders.*

5. *BHCS has to focus on building capacity on how to use dynamic quantitative research methods on evolving not confined topics (breaking the notion that the dictate of the P-value rather implementing the statistical techniques in efficient way so that it will predict with representative P-value – the real sense not nominal sense) and to be supplemented by the story of 15 years of change. The dynamic process of action research is to be documented following 'SMART' approach.*

OUTSOURCING OF MONITORING & EVALUATION

Table 3.2: Outsourcing of M&E to improve programme performance towards sustainability

		South 24 Parganas	North 24 Parganas	Howrah	Darjeeling
Perceived benefit of outsourcing of M&E	Saves cost in terms of human resource	0.0	0.0	0.0	100.0
	Saves cost for training and capacity building of programme person	0.0	100.0	0.0	0.0
	Saves travel cost	0.0	0.0	0.0	100.0
	Saves time of programme personnel	0.0	0.0	0.0	100.0
	Increases quality and quantity of output	100.0	0.0	100.0	100.0
M&E application software	Will accelerate outcome	100.0	22.7	45.5	100.0
	To be in-built	90.9	27.3	27.3	100.0
	To be easy to use	90.9	13.6	18.2	100.0
Complemented by	Baseline, Mid-term, End-line evaluations	90.9	22.7	27.3	100.0
	Periodic participatory review of action plans	90.9	22.7	18.2	100.0
	Periodic participatory review of implementation process	9.1	13.6	18.2	0.0
Linkage with	Partner level MIS	90.9	22.7	18.2	100.0
	Dashboard	90.9	18.2	18.2	50.0

Implementation partners think outsourcing or internationalisation of M&E can accelerate the efficiency, effectiveness and finally impact of the programme process. Among them, ***75 per cent of the implementers perceive it will enhance the quality and quantity of output, 25 per cent added that it will ensure JIT (Just In Time), 50 per cent thinks it will save cost related to human resource and their capacity building****. In addition to this,* ***under outsourcing, if a part of M&E can be digitised 90 to 100 per cent of the implementers in South 24 Parganas and Darjeeling perceive that it will accelerate progress towards outcome achievement, it should be in-built and cover project MIS and user-friendly****. They also agree with the view that the application software should be complemented by baseline, mid-line and end-line evaluations, periodic participation of the evaluators in action plan reviews, and the MIS should be linked with a dashboard to display monthly, quarterly and annual results at all hierarchical levels of the programme.*

COMMUNITY LEVEL STUDY TO ASSESS PROGRESS TOWARDS SUSTAINABILITY

BHCSP is helping to raise voice of the community members to demand services from the service providers. Geriatric group *mentioned that they need PHC and SC in the*

community, medicine stocks in SC will help them out to avoid hospital, numbers of staffs are to be increased for serving health facilities in community level, and piped water supply is needed in the community.

Likewise, ***mothers' group*** *also mentioned about their needs – indicating their increased awareness level on raising demand for necessary health services. They added that medical officers and adequate numbers of staffs are needed for providing better health care services to the community,* more *help is to be offered by SC and PHC to avoid district hospital, immunization should be restarting as soon as possible by Government initiation, Fast Aid kits should be provided in every household in the community, ORS supplies and BP machines are needed for the community.*

In the same way, ***adolescents' group*** *revealed that medical officers are needed for providing better health care services of the community. They also expressed need for well-equipped SC and PHC with adequate number of health workers.*

The assessment of the India project implemented by WBVHA could be classified as 'B' - category which is 'Fairly Good'. The organization should continue such efforts with some corrections and/or adaptations as recommended above.

APPENDIX

THE ORGANIZATION – WEST BENGAL VOLUNTARY HEALTH ASSOCIATION (WBVHA)

West Bengal Voluntary Health Association (WBVHA) *is an Indian local Health oriented NGO officially recognized by Indian authorities (this recognition implies meeting criteria on internal management, implementation capacity, technical expertise, yearly audits and reports).*

WBVHA is a non-profit, registered society formed in the year 1974. It is a federation of more than 120 health and development organizations across the state. WBVHA is federated to Voluntary Health Association of India, New Delhi – one of the largest health and development networks in the world.

WBVHA is committed to make the ideal of comprehensive health care service at ground level a reality. It gives equal emphasis to preventive and promotive aspects of health. Its conviction is that health is a basic right of all people, which is to be attained by active participation of people and community. It tries to mobilize the community based organizations and local government (Panchayats) for spreading awareness on public health issues. WBVHA advocates people-centered policies for dynamic health planning and program management in West Bengal. The beneficiaries of WBVHA's program include health professionals; researchers; social activists; government functionaries and media personnel.

In order to facilitate the idea, WBVHA provides training, health education, technical expertise, teaching aids, publications and documentation services to institutions working closely with all levels of government machineries, it also seeks to extend its services to the sectors left unattended by the conventional health care delivery system.

Mission of WBVHA

Making health and social awareness a reality to the people seeking assistance to improve the quality of life free from any bondage and social in -justice.

Vision of WBVHA

Create a positive attitude among people to adopt a multi-factor approach in order to facilitate health with rights, dignity and social human face.

OPERATIONAL AREA & TARGET GROUPS:

The target area is 25 blocks under 4 districts of West Bengal, India. WBVHA coordinates the functioning of 4 NGO-forums in 4 different districts, all together bringing together 29 local NGO's.

PROJECT TIME FRAME AND OBJECTIVES

60 months:- 2017 to 2021

Improve access to affordable, sustainable and equitable quality health services taking into account people's needs in an effective health system through a people centred partnership process with involvement of all stakeholders and policy makers.

THE PROJECT

PROJECT BACKDROP:

The Basic Health Care Support program implemented by WBVHA coordinates the functioning of 4 NGO-forums in 4 different districts, all together bringing together 28 local NGO's. They work with a network of Village Health Workers in different villages. The program aims at:

***Closing the gaps**: making people aware of the services that exist and how they can access them; making people aware of their right to healthcare and how they can organize themselves to claim for what is not provided for.*
***Influence policy**: by facilitating the implementation of the national health policy ("testing it") and documenting the process, problems and obstacles, the program proposes change so that policy corresponds better to the needs.*
***Stimulating strategic and functional partnerships** that are needed at every level to influence policy, from community up to policy level.*

The program has evolved throughout the years from a directing logic (what to do) to a coaching logic (how to do it) and is now scaling up and documenting the experiences that can influence policy.
The key objective of WBVHA is to facilitate peoples' movement through network of civil society organizations thus to raise the peoples' voice to seek for quality health care services.

Through its Basic Health Care Support program, WBVHA is promoting and facilitating district health forum – the district level healthcare NGO network to strengthen community managed local health system thus to work closely with government to increase the peoples' accessibility to quality and affordable health care services. Health Forum has provided an important enabling environment in a state with a poor record of public health intervention, to be held accountable and to improve the quality and quantity of services provided.

PROJECT ACTIVITIES PLANNED:-

Objective:

1. *Formative supervision (intervision).*
2. *Attention for crosscutting issues: (gender, environment, multi sector approach, HIV/AIDS)*

Output activity:

- *Capacity Building, promotion of good governance and developing strong network and linkage among communities*

- *Quality of care issues in the local health system have been identified & properly addressed and appropriate policy changes at different levels in partnership with the District Health Forums and other stake holders have been proposed and the evidence-based, people centred inclusive BHCS programme is acknowledged by International Health Organisations.*

- *Community empowerment leading to a more equitable society.*

QUALITATIVE CASE STUDIES ON PARTNER ORGANIZATIONS

A-DEEP has initiated formation of Geriatric groups since 2012 with WBVHA support. Currently there are 13 such groups with members ranging from 20-75 and a total of 466 elders with break up of 172 male members and 294 female members.. As reported by the NGO there were around 100 elders who were facing loneliness due to the breakdown of joint family system. As in the current social changes in Indian families, nuclear families are seen in abundance even in rural areas. A-DEEP facilitated training for the elders and their family members where necessary.

DISTRICT - HOWRAH - ITARAI ASHA DEEP – Howrah district: The NGO, A-DEEP is situated in Pancharul Gram Panchayat of Udaynarayanpur Block of Howrah district. The evaluator met Secretary, Project Coordinator and the staff. The evaluator also met Panchayat officials and Block Medical Officer of Health. The organization is partnering with WBVHA since 2009 and is essentially a grass roots community based organization with a stable management.Health programme of the organization include – Community awareness, Assistance to implementation to Govt. Health Programmes, Capacity building of Self Help Group leaders, Assistance of community members in enrollment in State Govt. Health Scheme (Swastha Sathi), Linkage with Govt. for disability certificate and benefits has also been done.

The NGO has initiated Basic Health Care in the Block since 2010 with WBVHA support. Village health Nutrition programme facilitated and immunization programme also facilitated, meeting on 2nd Saturday enforced. Strengthening local panchayat groups, awareness on prevention of early marriage, facilitation in Panchayat health plan, capacity building of Self Help Group.

SEVA AMDANGA – North 24 Parganas district: The NGO, Seva Amdanga is situated in Atghara, Baduria in North 24 Parganas District. The evaluator met the Project Coordinator and staff. The evaluator also met the DPHC, Panchayat officials and members, Block officials ASHA workers. Evaluator met few community Group members.. The organization is partnering with WBVHA since 2010 and is essentially a grass roots community based organization with a stable management all of whom are working as salaried employees. Programmes of the organization include – Child protection, linkage with different Government Department, training on agriculture, organic farming, awareness on dengue prevention and plastic hazards. The organization formed a village information centre where community gets information on about the Government schemes and other programmes.

INDRA NARAYANPUR NAZRUL SMRITI SANGHA (INSS) – South 24 Parganas district: The NGO Indra Narayanpur Nazrul Smriti Sangha (INSS) is situated in Patharpratima Block in South 24 Parganas. The evaluator met Panchayat officials at GP and Block level. The evaluator also met Project Coordinator of INSS; SSDC and HDC. INSS covers 3 gram panchayats under BHCSP.

The NGO has partnered with WBVHA since 2004 and initiated the Basic Health Projects. 29 villages, 14 sub centres and 54 samsads are included in the project. Currently the organization is focusing on community mobilization on health, stakeholder interactions, linkage with Government health programmes.

The NGOs are operating in basic health projects with support from WBVHA. The project area is politically unstable. No work could be done for 105 days in 2017. Since 2000 there has been no panchayat election. The Medical Officer Dr. J.N.Prasad, BPHC Tagda since 11 years said that the health camps have reduced and mobile health camps are irregular nowadays.

Government Department : The team leader evaluation met the Government functionaries and the local self Government (Panchayati Raj Institutions) at the partner level in the districts.

NEPALI GIRLS SOCIAL SERVICE CENTRE (NGSSC)– Darjeeling district: The NGO is located in Tagda in Darjeeling district. The evaluator met the Medical Officer, Takdah BPHC, Project Coordinators of all BHCSP partners namely, SKT;SKL;HSWS and also the members of People's Forum..

Limitations : The evaluation being a mid term one primarily focused on the start up and process interventions.