ENDLINE EVALUATION OF BASIC HEALTHCARE SUPPORT PROGRAMME, INDIA

EVALUATION CONDUCTED FOR: MEMISA, BELGIUM

The team of Evaluators

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SUMMARY (DR. MOUMITA MUKHERJEE)

Impact

Health Outcome

1. 100 per cent of the beneficiaries have successfully taken full ANC who were registered for pregnancy,
2. 100 per cent institutional delivery is achieved where members in the women group were pregnant,
3. PNC checkups have been taken by 100 per cent of the women who delivered their babies in the institution during this period,
4. 100 per cent of the children who belong to the families of beneficiaries have received full immunization
5. 80 to 100 per cent of the beneficiaries who were in need of inpatient care have received hospitalization care
6. 93 to 100 per cent of the beneficiaries who were in need of outpatient care have received the service in healthcare centre.

Healthcare Accessibility

7. 45.8 per cent beneficiaries experienced significant change in the service provision compared to previous phase with support and initiatives of BHCSP
8. BHCSP team members are successful in converting 64 per cent of knowledge into practice at higher rate, 24 per cent at moderate rate and 11 per cent at lower rate.
9. 64 per cent of the beneficiaries perceive high improvement, 6 per cent perceive moderate improvement and 30 per cent perceive less improvement in the quality of service is visible during this period of programme phase.
10. degree of BHCSP success is achieved at higher rate during COVID compared to pre-COVID situation in terms of gaining beneficiary satisfaction (52 per cent compared to 49 per cent).
11. Before the pandemic BHCSP was highly successful in tackling the governance gap in 57 per cent of the health service centres which has been increased to 64 per cent centres during pandemic.
12. In North 24 Parganas 86 per cent of the facilitators utilized RMP-community linkage to a great extent, 60 per cent in Howrah are fully successful.
13. Stakeholder 'satisfaction and cooperation' has been increased from before pandemic to during pandemic situation regarding BHCSP support to render both routine and emergency services.

Relevance

14. The relevance of the programme increased during COVID 19 compared to previous period

15. In all the districts stakeholders feel the positive change occurred in implementation from 13 to 33 per cent of healthcare service delivery points.

Efficiency

16. Before COVID 19 high level of efficiency was achieved with accelerated pace and reached above 90 per cent which has been reduced by 7 percentage point due to COVID 19 pandemic.
17. Operational efficiency increased during pandemic at higher rate (40 per cent) compared to before pandemic situation (36 per cent).
18. Technical efficiency gain is visible by 36 to 60 per cent with no difference by the impact of pandemic.

Effectiveness

19. Higher degree of BHCSP support is evident in 60 to 90 per cent service delivery points with respect to preparedness and response plan whereas 70 to 90 per cent variability in respect of efficient coordination during response.
20. Preparedness planning during pandemic reflects greater BHCSP support ranging from 60 per cent coverage area to 100 per cent coverage area
21. In the intervention districts beneficiaries mostly received full ANC (73 to 81 per cent), institutional delivery (67 to 79 per cent), PNC (64 to 79 per cent), full immunization (76 to 84 per cent), received hygiene kit (87 to 100 per cent), sought inpatient care (61 to 67 per cent).
22. New local initiatives for adolescent group, women group and geriatric group are evident in 75 to 100 per cent of the programme area
23. The level of advocacy has been conducted in Gram Panchayat at 87 per cent connected service centres in Darjeeling, 50 per cent in South 24 Parganas.
24. There is increase in effectiveness of monitoring activities at moderate degree in almost 80 per cent of the healthcare centres during corona pandemic.
25. **Partner organizations effectively managed political factors, community's attitude towards health seeking during health emergency, tried to maintain data reliability through multiple and repeat checks. However, the challenges would have been tackled smoother if access to adequate budget can be ensured.**

Sustainability

26. The programme districts have covered 75 to 100 per cent of the coverage area and imparted training on managing emergency response to healthcare, crisis governance, how to remain accountable to community and higher authority during crisis and how to create community resilience.
27. 67 to 90 per cent of the service providers are trained on different topics related to sustaining service during normal time as well as during disaster.
28. 75 to 100 per cent of the training programmes have covered risk informed transparency and accountability aspects in three districts except Howrah where 40 per cent of the training programmes have covered that.

29. **Among different activities started in modified and efficient manner after mid-term evaluation – one of them is enhanced monitoring of programme activities with data collection, analysis and report on training sessions review meetings, documentation of policy advocacy, bottleneck analysis, fishbone analysis, problem tree construction to identify barriers to implementation, reporting of the measures, report on case analysis, good practice and success stories.**
30. **Community members want to continue BHCSP as they believe they need more preparation with their support to be self sufficient.**
31. **Community members also want the scale up of the programme in more gram panchayats of the districts as they believe that what benefits they learnt to enjoy they want the same impact for their neighbouring villages.**
32. **Communities also want programme support extensively in the domain of WASH and nutrition.**

ABOUT MEMISA

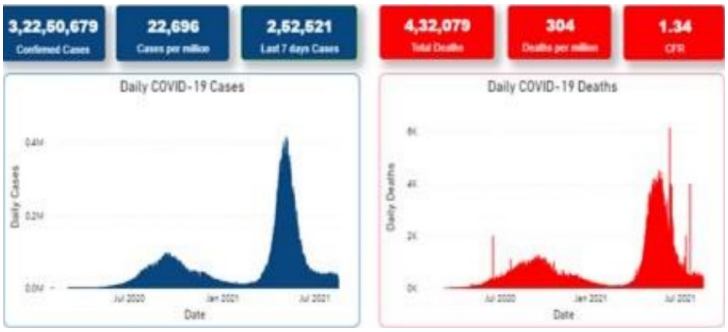
Memisa is a Belgian non-profit organization works in the field of development aid and cooperation with an objective to eradicate inequity in access to healthcare across socioeconomic groups, ensure quality care among vulnerable and marginalized communities. Memisa mainly focuses on addressing issues related to maternal and infant mortality. Memisa supports all the dimensions of healthcare access – physical availability, affordability, access to improved medical equipments and infrastructure as well as it strengthens health governance. Memisa programmes focus on universal health coverage among poor and marginalized population subgroups in respect of RMNCH+A as well as geriatric care. In India Memisa is implementing five year (2017 – 2021) programme to strengthen the health governance, enhance the supply, and support the demand side to increase access to quality care. The India operation is mainly demand driven and the implementing partner (Non Governmental Organization) is West Bengal Voluntary Health Association. In 2019 the midline evaluation is conducted and as per the review meeting mandates the process evaluation has resulted in operational and structural modifications. 2021 is the end year of the programme and end-line evaluation is planned to be conducted. This technical document is the inception report to present the study methodology to be followed under end-line evaluation.

CHAPTER I

BACKGROUND CONTEXT

The COVID 19 pandemic has brought into fore the actual degree of resilience in local healthcare systems across countries irrespective of economic status when both the public and private providers rendering primary to tertiary care were collapsing to offer services like testing, contact tracing, emergency curative care as well as routine health services. It is evident from the research that absolute incidence of COVID cases is higher in the Americas and the South-East Asian and South Asian countries whereas relative incidence per 100000 population is high in European continent. Unequal performance of health governance is visible in varying magnitude between HICs and LMICs in relation to crisis management. Given this backdrop the situation has huge impact on population with varied nature and degree in different parts of the world. LMICs are suffering longer trails due to suboptimal capacity of governance, extraneous factors affecting the availability of and access to services to combat health emergency as well as the most significant challenge – how to continue routine service delivery during pandemic crisis given scarcity of resource.

According to WHO India Situation Report (2021, 18th August), in the past 24 hours, 25,166 report of confirmed cases is evident - the lowest number of cases reported in single day after second wave. In India, highest number of cases in a day were 4,14,188; reported on 7th May 2021.

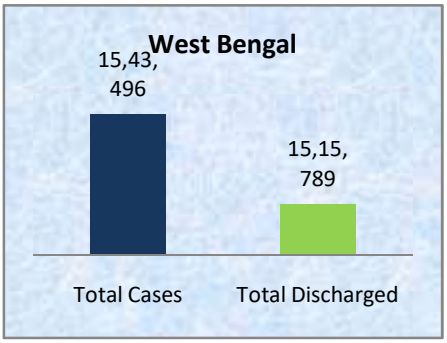


Source: (WHO India Situation Report 2021, 18th August; Pp. 1)

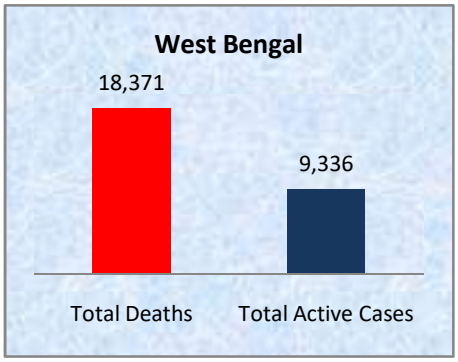
In the past week (11-17 August), as compared to previous week (4-10 August), seven states have shown an increase in cases while twenty-seven states have shown a decline in cases. Higher decline has been reported from A&N Islands (-57%), Uttar Pradesh (-41%), Arunachal Pradesh (-37%) and Madhya Pradesh (-32%); whereas Chandigarh (+96%), D&N Haveli (+33%), Punjab (+30%), Himachal Pradesh (+22%) & Jharkhand (+17%) have registered highest increase. In West Bengal the decrease is visible (-7%). According to the data received on 17th August, India shows testing of more than 484 million

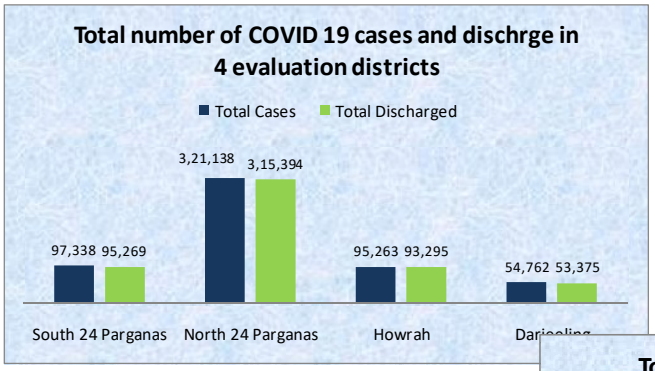
samples including RTPCR and Rapid Antigen. Test positivity rate in India is 2% in the present period (WHO India Situation Report 2021, 18th August; Pp. 1)[1].

WEST BENGAL SCENARIO[2]

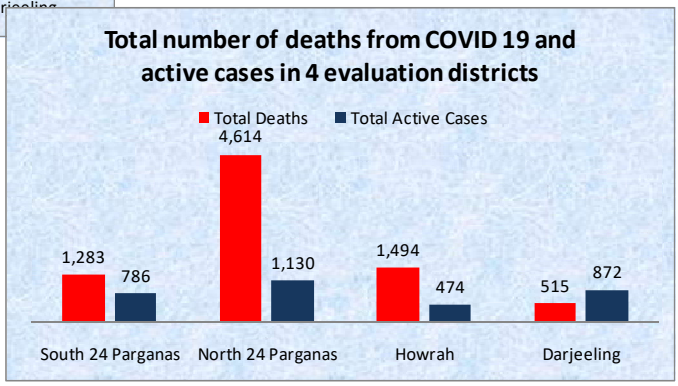


According to the report published by Department of Health & Family Welfare, West Bengal (2021), as on 23rd August, 2021 total number of cases has reached more than 15 lakh and number of death reported is 18,371 and total number of active cases reported is 9,336.





Number of total COVID cases till now is the highest in North 24 Parganas among the 4 focus districts. Rate of discharge is also higher overall as well as across districts. Number of death cases reported is the highest in North 24 Parganas and Howrah district reported second highest. Number of active cases is higher in North 24 Parganas, Darjeeling and South 24 Parganas.



KEY OBJECTIVE IN END-LINE EVALUATION

[1] https://cdn.who.int/media/docs/default-source/wrindia/situation-report/india-situation-report-81.pdf?sfvrsn=4f46659e_6

[2] West Bengal COVID 19 Health Bulletin 23rd August, 2021

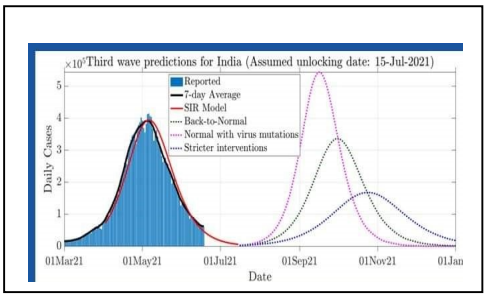
The end-line evaluation techniques will contextually mirror the mid-line evaluation. Therefore, the objectives and questionnaire and interview guide patterns will remain same with some contextual additions.

- Measure the Relevance dimensions of the intervention
- Measure the outputs, outcomes and assess the relevance impact, effectiveness, efficiency, and sustainability of the programme in terms of development,

SOME EVENTS WHICH IMPACTED THE PROJECT PARTNERS AND BENEFICIARY COMMUNITIES IN 2020 & 2021 : DR. RAJAT DAS

COVID 19 (CORONA VIRUS DISEASE-2019)

India along with several other countries are fighting against the Corona Virus disease (Covid 19) with several bouts or waves of the disease. In India there were two distinct waves of Covid 19 infections with the first wave reaching it's peak in September 2020 and the second wave began in March-April 2021. As per SIR (Susceptible-Infected-Recovered) model used in Epidemiology the third wave was expected in the first week of August 2021 and ending in October 2021. Moreover, at least 60 crore population need to be immunized by vaccination of two doses to reach Herd Immunity and walk without Mask (Ref : Position document by Prof. Dr. S. Arulrhaj the past National President of Indian Medical Association). A third wave was predicted in June 2021:



Pic – Covid 3rd wave prediction graph-June 2021

A study by Bhramar Mukherjee (University of Michigan,USA) and Swapnil Mishra (Imperial College – London,U.K.) in June 2021 that restrictions on crowding at social events, election rallies and Kumbh Mela (fair) could have mitigated India's second wave and averted an estimated loss of One Lakh lives. Classification was made with district wise positivity :- 1) less than 5% positivity; 2) 5% to less than 10% positivity & 3) over 10% positivity. West Bengal had only one district with more than 10% positivity earlier. During the second wave, as soon as the

cases slightly went down, people fatigued with lockdowns began to crowd tourist destinations. On 9th August,2021 Bengal recorded 49 straight days of a fall in the number of active cases with 675 new infections, 763 recoveries and 12 deaths. In all Bengal's active cases fell by 100 to 10,485 as reported.

LOCKDOWNS & JOB LOSS –

First one was during 23rd March till June 2020 :

According to the Centre for Monitoring Indian Economy (CMIE) a private research group – 7.35 million (over 7.3 million) jobs were lost in April 2021 with the unemployment rate rising to 7.97 % from 6.5 % in March 2021. Some 2.84 million salaried jobs were lost in rural areas and 0.56 million in the cities as per CMIE. However, there have been job recoveries recently as per reports.

POVERTY ASSESSMENT

The standard way of estimating poverty uses two steps : i) the National Statistical Office (NSO) carries out a sample Consumer Expenditure Survey every five years to see how much families are spending on necessities. ii) On previously set Poverty Line – a set of minimum expenditure criteria is applied to survey findings to determine what percentage of families qualifies as poor. Poverty Line is expected to be revised every 10 to 15 years. However, the National Government has refused to release the report of the 75th Consumer Expenditure Survey done in 2017-2018 claiming divergence between the findings and the Government administrative data. The National Government has not revised the poverty line which was fixed in 2005 which considers poor if expenditure is less than Indian Rupees 447/- in a month in rural areas and Rupees 578/- in a month in urban areas. The latest poverty data comes from the survey in 2011-2012 which put 21.9 % of the population below the poverty line.

WEST BENGAL STATE ELECTIONS

There was a long drawn Eight (8) phase election process starting from the 27th of March to 29th of April 2021 in this state which brought about mass gatherings amidst the pandemic without any physical distancing as essential to fight covid disease. This further worsened the scenario resulting in more deaths due to Covid subsequently.

VACCINE ROLLOUT

India initiated vaccination with two vaccines – i) Covishield developed by Serum Institute of India (SII) based in Pune, Maharashtra and ii) Covaxin developed by Bharat Biotech based in Hyderabad, Andhra Pradesh. India did some vaccine diplomacy by giving vaccines to some countries before covering it's own population which was suspended after opposition in the country. Meanwhile there was some confusion when India extended the gap between the two doses of Covishield from 4 – 8 weeks to 12 – 16 weeks which health experts felt that the longer gap leaves people exposed to severe infection and promotes development of mutants. India's own vaccine – Covaxin developed by Bharat Biotech had phase wise approval of various countries acceptance including WHO for travel. Unfortunately vaccine rollout is also considered a reason for surge in Covid cases as *Peltzman effect.* Mr. Sam Peltzman a Professor of Economics at the University of Chicago Booth School of Business claims that "individuals respond to safety measures with a compensatory increase in risky behavior". He observed that there was no decrease in automobile death rates in spite of safety measures and improved care safety technologies – people drove more recklessly owing to perceived safety of seat belts. Similarly after medications were introduced that lessened the risk of HIV transmission caused decreased intention to use additional protection. Thus consciously or not, even those who have not received a Covid-19 vaccine may forgo wearing face masks and social distancing when they know that others are receiving the vaccine. **Hence the need for counseling people.** As per the Health Ministry, the proportion of youth and children infected in the first and second waves were almost the same. Again there has been a **gender divide in vaccination** too. By *mid June 2021, India has partly or fully vaccinated about 101 million men which is 17% more than women*. Hence vaccine rollout at their doorstep could be the answer. SII planned to introduce COVOVAX (USA firm-Novavax's vaccine) by September 2021. West Bengal has incidentally managed well and ranked first amongst the major states, the side effects of vaccination that occurred amongst a few persons. The issue of fake vaccination in south Kolkata and neighbouring Sonarpur of South 24 Parganas district created a setback in late June 2021. Mixed vaccine doses have also been considered in neighboring country of Bhutan adjoining West Bengal state.

AMPHAN CYCLONE

Cyclonic storm on 20th May 2020 that dealt a heavy blow to especially the districts of South and North 24 Parganas and devastated several areas with sections of Kolkata and Salt Lake having many trees uprooted.

YAAS CYCLONE

Another cyclonic storm named Yaas which made landfall on the 22nd of May 2021 just about an year after Amphan which resulted in flooding and inaccessibility. Yaas affected areas included the districts of South 24 Parganas, North 24 Parganas, Purba Medinipur, Paschim Medinipur and Howrah. Thousands of villagers especially in Sunderbans of South 24 Parganas district struggled to fetch drinking water after losing their homes and livelihoods. Owing to Yaas, health services were also affected with the tune of damages to health infrastructure estimated at Euros 19.8 million.

STATE RESPONSE: DR. RAJAT KUMAR DAS

a) The State Government initiated **" DUARE TRAN "** – an outreach programme for providing financial assistance through camps the details of which were available at the respective District Administration offices of BDOs and SDOs. The dates of receipt of applications were 3-8 June,2021; assessment of applications : 19-30 June,2021 and disbursement of financial assistance : 01 – 7 July 2021. The assistance were credited directly to the bank accounts of beneficiaries. This scheme was done for the Yaas affected districts stated above as well as the tornado affected areas of North 24 Parganas, Birbhum and Hooghly districts of the state. The financial assistance was for resuming cultivation, repair of houses and worksheds, animal husbandry, fishing support and damaged equipment of weavers. Notably, more than 9 lakh plastic bottles were flushed out from the ecologically sensitive Sunderbans in 10 days of June 2021 after relief materials were sent post the cyclone as reported by the district administration. The state received 3,81,774 applications seeking compensation but about half were rejected as fake claims. **b)** The West Bengal state cabinet on 10th June 2021 approved the enhancement of Annual Financial assistance to farmers under the **Krishak Bandhu Scheme** from Euros 69.89 to Euros 116.48. This is more than the National Government's PM Kisan scheme which offers Indian Rupees Six thousand annually.

c) The West Bengal Government with the aim of promoting Universal Basic Income (UBI), has planned the **"Lakshmir Bhandar (Goddess Lakshmi's Treasure) scheme** which planned to give women heads of Scheduled Caste and Scheduled Tribes families Euros 11.65 and Euros 5.82 to general caste ones on a monthly basis. It was estimated that the scheme would cover 16 million beneficiaries and registration of beneficiaries to begin on 01 September, 2021. The

expected expenditure under this scheme is about Euros 1.16 billion. The applications would be collected in Duare Sarkar events from 15 August to 15 September, 2021.

d) School Education : Euros 116.48 financial support to be provided to over 10 lakh **students of Class XI and XII** so that they buy tabs to continue online studies. The programme is planned to cover 1 million students.

e) Mangrove Project : The state government after realizing that temporary embankments were being washed away in the Sunderbans delta region which are ravaged by cyclones almost every year; entrusted the Forest and Environment Departments with the task of studying the feasibility of creating a natural barrier by developing mangroves.

D) ASHA Workers :- These are females at the outreach level who are the first level of link between communities and Government primary health care and social services known as Accredited Social Health Activists (ASHA in brief) in West Bengal. In some other states such as Chhattisgarh where the concept originated they are known as "Mitanins" and in Jharkhand state they are known as "Sahiyas". On 24th May 2021. There are about 0.9 million ASHA workers in the country of which there are around 54 thousand in West Bengal. With the advent of Corona apart from their support to immunization and other services, they have been entrusted with identification of corona cases on a house to house search. However, the ASHA workers despite the added workload have not been given any financial incentive nor any protective measures provided.

E)FCRA:- The Government of India, Ministry of Home Affairs, Foreigners Division, FCRA Wing, amended Section !7 (1) of the Foreign Contribution (Regulation) Act, 2010 which was publicly notified on 13th October, 2021 - states that NGO note that all who have been granted FCRA certificate of registration shall henceforth receive only in designated " FCRA account" to be opened in the specified New Delhi Main Branch (NDMB) of the State Bank of India. The existing FCRA account holders have to open this account by the 31st of March 2021. It has also been clarified that the NGO has complete liberty to retain its present FCRA as the another FCRA account in any branch of any scheduled bank. All NGOs to note that they shall not receive any FC in any account other than the designated FCRA account in SBI-NDMB. *This means that all NGOs can receive foreign funds directly in their newly opened FCRA account in SBI-NDMB and cannot receive funds from intermediaries such as other NGOs in India.*

The effect has been far reaching – overnight this amendment gutted a reliable source of funding for tens of thousands of NGOs mostly working in the field of health, education and

gender. To receive foreign funds, charities must get affidavits and notary stamps and open bank accounts with the State Bank of India – New Delhi Main Branch.

METHODOLOGY (DR. MOUMITA MUKHERJEE)

The study has collected both quantitative and qualitative data. Analysis of quantitative data is conducted in STATA software where three files of data – beneficiary, partner and stakeholders – are separately analysed. Basic bivariate analyses show sample characteristics, respondents' profile, impact, relevance, effectiveness, efficiency and sustainability comparing before pandemic and after pandemic phase as well as by programme districts.

METHODOLOGY: DR. RAJAT KUMAR DAS

Phenomenon of Kubler - Ross model was observed during some of the interactions with the stakeholders in Darjeeling during the interactions against the backdrop of the COVID 19 epidemic.

Consider :- Kubler Ross Model :- Psychological view of MAN :

Applies to all Problems in Human Life

When a human goes through any tragedy, natural disaster, accident :

they pass through 5 stages :-

1 - Denial

2 - Anger

3 - Bargain

4 – Depression

5 - Acceptance

Denial : - Refusal to believe such a thing – never happened. Denied that Corona will not come to us. Even if it comes, repeated denial that it will not spread to our place due to hot climate.

Anger :- Getting angry. Angry over loss of income; loss of normal life due to lockdown.

Bargain :- Inwardly lamenting that the Corona may not have come and there should not have been a lockdown at all.

Depression :- It happened like this and goes in to mental pressure and depression.

Acceptance :- the last stage. The other way around is to accept it. Get used to live with Corona.

Evaluation Process / Tools for consideration :

LIKERT SCALE :

Various kinds of rating scales have been developed to measure attitudes directly (i.e. the person knows their attitude is being studied). The most widely used is the Likert scale (1932). In its final form, the Likert scale is a five point scale which is used to allow the individual to express how much they agree or disagree with a particular issue/statement.

Attitude Measurement: Likert Scale

Strongly Agree, Agree, Sometimes – middle path, Disagree, Strongly Disagree

Scoring

• Strongly Agree = 1 • Agree = 2 • Sometimes = 3 • Disagree = 4 • Strongly Disagree = 5

METHODOLOGY: DR. MOUMITA MUKHERJEE

KEY OBJECTIVES IN END-LINE EVALUATION

The end-line evaluation techniques will contextually mirror the mid-line evaluation. Therefore, the objectives and questionnaire and interview guide patterns will remain same with some contextual additions.

1. Measure the Relevance dimensions of the intervention
2. Measure the results of the project/programme (outputs, outcomes) and assess the impact, effectiveness, efficiency, and sustainability of the programme in terms of development,

RELEVANCE OF PROGRAMME LOGICAL FRAMEWORK –

- Which pillars are followed
- How far the pillars and Input-Output-Outcome components are modified to make them contextual and more relevant during the period 2019 – 2021?
- How the Roles and Responsibilities as per activities in parity with framework are revisited or maintained as per the changing needs and priorities of the communities?
- How the Risks are revisited and assumptions are modified?

IMPACT OF BHCSP

Assessment through collection of quantitative data; Analyze the difference in programme impact comparing the mid-line evaluation results to measure the change,

- How far the programme is successful in supporting communities and healthcare delivery to reduce structural and systemic gaps through effective policy design,
- How far the programme contributed to increase physical, social and economic accessibility of healthcare through engaging them in programme activities,
- Whether there is an increase in user satisfaction and utilization from 2019
- How far augmented emergency services to combat the pandemic have amplified the impact?
- How far the accountability of service providers and other stakeholders has been ensured through the programme implementation.
- How the pandemic situation is affecting the implementation and what mitigation strategies are followed?

EFFECTIVENESS OF BHCSP

The facilitation and supervision of collection of quantitative data,
Analyze the difference in programme effectiveness comparing the mid-line evaluation results to measure the change,

- How frequently Program Activity data has been collected and how far quality has been maintained,
- What techniques are followed to strengthen and implement programme monitoring,
- How far modification of content and / or methodology of respective components has been done,
- How far all these factors contribute to achievement towards outcome and controlled the impact of pandemic on outcome achievement,
- Analyze the collaboration and synergy in the field between Memisa and other actors through WBVHA to achieve its objectives,

EFFICIENCY OF BHCSP

Participatory Approach – Collection of Qualitative data following participatory approach, **Analyze the difference in programme efficiency comparing the mid-line evaluation results to measure the change,**

- In depth interviews with main implementing organization and district and/or block level stakeholders to assess the degree of resource utilization under the programme,
- Lessons learnt from the project,
- Bottleneck analysis

SUSTAINABILITY POTENTIAL OF BHCSP

Assess the programme compatibility with Sustainable Development Goals with respect to pace of outcome achievements,

Assess the organizational learning to estimate the degree of Sustainability achieved-

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

Draw key lessons and make practical recommendations for monitoring interventions,

- What the programme implementing partner and the district level authorities perceive about the success of the intervention
- What would be the planning process to increase the success rate during pandemic in the future
- What innovative techniques can be used to accelerate the process e.g., preparedness, response and recovery planning
- Appreciate the attention given to cross-cutting gender and environmental issues as well as digitalization as a political priority of the donor.

The aim is to identify the changes in last 2 years and related findings across study districts on the basis of which recommendations for programme could be formulated.

TIMELINE

With respect to End-line evaluation the activities tentatively need to start from 1st September to 24th December in 2021 considering the prediction of the 3rd wave of COVID 19.

End-line Evaluation 2021	September	October	November	December
Revision of Logical Framework and Secondary Research				

Inception Report submission and finalization. (Survey questionnaires and tool development)				
finalize the data collection Plan				
Data collection (1 to 1 by Interviewer)				
Date cleaning, Data Entry and Data analysis				
Drafting report and share with team				
Final Report				

THE EVALUATION- AT A GLANCE

The evaluation will at the outset collect information from WBVHA regarding the implementing partners in the district with regard to the following:-

Partner Selection process: - whether any process adopted? Whether any change from inception till date and why?

Programme Focus in districts:- what approach adopted ? Whether secondary data considered? Whether any change from inception till date and why?

The evaluation will follow mixed method approach.

DISTRICT/BLOCK LEVEL

- Interviews with district/ block officials will be conducted using Semi-Structured discussion guide.

IMPLEMENTING PARTNER LEVEL

- For data collection at partner level the questionnaire is designed as semi-structured questionnaire to measure effectiveness, to some extent efficiency and it contains questions mostly in interval scale and options.

GRAM PANCHAYAT LEVEL

- Structured questionnaire is prepared to interview ground level service providers who directly work with communities to capture the degree of impact visible from supply side with respect to access to service delivery. The extent of community interaction and participation will also help to assess their degree of involvement and accountability in increasing the access to health service delivery.

COMMUNITY LEVEL

- At community level, due to contact restrictions related to COVID 19, Focused Group Discussion were conducted later. FGD tool is prepared to measure the sustainability dimension at demand side where community members were interviewed.

KEY FEATURES OF THE TECHNIQUES TO BE USED IN DATA COLLECTION

1. The relevance of the questionnaire is tested in a review meeting with the WBVHA team and modifications incorporated
2. Detailed in depth and semi structured questions will help stakeholders to assess impact, effectiveness and sustainability of BHCSP through end-line evaluation
3. Measures of moderating factors – sectoral support, social support, environmental factors, digitalization, managerial issues, economic factors are covered to measure role of these factors as catalyst
4. Triangulation through qualitative method will be done to ensure error minimization at higher level of governance
5. The inclusion of the experience of ground level service providers, community members along with decision makers will be able to cover the holistic picture.

DEGREE OF COMPARATIVENESS

The study design is comparative using the methods under quantitative and qualitative approach. It is the end-line evaluation with components to measure the programme impact and effectiveness as well as relevance, efficiency and sustainability comparing

1. Stakeholders' view point and partner level experience to measure the **relevance** of the programme
2. Reduction in the gaps between supply and demand side will be explored from the interview with beneficiaries to assess the **impact**
3. A range of sector specific factors will be explored with implementers to measure their contribution towards **effectiveness**
4. Degree of attainment of operational **efficiency** will be measured through success of the programme over bottlenecks in optimum utilization of resources
5. Degree of **sustainability** achieved by the programme to be reflected from GP/ Block level stakeholders and beneficiaries

ENSURING SUBJECTIVE ACCURACY

Rigorous effort is given in designing the qualitative and semi-quantitative and quantitative evaluation techniques to depict the correct picture of the programme's achievements and/or shortcomings. Also the data set containing the responses will be thoroughly checked for consistency. Inevitably, however, the project may have limitations, and these may be avoided to get an error minimized data set and interpretation of the results.

a. ***Coordination*** – WBVHA will coordinate with the Government and partners regarding the evaluation.

b. ***Sampling*** – Purposive sampling procedure will be used for data collection. Along with it, recruitment process of investigators will be conducted based on their knowledge and experience.

c. ***Comprehensive Questionnaire***– The questionnaire and discussion guides are designed to take, on average, 20 to 30 minutes to complete at district, implementing partner and frontline worker level and

30 minutes at beneficiary level. For ethical reasons intimate, free and informed consents will be taken before interview.

d. ***Evaluation context*** – Every effort will be made to encourage transparent answers through asking simple and translucent questions, with promise of anonymity and privacy. Therefore to maintain ethics, names will not be disclosed and all the designations will be used in case of officials and service providers. However, any assessment takes place within some social and institutional context. Here, it will be conducted in government department, local self governance, and beneficiaries to assess how the socio-institutional dynamics in communities influence access to health services.

ACCURACY OF THE FINDINGS

To judge the accuracy of numbers, we first need to distinguish between two types of error: random error and systematic error (or bias). All values to be calculated from the quantitative data set will be assumed to be to some extent affected by these errors and are thus essentially will be estimates of some true (but unknown) values.

Systematic error (or bias) occurs when the estimates provided in the study are systematically higher or lower than the true value. This can, for example, be the result of sampling procedures or measurements. The current evaluation will be carefully designed to avoid such error. The contextualization of the instruments was conducted to minimise systematic bias.

Random error is the result of the fact that, for example, not all frontline workers in all of the districts will be interviewed. The results from the samples in the districts will invariably depart slightly from the findings that would have been obtained had it been possible to interview all frontline workers in these districts in respective GPs under selected blocks. In most cases this difference is small gets smaller the more respondents are there in the sample. We keep margin of error within 0.05 to 0.10 so that results get significance at 95% to 99% level of significance.

EVALUATION PROCESS AND STUDY TOOL FINALIZATION

QUESTIONNAIRE DEVELOPMENT

The questionnaires to be used are developed on the basis of previous studies took place in different developing countries. It mostly follow the techniques used in preparation of Demographic and Health Survey to assess different demographic and health conditions of women and children in respective study areas in the selected districts with respect to access to maternal and child specific services.

In terms of the scope and topics, the questionnaires are based on previous evaluation carried out in mid-line evaluation. This involved amongst other things a comprehensive review of existing research on

impact of development programmes on healthcare access among women and children.

The stage of developing the drafts of the questionnaires has followed the conceptual frameworks like Mosely Chen framework (1984) – covering research and policy issues that encompass the key issues, it optimizes question formats and response options so as to be readily comprehensible by respondents.

The questionnaires become exhaustive with respect to Memisa objectives and relevance.

TESTING OF THE QUESTIONNAIRES

The questionnaires are refined and finalized following

- Discussion with WBVHA officials
- Next, if any changes are required will be done based on the suggestions from Memisa, Belgium.

After finalization of the instruments -

1. The stakeholder, implementing partner and beneficiary level questionnaires will be modified but and translation will be done as per requirement.

SAMPLING

The end-line evaluation contains data collection at 4 levels -

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

Level - District	Persons to be interviewed	Nature of the questionnaire	Number of interviewee
South 24 Parganas	ACMOH I / II, BMOH	In Depth Interview	2
North 24 Parganas	ACMOH I / II, BMOH	In Depth Interview	2
Howrah	ACMOH I / II, BMOH	In Depth Interview	2

Darjeeling	ACMOH I / II, BMOH	In Depth Interview	2
Total			**8**

Level - Implementing partner	**Persons to be interviewed**	**Nature of the questionnaire**	**Number o interviewee**
State	WBVHA	Semi-Structured /Structured Questionnaire	2
District	District Coordinator WBVHA	Semi-Structured /Structured Questionnaire	4
South 24 Parganas	Programme Coordinator Interviser/Health Facilitator	Semi-Structured /Structured Questionnaire	6
North 24 Parganas	Programme Coordinator Interviser/Health Facilitator	Semi-Structured /Structured Questionnaire	6
Howrah	Programme Coordinator Interviser/Health Facilitator	Semi-Structured /Structured Questionnaire	4
Darjeeling	Programme Coordinator Interviser/Health Facilitator	Semi-Structured /Structured Questionnaire	4
Total			**26**

Level – Gram Panchayat	**Persons To be interviewed**	**Nature of the questionnaire**	**Number o interviewee**
South 24 Parganas	PRI, Health Supervisor, ANM ASHA, AWW	Structured Questionnaire	22
North 24 Parganas	PRI, Health Supervisor, ANM ASHA, AWW	Structured Questionnaire	22

Howrah	PRI, Health Supervisor, ANM ASHA, AWW	Structured Questionnaire	15
Darjeeling	PRI, Health Supervisor, ANM ASHA, AWW	Structured Questionnaire	15
Total			**74**

At the community level conducing Focus Group Discussion is conducted later due to COVID 19 restrictions – as per the discussion with concerned organization and the prevailing state rules.

Level – Beneficiary	**Respondents**	**Nature of the questionnaire**	**Sample Size**
South 24 Parganas	**Community**	**FGD tool**	**12**
North 24 Parganas	**Community**	**FGD tool**	**6**
Howrah	**Community**	**FGD tool**	**11**
Darjeeling	**Community**	**FGD tool**	**8**
Total			**37**
Level – Beneficiary	**Respondents**	**Nature of the questionnaire**	**Sample Size**
South 24 Parganas	B + IB	Structured Questionnaire	45
North 24 Parganas	B + IB	Structured Questionnaire	45
Howrah	B + IB	Structured Questionnaire	45
Darjeeling	B + IB	Structured Questionnaire	45

Total	**180**

*B = Beneficiaries; IB = Indirect Beneficiaries

SELECTION OF STAKEHOLDERS AT VARIOUS LEVELS

IDI AT DISTRICT / BLOCK LEVEL

At district level, stakeholders' selection for semi structured interviews will follow purposive sampling procedure. District and/or Block level officials from Department of Health & Family Welfare in South 24 parganas, North 24 parganas, Howrah and Darjeeling will be selected for face to face in depth interview – ACMOH I/II, BMOH.

SEMI-STRUCTURED/ STRUCTURED INTERVIEWS AT IMPLEMENTING PARTNER LEVEL

For conducting semi-structured/ structured interviews with implementing partners, in similar manner, purposive sampling method will be used to collect information. In each of the 4 districts the main programme implementation partners of WBVHA will be selected for conducting face to face interviews with District Coordinators, Programme Coordinator, Interviser/Health Facilitator.

STRUCTURED INTERVIEWS AT GP LEVEL

Structured interviews to assess impact of the intervention at the ground level will be conducted among frontline service providers in supplying health and nutrition services to the children. Here also purposive sampling procedure will be adopted to select Health Supervisor, ANM, ASHA, AWW who actively provide service to women and children in the selected gram panchayats. Along with them panchayat pradhan of the selected gram panchayats will also be interviewed.

BENEFICIARY LEVEL

At beneficiary level structured questionnaire will be used to capture the impact of BHCSP on health service access, change in economic access to healthcare comparing monthly expenditure on healthcare, change in seeking treatment like increase in pregnancy registration, number of full ANC, institutional delivery, number of PNC check up, immunization, treatment seeking for outpatient and inpatient care etc.

BENEFICIARY SURVEY

SELECTION OF SAMPLE POINTS AND ADDRESSES FOR SURVEY

Official at partner level of each selected district will be asked to share the complete beneficiary lists of direct and indirect beneficiaries to select them for each district. The GPs will be selected based on the selection of GPs under mid-line evaluation of the BHCSP programme. The approach to be taken reflects standard approaches to evaluations. The beneficiaries will be selected from the list using systematic circular random sampling method, but the precise approach may vary by districts reflecting different circumstances on the ground, the nature of sample frames available, and cultural differences with regards to face to face interviews, bearing in mind the subject matter.

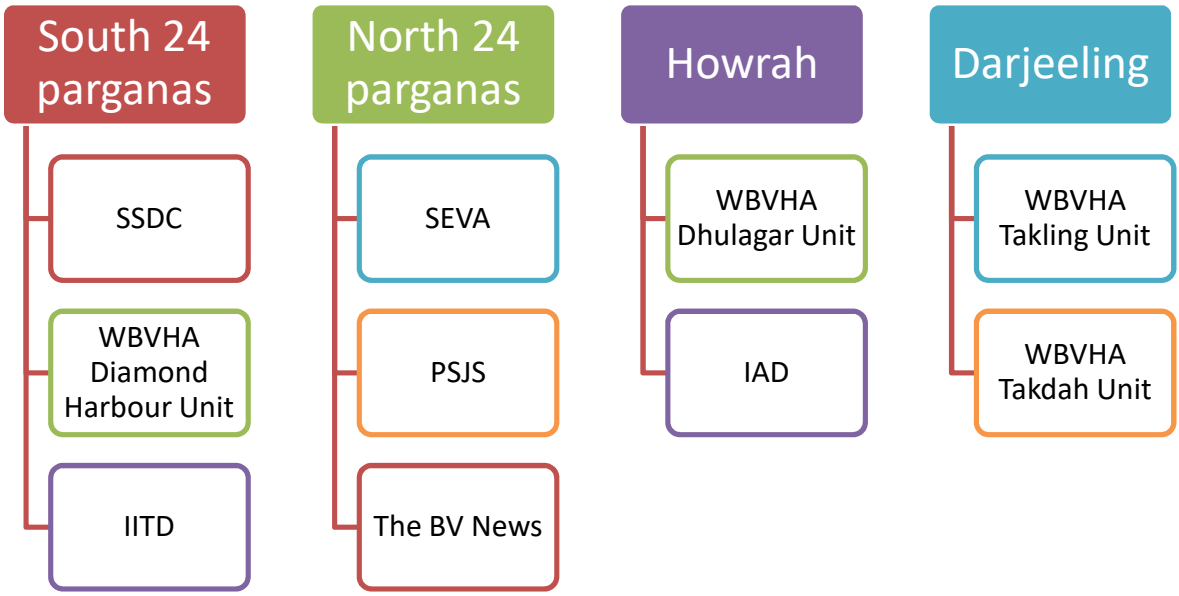
RESPONDENT SELECTION

An interview with beneficiary belonging to a particular group will be conducted. The interview with beneficiary will be conducted as s/he knows the most about the intervention and the service uptake. In around some of the cases, the respondent may be interviewed, along with other member of the group, to accompany him/her.

FIELD PLAN

Timescale					
	Interviewee	**Investigators**	**Sample Partners**	**Interviews**	**Data to be collected**
Gram Panchayat	Frontline stakeholders	Research Assistant	10	74	Quantitative
Implementing Partner – 4 districts	Coordinator, Interviser/ Health Facilitator	Research Assistant	10	26	Quantitative
District Level	DPHC/ ACMOH/ BMOH, BPHN	Researcher		8	Qualitative
WBVHA	State officials, District Coordinators	Researcher		6	Quantitative

FIELD LOCATIONS



FIELD WORK

FIELDWORK OVERVIEW

After discussion with WBVHA, the Fieldwork tentatively required to start from September, 2021 given the prediction of the 3rd wave of the pandemic.

RESEARCHERS, COORDINATORS AND INTERVIEWERS

Researchers and interviewers will be selected based on their experience, not just in research, but more specifically in face-to-face qualitative interviews, quantitative surveys, verbatim and transcription preparation where appropriate, and experience of research with respect to human development. The researchers and project coordinators need to understand the complexity and sensitivities present in the questionnaires and to be allocated in a way to achieve the best results in time and cost effective way.

All interviewers will receive intensive project-specific training and briefings on the study tools, covering all aspects of qualitative and quantitative study implementation. They will be guided through interactive sessions on how to conduct sensitive interviews about women and children and maintain due respect to all interviewees from government stakeholders to community members.

All researchers and interviewers will receive detailed and uniform instructions on technical part of the project to successfully conduct the interviews. These Training and briefing will cover the following topics:

1. Overall briefing on evaluation objectives, its components and the relevance

2. Detailed description of the sampling procedures where applicable
3. Full questionnaire review, clarifying terminology and data collection techniques
4. Interpretation of ethical rules and other ethical issues and protocols associated with this project, including cultural sensitivity, and how informed respondent consents are to be attained at all levels of interviews
5. Briefings on main modus operandi and protocols for interviewing the respondents
6. Rules of field management
7. Specific methods to convert refusals and maximise the response rate
8. A reminder of how the quality of their work will be supervised, controlled and managed, including back-checking procedures.

EVALUATION MODE AND LENGTH OF QUESTIONNAIRE

All the interviews will be conducted with paper and pencil/pen and qualitative interviews like IDIs will be recorded. In relation to IDI, the questionnaire will be given a moderate structure and in depth questions will be asked so as to rank the risks and vulnerabilities in the questionnaires with self-assessment and simultaneously the detail description of the reasons will be narrated. The interviews at different level will be done in face to face discussion mode following the concept of key informant interviews, in depth interviews while method is qualitative.

	Nature of instrument	**Mode of study**	**Interview timing**	**Number of persons involved**
District	Pen and Paper, Note, Recorder	Discussion in key informant interview mode	30 minutes to 1 hour	1
Partner level	Pen and Paper, Note, Recorder	Structured/Semi-structured questionnaire for evaluation	30 to 35 minutes	1 or 2
GP	Pen and Paper	Structured questionnaire	30 to 35 minutes	1 or 2
Beneficiary	Pen and Paper,	Structured questionnaire	1 hour 30 minutes	1 or 2

	Recording and Note			

ETHICS

Beneficiary's access to basic developmental services is to some extent sensitive topic involving their security issues, protection etc; it is therefore vital that fieldwork to be conducted in an appropriately ethical manner.

An essential requirement is to gain informed consent from all the respondents at various levels. Several mechanisms will be put in place to ensure that respondents get all the information necessary to make an informed judgment about taking part in the study.

1. Each individual will be briefed and explained the social relevance of evaluation through face to face interviews, discussions, interactions.

2. Particular attention will be taken to ensure that the text in the questionnaires and words to be spoken and consent form – all are to be age appropriate, hierarchy appropriate. Across the districts, Bengali version of the text will be tailored for survey as required.

3. Secrecy and confidentiality of responses will be guaranteed to the respondents.

4. Interviewers will be selected based on their experience and further training and briefing will be provided.

5. Whilst in the field, all respondents will be advised of the fact that it is their right to stop the interview at any point and that they could choose not to answer a question if they feel uncomfortable in doing so.

In designing the questionnaire, several measures will be put in place to make the respondents as comfortable as possible.

Finally, confidentiality and secrecy will be guaranteed during the data processing stage of the project by removing names of the respondents from analysis and in the report matrix.

Overall the end-line evaluation will provide a direction for future implementation. The evaluation ultimately will help to measure the programme performance within the given timeframe to fulfill the objectives of Memisa towards achievement of social benefits over social cost to accelerate the pace of development.

ANALYSIS

Different indices are estimated using Principal Component Analysis (PCA). The indices created are

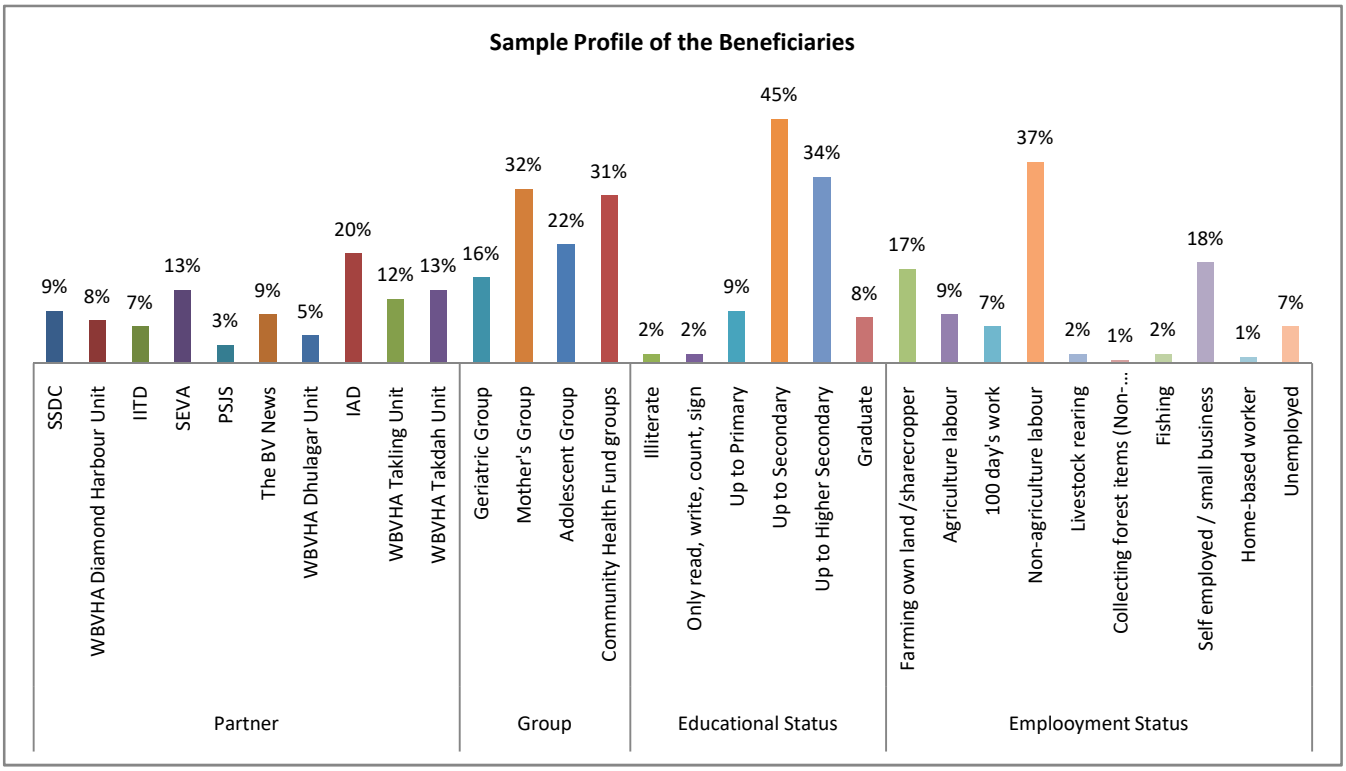
1. **Impact - Community**
    a. Accessibility Impact Index
    b. Acceptability Impact Index
    c. Perceived Quality of Care Index
    d. User Satisfaction Index in terms of success of BHCSP
2. **Impact of BHCSP towards increasing governance effectiveness**
    a. Governance Strengthening Index - Stakeholders' perspective
    b. Governance Strengthening Index - Partners' perspective
    c. Stakeholder Satisfaction Index
    d. Partner Satisfaction – Stakeholder Cooperation Index
3. **Efficiency**
    a. Monitoring Efficiency Achievement Index – Stakeholders
    b. Monitoring Efficiency Index – Programme
    c. Operational Efficiency Index – Programme
    d. Technical Efficiency Index – Programme
4. **Effectiveness**
    a. Monitoring Effectiveness Index – Stakeholders
    b. Monitoring Effectiveness Index – Programme

After running PCA, the score of component 1 is taken to categorise in three to two point scale to create ordinal variable according to degree of impact, efficiency or effectiveness.

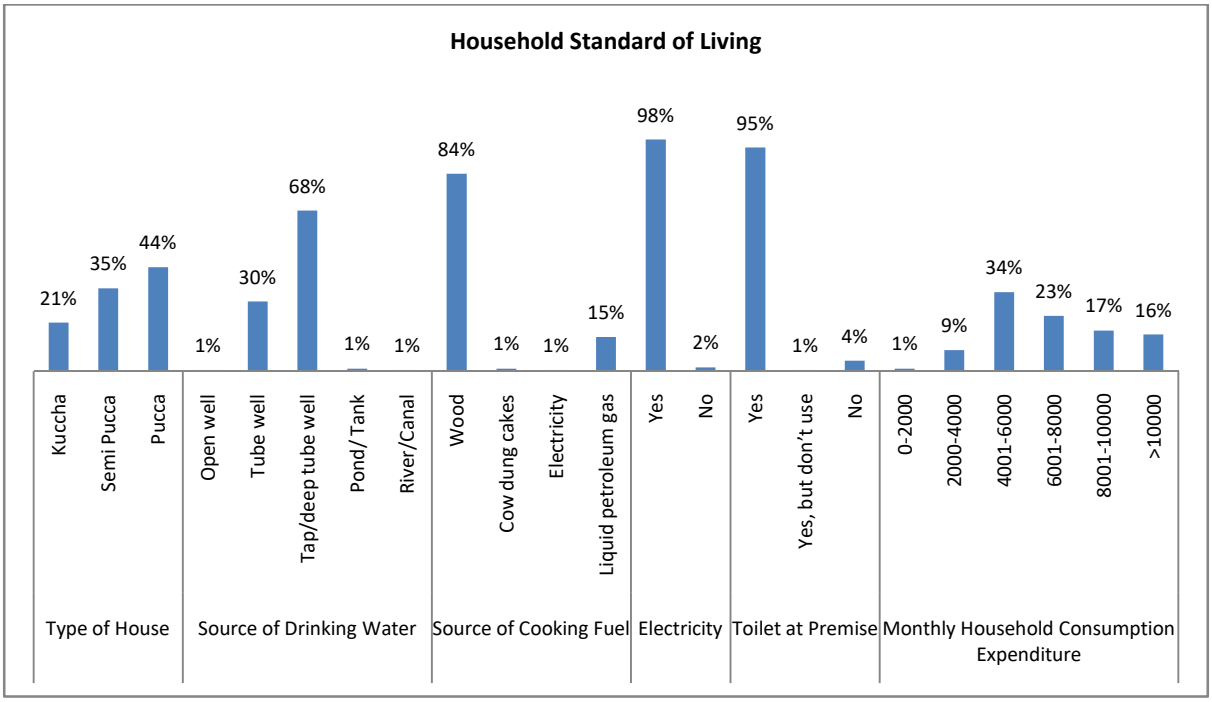
	Nature of the variable	**Weightage**
Variables Used to conduct PCA	Ordinal, categorized into 2 to 5 point scales	50% / 33%/ 25%
Variables Created from each component 1 scores	Ordinal, categorized into 3 point scale	33%

ANALYSIS AND FINDINGS (DR. MOUMITA MUKHERJEE)

BENEFICIARY PROFILE

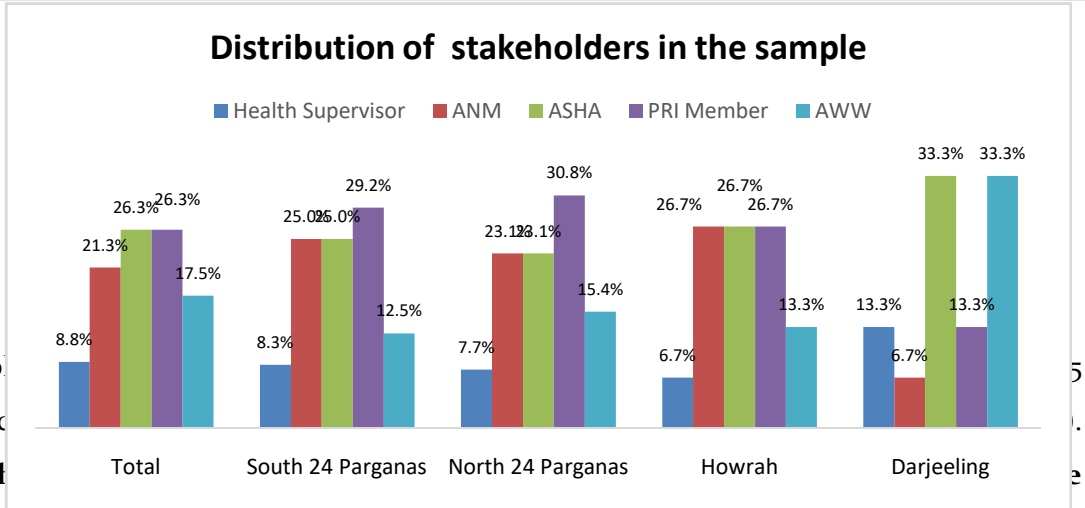


The beneficiaries interviewed for the end-line study are selected from ten partner organizations from four implementation districts. Among the sample respondents of the beneficiaries 16 per cent belongs to geriatric group, 32 per cent are from mother's/women's group, 22 per cent are from the adolescent group and 31 per cent from the community fund group. As per the educational status, 45 per cent of the beneficiaries are educated up to 10th grade and 34 per cent up to 12th grade. Additionally, among all the beneficiaries most of them are working (except elderly and adolescents) among which 17 per cent are farming their own land, 9 per cent work as agricultural labourers, 37 per cent are working in non-agricultural sector as labourers, 18 per cent are engaged in small business.



Standard of living of the households are measured based on the type of house, access to safe drinking water, source of cooking fuel, access to electricity, sanitary latrine, and monthly consumption expenditure. It is evident that most of the households live in semi-pucca (35 per cent) or pucca houses (45 per cent), 30 per cent use water from tube well, 68 per cent can access tap water or deep tube well, 84 per cent use wood as fuel for cooking, 98 per cent have access to electricity at home, 95 per cent have sanitary toilet at home and 94 per cent use it, most of the families belong to low to middle income categories (57 per cent).

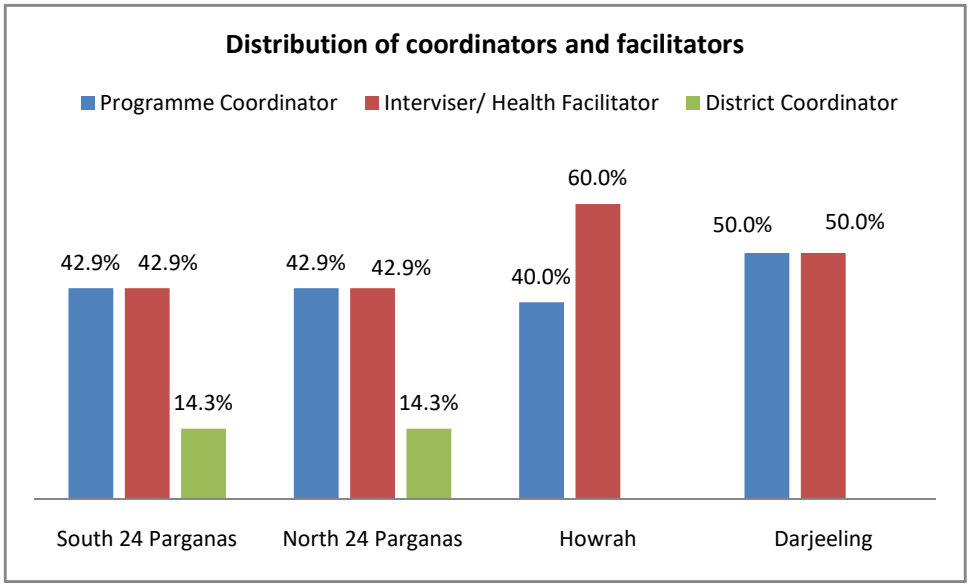
SERVICE PROVIDERS' PROFILE



The samp 5 to 33 per c . **During th e programme communities became highly vulnerable during the outbreak of coronavirus pandemic. BHCSP facilitators and programme coordinators provided**

great handholding support to the ground level stakeholders to maintain programme mandates.

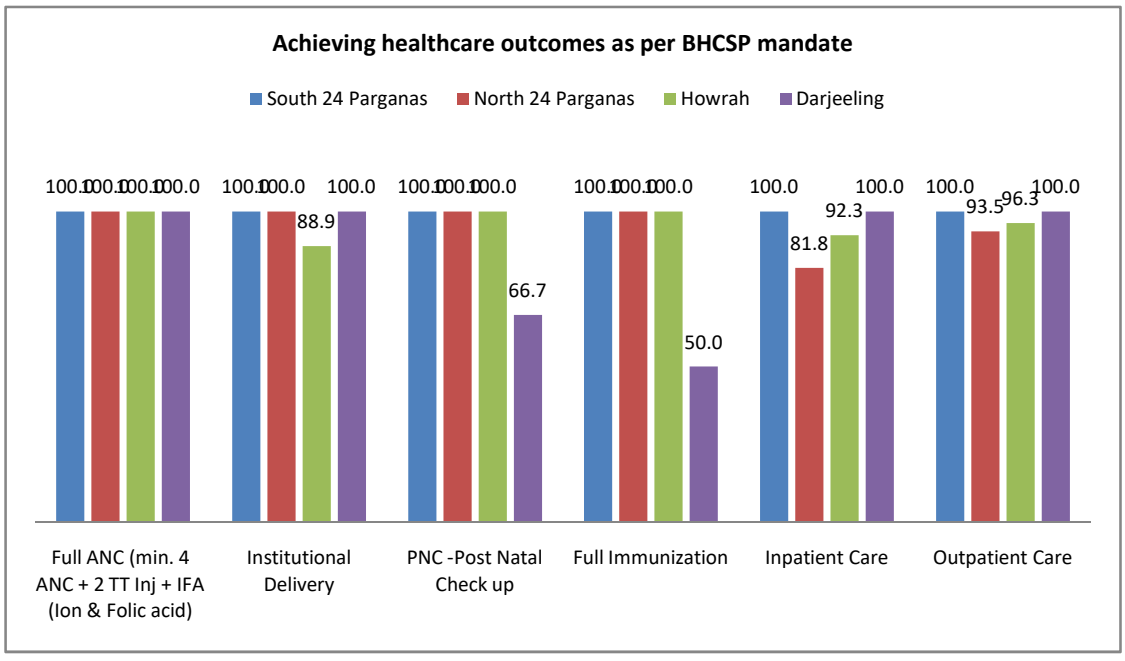
PARTNERS' PROFILE



Among the sample respondents in the partner's set district coordinators are interviewed in South and North 24 Parganas comprising of 14 per cent in each of the districts. Rest of the interviewees is from the programme coordinators (43 per cent) and facilitators (43 per cent) group. In Howrah district 60 per cent of the respondents belong to health facilitators and 40 per cent are from coordinators which are selected 50 per cent each from the both the groups.

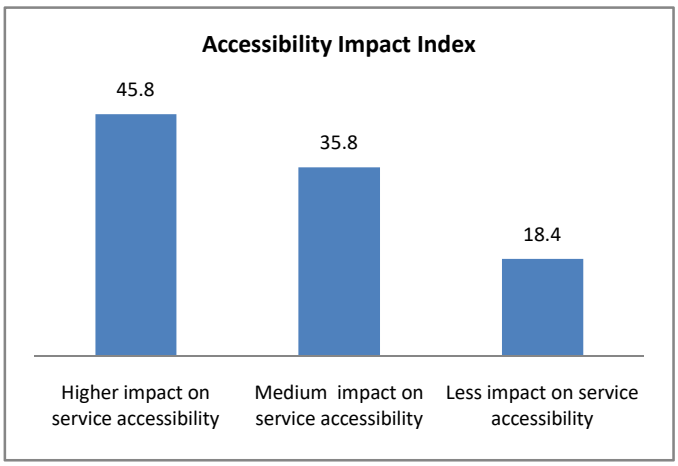
Picture 1: Interview with adolescent group, women group and geriatric group members

According to BHCSP outcome indicators communities served by BHCSP have attained good healthcare outcomes during the current phase of the programme. BHCSP facilitators

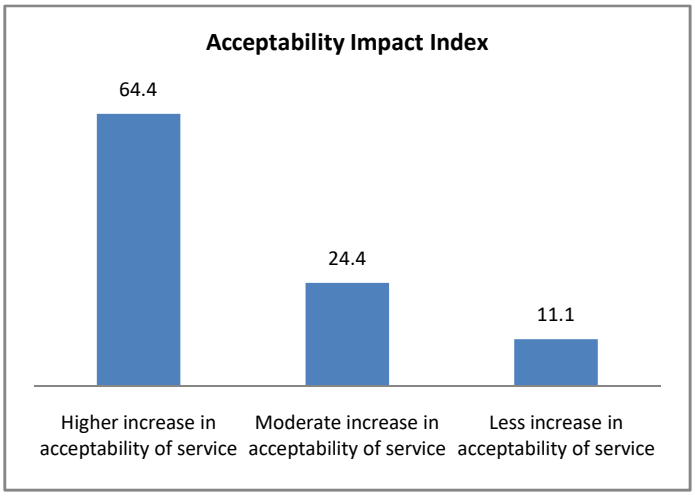


successfully helped the families covered under the programme through registering under different groups to receive care from the healthcare centres.

- 100 per cent of the beneficiaries have successfully taken full ANC who were registered for pregnancy,
- 100 per cent institutional delivery is achieved where members in the women group were pregnant,
- PNC checkups have been taken by 100 per cent of the women who delivered their babies in the institution during this period,
- 100 per cent of the children who belong to the families of beneficiaries have received full immunization
- 80 to 100 per cent of the beneficiaries who were in need of inpatient care have received hospitalization care
- 93 to 100 per cent of the beneficiaries who were in need of outpatient care have received the service in healthcare centre.

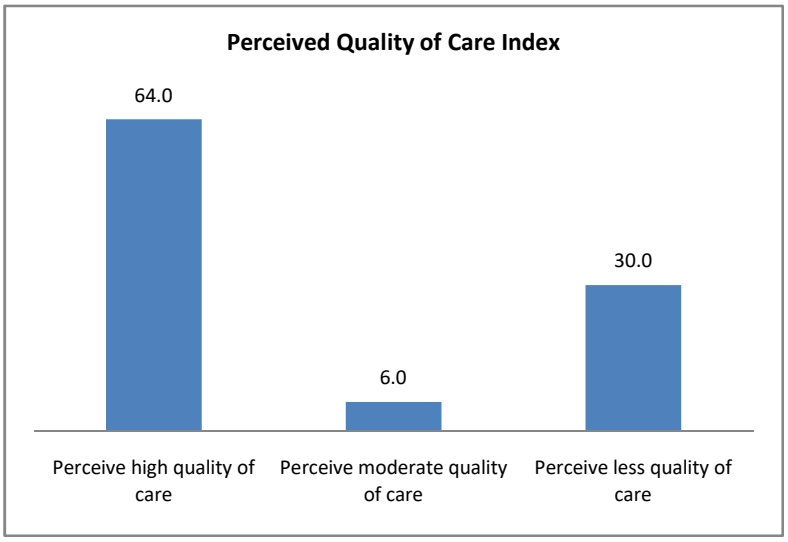


Beneficiaries were asked whether they experienced improved service in sub-centre, primary health centre, block primary health centre, whether community leaders are helping in health seeking and BHCSP team members are connecting them to service centres. The interval scale is used in a five point scale – 'Strongly Agree', 'Agree', 'Neither Agree nor Disagree', 'Disagree', 'Strongly Disagree'. After principal component analysis the score of component 1 is categorized as higher, medium and lower impact of BHCSP on increasing access to service. 45.8 per cent beneficiaries experienced significant change in the service provision, 35.8 per cent

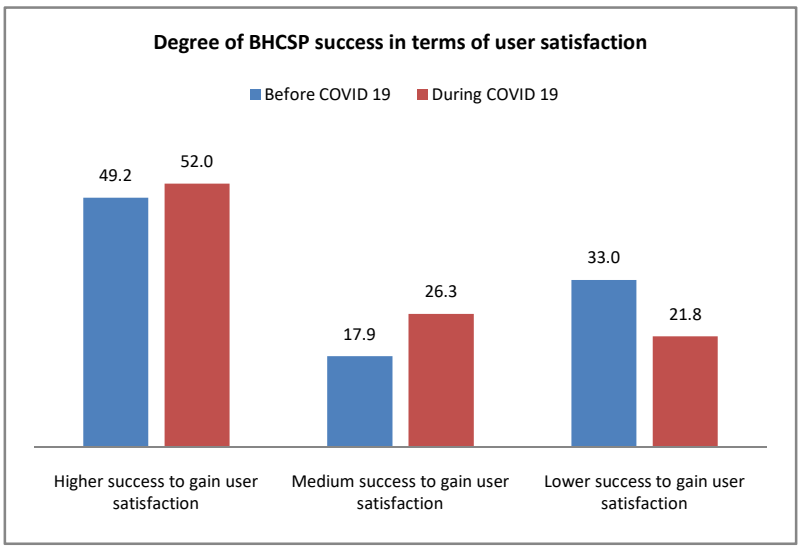


experienced moderate improvement.

Beneficiaries were also asked that how far the BHCSP team helped them to reach the providers to reach service, raise voice if service is not provided or poorly rendered. The responses are again measured in subjective four point scale with options – 'Not at all', 'Sometimes' , 'More often', 'To a Great Extent'. After conducting the principal component analysis the score of component 1 is categorized in higher, moderate and less increase in acceptability of services by the beneficiaries where it is evident that BHCSP team members are successful in converting 64 per cent of knowledge into practice at higher rate, 24 per cent at moderate rate and 11 per cent at lower rate.



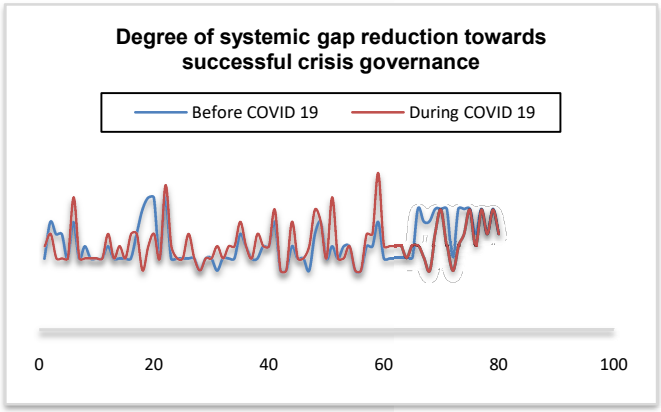
Perceived quality of care in any healthcare system covers the experience of healthcare seekers in health centres and hospitals where questions were asked on whether Health workers are always present in the health centre, Doctors and nurses are present, Health staffs behave friendly, Health centres/ hospitals are clean, Queue in the service centre takes time, Centre/ hospitals are well equipped. PCA score of component 1 is categorized and it is evident that 64 per cent of the beneficiaries perceive high improvement, 6 per cent perceive moderate improvement and 30 per cent perceive less improvement in the quality of service is visible during this period of programme phase.



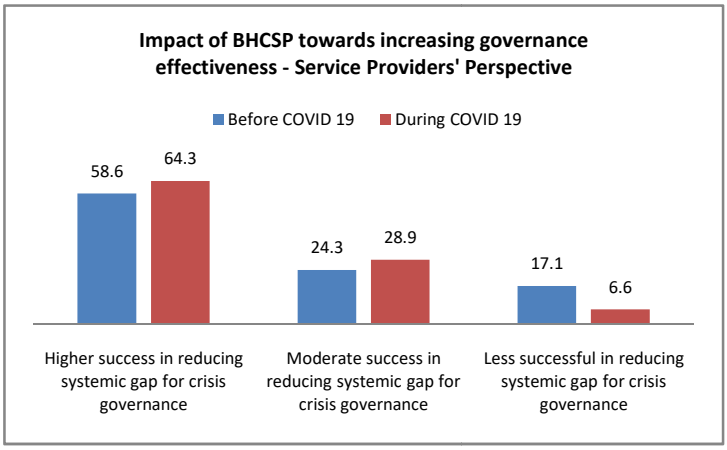
Then beneficiaries were asked in what extent partner staff members helped them to seek service in health facilities, raise voice if service is not given, collectively raise voice if they

get poor service in their community, collectively raise voice if they do not have service in their community, address their need, and make the service provider accountable. The PCA score of component one is used to create one tercile index which is compared for pre-COVID and during COVID period. It is evident that degree of BHCSP success is achieved at higher rate during COVID compared to pre-COVID situation in terms of gaining beneficiary satisfaction (52 per cent compared to 49 per cent).

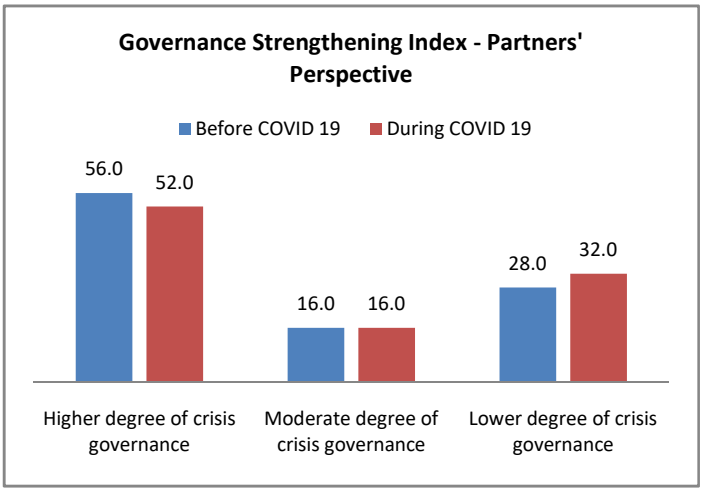
DEGREE OF SYSTEMIC GAP REDUCTION TOWARDS SUCCESSFUL CRISIS GOVERNANCE



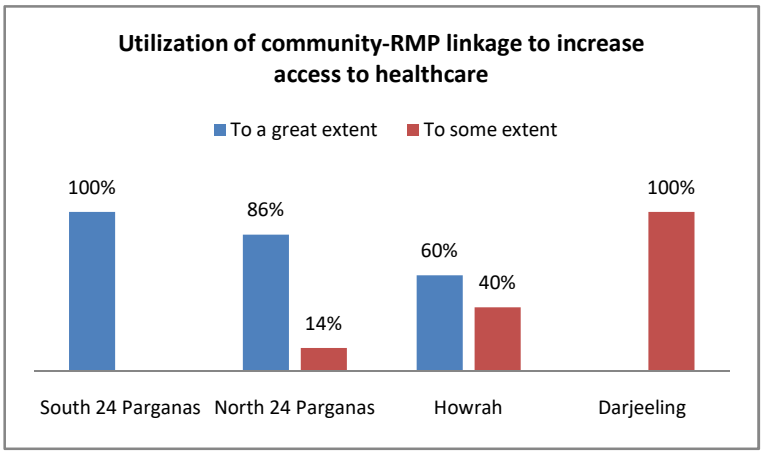
Impact of BHCSP on strengthening public health governance is estimated using responses related to the operational items like – how far they contributed to increase access to services of SC/PHC (Sub Centre/Primary Health Centre), Accountability to higher level management, community, helped in conducting data collection and analysis to assess the change in outcome, and helped to maintain compliance with service delivery guideline. Variables are measured in tercile interval scale with categories 'To a great extent', To some extent' and To a little extent' (each having the weightage of one-third) Factor analysis is run to generate the score measuring the degree of impact created. The distribution of the score shows high variability during pandemic compared to the previous situation implying - as and when the requirement changed the support was given. The governance effectiveness index is categorized in three groups (each with 33.3% weightage) where responses under each one-third segment of the score distribution are reflected. The three categories are 'Higher success', Moderate success' and Less success'. It is evident that BHCSP is highly successful in reducing systemic gaps more during pandemic compared to previous time according to the response of stakeholders. Before the pandemic BHCSP was



highly successful in tackling the governance gap in 57 per cent of the health service centres which has been increased to 64 per cent centres as the requirement rose due to sudden increased need of strong governance during pandemic. As per partners' perspective, governance strengthening initiatives suffered to some extent due to shifting of the focus towards crisis response during pandemic and major initiatives towards strengthening was concentrated on public health emergency and response.

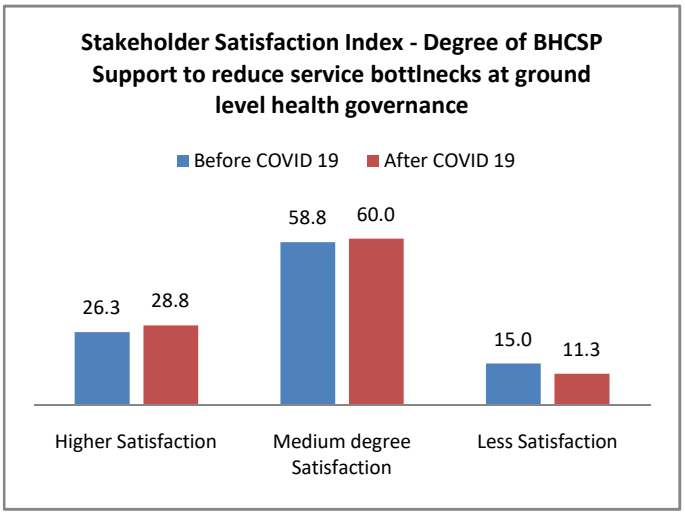


UTILIZATION OF COMMUNITY RMP LINKAGE

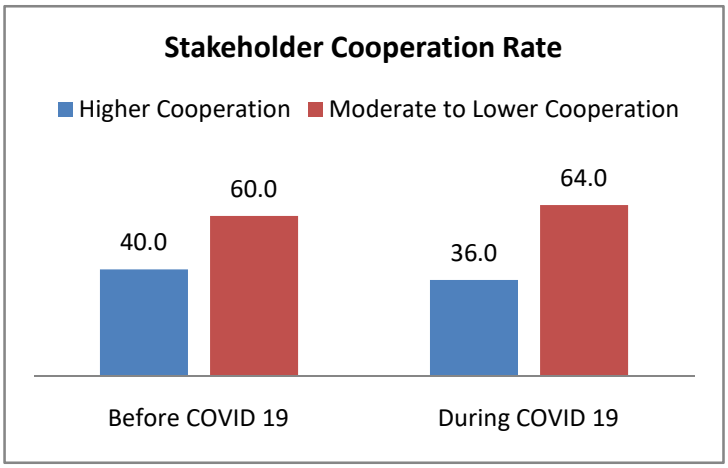


Partner coordinators and facilitators utilized less qualified providers to make community understand the utility of health seeking from the health centre. In South 24 Parganas all the partner facilitators used the linkage to increase access to healthcare. In North 24 Parganas 86 per cent of the facilitators utilized the linkage to a great extent where 60 per cent of them in Howrah was fully successful whereas 100 per cent of the partner intervisers or facilitators were partially successful.

STAKEHOLDER SATISFACTION INDEX



Stakeholders were asked about how far BHCS programme coordinators and intervisers are successful in reducing service delivery related bottlenecks. They were asked how far they have received active cooperation, collaboration, technical support and handholding support from programme personnel to render service. Partners have been asked how far the stakeholders were cooperative to all these activities. Responses are measured in interval scale (Tercile with options 'Always', 'Sometimes' and 'No' having equal weightage of 33.3%). The responses are used for exploratory factor analysis and the score of factor 1 is taken to create stakeholders' satisfaction which is categorized in tercile scale where each category represents response related to one third of the data. The categories are 'Higher satisfaction', 'Medium degree satisfaction' and 'Less satisfaction'. Stakeholder satisfaction has been increased from before pandemic to during pandemic situation regarding BHCSP support to render both routine and emergency services. However, according to partners' point of view average cooperation of service providers increased. It was expected more.



RELEVANCE

District Coordinator, WBVHA

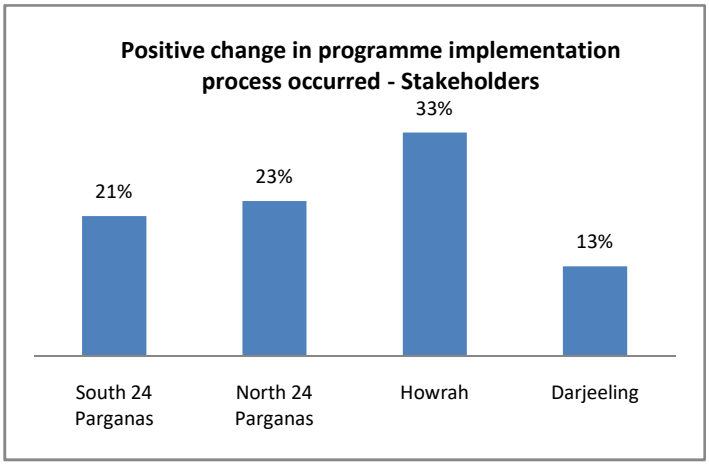
District Coordinator, WBVHA

WBVHA

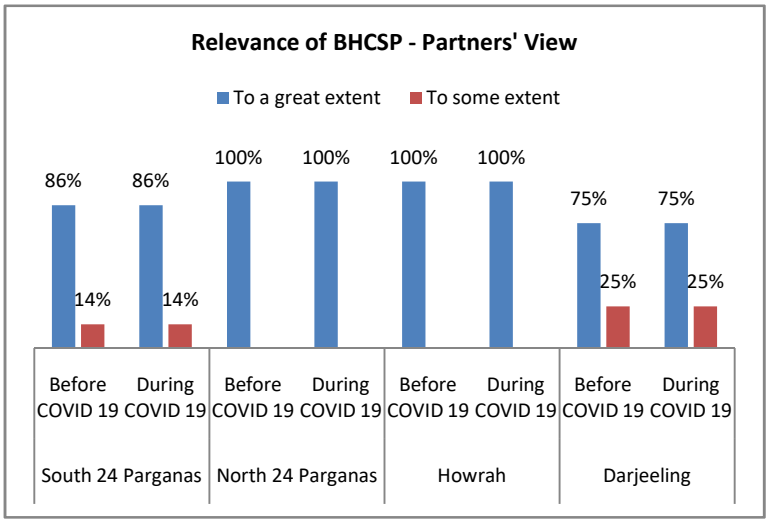
WBVHA

Picture 2: Interview with WBVHA

The relevance of the programme to the contextual need and changing needs due to pandemic in the field area during COVID 19 reflects that the significance increased from 79 per cent to 83 per cent in South 24 Parganas, in North 24 Parganas the extent of relevance was 92 per cent which remained same even during the pandemic. In Howrah the relevance felt among 100 per cent of the service area and remained same among all the centre stakeholders. In Darjeeling district before COVID it was 47 per cent and 33 per cent of the stakeholders feel it is relevant to some extent. The degree remained same during the pandemic too.

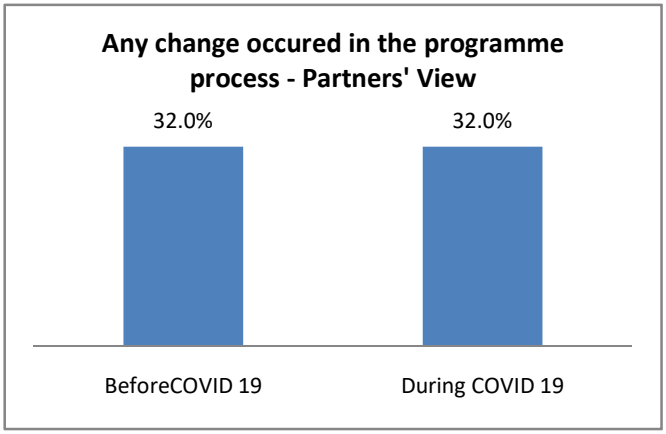


As another relevance indicator the stakeholders were also asked whether the relevance of the programme increased with change in programme implementation process compared to mid-



term phase. In all the districts stakeholders feel the positive change occurred in implementation from 13 to 33 per cent of healthcare service delivery points.

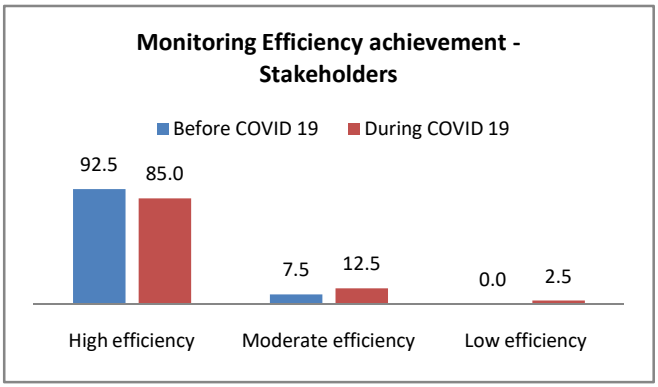
Partner organizations across district felt that presence of BHCSP is highly relevant all the time and the programme remained equally important during pandemic given the new community need identification requirements, increasing demand for awareness due increasing need for health seeking to reduce the rate of transmission and increase the rate of cure, build more resilient community as well as the health system. According to partner coordinators and facilitators 32 per cent of them have seen changes reflected in the implementation process after mid-term phase and the change implemented in consistent pattern even during the pandemic crisis.



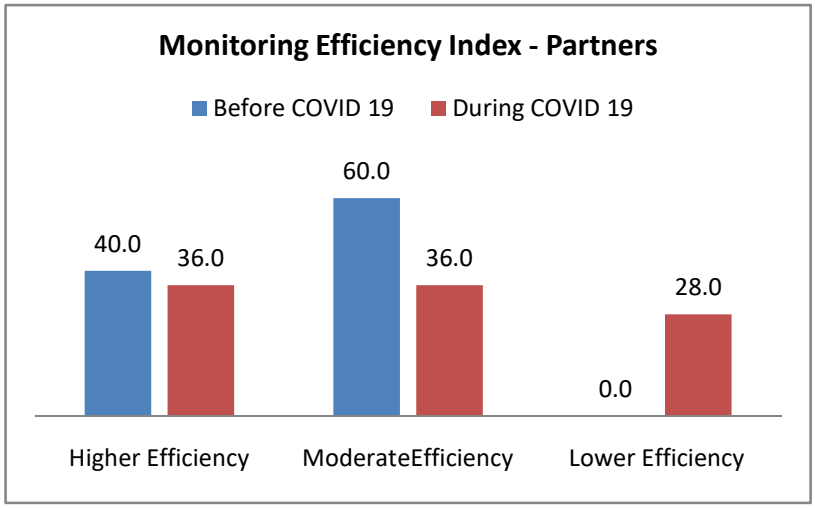
EFFICIENCY

Picture 3: Interview with Programme coordinators, Intervisors and Facilitators in four districts

MONITORING EFFICIENCY INDEX

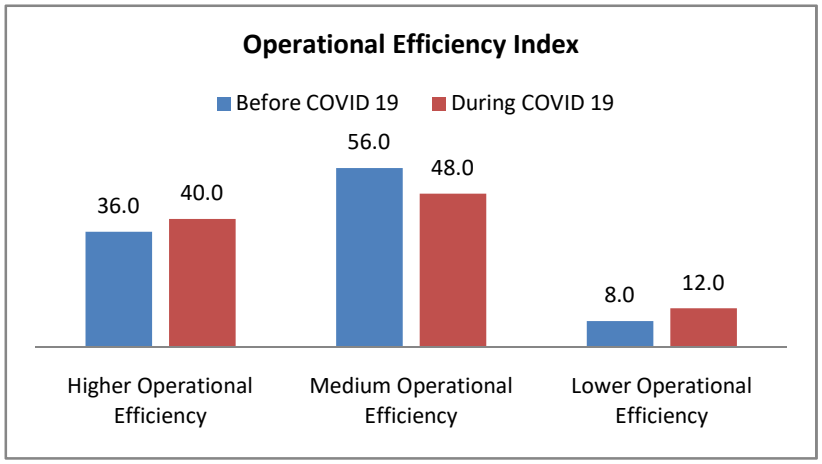


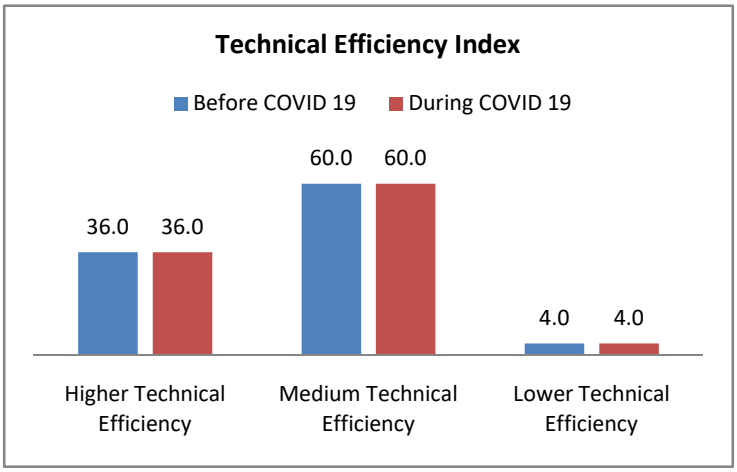
Monitoring efficiency is estimated using the variables Routine activity conducted, Follow-ups conducted, Programme team conducted monitoring activities, Team has dedicated team for analysis. The variables are binary variables. The monitoring efficiency score is generated and then categorized in three groups – High efficiency, Moderate efficiency and Low efficiency. It is evident that before COVID 19 high level of efficiency was achieved with



accelerated pace and reached above 90 per cent which has been reduced by 7 percentage point due to COVID 19 pandemic. In relation to the experience of partners, high to moderate efficiency has increased at a higher rate before COVID compared to during pandemic situation (60 to 40 per cent compared to 36 per cent efficiency gain).

Operational efficiency in monitoring is measured by factors where questions were asked on how far programme team changes strategy based on M&E results, M&E system related practice change took place or not, Detailed documentation through comprehensive report has been done or not, Dissemination and discussion on way ahead took place or not – measured in three point interval scale – 'To a great extent', 'To some extent' and 'Not at all'. The component 1 of the PCA is used to create the operational efficiency index with three categories – higher, medium and lower operational efficiency. It is evident that operational efficiency increased during pandemic at higher rate (40 per cent) compared to before pandemic situation (36 per cent).





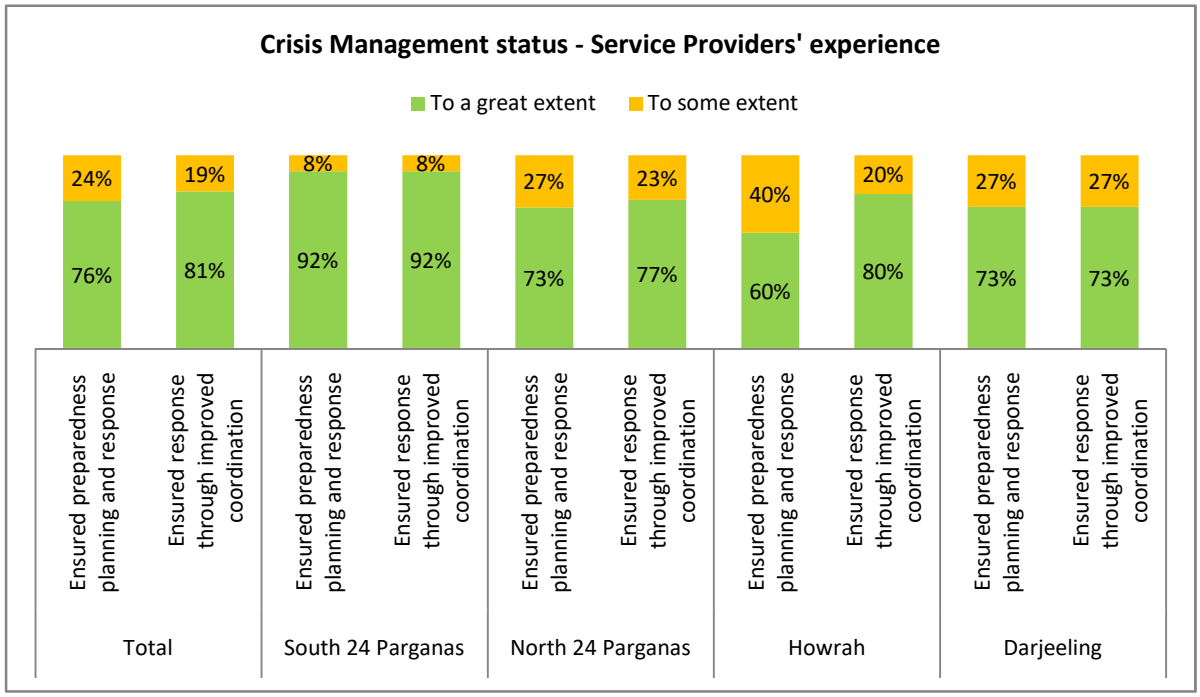
Technical efficiency score is generated following PCA technique using the questions – whether they have developed and used any comprehensive M&E Application software, M&E Application software is in-built or not, Complemented by periodic participatory review of action plans or implementation process, whether any linkage with MIS and reporting dashboard is created. It is evident that technical efficiency gain is visible by 36 to 60 per cent with no difference by the impact of pandemic.

EFFECTIVENESS

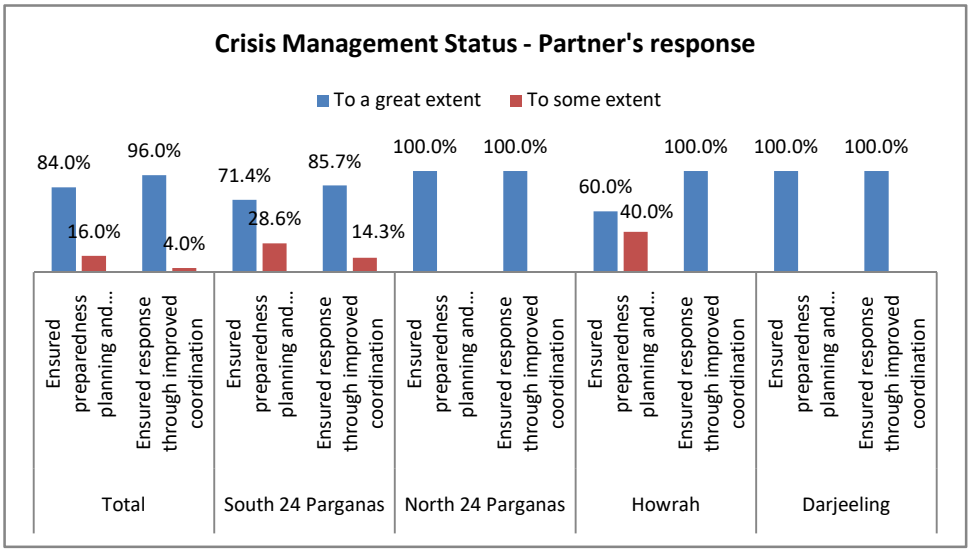
Picture 4: Interview with ground level stakeholders

CRISIS MANAGEMENT EFFECTIVENESS

As part of new contextual requirements they created crisis management system and also helped the ground level healthcare system to build and implement crisis governance. Among



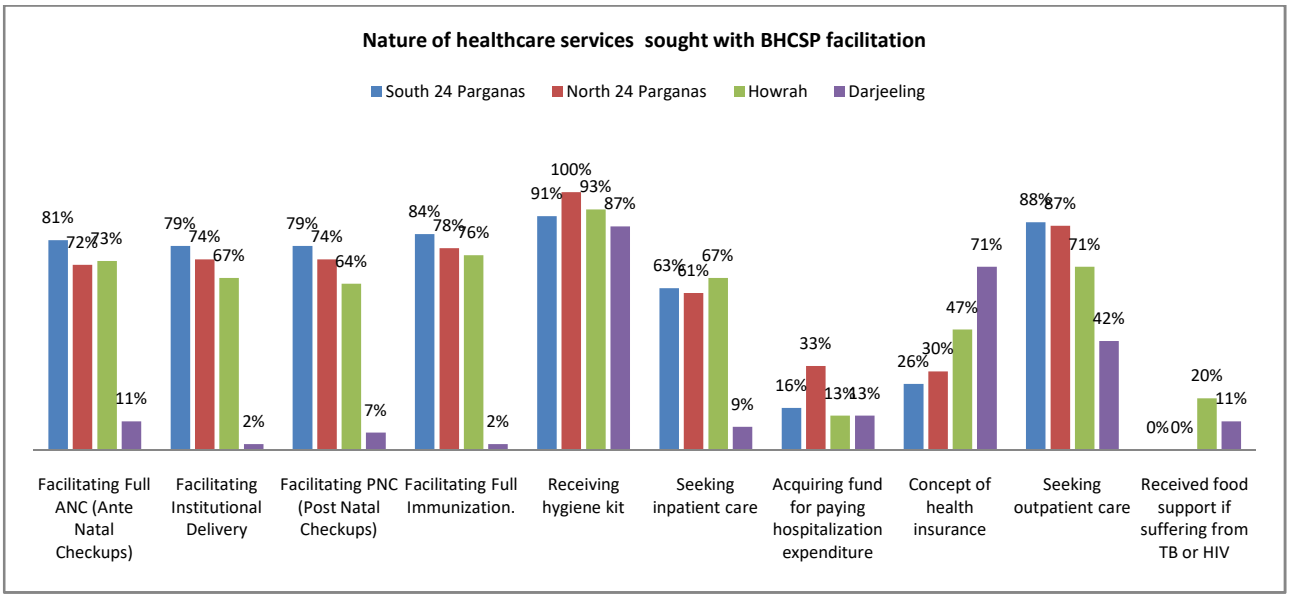
different activities they ensured



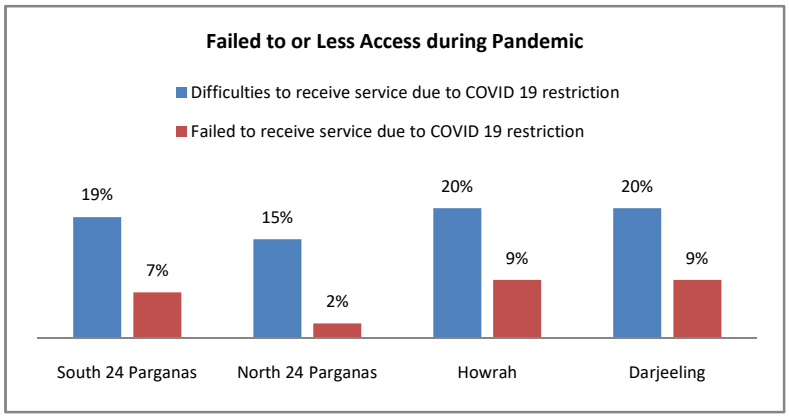
preparedness planning of emergency healthcare service and response, improved coordination which are visible 100 per cent implying covering all the service delivery points under the programme coverage area. Among them 76 per cent coverage area reflects immense support while 24 per cent area reflects moderate support. As per district level heterogeneity is concerned the higher degree of support is evident in 60 to 90 per cent service delivery points with respect to preparedness and response plan whereas 70 to 90 per cent variability in respect of efficient coordination during response. Therefore, during COVID 19 pandemic the public health emergency situation was well managed by ground level health workers and self governance with support, facilitation, capacity building and active participation of BHCSP team.

Due to sudden outbreak of corona virus pandemic WBVHA and its partners were always available where needed for tackling the public health emergency. They facilitated the ground level public health crisis management system to help the ground level health workers in executing crisis governance. There were multiple activities among which they created preparedness planning related to the emergency healthcare service and developed planned response mechanism evident among 86 per cent of the partner areas, improved coordination which is visible 96 per cent implying covering most of the service delivery centres under the BHCSP coverage area. District level variability in respect of preparedness planning reflects greater support ranging from 60 per cent coverage area to 100 per cent coverage area while 29 to 40 per cent area reflects moderate support. As per district level heterogeneity with respect to efficient coordination mechanism is concerned the higher degree of support is evident in 86 to 100 per cent service delivery centres during response. Hence, during corona pandemic the frontline health workers and self governance have received effective facilitation and necessary

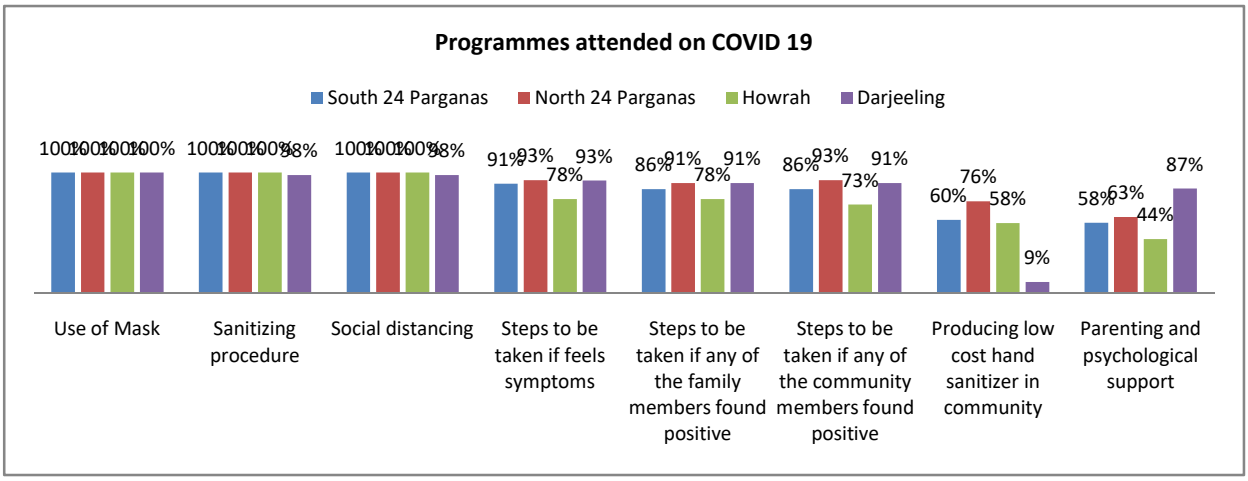
disaster management technical support to handle public health emergency situation from the BHCSP team.



In the intervention districts beneficiaries mostly received full ANC (73 to 81 per cent), institutional delivery (67 to 79 per cent), PNC (64 to 79 per cent), full immunization (76 to 84 per cent), received hygiene kit (87 to 100 per cent), sought inpatient care (61 to 67 per cent) among them 13 to 33 per cent received fund for hospitalization and 71 to 88 per cent received facilitation support for seeking outpatient care.



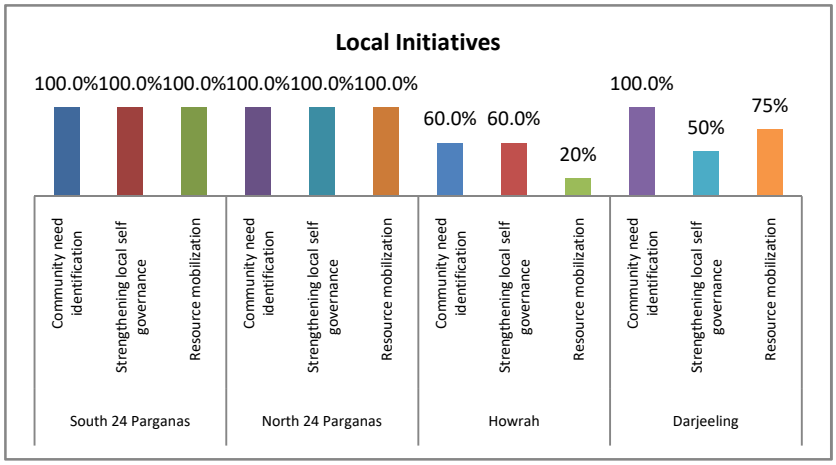
Due to immense support and facilitation of BHCS facilitators and coordinators only one fifth of the beneficiaries faced difficulties in seeking care who were in need of care and less than 10 per cent failed to receive care.



In all the intervention districts 100 per cent of the beneficiaries have attended different programmes arranged by BHCSP on COVID 19 covering how and when to use mask, process of sanitizing, rules on social distancing etc. 78 to 93 per cent of the beneficiaries attended programmes on how to understand corona symptoms and what steps to be taken if the members, their family members, or community members found positive. They were also trained on how to produce low cost sanitizers, parenting and psychological support to ailing members.

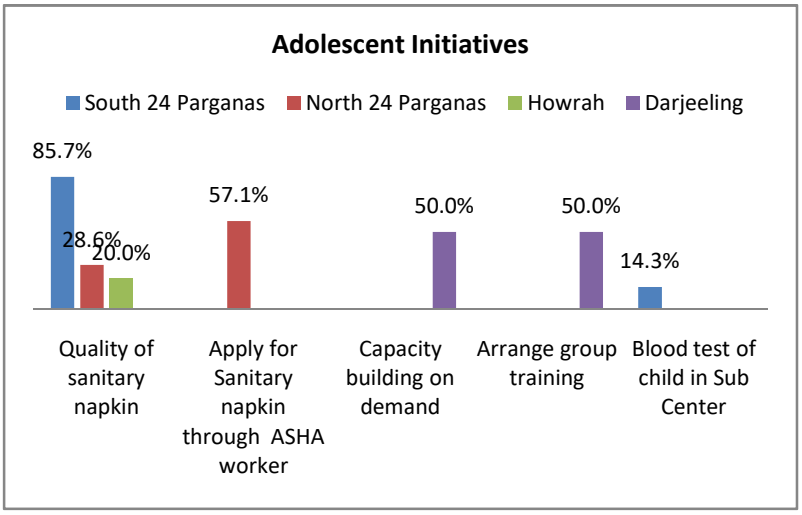
MODIFIED PROGRAMME COMPONENTS

LOCAL INITIATIVES



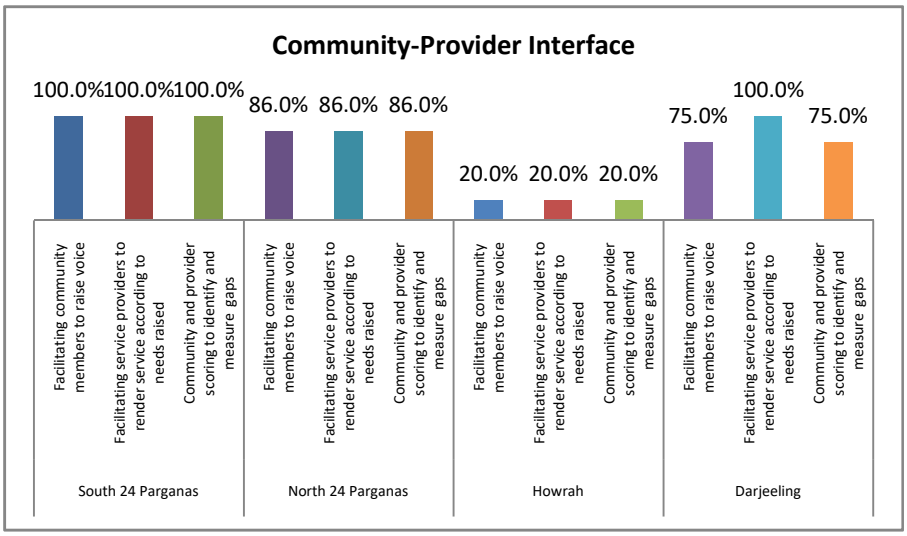
BHCSP had different revised programme components implemented based on process evaluation results to improve the outcome indicators compared to the mid-term intervention outcomes. Those are different local initiatives, community-provider interface activities, initiatives taken for adolescents, women and elderly groups, policy advocacy at GP block and district level governance etc.

Under local initiatives most of the partner facilitators were engaged in community need identification, local self-governance strengthening and resource mobilization for programme purpose. In Howrah 60 per cent of the partner facilitators in Howrah were involved in

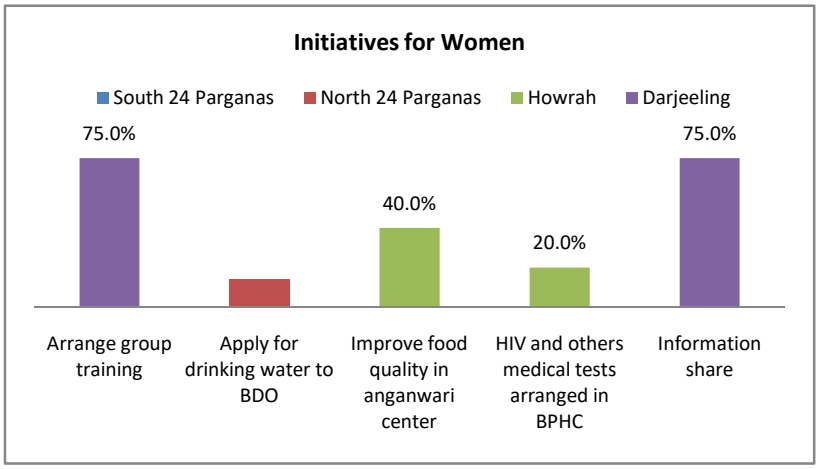


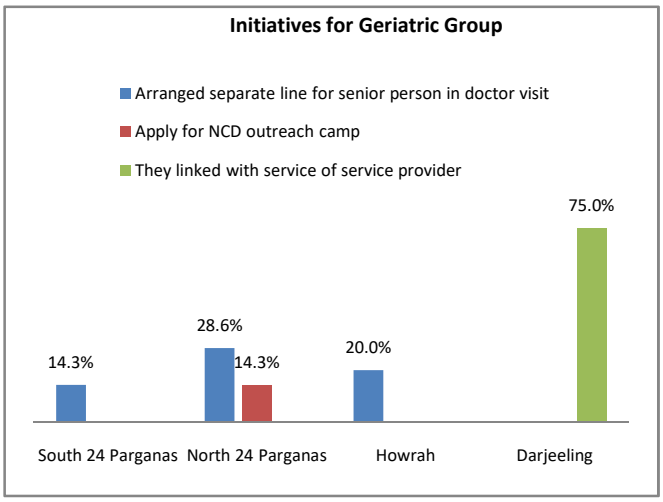
community need identification and governance strengthening, 20 per cent were engaged in resource mobilization. In Darjeeling district 100 per cent of the coordinators and facilitators were engaged in need identification, 50 per cent were involved in governance strengthening and another 50 per cent mobilized programme resources.

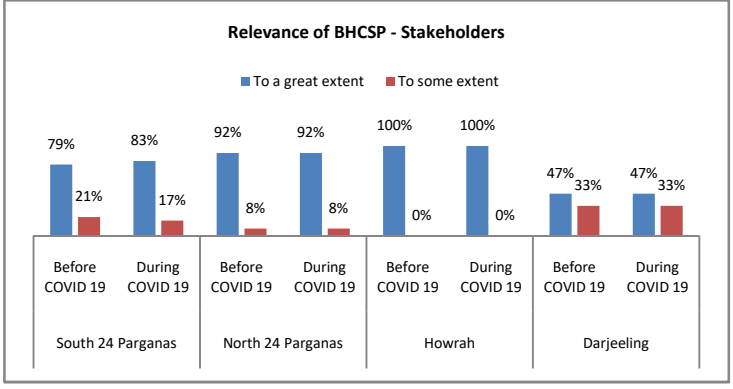
Community/provider interface is another initiative where partners were engaged in building community empowerment through training them how to raise voice to claim the right to survival on one hand and on the other side facilitated service providers to serve the community needs raised. Gap identification and quantification are conducted through community-provider scoring – tool easing the monitoring process too. In South 24 Parganas the initiative was implemented in 100 per cent coverage area, 86 per cent coverage area in North 24 Parganas, 75 to 100 per cent area in Darjeeling, however, only 20 per cent implementation area had such intervention in Howrah.



During implementation process modification, among several programme initiatives the group specific activities conducted are related to initiatives for adolescents, women and elderly. Among adolescent initiatives 86 per cent facilitators talked about quality of sanitary napkins to be considered for use during menstruation, 14 per cent make them aware about utility of doing pathological tests in South 24 Parganas. In North 24 Parganas they helped them to know about how to apply for sanitary napkins (57 per cent) and arranged group training to make them aware (50 per cent). In Howrah 20 per cent of the facilitators were engaged in training the adolescents about what kind of sanitary napkins are to be selected for use, the brand and quality of the material to maintain reproductive health. In Darjeeling 75 per cent of the facilitators arranged group meetings for women to increase awareness about health seeking behaviour and shared information. In North 24 Parganas 14 per cent of them helped the women group on how to send application to block development official for drinking water and sanitation line at home, In Howrah 40 per cent of the facilitators were engaged in building women group's understanding on how they will raise voice to improve the quality of supplementary nutrition in ICDS centre and how they can access it, 20 per cent of them arranged different medical tests in BPHC for community women. For geriatric group 14 per cent of them in South 24 Parganas, 29 per cent in North 24 Parganas and 20 per cent in Howrah always arranged separate

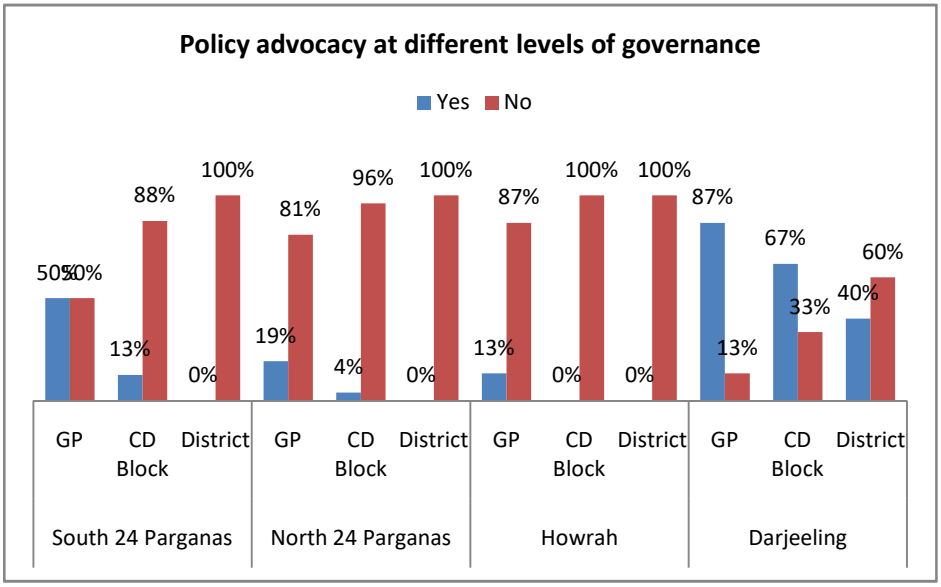






line for senior community members while they had doctor visits, 14 per cent in North 24 Parganas helped them to apply for NCD outreach camps and 75 per cent of facilitators connected elderly community members to service providers when they needed healthcare.

EFFECTIVE POLICY ADVOCACY



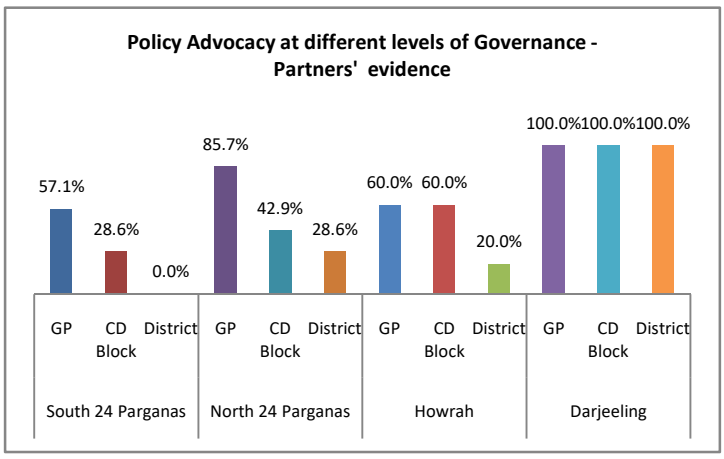
Ground level policy advocacy on different programme mandates along with implementation of public health response mechanism were conducted by BHCSP coordinators to strengthen the capacity of frontline health workers. The level of advocacy has been conducted in Gram Panchayat the most which took place at 87 per cent connected service centres in Darjeeling, 50 per cent in South 24 Parganas. However, the activity was conducted in one out of five centres in North 24 Parganas and Howrah. In Darjeeling the policy advocacy is evident with three out of five Block level stakeholders and two out of five District level stakeholders.

	South 24 Parganas	North 24 Parganas	Howrah	Darjeeling
Covid-19 vaccine	17%	20%	0%	15%
Child marriage	25%	0%	0%	0%
community right	17%	0%	0%	0%

ADO meeting arrange	25%	0%	50%	0%
No supply napkin	17%	0%	0%	0%
installation of sanitary napkin machine	8%	0%	0%	0%
Electric line problem	8%	0%	0%	0%
Mid day meal problem in pandamic situation	17%	0%	0%	0%
SC building repair	8%	0%	0%	0%
Road repair	8%	40%	0%	0%
Tubewell repair for arsenic free Drinking water	17%	20%	50%	0%
Plastic problem	8%	0%	0%	0%
Dengue	8%	0%	0%	0%
Child labour	8%	0%	0%	0%
Good medical service of senior person	0%	20%	0%	0%
Permanent Anganwadi center	0%	0%	0%	31%
Arrange weight machine in center	0%	0%	0%	8%
Safety	0%	0%	0%	8%
Training	0%	0%	0%	15%
Many issue through J.K.S.S.	0%	0%	0%	8%
Good quality food	0%	0%	0%	15%
Salary	0%	0%	0%	31%

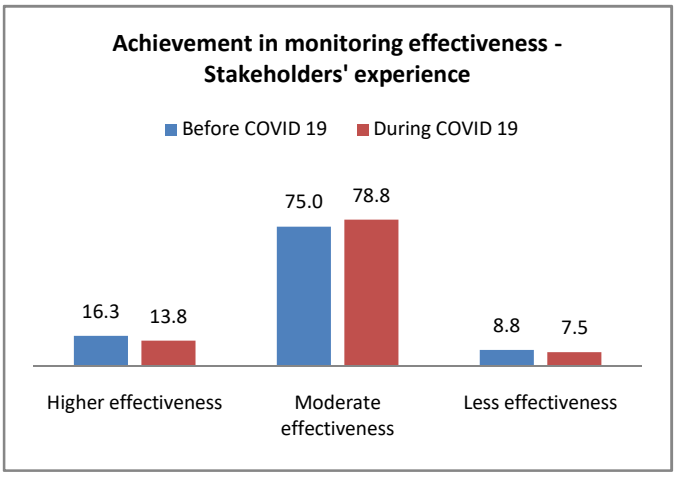
In the policy advocacy activities stakeholders in South 24 Parganas mentioned about fourteen issues and in Darjeeling about eight issues been covered.

Policy advocacy at different levels of governance has been arranged to satisfy identified community needs,

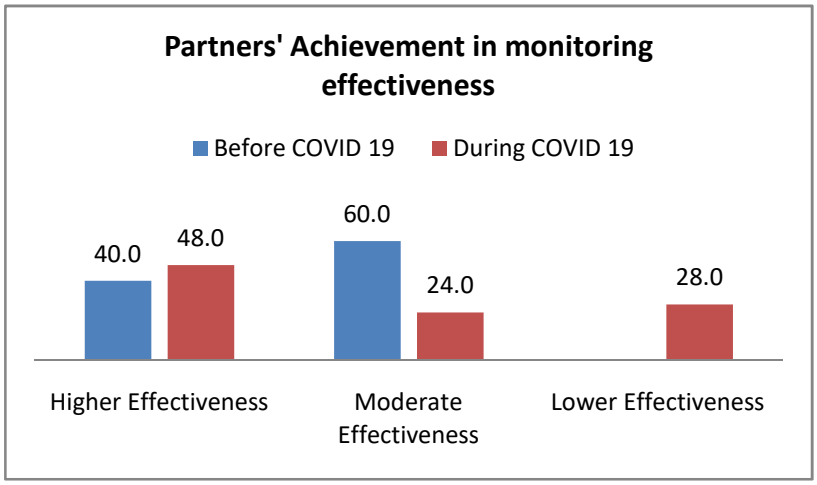


raised by communities, reducing the demand-supply gap after periodic measure through community-provider scoring. In all the districts the GP level advocacy was conducted more (57 to 86 per cent) followed by CD Block (29 to 60 per cent) and District (20 to 29 per cent) level except Darjeeling where the policy advocacy coverage was 100 per cent as per the coverage distribution of the programme coordinator and facilitator.

MONITORING EFFECTIVENESS INDEX

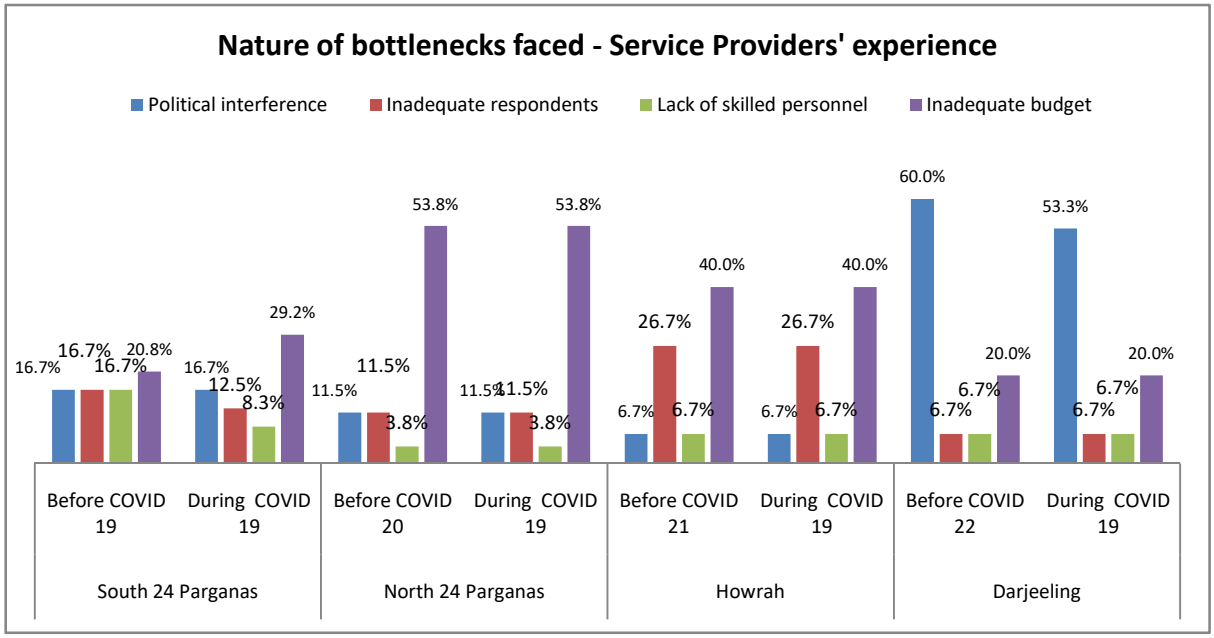


Improvement in monitoring activities and influencing the monitoring of health workers is evident. Variables taken to compute the factor analysis to create monitoring effectiveness score are - Projects monitored with plans at inception (To a great extent, To some extent, To a little extent), Results are shared with Communities and stakeholders (Always, Sometimes, Never), Sharing is followed by modification in targets and strategies (Always, Sometimes, Never), Acceptance of monitoring results among team and higher levels of governance (To a great extent, To some extent), Degree of integration between stakeholders and BHCSP team (To a great extent, To some extent). The variables are in tercile scale (33.3% weightage to each category) or dichotomous categorical variable (50% weightage to the categories) as other variables. The variables are used for factor analysis and the generated score is ordered at tercile scale - Higher effectiveness, Moderate effectiveness, Less effectiveness. Marginal fall in higher level of effectiveness may be caused due to lack of skilled personnel during pandemic crisis, more involvement of staff members to increase community's willingness to visit health centre due to fear of transmission etc. There is increase in effectiveness of monitoring activities at moderate degree in almost 80 per cent of the healthcare centres

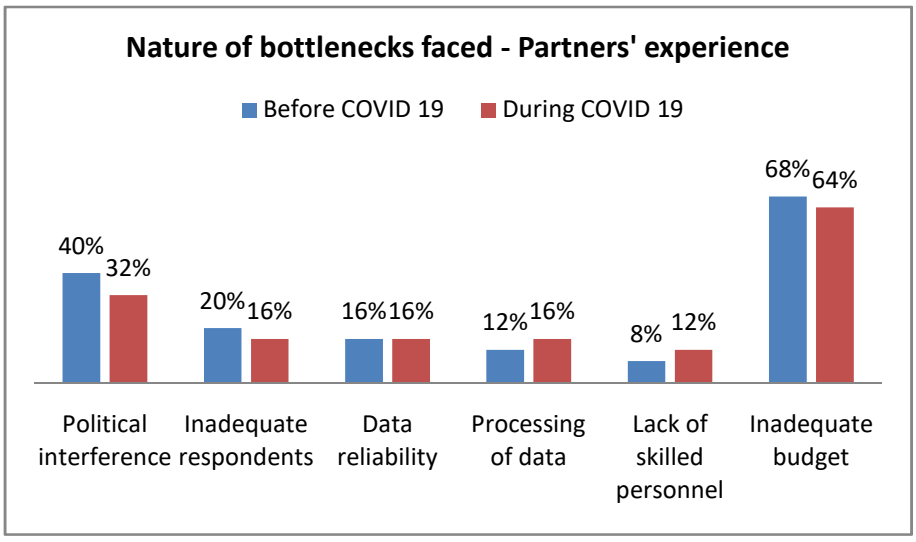


during corona pandemic. As per partner's response higher effectiveness is achieved during pandemic compared to previous time with improvement in the implementation process, analysis and documentation activities and strengthening the local level health governance.

MANAGING EXTERNAL AND INTERNAL RISK IN PROGRAMME IMPLEMENTATION



Sudden emergence of public health emergency has brought unknown responsibilities on the programme team who effectively supported the stakeholder community to manage political factors, inadequate response of communities in health seeking along with shortage of ground level health human resource during pandemic. However, the stakeholders faced with budget crunch to manage ground level response mechanism – varying from 29 per cent to 54 per cent of the health

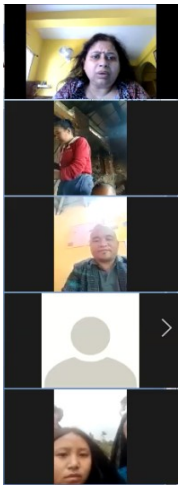


service points. It seems the programme team faced more bottlenecks before pandemic situation compared to pandemic situation. The reason is partner organizations effectively managed political factors, community's attitude towards health seeking during health emergency, tried to maintain data reliability through multiple and repeat checks. However, the challenges would have been tackled smoother if access to adequate budget can be ensured.

SUSTAINABILITY

COMMUNITY INTERACTION

Darjeeling



The study has found the achievement of financial, social and environmental sustainability to some extent in all the intervention districts.

Social sustainability - As per the views of adolescent group members screening, awareness programme all are provided along with community training programmes to different groups about adolescent health and hygiene. However, if BHCS programme ends adolescent group in Darjeeling said that it will be difficult to know more about health. They said they want basic healthcare support programme to continue to know more about healthcare. **It implies the knowledge shared till now can be practiced and they realized that with time they need to know new things with time.**

Mother's group members said that they are learning about healthcare practice about them and their children from BHCS only. If the programme stops it will be a problem because they are imparting training on every aspect of healthcare, and community needs more handholding support in this respect. They are not fully prepared yet to seek care independently, without basic healthcare support it is difficult to get access to any service. The Self Help Groups have received periodic trainings; however, more training is required to strengthen the existing SHGs.

Financial sustainability - With respect to creation of health funds some of the SHG members are confident that they can continue the process. However, in relation to access to information, ensuring basic rights related to health seeking continuity of BHCS is required. As for an example, during immunization days ASHA workers become busy and if any of the pregnant women need medical help SHG members take them hospital with the help of health

facilitators. These are typical cases which may arise anytime and SHGs are not that strong to provide the support on their own right now. They need to gather more experience with handholding support of BHCSP members to become self sufficient.

Geriatric group members also have shared similar views. Geriatric groups will face difficulty in healthcare seeking or collecting pension from bank because it is difficult for them to stand in the queue for long hours which is done and supported by intervisers and health facilitators under the programme.

Environmental sustainability – Good impact has been indicated in terms of generating hygiene practice behaviour in the community. Also communities are learnt about solid waste management and practicing the same which is a major environmental cocern. More emphasis is to be given on exploring the access to safe drinking water and sanitation in future.

Howrah

In Howrah district we had Focused Group Discussion with 8 community members. They were also asked how far they feel they are well equipped if the BHCS programme ends. Community people want the programme to continue.

Social sustainability - According to them, "*though we have learnt a lot from the facilitators of the NGO, we want to learn more and now we understand there is lot to learn which needs the continuity of the programme*." They shared that basic healthcare support programme helped them to seek timely healthcare with reduction of challenges and hazards in the way of health seeking. So they want this help without any break or discontinuity.

They were then asked how far the SHG members have received training and whether they can work on the ethos of BHCSP. They replied that most of the Self Help Groups and their members have received training and working as per BHCSP training and awareness generation programmes. According to them new groups are getting created and these group members require training from BHCSP facilitators. ***They believe that the first or initial training is to come from BHCSP as their mode of discussion; way of imparting training creates rapid and deep impact. SHG members and community leaders are learning this process but they need more time to reach at BHCSP level.*** To familiar with new changes they need the support from BHCSP. For example, they know they have to link ASHA worker when a pregnant women needs to go to institution. They can do that but if she faces any complication and availability of health worker takes time, workers from BHCSP takes immediate decision to solve the issue for which community members not prepared yet.

Financial sustainability - Furthermore, they also added that new government policies and schemes are coming all the time for which they need training and support to access the new schemes from time to time. In relation to the creation and maintenance of health fund BHCSP has taught them the procedure, however, they need BHCSP support in the process further if they face any challenge to continue it. In practice of it they need their monitoring to minimize error, rectification and modification as and when required to maximize benefit. Another crucial point is their voice is not prepared and accepted in local governance to that extent which is required to fulfill the requirements.

Environmental sustainability - Another example is related to the time of COVID 19 pandemic where they learnt how to maintain health and hygiene behaviour to save the community environment from sudden disasters. If they face similar challenges in future they need BHCSP to support them to survive. They also learnt about solid waste management in community to maintain safe environment. They started to practice for example, how to collect and separate different types of solid waste. In order to improve the environment further, they need extended focus on water and sanitation domain – increase access to safe drinking water with practice of how to combat water scarcity, increase the use of toilet etc.

They also recommended that

1. If basic healthcare support programme helps the elderly group to access medicine without standing in the queue – may be connecting them to pharmacy or other medicine supplier – that will be of great help.

2. Secondly, they got immense help from BHCSP camp on detection of cervical cancer. If this camp stops then the community will suffer and the prevalence and suffering will increase as the detection and early treatment possibilities will end.
3. BHCSP has taught solid waste management which may have more dimensions to be learnt.
4. They need more support in the dimension of Water, Sanitation and Hygiene, assessment of source of drinking water to increase access to safe water.
5. More support is required in the next step of nutrition which is to be added along with healthcare support programme.
6. More support is required to help them create their own voice in local self governance related to access to health and nutrition services.

North 24 Parganas

Social sustainability - They expressed that if the programme ends they can start discussion within group how to manage the healthcare seeking and smoothen the access to healthcare services. What they feel is that they need the help of support programme in relation to fund, the quality of IEC materials – in this respect support is required. Community leaders can start running the awareness programmes but are unable to create the IEC materials required to support the training. However, basic healthcare support programme has created community leaders who escort pregnant women and seek children to hospital if ASHA workers are not available at the moment. They also added that they can provide the support in a small area whereas this area of Baduria has places where this support has not reached. So there are lots of places where this support is to be reached. In other words, they indicated that BHCSP needs to be scaled up in nearby gram panchayats and villages. When they were asked how far they are well equipped, one of the community leaders shared that BHCSP has supported and built capacity of 120 SHGs out of 225.

Financial sustainability – They added that they have learnt health fund creation and maintenance. They can run it confidently. But it is to be taught to the rest of the 100 SHGs so that equity can be achieved with increased coverage.

Environmental sustainability – Like other areas, they have also learnt solid waste management techniques; they are practicing the same and trained community members to practice it. They need more support on solving problems related to water sources and sanitation.

They also recommended that

1. Other that existing 25 adolescent groups more groups are to be created by BHCSP with follow up visits to Anwesha clinic, linking them to government schemes to increase the coverage
2. They believe that the training on the issues covered by BHCSP should continue for the rest of the self help groups as they have mentioned before that quality and effectiveness of BHCSP training are significantly impactful and can bring rapid progress compared to full dependence on community only for continuing the training and support.
3. BHCSP support is required to improve access to ICDS services and improving the access to water sources
4. They want to include more geriatric healthcare support in sub health centre
5. They need more time to prepare themselves as self sufficient for which they want BHCSP to continue to support them
6. Their voice is not yet effective to build tube wells and bring doctors in the healthcare facilities for which they need BHCSP
7. They want BHCSP support to create community meetings with BMOH and CMOH – higher level of district health governance to create and bring the community voice directly to them. Such meetings are to be made periodic and continuous.

South 24 Parganas

Similar to other districts community members in South 24

Parganas were also asked that how far they can continue the practice of healthcare seeking, creation and maintenance of health funds and maintaining of groups if basic healthcare support programme ends.

Social sustainability - They shared that if BHCSP ends how they will come to know about new healthcare services and schemes, these will completely stop because NGO workers and facilitators they know them first and then share with community, arrange training etc. Community leaders can explain about old schemes and services but community will remain deprived with respect to new schemes. They are helping pregnant women and adolescent girls to have access to IFA tablets, access healthcare in timely manner, help elderly group to do the routine health checkup in sub centre on time. However, if they do not receive handholding support from BHCSP anymore the pace of support will be hampered. It will be decelerated.

Financial sustainability - The community is still having people who are not covered under the programme yet and they continue to practice taking loan from moneylenders as they need training on health fund creation. If BHCSP support ends it will not be possible to scale up the programme with same pace and quality to make it impactful and this will continue to push them towards impoverishment through financial catastrophe.

Environmental sustainability - They are providing support to community in terms of cleaning the surrounding from stagnant water, train community members on how to separate solid waste, how to manage them etc. They started to practice it. However, given the context of disaster proneness, they need more training on how to manage water scarcity during flood and inundation, how to raise voice to have more tube wells in highland areas, how to reduce salinity and many more.

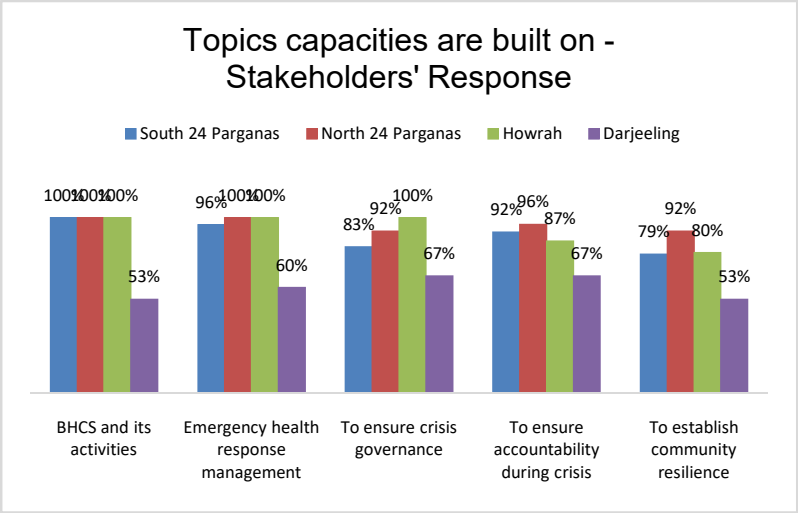
Their recommendation

1. BHCSP support is to be extended in detail to improve care for anemia among adolescents and mothers
2. It is to be extended to enhance ICDS service for children and adolescents to reduce the likelihood of giving birth to undernourished children
3. Rest of the SHGs is to be trained and equipped with the help of BHCSP. Community leaders need more time to be well prepared to be self sufficient. They are not fully prepared to support the community as supported by BHCSP
4. In summer they will suffer from water scarcity which will aggravate during flood situation. They need support in this respect too

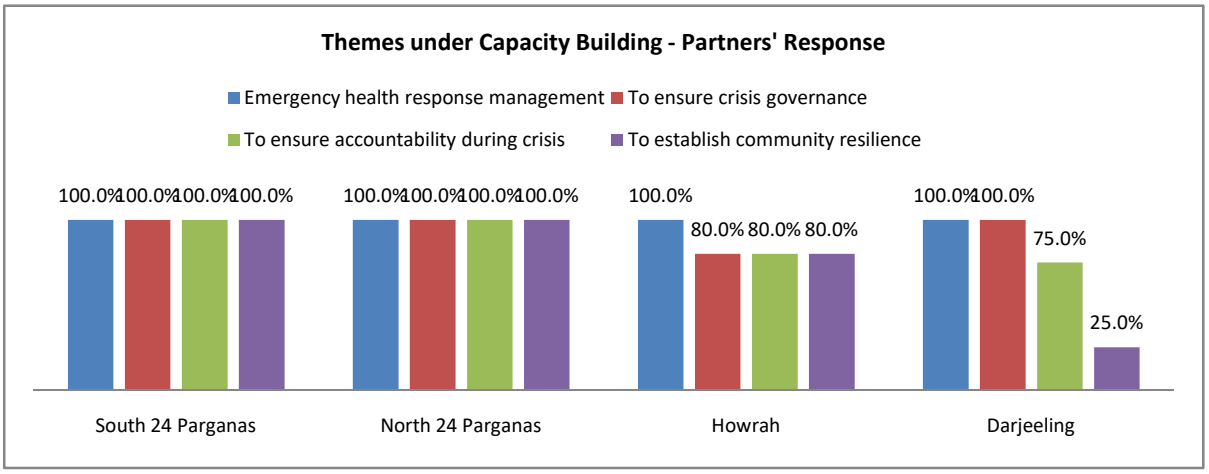
5. They want support from BHCSP to create access to anemia test for each girl and women, access to other health tests and sanitary napkins
6. To some extent they need support on livelihood issues
7. More support is to be created for elderly population in sub centre
8. More training is required on the awareness regarding new variants of COVID 19

CAPACITY BUILDING OF STAKEHOLDERS

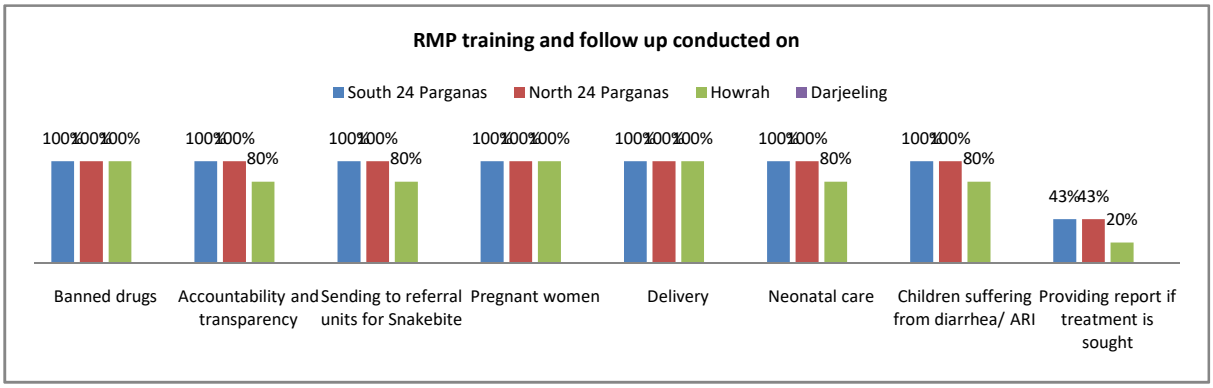
DIFFERENT THEMES COVERED UNDER CAPACITY BUILDING



Capacity building of the service providers is conducted through different programme activities to help them respond and continue basic programme objectives. Three of the four districts covered all the service delivery centres to facilitate routine as well as emergency services following BHCS programme mandates. There are scopes to arrange more programme days in Darjeeling covering all the centres and more days in a year. Coverage in relation to capacity building on management of health risks and emergencies, crisis related accountability are 90 to 100 per cent in the three district which show 60 to 67 per cent coverage in Darjeeling. Capacity building with respect to ensuring crisis coordination and management as well as building community resilience to combat



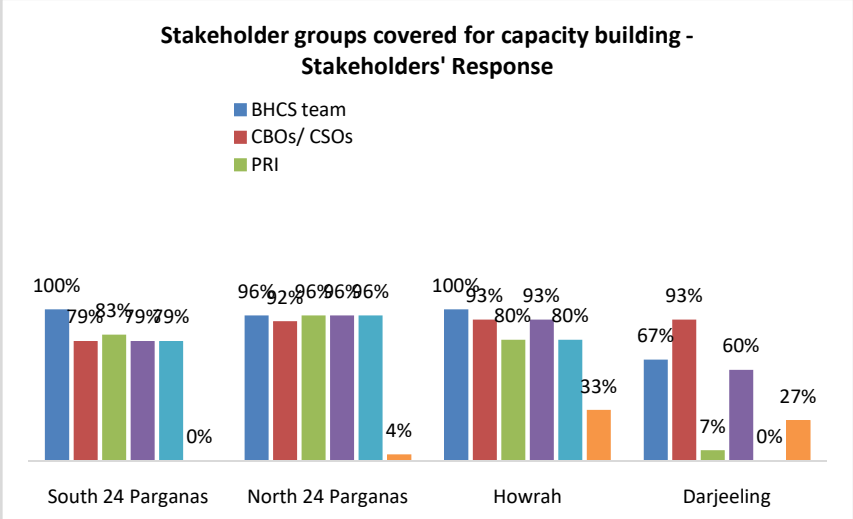
public health emergencies like corona virus pandemic covered 83 to 100 per cent and 79 to 92 per cent respectively. As per the sharing at partner level, capacity building activities for frontline health workers and senior level at CD Block or District level are conducted in all the districts. South and North 24 Parganas has covered 100 per cent of the coverage area and imparted training on managing emergency response to healthcare, crisis governance, how to remain accountable to community and higher authority during crisis and how to create community resilience. In Howrah 80 to 100 per cent of the programme is covered under capacity building of the stakeholders. In Darjeeling 75 to 100 per cent is covered except building community resilience – imparted in 25 per cent of the area.



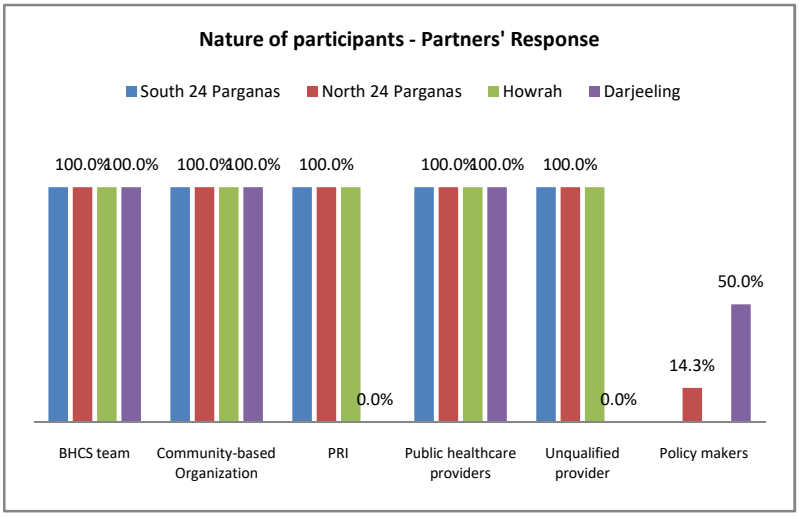
All the capacity building activities for the less than qualified rural medical practitioners covered modules on banned drugs, accountability and transparency, when to send in referral, symptoms of pregnancy, pregnancy complications, child delivery, basics of neonatal care, home management of diarrhea/ARI, report after each treatment is sought. Except in Darjeeling 20 to 80 per cent of the module topics mentioned are covered.

NATURE OF TRAINING PARTICIPANTS

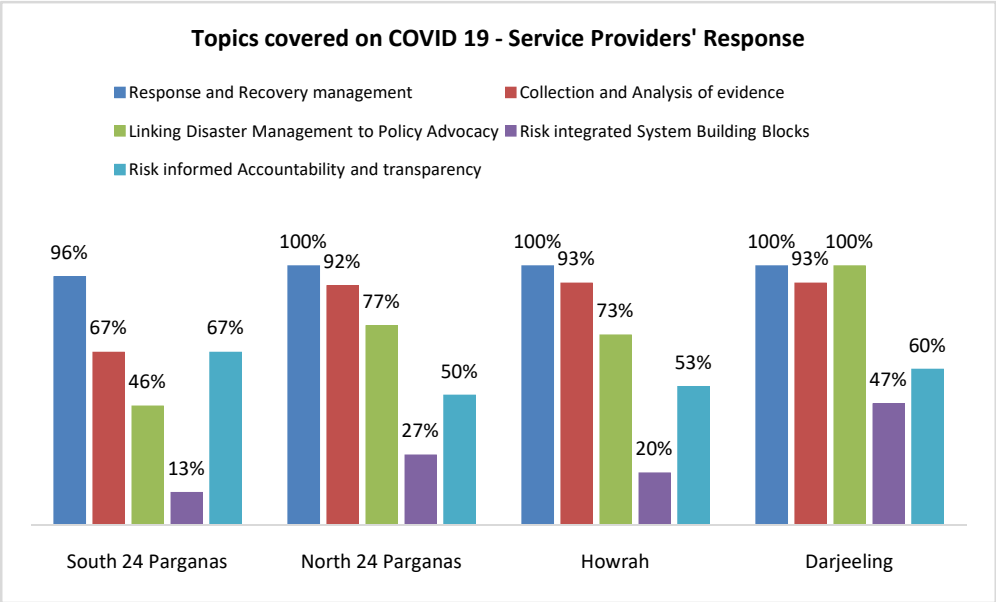
Capacity building conducted for different government stakeholders and nongovernment CBOs and CSOs. In South 24 Parganas, 79 per cent CBOs, public health providers, less than qualified rural providers



and 83 per cent of PRI members are trained. Above 90 per cent of all the categories are imparted training in North 24 Parganas. Policy makers or district / block level officials took part in Howrah and Darjeeling to some extent and in North 24 Parganas to a very less extent. In Darjeeling the training imparted mostly on CBOs (93 per cent) whereas capacity of 60 per cent of public healthcare provider are built. As per the partners, in all of the training programmes team the respective BHCSP PRI members, local CSOs, members, frontline health workers engaged in the programme, less than qualified providers in the community attended the training programme, 14 per cent policy level officials in North 24 Parganas and 50 per cent in Darjeeling have attended the capacity building programmes.

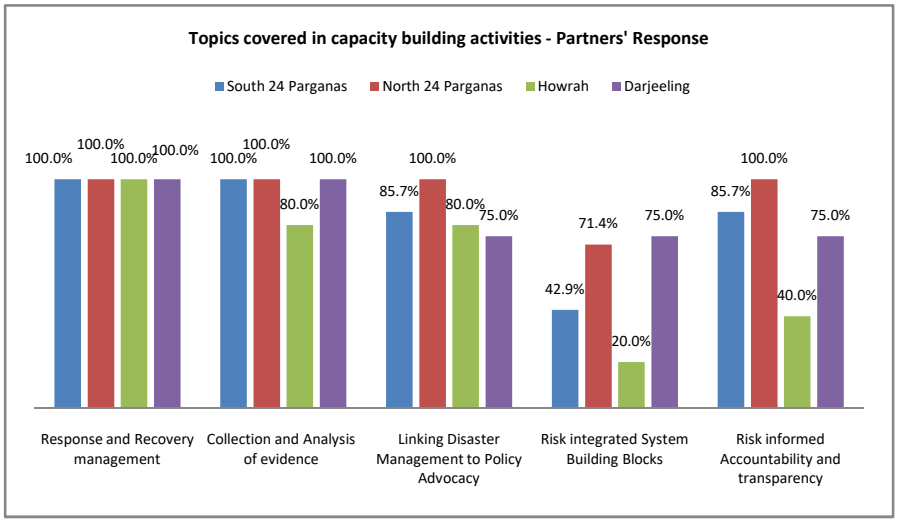


CAPACITY BUILDING COVERED THE TOPICS – COVID 19



Across the districts 96 per cent to 100 per cent of the stakeholders are trained on efficient response management related to COVID 19 pandemic. More than 90 per cent of them are trained on data collection on number

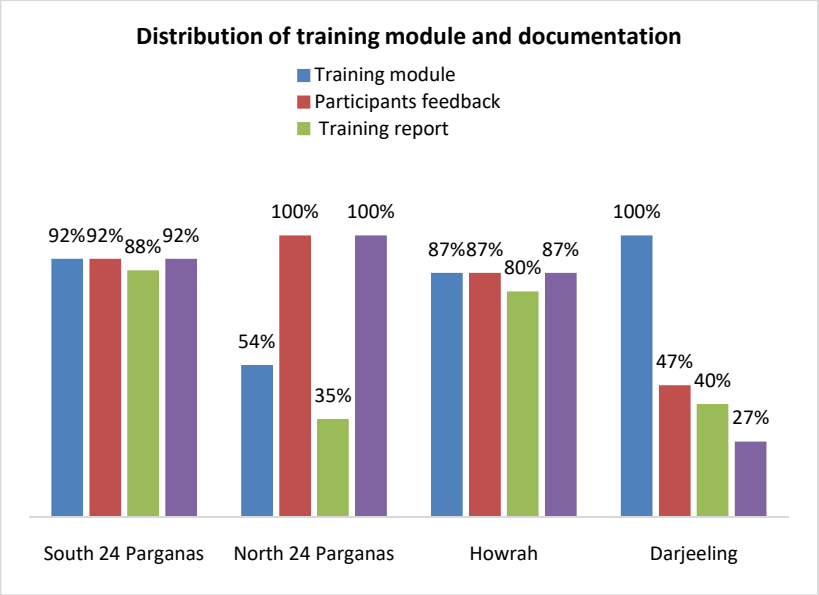
of positive cases, rate of cure, rate of transmission etc., which is 67 per cent in South 24 Parganas. Building capacity on how to link health crisis management with policy advocacy during pandemic has been conducted for all the service providers in Darjeeling who were trained on different topics. It is evident among 73 to 77 per cent among them in North 24 Parganas and Howrah, however, among 46 per cent of them in South 24 Parganas. Topics related to risk informed accountability and transparency during pandemic was covered among 50 to 67 per cent of them whereas how to create and maintain risk adjusted healthcare system at all the levels of governance has been covered among very less – with a district level variability from 13 to 47 per cent.



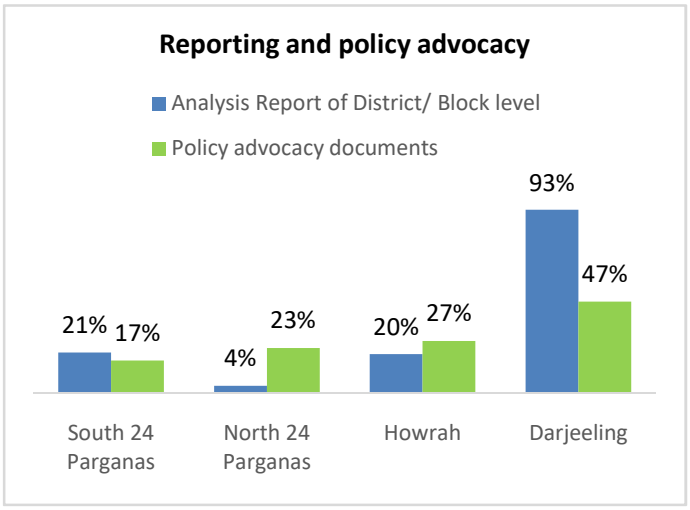
According to the partners, within the four themes topics covered are response management, evidence collection and synthesis, policy advocacy on emergency management in public health, risk integrated governance, accountability and transparency. All the capacity building activities conducted by different programme personnel have covered response and recovery management across districts. 100 per cent of the facilitators and coordinators have covered data collection and analysis of data in South 24 Parganas, North 24 Parganas and Darjeeling, 80 per cent in Howrah. Training activities on linking emergency management and response shows district level heterogeneity from 75 to 100 per cent coverage of the topic. Among the training programmes 43 per cent of the trainings in South 24 Parganas have covered risk integrated governance, 70 per cent of the training programmes in North 24 Parganas, 75 per cent in Darjeeling have covered the same. However, only 20 per cent of training activities in Howrah have covered the topic. Furthermore, 75 to 100 per cent of the training programmes have covered risk informed transparency and accountability aspects in three districts except Howrah where 40 per cent of the training programmes have covered that.

DOCUMENTS MAINTAINED AND SHARED WITH STAKEHOLDERS RELATED TO CAPACITY BUILDING

In different districts training modules are distributed in varying extent. In Howrah, South 24 Parganas and Darjeeling 87 per cent to 100 per cent participants received training module which is evident among 54 per cent of the participants in North 24 Parganas. Session feedbacks are taken from 87 to 100 per cent of the participants in three districts but it is much lower in Darjeeling (47 per cent). Training report is shared with 88 per cent participants in South 24 Parganas, 80 per cent in Howrah whereas with 35 to 40 per cent in North 24 Parganas and Darjeeling. In three of the districts follow up actions are taken with 87 to 100 per cent participants which was possible for one out of three in the Darjeeling district.



DOCUMENTS MAINTAINED RELATED TO PROCESS CHANGE AND REFLECTED IN ADVOCACY – REFLECTION FROM THE SERVICE PROVIDERS

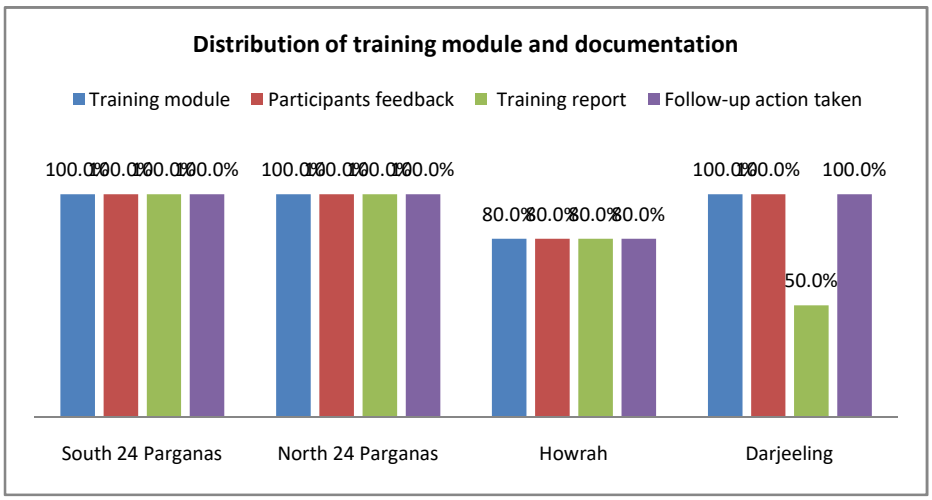


Training and feedback consisting of regular data analysis and reporting related to capacity building of stakeholders are conducted and shared with one out of five stakeholder participants in South 24 Parganas

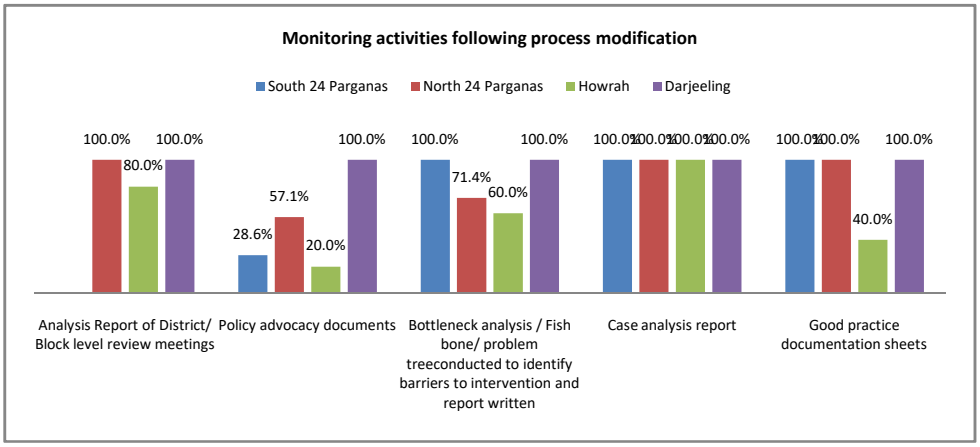
and Howrah, and with 93 per cent in Darjeeling. Policy advocacy documents for the stakeholders were shared with one out of five to one out of three which is evident for 47 per cent in Darjeeling.

DOCUMENTS MAINTAINED AND SHARED WITH STAKEHOLDERS RELATED TO CAPACITY BUILDING – INFORMATION FROM PARTNERS

In different districts training modules are distributed in different extent. In all the districts 80 per cent to 100 per cent participants received training module. Session feedbacks are taken from 100 per cent of the participants in three districts but it is 80 per cent in Howrah. Training report is shared with 100 per cent participants in South 24 Parganas, North 24 Parganas, 80 per cent in Howrah while with 50 per cent in Darjeeling. In three of the districts follow up actions are taken with 100 per cent participants which was possible for 80 per cent in the Howrah district.

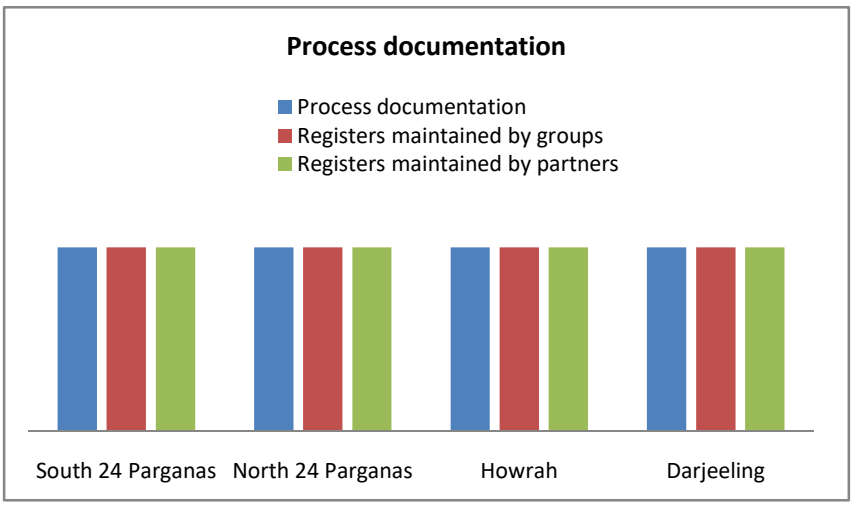


ACTIVITIES RELATED TO PROCESS CHANGE



Among different activities started in modified and efficient manner after mid-term evaluation – one of them is enhanced monitoring of programme activities with data collection, analysis and report on training sessions review meetings, documentation of policy advocacy,

bottleneck analysis, fishbone analysis, problem tree construction to identify barriers to implementation, reporting of the measures, report on case analysis, good practice and success stories. South 24 Parganas concentrated on strengthening policy documentation (29 per cent), fishbone/problem tree analysis (100 per cent), case analysis (100 per cent), good practice documentation (100 per cent). North 24 Parganas has shown 100 per cent analysis of review meetings, 57 per cent documentation of policy advocacy, in 71 per cent areas fishbone analysis is done, 100 per cent case analysis and 100 per cent success story documentation are conducted. In Howrah activities are conducted from 20 per cent to 100 per cent variability where fishbone analysis has been conducted in 60 per cent cases, review meeting analysis and reporting is conducted in 80 per cent cases, case analysis reporting is done in 100 per cent cases whereas success story with good practice and policy advocacy documentation had scopes for improvement. In Darjeeling all the practices are followed in 100 per cent cases.



All the partner organizations have conducted process documentation, maintaining registers by them as well as ensuring by the groups.

QUALITATIVE IN DEPTH THEMATIC ANALYSIS (DR. MOUMITA MUKHERJEE)

THEME 1

THE MECHANISMS FOR ENSURING BHCSP PROGRAMME GENERATE CREDIBLE ANDRELEVANT OUTPUT FOR BETTER HEALTH OUTCOME

According to Takdah BMOH, the community people are more conscious, they raise their voice on access to health system. The areas where BHCSP personnel are working the people are cooperative and conscious and the health delivery system is good as because the workers go door to door in the community to make aware, whereas in my areas where BHCS is not operating the general masses are not cooperative.

The medical officer in Takling PHC shared that BHCSP is helping both the demand and supply of healthcare in the area of Takling PHC. They are socially active and always in touch with doctors in primary health centres.

BMOH in Udaynarayanpur Howrah BPHC added that with BHCSP support service delivery at health centres became smooth and it helped to ensure community's health seeking. This in turn reduced the health risk and increased the timely cure.

THEME 2

DEGREE OF EFFECTIVENESS IN TERMS OF BRINGING THE CHANGE

According to Takdah BMOH, the Gram Panchayats in the Block where BHCS is active, there is a drastic change in the health service delivery system as compared to other Gram

Panchayats.

In relation to the success of the programme in achieving impact to strengthen the health governance, he said that

"***In terms of Health Governance in our block as you know there are various post lying vacant like ANM, 2nd ANM, Health Assistant (Male) but the areas where BHCS is working I do not see any drawbacks in health Governance as the work is running smoothly and effectively by BHCS worker and the community members are more aware and conscious.***"

With respect to the success of BHCSP in supporting communities and stakeholders inemergency public health management during pandemic, the BMOH in Takdah unit added that during the pandemic the role played by the NGO is commendable. There was scarcityof health staff but the members of BHCSP have provided full support in making quarantine centres, to keep people under home quarantine, ensuring sanitization and awareness on COVID 19 and also during vaccination which is highly creditable.

According to Takling PHC medical officer as they are working effectively with the community change in community knowledge, attitude and practice of healthcare is visible with increased acceptance of healthcare service. He mentioned that BHCSP is successful in achieving impact in the supply side– strengthening of the healthgovernance. "***They are very active. I stay in this center and provide service as because of them number of patients in outpatient department has increased than before. Our health services are being delivered well in all the centres***."

BMOH in Udaynarayanpur BPHC stated that Itarai Ashadeep (IAD) has helped the healthcare workers to a great extent. During the pandemic, IAD workers have created awareness amongst the general population regarding the COVID-19 outbreak

BMOH, Baduria Rural Hospital, North 24 Parganas stated that Basic Healthcare Support Program by SEVA organization has helped in rendering health care services to some extent. They kept in touch with the healthcare workers during the COVID-19 pandemic and helped to render the service. Masks and sanitizers were provided to the healthcare workers as well as general population.

THEME 3

DEGREE OF SUCCESS OF BHCSP IN SUPPORTING COMMUNITIES AND STAKEHOLDERS IN EMERGENCY PUBLIC HEALTH MANAGEMENT DURING PANDEMIC

Takdah BMOH also said that the BHCS project Coordinator and his team helped a lot during this pandemic. Though they were not able to reach all the places, in this situation they report it to the centre and bring the community people to them. Really, they tried hard from their level. They have made a huge impact in the community. So community people come to seek health care. "***BHCSP Team and community groups helped a lot during pandemic. They helped us while setting up Quarantine Centre, Awareness on Covid, treatment and Sanitization***".

As the medical officer of Bidhichandrapur PHC in Howrah said IAD has led to the formation of different groups within villages, such as elderly group, teenage group and women's group.

As per demand in Amdanga area of North 24 Parganas, adolescent girls are given free sanitary napkins for a duration of 2-3 months and counselling sessions are also held – added by BMOH of the rural hospital.

THEME 4

THE SUCCESS OF THE PROGRAMME IN INFLUENCING POLICY AS WELL AS COMMUNITIES TO ENHANCE HEALTH SERVICE ACCESS

As per BMOH's view in the Takdah unit of Darjeeling, the BHCSP Programme has made the people aware about the benefit of healthcare seeking in need and in timely manner. Now they come by themselves in search of health services. There are eleven Gram Panchayats in his block out of which BHCSP personnel are working, in four to five Gram Panchayats where people are more conscious on health services.

As per PHC medical officer's view in Darjeeling district, BHCSP teams have influenced the community a lot creating community groups and also encouragingpeople to seek health care under public health service.

BMOH in Pancharul BPHC in Howrah have shared that elderly persons have visited BPHC to raise their demands for healthcare in certain medical facilities. They were asked to make a separate queue (meant for elderly groups) if they visit any government hospital, so as to avoid long waiting hours in the hospital.

THEME 5

DEGREE OF SUCCESS IN ENSURING AVAILABILITY OF QUALITY HEALTH SERVICE

To talk about quality health services and its availability, BMOH in Darjeeling district responded that the services and supplies which they receive from higher authorities, they try to disseminate among the community but in many areas where BHCSP is not prevalent people arenot aware and they tend to go to other places (private) instead of health centres even if the authority try to create demand for health seeking in public facility. They pay for the services and medicines which is free in public facility- communities in BHCSP area they know it and therefore access care - BHCSP helped them to succeed in creating demand for healthcare.

MO, PHC in Takling unit of Darjeeling also reported that they have a huge impact on quality health care availability. Many patients visit to the nearest Sub- Centre and Primary Health Centre and receive improved service than before.

Road has been constructed for peoples in North 24 Parganas programme area according to the BMOH, Amdanga Rural Hospital in North 24 parganas where they avail health services in Shikira Sub-Centre, and solid waste management system is built in the Dariyapur Sub-Centre.

Degree of success in ensuring affordability of quality health service through generating common fund for supporting inpatient care utilisation

BMOH of Takdah unit in Darjeeling admitted that he does not have much knowledge about this matter since their hospital is absolutely free, but if anyone generates common fund for health then it is a good thing.

According to the MO, PHC the BHCSP also helped the community to know the best

accessible free healthcare service offered in public facilities and to identify how to access the cheapest ambulatory service. "***Patients admitted to my PHC do not have to pay anything, it's free; since we do not have ambulance, and they have to pay for the ambulance through common fund***".

According to medical officer of Bidhichandrapur PHC in Howrah, Elderly people seek to get their blood pressure checked, blood tests done from Sub-Centre, as well as receive their medicines from the Sub-Centre itself. Adolescent girls have claimed for good quality sanitary napkin from the Sub-Centre. Appropriate measures have been taken on these issues, and the elderly are provided with training and counselling sessions. In Kakdwip also adolescent girls demanded for quality sanitary napkin, and measures have been taken to meet their requirements.

As per the ACMOH of Kakdwip, SDH IITD's collaboration has enabled to conduct training for Rural Medical Practitioners as well as adolescent females. Rural Medical Practitioners have also been trained in Darjeeling according to the experience of medical officer in Takling unit.

THEME 6

DEGREE OF SUCCESS IN ENSURING PHYSICAL ACCESSIBILITY TO ACCESS QUALITY HEALTH SERVICE

According to the BMOH knowledge many community members are benefiting from the health services. During the time of emergency, people have sought services from public facilities. Talking about quality healthcare access – medical officer in PHC shared that the existing services are now rendered with more care looking at the cleanliness and behaviour of staffs towards the community they serve. He mentioned that the increase in physical accessibility is made possible through creating access to ambulatory service.

According to the BMOH of the Pancharul BPHC the more accessibility includes, for example, for those who cannot even visit a hospital, their medicines shall be handed over to their advocates after checking the prescription. The system is built with their help in such a way, that each advocate is provided with medicines for approximately 5-6 elderly patients. Appropriate actions have been taken on these issues.

THEME 7

EVIDENCE BASED ADVOCACY TO SUPPORT DECISION MAKINGAND LEARNING

BMOH said that the BHCSP team working in collaboration with others community groups and working very well in advocacy in Takdah area. In his view, to some extent it is evidence based. The medical officer in Takling PHC also said that BHCSP talked about evidence-based advocacy in policy advocacy meetings. Facilitators are also accompanied by community group members. However he also shared that "***I think they need to know more about government healthsystem so they can talk or do advocacy about other things***".
According to the medical officer in PHC in Takling unit of Darjeeling their advocacy has had same effect.

BMOH, Amdanga Rural Hospital in North 24 parganas stated that during the pandemic, BHCSP gathered health related information of the villagers and kept a track of it which ultimately helped the healthcare system. Apart from that, masks and sanitizers were provided and registers maintained.

THEME 8

THE DEGREE OF SUCCESS IN THE ADVOCACY AT ALL LEVEL OF GOVERNANCE

As per the BMOH in Darjeeling district, BHCSP is successful in their advocacy programme across different hierarchies of governance.

As per the experience of Bidhichandrapur medical officer the groups perform discussions on different health-related factors, which has increased the general awareness of rural people with regards to health and also helped them to avail govt healthcare services in a better way. In order to prevent Dengue, SEVA community coordinated with the leaders and conducted a cleaning drive to ensure source reduction of mosquitoes, and also generated awareness among people as mentioned by BMOH, Amdanga Rural Hospital in North 24 parganas. He mentioned "***We were requested to organize NCD screening, Outreach Camp. Arrangements have been made and currently, again the screenings are conducted***."

ACMOH, Kakdwip SD Hospital, South 24 parganas has also said that the way IITD workers have created mass awareness with respect to COVID-19 pandemic has increased the standard of public health in the area.

THEME 9

EVIDENCE BASED PRACTICE

According to the BMOH's view in Takdah unit of Darjeeling evidence collected by BHCSP team members is used for in-depth assessment of issues followed by decision making.
He said, "***This kind of Advocacy do help us a lot, as I can speak to CMOH and higher authorities with the results of the activities for the improvement of health system on my area***".
PHC officer has also shared that BHCSP team members have very effective reach in community. They raised many community issues of which PHC doctors and health workers are now considering under service.

THEME 10

THE IMPACT OF THE ACTIVITIES UNDER THE IMPLEMENTATION PROGRAMME

BMOH in Takdah unit of Darjeeling believes overall it has good impact. According to him if this kind of impact can be created in other Gram Panchayats, it would be great. The areas where BHCSP works are far moreadvanced as compared to other areas.

ACMOH, Kakdwip SD Hospital, South 24 parganas stated that "***I believe that the activities done by the IITD workers in coordination with the government healthcare workers have made the outcome fruitful and effective. Especially during the COVID times, it would not have been possible for the health workers to tackle the crisis alone without the support of the IITD Kakdwip workers. Jointly working in SAFE HOME has been quite helpful as well***".

BMOH, Baduria Rural Hospital, North 24 Parganas also said elderly peoples were unable to wait for long hours in the hospital in order to avail health services. On being informed, he arranged for a separate queue specifically meant for elderly group. SEVA has also prepared a shade along with seating arrangement for children, pregnant women and postpartum mother who visit the Sub-Centre for availing health services. SEVA also undertook a one-day orientation for ANM and RMP.

Healthcare service improvement – BMOH in Takdah unit said that PHC and Sub-Centres are providing health services better than before given the context that the ASHAs are merely recruited who are providing services to the community.

The PHC medical officer in Darjeeling shared that the having very nice grip on community, BHCSP has created impact on nature of service delivery and the quality of service.

Additionally, BMOH, Baduria Rural Hospital, North 24 Parganas stated that "***In the first place, teenage girls were not receiving good quality sanitary napkin from the hospital. Moreover, they had put this matter in writing. I informed the higher authority regarding this issue.***"

- **Health status** - BHCS has created impact on the health status within the local community. Nowadays with their help many medical camps are organized and cases of diabetes, hypertension have beenidentified. They are also getting free treatment in timely manner. Sub-Centres and PHC - which is also a 10 bedded Rural hospital - are providing timely and free health services with the handholding support of the programme. With respect to health status improvement the BMOH of Darjeeling district shared that BHCSP areas show more improvement compared to other areas. He shared that "***Talking about health service delivery, under my BPHC there are 20 Sub-Centres and 2 PHCs, but as you know there are many posts lying vacant which in turn is hampering on health service delivery in a way***".
- **Health service delivery** – He also mentioned that though the health delivery is very good in the locality, there is need of ambulance in this area to improve the health services further. BHCSP Team is also conducting several health camps in this area which are supplementing the public health services.

  BMOH, Amdanga Rural Hospital in North 24 parganas stated that "***SEVA community has cooperated with the healthcare workers in terms of immunization coverage of the block, rendering services such as ANC, PNC for women as well as organizing out reach camp. Moreover, it has helped us***."

  As per Medical Officer of Bidhichandrapur PHC in Howrah, ItaraiAshadeep (IAD) workers are constantly working by keeping in touch with Sub-Centre level-A ANM & ASHA workers. Moreover, immunization and other healthcare services can be more easily delivered now.

- **Healthcare service accessibility** – According to the medical officer of the PHC health

services accessibility is improved to a great extent than before. BMOH in Pacharul BPHC also mentioned that the awareness level has increased in those places where the IAD workers have actively played a role. Such zones are having better access to government healthcare services.

CASE SUCCESS STORIES

CASE STORY 1: SOUTH 24 PARGANAS DISTRICT

EFFECTIVENESS OF COMMUNITY MANAGED HEALTH INFORMATION SYSTEM

Title of the Story	**The Problems Faced By Migrant Workers During Covid Pandemic and BHCSP's Initiative To Solve The Problems**
Place/Location	Vill-South Gobindapur, Ramganga Gram Panchayat, Block – Pathar Pratima, South 24 Parganas, West Bengal

The complexity of the situation, Identify the problem – reasons. Identify the gaps like policy, operational, infrastructure, governance, leadership, Human resources

South Gobindapur is a village under Ramganga Gram Panchayat in Pathar Pratima Block of South 24 Parganas. This village is inhabited by about 3500 people and about 90% of the population are literate. Majority of the families belong to lower middle-class category. Predominant occupation of the people is farming and fishing. Apart from that, about 150-200 youth work as daily labour, in factory, office, court and as temporary worker in other districts and states. In this village there are 8 Anganwari Centres, 1 child education centre and 2 primary schools. From the centre of the village the nearest health sub centre is about 1 kilometre and the BPHC is about 4 kilometres away and a river is needed to be crossed to reach there. The villagers depend on village quack doctors apart from sub centre and BPHC for the treatment of their general diseases.

During Covid pandemic and lockdown, the migrant workers were compelled to come back to their own villages from different other districts and states. During that time, on 27/05/2020 Narayan Jana, aged 24 years, son of Subhash and Kajol Jana came back to the village leaving his job as driver in Haryana. After coming back his thermal scanning was done at BPHC and according to the instruction of the hospital he started staying at a primary school, a bit far away from his home for few days. After 2 days local people advised him to go back to his home as he had no symptoms of the disease. Accordingly, Narayan went back to his home. After

getting this news, on 30/05/2020 Gita kamila, the local ASHA worker and INSS health worker Chandana Bera went to his home to convince him to go back to the quarantine centre. But Narayan did not agree to the proposal. He said as there was no arrangement of food, members from his home were supposed to take food for him. So, he wanted to stay at home separately from others. Gita and Chandana reported the matter to the Panchayat Pradhan. On 1/06/2020 Shankar Patra, one of the relatives of Narayan called Chandana to inform that Narayan's neighbours were expressing their displeasure on the issue of his staying at home and so he asked for an arrangement to send Narayan to the quarantine centre. Then Chandana advised him to take Narayan to South Mahendrapur School centre. Shankar Patra again requested Chandana to accompany Narayan to the centre. After that Chandana and Shampa, the health workers of INSS went to Narayan's home on 2/06/2020 and explained him about the detail rules and facilities of the centre. From 1/06/2020 the arrangement of food for inmates had started and Narayan started staying at the centre. The next day on 3/06/2020 all the staff of INSS and the ASHA workers of Jogindrapur sub health centre went to visit the quarantine centre and to enquire about the problems faced by the inmates. There the INSS staff, ASHA workers and BHCS Programme Coordinator Gurupada Das interacted with all the inmates maintaining physical distance. From the discussion it came out that there was no problem regarding food but they were not feeling safe to stay together with people coming from different other states. Immediately the matter was informed on behalf of INSS to the local village doctor Ajit Pal, who was the in-charge of the centre. Dr. Pal realised the importance of the issue and immediately made arrangement to keep the people coming from different states separately. He informed that there were 41 inmates at the centre at that moment. While enquiring about their health, it came out that Narayan Dhara from Gobindapur was suffering from boil pain and Narayan Jana was suffering from cough. At once, INSS staff Shampa Bera contacted ANM staff regarding the medicine for boil and followed up with 2nd ANM staff to deliver the medicine to Narayan Dhara. Then Gurupada Das came to know from Narayan Jana that his problem of cough has increased from the last two days. Narayan was very nervous and scared and requested Gurupada Das to arrange for his check-up. Mr. Das discussed the matter with the in-charge of the quarantine centre and he said that the permission of Pradhan and Upa-Pradhan was required in this regard. So, Immediately Mr. Das went to the Panchayat office along with other health workers and discussed the whole matter. After getting permission from Pradhan and Upa-Pradhan the health workers, Chandana and Shampa informed the matter to Narayan's parents and arranged to send him to BPHC in a toto along with his parents. At BPHC Narayan had to wait for long time and facing lot of difficulties he

called Chandana and Chandana in turn discussed with her coordinator Gurupada Das and ANM. At last, at about 8.30 p.m. his check-up was done and he returned to the quarantine centre. According to the medical report Narayan had no problem. So, he was relieved. However, another problem cropped up when Narayan's parents returned home after dropping him to quarantine centre. The neighbours were of the opinion that since they travelled with Narayan in the same toto, they have to quarantine themselves in the home and won't be allowed to come out. Narayan's parent informed the matter to Chandana and in discussion with the Pradhan, arrangements were made to supply drinking water and other required things to their home. Ultimately Narayan returned home from quarantine centre after 7 days on 10/06/2020 and stayed in home quarantine for 7 more days.

Key Stakeholders and their roles

ASHA: • Have kept information about the migrant workers who have returned home • Have given required advice to the migrant workers and convinced them to move to the quarantine centre. • Followed up at quarantine centre enquired about the problems faced by them	PRI: • Arranged quarantine centre and food for migrant workers Encouraged NGO/BHCS workers
Community: • Pressurised the migrant workers to go to quarantine centre in order to prevent the spread of Corona infection. • They were conscious about their own safety.	Community Leader: • Have extended help to migrant workers and their families being conscious about their own safety.

BHCSP Staff:

- Have performed all positive roles to prevent Corona
- After knowing the problems of the migrant workers in discussion with them, discussed the matter with Panchayat
- Have solved the problem in discussion with the in-charge of the quarantine centre
- Arranged required medicines for the sick person and delivered themselves
- Arranged to take the sick person to BPHC
- Maintained regular contact with BPHC and arranged for check-up of sick person
- Utilized the community leaders by encouraging them in order to solve Narayan's family problems
- Discussed with the Panchayat regarding the problems of the community.

ASHA workers could have taken the following additional steps:

- After knowing the problems faced by the migrant workers at quarantine centre and at home quarantine, they could have discussed the issues with the Panchayat Pradhan, BMOH and Health Supervisor.
- They could have arranged the necessary medicines themselves.
- They themselves could sent the patients to BPHC
- They could have taken initiative to solve the problems faced by Narayan's family.

PRI could have taken the following additional steps:

- Arrange to administer
- Take more initiative to solve the problems
- Arrange to send the sick resident migrant workers to BPHC

Community could have taken the following additional steps:

- Could have been more empathetic to the migrant workers and their family
- Could have arranged for Narayan's stay at the primary school for at least 5 more days.

Community Leader could have taken the following additional steps:

- Could have taken initiative to convince the neighbours of the migrant worker's family who expressed their displeasure
- Could have contacted the Panchayat

BHCSP Staff could have taken the following additional steps:

- Should take initiative to share this story in fourth Saturday meeting and in other forums to encourage others.

Strategies adopted to manage the complex situation.

- Narayan and his family members were contacted and they were made aware about the necessary steps to be taken.
- Convincing Narayan and his family members to send Narayan to the quarantine centre with collaborative effort of the ASHA workers.
- Visiting the quarantine centre along with ASHA workers and enquire about the problems faced by the inmates.
- Solving the problems faced by the inmates in discussion with the in-charge.
- Having discussion with the Panchayat Pradhan regarding the illness of Narayan and sending him to BPHC for check-up.
- Having discussion with Narayan's family members and then discuss the matters of concerns with the Panchayat Pradhan.
- Extending co-operation to Narayan's family through encouraging the community leaders.

The results

- Narayan has returned home in good health.
- Narayan's family members are living in a normal atmosphere away from all mental suffering.
- At present all the family members of Narayan are in good health and leading a normal life.
- The neighbours are out of fear and living a normal life.
- On behalf of the Gram Panchayat it was announced that the persons who will extend their helping hands in such incidences, will be granted man days.

How were opportunities in the context created and/or seized to foster positive change?

- As Panchayat announced about incentives in cases of co-operation by community people, more and more community people will be interested to extend their helping hands.
- Opportunities has been created to share such cases at different levels and encourage others.

What supply side strategies and/or techniques were used to deal effectively with complexity?

- Home visit and identifying the problems faced by migrant workers
- Convincing the migrant worker and family members regarding the importance of moving to quarantine centre
- Visiting quarantine centre and enquiring about the problems faced by the inmates
- Discussion and follow up with the Gram Panchayat Pradhan, Upa-Pradhan, centre in-charge etc.
- Ensuring proper cooperation to the migrant workers through encouraging health workers and community leaders.

Changes at different levels

Community level changes

- As a result of working on BHCSP agenda for a long time, acceptance has been created at the community level
- Due to the presence of the BHCS health workers all the time during the Covid pandemic and lockdown period, their acceptance has increased considerably at the Panchayat level as well as at community level. As a result, it was possible to solve some of the emerging problems.
- The presence of active trained community leaders in the locality was helpful in solving emerging problems through their co-operation and sincerity.
- A good relationship has been established with government health workers and scope has been created to solve problems collaboratively.

CASE STORY 2: HOWRAH DISTRICT

Title of the Story	**Benefit of the Supply of NCD Medicines to Geriatric Group members During Covid-19**
Place/Location	Vill: Itarai, Pancharul Gram Panchayat, Howrah, West Bengal

Give some elements that illustrate the complexity of the situation, Identify the problem – reasons. Identify the gaps like policy, operational, infrastructure, governance, leadership, Human resources

Itarai is a remote village under Pancharul Gram Panchayat. Majority of the people in this village are dependent on agriculture. Majority of the people are literate and total population is 2150.

Through the Itarai Ashadeep BHCS programme the Geriatric Groups were formed. There is total 13 Geriatric Groups – Itarai, Khodaitarai, Jagannathtala, Kaharpara, Mahishpara, Burimanashatala, Uttar Harishpur, Kankrai, Binodbati, Santoshchak, Gaja, Belgram, Sultanpur. At present total members of groups are 470. Out of these 470 members 119 are suffering from hyper tension, 25 are suffering from blood sugar and 11 are suffering from asthma.

During the Covid pandemic and the consequent lockdown, the aged people and the children were in high-risk category. Particularly, people with blood sugar, high pressure and asthma were in high-risk category and they confined themselves within home. Under such circumstances, a problem was created regarding the supply of medicine to these aged people belonging to high-risk category. After that, 5 leaders of the geriatric group met the BMOH at BPHC and there was discussion on how elderly people can collect medicine from BPHC maintaining social distance. Then BMOH instructed the geriatric leaders that everybody need not come only the people who take medicines on blood sugar, high pressure and asthma should come at the BPHC with the prescription and arrangements will be made to supply medicine for the whole month according to the prescription. Following that instruction, the

geriatric leaders went to all the members of their group, shared the instruction, collected prescriptions from all the members suffering from blood sugar, high pressure and asthma and then collected medicine from BPHC and helped them by supplying the medicines. During the pandemic situation and consequent lockdown, medicines were regularly supplied from BPHC.

Key Stakeholders and their roles

- In this case the geriatric group leaders, BMOH and the Block Primary Health Centre played a very positive role in providing medicines to the high-risk category elderly people during the lockdown period.

Description of the way you have dealt (or failed to deal) with this complex situation.

- Geriatric leaders met the BMOH at BPHC and discussed regarding the availability of medicine for the high-risk elderly patients during pandemic situation.
- The BMOH made arrangements of supply of medicines for high-risk category of elderly people for the whole month through BPHC according to the prescriptions.
- The information was shared at 4^{th} Saturday meeting
- Geriatric leaders collected Information about the requirements of medicine from elderly people through home visit and made arrangements of supplying the medicines.
- Knowledge was developed regarding the Government schemes and services.

What were the results (positive but also negative effects, and any unintended effects)?

- At present the geriatric members, who are unable to go to BPHC, are getting medicine sitting at home with the cooperation of the leaders of the group.

How were opportunities in the context created and/or seized to foster positive change?

- All the group members were oriented on the Government schemes and services and they in turn helped people to enjoy the facilities through the BPHC.

What strategies and/or techniques were used to deal effectively with complexity?

- Meeting of geriatric leaders with the BMOH
- Sharing of information
- Home visit and collecting the information regarding requirement of medicines
- Supplying the medicines to the high-risk elderly people at home according to their prescriptions.

Changes at different levels - Community level changes

- Community people became aware about the government facilities regarding the availability of medicines for high-risk category of elderly people from the BPHC.

CASE STORY 3: NORTH 24 PARGANAS DISTRICT

EFFECTIVENESS OF COMMUNITY MANAGED HEALTH INFORMATION SYSTEM

Title of the Story	**Community Initiative to Activate the Health Centre**
Place/Location	Vill -Nakurdaha, Bashirhat (Near Bangladesh Border), North 24 Parganas, West Bengal

Give some elements that illustrate the complexity of the situation, Identify the problem – reasons. Identify the gaps like policy, operational, infrastructure, governance, leadership, Human resources

Nakudaha Primary health center is situated at Bashirhat, North 24 Parganas. At the extreme corner of North 24 Parganas, there is the Border of Bangladesh. There one of the remote villages is Nakurdaha. People from about 14 villages of the two Gram Panchayats - Itinda Panitar and Nakurdaha come to take medical facilities from this health center. Predominant occupation of majority of the people of this border area are farming and day labour. Some people have their own small business. The village is inhabited by people belonging to BPL

category, backward classes and mixed category of people. Essential Government facilities are not easily available in this border area, communication system is not developed and political and governmental rules and regulations create barriers on the way of providing services to people. On top of that, there is the refugee problem. 60% people are literate but the village is lagging behind in terms of awareness and higher education. The vulnerable families are deprived of government facilities for a long time.

Nakudaha Health Center was established 30 years ago with collaborative effort of distinguished people and social worker of this area, before that there was no health center in this area. People had to go to Kolkata for their treatment. People demanded for a permanent hospital, where there will be doctor for 24 hours and facilities will be available for people.

In response to people's demand the Government Health Department constructed the Nakudaha Primary Health Center. In that hospital 10 beds were sanctioned and a doctor was also appointed. People could avail general medical treatment and minor surgery facilities from this hospital. However, unfortunately the doctor became irregular and could not continue for long time and as a result the hospital was almost on the verge of being closed. Then the hospital continued to run with the help of one government appointed pharmacist and a nurse. Developmental activities were continuing in the village for long time through the Basic Health Care Project. So, BHCP conducted meeting with the people of the locality on the issue of need for a permanent doctor in the health center. The issue was also discussed in 4th Saturday meeting. Adolescents group also placed their demand for a doctor through meetings and charter of demands. On behalf of Panitar Palli Unnayn Samity visit and meetings were conducted with health officers. Apart from that, the matter was discussed with political leaders as well. Thus, political pressure and pressure on behalf of NGO was created on health department. At last, from March 2021 doctor started coming regularly to the hospital.

Key Stakeholders and their roles

In this case direct stakeholders are BMOH, CMOH, Sabhapati, DPHC, DM, Pharmacist and Nurse.

It was the responsibility of the direct stakeholders to appoint a permanent doctor in the health centre and to provide people of that area with a proper health infrastructure. But they were indifferent about their responsibility. Proper steps have not been taken regarding the administration of the hospital.

Indirect Stakeholders are Panchayat members, general public, political leaders, Palli Unnayan Samity, Adolescent group.

The indirect stakeholders have collaboratively created pressure on the key direct stakeholders to appoint a regular doctor and to make the hospital functional.

Description of the way you have dealt (or failed to deal) with this complex situation.

- Despite different obstacles and difficulties, FGD was conducted with general public, which reflected their experiences and problems on health and health infrastructure related issues and their demand was noted.
- Rapport was established with government officials
- The issue was discussed at different forums including the 4th Saturday meeting
- Adolescent group prepared and placed their charter of demands
- Pressure was created on Health Department from different sections and thus, ultimately the hospital started providing regular health services with the presence of a regular doctor.

What were the results (positive but also negative effects, and any unintended effects)?

- Now doctor is coming regularly in this hospital and outdoor clinic has started, where aged people and pregnant mothers are being provided all the required facilities regularly.

How were opportunities in the context created and/or seized to foster positive change?

- Opportunities has been created to solve some other problems following the same

strategies and establishing rapport with different departments - in discussion with general public, NGO, political party and different relevant departments.
What strategies and/or techniques were used to deal effectively with complexity? • Conducting meeting with the local people • Discussing the matter in 4th Saturday meeting • Visiting different departments • Discussion with different health officers • Adolescent group conducted meetings and placed their charter of demands on health rights
Changes at different levels - Community level changes • People have again begun to approach the health centre regarding their health-related problems

CASE STORY 4: SOUTH 24 PARGANAS DISTRICT

EFFECTIVENESS OF COMMUNITY MANAGED HEALTH INFORMATION SYSTEM

Title of the Story	**Prevention Of Child Delivery At Home**
Place/Location	Suryanagar Gram Panchayat, Block- Kakdwip, South 24 Parganas, West Bengal.
Give some elements that illustrate the complexity of the situation, Identify the problem – reasons. Identify the gaps like policy, operational, infrastructure, governance, leadership, Human resources	

Under Suryanagar Gram Panchayat the VHSNC, Health Fund Groups, SHG and Community leader (Baby) has been working successfully since 2016 and has been able to prevent child delivery at home in three Samsads.

This area is surrounded by river. In this area the residences are 14 kilometers away from the main road - NH12. The condition of roads is very bad and it is difficult to travel even by van. The Kakdwip Hospital is 26 kilometers away from this area. The inhabitants are socially backward and extremely poor. Majority of the people belong to schedule caste and minority community. Main livelihood of the people is fishing and some go outside to earn their living. The people of this area are superstitious and they do not maintain good relationship with their neighbours. They do not entertain the strangers and behave roughly.

During 2017 there used to be high occurrences of delivery of babies at home particularly in the three samsads – Uttar Chandranagar, No.1 and No.2 Samsad and Thakurchak Colony under Suryanagar Gram Panchayat. They did not used to give any importance to government services provided by government health workers. Under such circumstances, BHCS workers started working in these three samsad areas since 2016 and started orienting community people on institutional delivery. Since 2016, 10 families were convinced for institutional delivery. All these families had tendency towards delivery at home. Government health workers like BMOH, ANM, ANM Supervisor tried to orient and convince 5 families out of these 10 families in different ways but the attempts were not very fruitful. Later, in 4th Saturday meeting the Health Supervisor asked the BHCS worker to visit those houses. Accordingly, the BHCS worker visited those houses along with VHSNC, community people including SHG leader and Community leader (Baby). They had to face lot of difficulties. First of all, those families did not allow them to enter their houses as few days ago BMOH and Health Supervisor visited their houses. Afterwards, when they saw the VHSNC members and community people, they allowed them to sit.

Then BHCS Coordinator interacted with the head of the family and wanted to know where the baby would be delivered. He responded that the baby would be delivered at home and as reason he gave different explanations like – the previous baby was born at home, there was nobody to stay at hospital etc. and also gave some religious reasons. Then he said if the father agrees then the delivery can take place at hospital. So, there was discussion with the father and BHCS Coordinator gave him examples of other mothers, who had institutional delivery. From VHSNC and PRI it was warned that ration card will not be given and SHG leader said

group facilities will not be available unless there is institutional delivery. Apart from that, the Baby Network Group informed that the facilities available in case of delivery at hospital will not be available in case of delivery at home. The facilities of institutional delivery like Janani Suraksha Yojana, Nischay jan service, Bangla Matritwa Prakalpa and free treatment till one and half months after the child birth etc. were explained and they were also warned that all these facilities will not be available in case of delivery at home. Thus, after convincing in this manner finally they agreed and institutional delivery took place.

Key Stakeholders and their roles

In this case the key stakeholders are BMOH, ANM, Health Supervisor, ASHA, VHSNC, SHG, Community Network, BHCS worker, Community leader (Baby).

BMOH, ANM, Health Supervisor and ASHA tried to convince the families but initially failed to convince them. When BHCS workers, Community leader (Baby), VHSNC, SHG Health Fund Group, Baby Network all worked in collaborative manner, it was possible to ensure institutional delivery.

Description of the way you have dealt (or failed to deal) with this complex situation.

- Community households were visited by BMOH, ANM, Health Supervisor and ASHA.
- Then BHCS workers, Community leader (Baby), VHSNC, SHG Health Fund Group, Baby Network all visited collaboratively.
- Community groups discussed with the head of the families and tried to convince them.
- The facilities available on institutional delivery was explained to them and at the same time it was also explained that all these facilities will be withdrawn in case of delivery at home.
- Ultimately the families were convinced and institutional delivery was ensured.

What were the results (positive but also negative effects, and any unintended effects)?

- With the combined effort of BMOH, ANM, Health Supervisor and community groups

ultimately it was possible to convince the families and ensure institutional delivery.
How were opportunities in the context created and/or seized to foster positive change? • Opportunities were created to spread awareness on the importance of institutional delivery as well as different facilities available as part of government schemes in case of institutional delivery. • Acceptance of the community groups increased in the community.
What strategies and/or techniques were used to deal effectively with complexity? • Home visit • Discussion with the family members • Sharing the facilities available for institutional delivery.
Changes at different levels - Community level changes • Community people realised the importance of institutional delivery. Now incidents of delivery at home are not taking place in those areas.

DR. RAJAT KUMAR DAS : DARJEELING DISTRICT VISIT REPORT ON STAKEHOLDERS

As suggested by our Co-Evaluator that we follow the earlier Mid Term model of the evaluation visits, I refrained from any project community level interactions and community level stakeholder meets.

On 29 September, 2021 m et the District Tuberculosis Officer (DTO), Darjeeling district – Dr. Debjani Basu Mullick at her office in Siliguri. She mentioned that she had organized a virtual meeting with all NGOs in the district with time slots wherein the NGOs outlined their work status. Incidentally, her husband Dr. Anupam Bhattacharya is the ACMOH – Sadar, Darjeeling district who is also aware f WBVHA activities.

Pic: Darjeeling-Siliguri – District Tuberculosis Officer meet – Sept2021

Held discussions with the Chief Medical Officer of Health, Darjeeling district – Dr. Pralay Acharya who suggested that if possible within WBVHA's project mandate, they look into general amenities that affect health such as road, transportation, water supply and food – nutrition issues.

On the 04th of October, 2021 had discussions with the Deputy Chief Medical Officer – II of Darjeeling district – Dr. Tulsi Pramanik who suggested that WBVHA should increase focus on Non Communicable Diseases (NCD) apart from adding thrust to finding new members to their HIV – AIDS project in the district.

DR. RAJAT KUMAR DAS: **OBSERVATION**

Following up on the Deputy Chief Medical Officer – II of Darjeeling district – Dr. Tulsi Pramanik suggestion that WBVHA should increase focus on Non Communicable Diseases (NCDs – hypertension, diabetes, asthma, obesity etc.).

It is to be noted that – the prevalence of NCD in Bengal (17.8%) is higher than the national average (11.6%) according to the study by Assocham & the Delhi based Thought Arbitrage Research Institute. Also 61% in Bengal do not undergo periodic health check-ups while that national average for the same is 47%. The state's demography and high population density are among the causes of the high prevalence. 20% of the men among the new cancer patients in Bengal have lung cancer while among women breast cancer (24.8%) is most prevalent.

PATH AHEAD :-

Recommendation 1 : Consider working on choosing from these issues which are suitable to your partners and based on your strengths and ground realities.

India ranks at 94 in Global Hunger Index:

NEW DELHI: India ranked 94 among 107 nations in the Global Hunger Index 2020 and is in the 'serious' hunger category with experts blaming poor implementation processes, lack of effective monitoring, siloed approach in tackling malnutrition and poor performance by large states behind the low ranking. Last year, India's rank was 102 out of 117 countries. Neighboring Bangladesh, Myanmar and Pakistan too are in the 'serious' category but ranked higher than India in the year's hunger index. While Bangladesh ranked 75, Myanmar and Pakistan are in the 78th and 88th position. Nepal in 73rd and Sri Lanka in 64th position is in 'moderate' hunger category, the report showed. Our experts blame poor implementation, siloed approach.

{ Source-HINT (Health in News Today)Oct.2020 Issue 3 }

National Family Health Survey – 5 : 2019-2020 –

The recent National Family Health Survey (NFHS) – 5 : 2019-2020 : reflects some areas for continuous, more focal and sustained interventions such as :

a)Women age 20-24 years married before age 18 years (%) :- **NO change i.e. 41.6 in 2015-16**

b)Unmet need for family planning :- **Little change – 7.5 in 2015-16 to 7.0 in 2019-20**

c)Mothers received post natal care : **Slow increase – 61.1 in 2015-16 to 68.0 in 2019-20**

d)Children with fever/ARI symptoms taken to health facility/health provider :- **Little change – 73.5 in 2015-16 to 71.3 in 2019-20**

NUTRITION :

i)Newborns breastfed within 1 hour of birth(%) : **Slight increase from 47.4 in 2015-16 to 59.4 in 2019-20.**

ii)Children under 6 months exclusively breastfed(%) : **Nearly NO increase – from 52.3 in 2015-16 to 53.3 in 2019-20.**

iii)Children age 6-8 months receiving solid or semi-solid food and breastmilk (%) : **Slow increase from 52.0 in 2015-16 to 67.8 in 2019-20.**

iv)Children under 5 years who are stunted (height for age) (%) : **INCREASED from 32.5 in 2015-15 to 33.8 in 2019-20.**

v)Children under 5 years who are wasted (weight for height) (%) : **NO CHANGE 20.3**

vi)Children under 5 years who are Severely wasted (weight for height) (%) : **INCREASED from 6.5 in 2015-16 to 7.1 in 2019-20**

vii)Children under 5 years who are Underweight (weight for age) (%) : **INCREASED from 31.6 in 2015-16 to 32.2 in 2019-20**

West Bengal State Survey :

A survey carried out by the Women and Child Development Department in September 2021 revealed that the number of children suffering from malnutrition increased nearly twofold with the

closure of ICDS centres following Covid (August 2020 it was 3.5 lakhs children malnourished which increased to 6.7 lakhs in September 2021). According to the latter survey there were 18,162 children with severe malnutrition and 6.52 lakhs children with moderate malnutrition. The state has 1,17,120 ICDS centres covering 73.45 lakhs children under 6 years of age.

Tuberculosis control : There was a 25% fall in India's count of new TB cases during first half of 2021 when compared with corresponding period of 2019 which indicates trouble with the country's effort in juggling with resources for Covid 19.

OUTCOME HARVESTING :

Outcome harvesting is a monitoring and evaluation methodology used to identify, describe, verify and analyse changes brought about through a development intervention.

Recommendation 2 : Consider using Outcome Harvesting as a monitoring methodology which has been developed by intrac for civil society (Document shared).

RECOMMENDATIONS (DR. MOUMITA MUKHERJEE)

PROGRAMME COMPONENT

1. If basic healthcare support programme is to extend support to the groups to access medicine connecting them to pharmacy or other medicine supplier.
2. Health camps are to continue as before with addition to few more preventable diseases.
3. BHCSP has to extend more support in solid waste management as it is a significant driver to prevent diseases.
4. New BHCSP is to extend to Water, Sanitation and Hygiene, assessment of source of drinking water to increase access to safe water, increase use of toilet, awareness on faeces management and other hygienic measures as separate section.
5. Programme is required in the next step of nutrition which is to be added along with healthcare support programme. BHCSP support is required to improve access to ICDS services and improving the access to water sources
6. More support is required to help them create community's own voice in local self governance related to access to health and nutrition services. Initiative towards micro-planning is to be added in the programme agenda.

7. More adolescent groups are to be created by BHCSP with follow up visits to Anwesha clinic, linking them to government schemes to increase the coverage further.
8. The training and awareness programmes on the issues covered by BHCSP are to continue for the rest of the self help groups as they have mentioned that quality and effectiveness of BHCSP training are significantly impactful and can bring rapid progress compared to full dependence on community only to continue the training and support.
9. BHCSP is to strengthen local self governance and health centres to include more geriatric healthcare support in sub health centre
10. More follow up training and awareness programmes are to be conducted in the community along with handholding support to trained members to facilitate them to raise their own voice, seek service and facilitate other community members and measure their progress.
11. BHCSP support is to create community meetings with BMOH and CMOH – higher level of district health governance to create and bring the community voice directly to them. Such meetings are to be made periodic and continuous.
12. BHCSP support is to be extended in detail to improve care for anemia among adolescents and mothers
13. Rest of the SHGs is to be trained and equipped with the help of BHCSP. Community leaders need more time to be well prepared to be self sufficient. They are not fully prepared to support the community as supported by BHCSP.
14. BHCSP is to create access to anemia test for each girl and women, access to other health tests and sanitary napkins through sub centre and SHGs
15. More training programmes are to be arranged on the awareness regarding new variants of COVID 19

M&E COMPONENT

The M&E model application along with research and capacity building service is to be created covering services

- Baseline situation analysis,
- Action plan design based on Baseline results,
- Daily feed of activity specific data,
- Generation of monthly and quarterly monitoring reports,

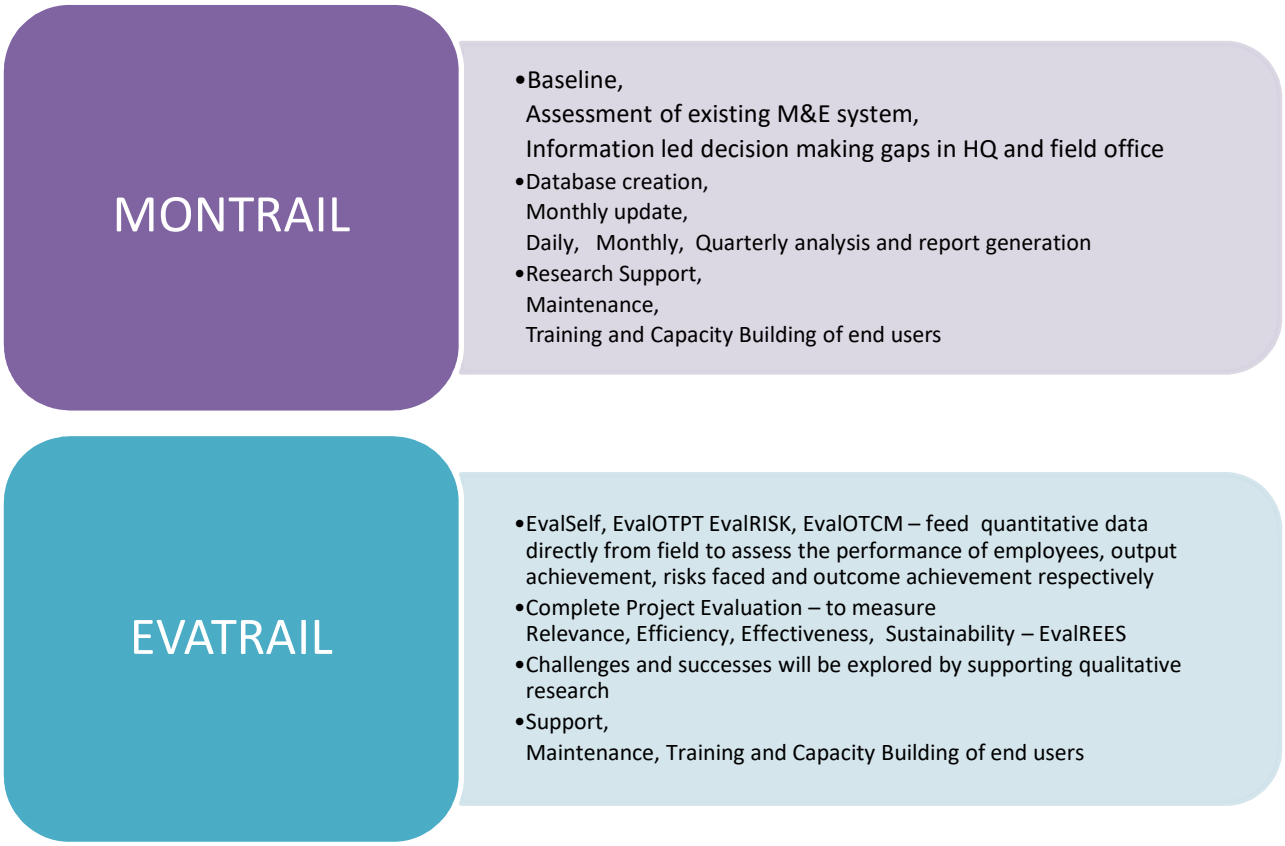
- Data collection, analysis and report under mid-term process evaluation,
- Tracking implementation based on mid-term evaluation feedback,
- Periodic evaluation and report.

MONEVA SOLUTIONS– THE INNOVATIVE MONITORING & EVALUATION MODEL

The monitoring and evaluation system will have two layers. Head quarters (HQ) of the organizations at international and/or at national level will have a common M&E department and/or programme specific wings. Each unit will have field implementation partner organisations (NGO) who performs the intervention at the community level. At this level, NGOs conduct programme activities on daily basis and maintain data on those activities. Data storing, maintenance and analysis strengthening can be done in spite of manpower shortage, lack of time, deficiency in applying innovative process and/or having limited understanding. The capacity of field level organizations will be strengthened too.

In HQ location, the M&E division and programme specific M&E wings will maintain project specific management information systems (MIS) using analytics support. At HQ and Field level, first the assessment of systemic gap is to be done followed by application development, research and capacity building to increase knowledge and enhance quality of the service.Though it increases one time cost; the degree of uncertainty and implementation lags will be minimised and eventually abolished to enhance the quantity and quality of both M&E and programme outputs as well as long-term outcomes.

The service package at a glance – MONEVA Solutions contains two parts – MONTRAIL and EVATRAIL. Three parts of MONTRAIL and four parts of EVATRAIL are described below –



- At the time of **data collection,** the questionnaires will be fed into the system for **data capturing**. Investigators and supervisors will be trained on how to collect the data in the field using an android so that data collection time and cost on collection will be reduced. The quality of data will be enriched as likelihood of error will be minimised. For example, if there is a 'skip' after a question, the system will not allow to enter data if condition is violated.
- **Data profiling** will help to structure the database as per variable definitions based on Activity-Output-Impact-Outcome specific indicators followed by data entry and data cleaning.
- **Feeding of project specific indicators** will be done simultaneously with data profilling based on the logical framework of the project.
- **Data analysis** will be done automatically based on the indicators followed by generation of **comprehensive fact sheet**.
- Staffs at field and HQ level will be trained on how to operate MONEVA, annual maintenance service will be rendered.

CONCLUSION –

The Project Has Achieved The Intended Goal And Objectives. The Path Ahead Would Be Either To Continue With This Project Or Initiate A New Project Based On The Above Recommendations And Take Into Account The Current Realities And Needs Of The Communities And The Partners.

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