Sida Evaluation 03/24

Integrating Social Support in Reproductive and Child Health Rajasthan, India

Project period 2000–2003

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Department for Asia

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Glossery of Terms

ANM	Auxiliary Nurse Midwife
ARTH	Action Research and Training for Health
ARI	Aadhar Research Institute
Amritchuran	Nutritious Supplement
Bachat	Savings
CHC	Community Health Centre
CBD	Community Based Depot
CEDAW	Commission for Elimination of All Forms of Discrimination against Women
Dhanis	Hamlet
Dai	Traditional Birth Attendant
HIV / AIDS	Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
IEC	Information, Education and Communication
ICDS	Integrated Child Development Scheme
IT	Information Technology
ICPD	International Conference on Population and Development
Kishori Samooh	Adolescent Girls Group
NGO	Non-Government Organization
NETWORK	In capitals to denote a larger, synergistic entity
MTP	Medical Termination of Pregnancy
MCH	Maternal and Child Health
Mahila Samooh	Women's Group
Mahila Shisha Karmi	Woman Education Worker
Manch	Forum
Melas	Fairs
MIS	Management Information System
PHC	Primary Health Centre

PRI	Panchayati Raj Institution
PHA	People's Health Assembly
Panchayat	Local Self Government
Panch	Elected Member of Panchayat
RTI	Reproductive Tract Infections
RCH	Reproductive and Child Health
RH	Reproductive Health
SHG	Self Help Group
Sida	Swedish International Development Agency
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
SARA	Social Action for Rural Advancement
Sarpanch	Headman of Panchayat
SWRC	Social Work and Research Centre
TOR	Terms of Reference
TSVS	Tilonia Shodh Evam Vikas Sansthan
UNFPA	United Nations Population Fund
VDC	Village Development Community
WLL	Wireless Local Loop

Section 1: Executive Summary

About the Project

From 2000 to March 2003, Sida supported a network of eight NGOs to implement a project to improve the RCH status of women and children in 100 villages of three northern districts (Jaipur, Ajmer and Sikar) in Rajasthan. The project was implemented through the network coordinated by Aadhar Research Institute, Jaipur. The implementation strategy was to increase the demand for RCH services by organizing activities involving community based institutions, local-self government institutions and grassroots beneficiaries. This was expected to utilize and integrate the activities of the health and family welfare and ICDS workers in the respective villages. The NGOs supported under the present project have substantial experience in issues of rural development and related community-based social action. They have strengths in different aspects of social development, for example, education, water resource development, environmental issues and so on. However, these NGOs are new in the area of Reproductive Health.

The objectives of the project were:

1. To create demand for appropriate RCH services through increased awareness, advocacy and sensitization to contextual geo-cultural requirements, at all times emphasizing gender sensitivity and women's equality in RCH matters.
2. To follow a life cycle approach with the coverage of all age groups and both genders.

Two annual reviews and a detailed financial audit have preceded this End of Project evaluation.

Objectives of the Evaluation

- To assess the achievements of the project,
- To review the capacity of networking NGOs in contributing to the project objectives including their managerial effectiveness,
- To assess the processes of community mobilization and issues of sustainability,
- To recommend a future course of action.

Methodology of the Review

Stage-1: A briefing meeting at Sida, New Delhi

Stage-2: Meeting with Network Coordinator and participating NGOs, Jaipur

Stage-3: Desk Review of the project and NGO documents

Stage-4: Visit to project villages and interaction with NGO staff and village health workers, *dai*s and PRI members, government health functionaries, and various community groups and beneficiaries.

Stage-5: Meetings on Gender with women staff of NGOs and with NGO heads to share findings and get their feedback

Stage-6: Presentation to Sida and report writing

Findings: Overall Impressions

Achievements.

- Clearly the RCH Project has achieved what it set out to do. It has succeeded in creating demand for basic reproductive health services, mainly maternal and child health services.
- It has managed to get the health system to improve itself to some degree to service this demand.
- Immunisations against tetanus in pregnant women and safe deliveries have increased as a result of this project.
- Although the Project data indicates safe deliveries have increased only by 5%, the impression conveyed to the Review Team by the village women is that many safer deliveries are happening now than before the RCH Programme.
- Some adolescent girls in each village have been exposed to information related to their health and women's bodies and know that they can discuss such problems and seek health care. This has happened within adolescent boys too but to a lesser extent.
- ANMs are responding better (around three-fourths of them), relationship with the PHCs has improved. Availability of supplies from the PHC to the people has improved in practically all project villages.
- Panchayat members are beginning to take interest in health and now know that it is part of their responsibilities.
- Network member organisations' unique strengths have been used for this project.
- The emergency fund, a highly useful intervention, has, in some villages, been expanded beyond the original amount given by the project through people's contribution.
- Understanding of the goals and objectives of the RCH project exists within the NGOs.
- Forward-looking leadership style and teamwork is observed among the partner NGOs.
- Environment building and involvement of stakeholders is conceptually and practically visible within the project period. NGOs' ongoing managing strategies have enabled the local community to participate and contribute to programme objectives.
- Importance of awareness about HIV/AIDS using RH is understood by the NGOs. But strategic interventions using RH approach are yet to be devised.
- Each network NGO understands the efficiency of project management including quality, quantity and timeliness of delivery of inputs. Project management of all these NGOs, using intersectoral work within the grassroots set up requires further attention.
- Technical capacity of these NGOs was addressed by an external agency ARTH, Udaipur. But each NGO's institutional capacity and their respective contribution to the project and effectiveness of networking system are yet to be enhanced.
- Sustainability is understood as continuity of the existing project activities even after the end of the project period, by the NGOs. But sustainability is not understood as the continuity of the Network relationship and participation of various community groups, including PRIs, to manage the government cooperation necessary to meet the increasing demand for RCH services.

Some Limitations

- The concept of networking has not been realised to its fullest extent. Networking has remained limited to: implementing of a common programme of activities in 100 villages in different field areas, undergoing some training and capacity building activities together, regularly meeting and sharing experiences. Differential and unique strengths of each member NGO have not been

utilised sufficiently to built the strength of the NETWORK. Also the NETWORK has not carved out a larger agenda for itself to influence health policies and programmes in the state.

- The concept of Reproductive Health as implemented by the Network has remained focused on safe motherhood while bringing in adolescent girls and to a lesser extent, boys into the purview. Men's involvement for women's health is realized as an important issue in Reproductive Health. However several other RH issues like infertility, MTPs, indiscriminate use of Oxytocin-pitocin, are not recognized as coming under the purview of Reproductive Health. Similarly, at this point in time no conscious work is happening on older women's problems.
- The partner organizations are grappling with how to introduce discussions on HIV/AIDS in the community and what kinds of locally specific HIV/AIDS programmes can be implemented in conjunction with the RCH.
- Good and effective advocacy has been done at the community level and up to the PHC level. Five members of the Network working in the Jaipur District have not interfaced with the District Health authorities as a Network.
- The use of health mapping and micro planning exercises was limited to understanding of village situation only. These could have been used for community mobilization and operationalisation of project activities. This would have brought the community and NGO staff closer within the existing RCH activity. A community based and community managed monitoring system could have been established and strengthened within this period.
- Relationship with PRIs was limited to information sharing and capacity building activities. Work with the PRIs could have generated a demand for quality of care among the village community especially the target groups for the project. Organisation of health camps and health *melas* remained key project activities and could not be converted into effective strategies to generate community support for ongoing demand for RCH services. Similarly, IEC interventions remained limited as sets of activities to be carried out but did not become mass mobilisation strategies for generating community demand.
- Gender sensitization remained limited to understanding within the project team. It could not be sufficiently mainstreamed into the programme.
- Use of log-frame for tracking the periodic changes was not utilized for monthly meetings and feedback to the NGO functionaries.

Recommendations

Related to the Network

- The Network must develop a vision of its larger role and develop its capacities to fulfill that role.
- The Network will need to organize itself to provide research, documentation training, advocacy and technical support to its members. The structure, systems and processes that the Network will adopt should be decided. The Network partners will need facilitation for this.
- Different kinds of capacities need to be built up within the Network. The rights perspective needs to be strengthened. Participatory training skills need to be developed at various levels within the network. Management skills including project design and log frame for project management, need to be developed.
- Design and develop a training strategy to support the ongoing RCH work. This is important to sustain the impact of the project.
- Gender mainstreaming within the programme is suggested and the design of the log-frame must include indicators for this. Capacity building will be required for this.

- Designing and development of culture specific prevention messages using RCH framework is important for sensitizing and creating community awareness for HIV prevention.
- The network must become a part of larger health movements in India.
- As the Network begins to formalise itself, it must also formalise, to some extent, its relationships with various stakeholders. Sustainability planning should also be an agenda with various stakeholders so that the project activities and the impact are sustainable beyond the project period.

Recommendations for Strategies and Approaches

- Panchayat should be the unit of programme implementation. Selection of villages should be done according to Panchayats.
- The unit for advocacy should be the District. Rather than spreading itself too thin, the Network must restrict itself to a few districts of Rajasthan with two to three NGOs per district.

Programmatic Recommendations

- Focus of work of the next project should be adolescent girls and boys. Rights based adolescent programmes should be designed and implemented. Work with adolescents can be done effectively through the school health programme. This should be explored as well as the strategy of working through peer educators.
- Interlinkages between the concepts of HEALTH, REPRODUCTIVE HEALTH. RIGHTS, GENDER and other sectors like ENVIRONMENT WATER, SANITATION, EDUCATION have to be programmatically forged. Programmatic linkages between HIV/AIDS and RCH will need to be developed for creating community awareness about prevention.
- Implementation of Reproductive Health should go beyond MCH, to incorporate issues related to infertility, safe abortions, RTI/STIs/STDs and so on.
- Village level work should be done through a formation of Village Development Committees to promote convergence. Decentralized and village based monitoring systems should be promoted by building capacity for maintenance of essential records at the village level.
- For programmatic interventions, the Network must be guided by the Draft RCH II document of the Government of India. The contents of this document indicate that there may be several opportunities that the new Sida supported project could avail of.

Management related Recommendations

- The network partners need to learn about which data is relevant for their purpose and develop an appropriate HMIS based on this understanding.
- Management tools should be used regularly and appropriately, for example the log frame.

Generic Recommendations

- Use of IT in programme management. Creation of a culture of e sharing through e-group learning and development of website of the Network.
  Use of village based IT system for decentralized management.

Lessons Learned

- Before any networking project, the concept of network should be clear among networking partners including donors. Otherwise valuable opportunity is lost.
- Selection of networking partners and the level of operation of the respective partners is important for the effectiveness.

- This networking system has the potential to address intersectoral action for health.
- Capacity of network partners and network coordinator is important to manage the relationship and programme effectiveness.
- For value based advocacy the collective agenda and response is more important than the individual NGO's interest.
- Capacity building as a concept includes technical training workshops, exposure and study tours, on the job training and mentoring. Within this project, capacity building is synonymous with the technical training given by ARTH. Technical training workshops need to be sufficiently accompanied by assistance for developing managerial effectiveness.
- Creative agendas for channeling the energies of adolescent boys are important within the context of the existing vacuum, and the initiatives of rightwing forces to coopt the youth to further their divisive agendas. Also modules and methodologies are required for addressing adolescent boys reproductive and sexual health issues.
- Making changes in the constitutions and policies do not necessarily make NGOs and programs gender sensitive. Ongoing reflections and gender sensitization efforts are required in NGOs and programmes.

Section 2: About the Project

In March 1998, a pilot project was initiated on 'Community Needs Assessment in Reproductive and Child Health in 20 villages of Rajasthan. Four community-based non-governmental organizations, Aadhar Research Institute (ARI), Social Action for Rural Advancement (SARA), Prayatna, and TSVS implemented the pilot project. The needs' assessment used the techniques of health mapping and micro planning. The pilot project evolved into 'Integrating Social Support in reproductive and Child Health' in May 1999. This project had as its immediate objective 'to increase demand for appropriate RCH services in target 20 villages through increased awareness, advocacy, sensitization to contextual socio-cultural, and geographical requirements'. Village level groups were formed: women's groups, adolescent boys' and girls' groups, and core groups, to act on health issues. The project continued till July 2000. In September 2000, a proposal for phase II of the project was submitted to Sida. Through this proposal the network was expanded to 8 organisations, working in 8 blocks of 5 districts of Rajasthan. The new organizations were Vishakha, Vihaan, Atma, and Manthan.

The immediate objectives as outlined in the proposal were:

1 to create demand for appropriate RCH services through increased awareness, advocacy and sensitization to contextual geo-cultural requirements at all times emphasizing gender sensitivity and women's equality in RCH matters.

2 to follow a life cycle approach with the coverage of all age groups and both genders.

The strategies outlined in the proposal included:

1. Bringing service providers from the RCH into closer and more responsible working relationship with an informed and actively participating community.
2. Intensive advocacy with the PRIs and PHCs. Strengthening of Gram Panchayats and Panchayat Samiti ward committees was envisaged, as a significant mechanism for sustaining community participation in needs assessment and planning processes. This was to have ensured a greater responsibility of the PRIs and enhance sustainability.
3. Empowerment of women and adolescents through training and regular interaction.
4. Promoting involvement of men and youth was considered crucial to sensitise them to harmful and discriminating traditional practices, different interpretations of masculinity and importance of communication in families.
5. Evolving a monitoring and review system with a MIS involving community representatives through participatory processes.

Sida provided a total contribution of Rs. 1, 32, 75,000 to the network project. The project, which was supposed to have ended in October 2002, was extended up till March 2003. The project has been successful in meeting its objectives. It has resulted in

➢ Greater discussions among women and girls in the project villages on issues related to reproductive health

➢ Women and girls seeking treatment for their reproductive health problems

➢ Local people becoming aware of the services that they are entitled to and acting to get those services.

- ➢ Greater responsiveness of the Primary Health Centers and the ANMs
- ➢ Panchayat members realizing that health and not only physical infrastructure are important development issues
- ➢ Adolescent boys are beginning to discuss their problems and gaining information on important aspects of safe motherhood
- ➢ Capacity building and gender sensitization of the staff of the 8 NGOs.
- ➢ Some capacity building of the network in developing systems for management

Detailed results of the project are presented in Section 4 on Findings

Section 3: Methodology of the Review

Issues Addressed

The issues to be addressed by the evaluation as outlined by Sida's Terms of Reference were

- *The continued relevance of the project (approach, objectives, modalities of implementation, etc.) with regard to the prevailing context and the Convention on the Rights of the Child, Cairo, CEDAW and other relevant conventions;*
- *The project outputs with regard to the expected end-results;*
- *The effectiveness of the approach/strategy being used to produce these results;*
- *Gender concerns at various levels of project implementation and gender sensitivity of the project staff;*
- *Strategic approaches related to HIV/AIDS issues included in the program;*
- *The efficiency of project management, including the quality, quantity and timeliness of delivery of inputs;*
- *The efforts put in for capacity building and institutional development and the development of networking systems and coordination;*
- *The institutional collaboration between the network partners: clarity in roles and responsibilities, scope for improvement;*
- *Early signs of potential impact and sustainability of results, including the contribution to capacity development.*

A participatory mode of evaluation was followed. In a daylong workshop with the Network Partners, they were first asked

- To identify the aspects and dimensions of the project that they wanted evaluated,
- To identify the questions in their field areas for which they wanted some answers.
- Their perceptions of achievements, results and strengths of the project, and also the limitations, weaknesses and problems.
- Their suggestions for methods to be used and modalities of the review.

The evaluation issues in Sida's TOR were shared with the Network Partners. A consensus was reached that Sida's TOR and the Network Partners' TOR matched.

Methodology Followed

A Desk Review was done of the initial documents sent be Sida as listed in Annexure 2. Additional documents were referred to including records, reports, formats, training curricula reviewed at each NGO.

Checklist and Guidelines were designed to aid visits to NGOs, visits to the villages, interviews with main stakeholders. (Annexure 5)

Three workshops were conducted.

- Introductory workshop with network partners to plan the scope and design of the evaluation and initiate their own evaluation of the project.
- A half-day workshop with the women staff of the Network to get their perceptions of the extent of gender mainstreaming within the project.

- A final workshop with the Network Partners to discuss the findings, recommendations and future directions.

The programme followed during the evaluation is given in Annexure 3.

Activities Done

In depth Semi Structured Interviews	12
Semi Structural Interviews *Dais* Panchayat members • Male • Women AWW CBD School Teachers Adolescents • Male • girls Village Women Village men	 13 4 4 3 3 4 8 8 11 15
Number of Villages visited	17
Number of PHCs / CHCs visited	7
Government healthcare providers	13
Self administered Semi structured questionnaires	7 on response 1 – VISHAAKHA

Inter Evaluation Team Processes

Both members of the Evaluation Team conducted the introductory and final workshop with the network partners. Renu Khanna conducted the women staff's workshop.

Both members of the team visited the first three and the last NGO together. These organisations were Vihaan, Aadhar Research Institute, Vishaakha and Prayatna. The visits to the middle four organizations were divided up as follows: Manoj Kar, TSVS and Manthan and Renu Khanna, SARA and ATMA

Daily review and planning meetings were held except for the two days on which the review team members went separately.

The evaluation team members would like to warmly acknowledge the openness of the NGO heads and the staff. This openness and cooperation made the review task easy and enriching. We would also like to thank the Network Coordinator and the Secretariat staff for their administrative and other kinds of support. This greatly expedited the preparation of the report.

Section 4: Findings

The Context

The most significant feature of the context within the Sida supported RCH Project is being implemented is continuing drought since last four years. At the time of the evaluation, the hardship of water, food and fodder scarcity was at its acutest. This came up repeatedly in the Review Team's discussions with the rural people as well as the NGOs' representatives. In the villages that we visited, almost half the families are reported to have migrated, women – hardly any men- were at the drought relief work sites from 6.30 am to 1 pm. The drought is worsening the already poor health status of the people. People are experiencing this in terms of lowered food availability and increased energy expenditure as well as worsening quality and quantity of the water available. In some villages in Dudu and Sambhar blocks, people have to buy water. The RCH programme is affected by the drought in terms of lack of continuity in immunization and ANC because of migration. Also, people are in no mood to listen to health related messages. Their concern is food, fodder and water.

The other contextual factor is the state of the Government health services. In many of the NGO visits, the team members were told that the PHC staff is not at their workstations, more often than not. Because of the proximity to Jaipur, Medical Officers do not stay at the PHCs, preferring to commute 50-60 kms from Jaipur to the PHCs (Chomu PHC, Dabij PHC). ANMS do not wish to live in remote sub-centres and in the absence of adequate transport facilities fail to provide services to distant *dhanis*. Many of them go on long leave (Dudu Block) or are marking time trying for transfers to Jaipur (Bichhoon PHC ANM, Chittora sub-centre, Renwal PHC). With 6 ANMS not in position, more than 20% of the RCH Project villages are still not receiving the basic MCH services on a regular basis. Laboratory facilities are inadequate. Testing facilities are inadequate. Testing facilities for HIV/.AIDS were not available at any of the six facilities that we visited. Staff shortages were mentioned many times, especially by the Naraina Hospital Incharge. However, we could not judge the extent of this due to lack of adequate data. (**Recommendation: NGOs should regularly monitor staff situation in government health facilities in their areas.**)

The RCH Programme has to be situated within the context thirty years of Rajasthan's pioneering developmental work. In the voluntary sector in the '70s SWRC Tilonia became a model whereby urban professionals and rural social animators joined hands to address the needs of the local people. Through the government sector, grass roots movements were created through the Women's Development Programme and the Shiksha Karmi and Lok Jumbish Programmes. Also, the USAID supported Govt. of India's PVOH (Private Voluntary Organization in Health) project in the 1990s, which aimed to build support services' capacity of bigger NGOs and MCH care services of smaller NGOs, was the foundation for the network NGOs' community health work.

The Sida supported RCH Project in a sense builds on the legacy of these earlier efforts. Most participating NGOs share the Tilonia ethos of rigorous grass roots contact. Some network NGOs are building on their Shiksha Karmi and Lok Jumbish work in the RCH villages. However, what was surprising was that most villages that the evaluation team visited did not appear to have been influenced by the Women's Development Programme. Formation of women's groups was a very recent phenomenon (only through the RCH Programme). The path breaking work of the Ajmer Mahila Samooh 'Sharir Ki Jaankari' (a simple pictorial book created by local women on reproduction and physiology in the '80s) does not appear to have touched these villages, whereas it served as a model for rural women in many other parts of India. In each village that we visited women

and girls professed that knowledge of their bodies was very new. This means that the two educational programmes did not sufficiently use knowledge of our bodies and our health to base their educational content on.

Overall Impressions

Achievements. Clearly the RCH Project has achieved what it set out to do. It has succeeded in creating demand for basic reproductive health services, mainly maternal and child health services. And it has managed to get the health system to improve itself to some degree to service this demand. Specially, immunisation and safe deliveries have increased as a result of this project. Immunisation against tetanus in pregnant women has increased between 20% and 30% (Narrative report on RCHR Activities, Oct. 2000 – Sept, 2002, pg. 12). Although the Project data indicates safe deliveries have increased only by 5% (page 13 of above report), the impression conveyed to the Review Team by the village women is that many more safer deliveries are happening now than before the RCH Project. At least some adolescent girls in each village have been exposed to information related to their health and women's bodies and know that they can discuss such problems and seek health care. This has happened within adolescent boys too but to a lesser extent.

Although awareness raising work was initiated with the men, it did not gain adequate momentum or reap any noticeable results in terms of behaviour.

ANMS are responding better (around three-fourths of them), relationship with the PHCs has improved, although in 4 or 5 PHCs out of 17 that the RCH Project is relating with the situation is still far from satisfactory. Availability of supplies from the PHC to the people has improved in practically all villages. Panchayat members are beginning to take interest in health and now know that it is part of their responsibilities.

Network member organisations have their own strengths and innovation that they have used. For example, Vishakha with its earlier experience of production of literacy material has been bringing out 'Tamasti' a health magazine for neoliterates; Vihaan with its medically trained head of the organisation, has trained its *dais* to measure blood pressure and temperature, SARA's innovative experiment was to distribute a nutritional supplement, *Amrit chooran* to malnourished children and pregnant women; Prayatna made and distributed sanitary pads to adolescent girls to popularise cotton cloth pads instead of pads made from old synthetic clothes and TSVS has concentrated on record keeping. Interventions have been used variously and differently. For example, in some villages the emergency fund, a highly useful intervention, has been expanded beyond the original amount given by the project through people's contribution. In other villages it has remained the same. In some villages *dais* also function as CBDs, in other villages to promote men's involvement, men are CBDs.

Some Limitations. The concept of networking has not been realised to its fullest extent. Networking has remained limited to: implementing of a common programme of activities in 100 villages in different field areas, undergoing some training and capacity building activities together, regularly meeting and sharing experiences. Differential and unique strengths of each member NGO have not been utilised sufficiently to built the strength of the NETWORK. Also the NETWORK has not carved out a larger agenda for itself to influence health policies and programmes in the state.

The concept of Reproductive Health as implemented by the Network has remained focused on safe motherhood while bringing in adolescent girls and to a lesser extent, boys into the purview. Men's involvement for women's health is realized as an important issue in Reproductive Health. However several other RH issues like infertility, MTPs, indiscriminate use of Oxytocin-pitocin, are not

recognized as coming under the purview of Reproductive Health. Similarly, at this point in time no conscious work is happening on older women's problems, or on mental health. The partner organizations are grappling with how to introduce discussions on HIV/AIDS in the community and what kinds of locally specific HIV/AIDS programmes can be implemented in conjunction with the RCH. Good and effective advocacy has been done at the community level and up to the PHC level. Five members of the Network working in the Jaipur District have not interfaced with the District Health authorities as a NETWORK. An important advocacy issue that the Network could have taken up relates to the role of the *dai* or the traditional birth attendant in a situation where a 'skilled birth attendant' is being proposed in place of the traditional *dai*. The *dais* who were trained through this project fulfilled their functions very effectively. Documentation of this experience and using it for state level advocacy is one example of the powerful role that the Network could have played.

Detailed Findings are given in the next section. This section of report is organised around the issues specified in the TOR (Annexure 1)

Relevance of the Objectives of the RCH Project

From the ***perspective of the community***, the objectives of the RCH Project are extremely important. Many reproductive health issues are never spoken about even in so-called 'advanced' communities let alone in the infrastructurally, and geographically remote, highly patriarchal communities such as in these 100 villages of Rajasthan. Reproductive Health is considered a 'women's issue with men absolving themselves of responsibility of knowing about women's and children's health and initiating health promotion actions within families and communities. Further, health is seldom a subject that Panchayats are concerned about Also there is low awareness of HIV/AIDS in the field areas. Much of the work currently going on in HIV/AIDS field addresses fear and stigma. This project affords an opportunity of linking RH with HIV/AIDS to mitigate the fear and stigma.

The current situation in the state in relation to the drought also makes the RCH Project very necessary. Some support can be afforded to adversely affected women and children in terms of nutrition and health care.

From the ***perspective of the Rajasthan State*** also this project is relevant. Last twenty years have seen a lot of work in the education sector in terms of creating awareness and a movement for right to education. A similar movement has not occurred in the health sector. This project has initiated a fledgling movement towards a right to women's and children's health. This NETWORK has a scope of creating a model. Other experiments going on in Rajasthan, for example the UNFPA's Integrated Population and Development Project, can be effectively linked with the Sida RCH Project on several dimensions like Gender and Health Training, production of gender-sensitive health education material, creation of participatory training resource materials for adolescent girls and boys, and so on. The project is highly relevant from the ***point of view of the network NGOs***. All of them are community based and have a good support with the community. Their strengths lie in other programmes to do with livelihood issues and education. They also have a perspective that links health to environment issues. None, except one, have technical competence in health, but have demonstrated a willingness to develop their technical capacities. The different strengths amongst the network partners can be an opportunity to experiment with integration of reproductive health with different sectors.

An analysis of the ***macro context*** also makes the objectives of the RCH Project highly relevant. Several Right to Health networks and campaigns are going on nationally and internationally (for

example, the PHA movement, CEDAW shadow country report efforts, reproductive and sexual rights campaign groups in response to latest US policies to change the ICPD Programme of Action). These can draw strength from a dynamic Sida supported RCH Network. Sida support for the RCH Network also contributes to the declaration of 'Millennium Development Goal' of reduction of under-five and maternal mortality. And there is congruence between the project and the two key cross cutting themes of UN Development Assistance Framework (UNDAF) in India, promotion of gender equality and strengthening of decentralization. In the light of the second phase of the national RCH Programme which is currently being designed, a new Sida supported RCH Project will be able to incorporate many of the village and district level interventions being planned in RCH II.

Approach

The Project emphasised demand creation without adequately spelling out how the demand would be met. It was thought that mobilisation of communities to demand ANM's services would be sufficient. Or else annual diagnostic and treatment camps would meet the increasing demand of services. The NGO staff are now realising that pressure at the PHC level is not sufficient, the higher levels of the health system also need to informed and mobilised, and collectively.

Conceptualisation of services was restricted to safe motherhood i.e. immunisation, antenatal care and contraception. Although work was done on identification of infertility and their referrals for treatment, this was not recognised as a reproductive health service that needs to be strategically planned for. Nationally and internationally, violence against women has been recognised as a reproductive and health public issue. One network organization has been working on violence against women for many years but does not appear to have sufficiently conceptualised or programmatically linked their violence and health work. In one village (Pratappura) women readily admitted there is violence against them and demanded to know what they can do about it. This is an area that the Network NGOs need to address within their RCH Programmes.

Modalities of Implementation

Modalities of implementation need to be looked at both from the organizational and programmatic perspectives. Organisationally, the RCH Project was to have been implemented through a network of eight NGOs. The Project Proposal – Phase II gives a detailed description of how the network was to have functioned. The principles stated in the proposal on which the network was to have worked have not been sufficiently actualised. For example, *strengthening advocacy* or *sharing of work responsibilities* does not appear to have happened to a sufficient or desirable extent. Similarly, the structure of the Secretariat consisting of the coordinating agency and two support organisations does not appear to have worked too well.

Another point that needs to be mentioned is that the role of the coordinating secretariat had not been properly conceptualised at the time of planning the project. For example, a network of this kind with intensive field level activities needs a clearing house of resource material. It also needs some documentation and research skills as well as the skills of identifying advocacy issues and developing strategies for advocacy. The secretariat, in our opinion, was grossly under-staffed and under- budgeted. However, within the given constraints, it has worked very well.

In hindsight, there is a consensus that the RCH Project was over structured. Too many activities were planned with too many village-based groups, pressurizing the staff to fulfill the targets. To the Review Team it also appeared that to some extent there was a top down approach characterizing

the project. The RCH Project became a vertical programme, not sufficiently linked with the NGOs' other programmes or with community concerns. An example of this is the conceptualisation of Core Group only for RCH. In our opinion the Core Group should be thought of and promoted as the Village Development Committee whose one function is promoting health issues. In every village if different programmes were handled through differently named committees made up of the same set of people, there would be rank confusion. Similarly, we found that in many villages the Mahila Samooh of a set of women discussed health issues, while the Bachat (Savings) Group of the same women, met to do savings and loaning activities. The Mahila Samooh should be a generic forum carrying out all the activities that its members are concerned with, be it Drought Relief, Health, Girls Education, Violence against Women. **(Recommendation: Network NGOs should work on creation of strong village level institutions, where there is convergence. These institutions will then be powerful instruments of sustainability.)**

Selection of villages is an issue that needs to be thought through from the point of view of strategic strengthening of village level or local self-governance institutions. Each project village had a few ward *panch* members with whom the NGO staff interacted consistently. The entire Panchayat was never systematically addressed although in some NGOs, staff members attend the monthly meeting. The Sarpanches of the project villages were exposed to at least one training. However, there are several arguments in favour of selecting all villages that fall in a Panchayat. Strategic intervention in terms of regular training and gender senstisation of all Panchayat members and separate capacity building of women Panchayat members will contribute significantly to beyond the project objectives, in building sustainable structures. This will also help in effective use of Panchayat resources eg the Health and Transport fund that is supposed to be available with the Panchayat. The Panchayat will also become a strategic target for the village groups' advocacy efforts and in turn can be built up to be an advocacy body. Also in terms of impact assessment, data from all the Panchayat villages will reveal patterns and trends.

Getting ARTH to build the technical capacity of network members was a good intervention. However, the network would have benefited with capacity building in other areas too, like drawing up training modules for adolescent girls and boys using creative participatory methodologies, producing IEC material, documentation and analysis of data, advocacy strategies and skills and so on.

Project Outputs with respect to Expected End Results

A review of the project documents indicates that the purpose of the RCH Project was to create an awareness of the importance of reproductive health in the villages and to create a demand for services. According to the annual reviews, audit report narrative report of the project, our visits to around 15 villages and interaction with the staff, we can conclude that the project has resulted in greater openness to RCH related matters in the villages.

- There are open discussions on contraceptive related matters and greater demand for them. All CBDs reported that demand for contraceptures is increasing although no project data is available on this. Seeta Devi the TBA from Pinach village as well as the doctors in the Narena Health Centre stated that Muslim women are increasingly seeking contraceptives.
- Treatment seeking for women's health problems has begun. The health camps organised under the RCH Project have had several good effects. Girls have taken treatment at these camps. Women who have been treated at the camps, have established a relationship with the visiting doctors and now approach them on their own (Dr. Sushila Sharma, Khatu Shymaji CHC). Camps have been organised for men and adolescent boys and boys have spoken to the doctors about their problems. (Mahender of Nolasia)

- Girls are expressing increased awareness of health and nutrition and practices around menstruation. Some girls are demonstrating increased agency. Kampoori of Bhagwatsar Kankaria stated how she would be prepared to convince her husband to use contraceptives and have only two or three children. Antenatal care has increased. Before the RCH Project, in the absence of skilled and trained birth attendants, many more deliveries had to be rushed to the hospitals. Now more deliveries are being successfully conducted in the villages through trained birth attendants.
- Responsiveness of the ANMS has increased. Most of the network NGOs have learnt that a confrontational approach with the government health staff may not work as well as cultivating and nurturing a supportive relationship with them. Many NGOs go out of their way to ease the ANM's difficulties so that their project villages get better services. For example, the Prayatna staff provides transport to the ANM even for the non-RCH Project villages.
- Most of the government health personnel whom we spoke to expressed a genuine appreciation of the corresponding NGOs efforts. This was noticeable in Khacharyawas PHC, Khatu Shyamji CHC, Narena Health Centre and Chomu PHC. The staff from these health centres have worked closely with the NGOs, participating in their health camps, treating their referred patients with extra care. The NGOs have responded by becoming DOTS centres, helping in pulse polio, organising sterilisation camps on their premises. Most NGOs now receive regular supplies of contraceptives, iron-folic acid and ORS packets from the PHCS.

The Network Partners mentioned at least two other unintended positive effects. One was the mainstreaming of the RCH project philosophy and content in programmes of other donors, for example Plan International. NGO staff mentioned how they were called upon to redesign the educational programmes of the Plan International to include RCH interventions. And secondly, each NGO has been facing demand for RCH related activities from the surrounding non- RCH project villages, Panchayat members, school teachers and health care providers. People from surrounding villages have attending the diagnostic camps and health *melas* organised by the RCH project.

Effectiveness of the Approach and Strategy

Overall the approach and the strategies adopted by the project have been satisfactory. The first step was to create an atmosphere and an environment in the villages through IEC campaigns. And the other main strategy was to create clusters of people in villages representing different age cohorts and both genders. Both the environment building and the group formation strategies appear to have been effective. We describe below some of the effective interventions and some others where some remedial action may be required.

Some of the effective interventions under the RCH Project are the Emergency Fund and Health Camps. Many villages managed the Emergency Fund creatively. They found several ways of augmenting the fund. They used it judiciously to service all emergency health needs in the village. Restricting the use of funds to only women's health needs would have not been ethical and may have resulted in opposition or resistance. Despite this, the Narrative Report indicates that in 72.38% instances the emergency fund was used for women's needs and 10% for children's emergency needs.

As mentioned earlier, Health Camps served the important purposes of making services available when demand increased and also of showing women whom to go to for their future health needs. Vishakha's weekly gynaecology camps demonstrate that the demand for health services does not decrease. It is universally felt by NGO staff as well as women's groups' members that in the future project there should be more such camps.

While the work with adolescent girls has broken age old barriers of getting them to talk about their bodies, menstruation, immunization and contraception, a lot more needs to be done with them in terms of assertiveness training and negotiation skills. Only in one field area did the girls use the language of rights in their discussions with us. The rights approach, rather than the approach of being 'good future mothers' is an important base for adolescent girls' programme.

The RCH Project is still weak on the rights perspective. The meanings of Right to Health, Reproductive Rights and Sexual Rights in the widest sense of the terms does not appear to be adequately and universally understood by all those involved in the project. The last ARTH workshop was on gender and reproductive rights, but it appears as through the two concepts have got mixed up in the understanding of the NGO staff. **It is important that right to health, and reproductive and sexual rights be deconstructed so that the network can formulate rights based strategies for their work.**

Several network partners are doing school health under the RCH Project. Some useful interventions have been provision of medicine kits and in some villages, water tanks. However, it is unclear whether a consciously designed, technically sound school health programme is being implemented. For instance, in the Bhagwatsar Kankaria school medicine kit, no deworming medicine was seen. Also, it is now well recognised that iron supplementation in adolescent girls gives very good results. However, the School Health Programme has not incorporated iron-folic acid supplementation for adolescent girls (except in Vihaan's schools). Adolescent sexual and reproductive health including life skills enhancement can be made an integral part of the School Health Programme in the middle schools in project villages. Women teachers and Mahila Shiksha Karmis can also play an important role in the work with adolescent girls.

The partner NGOs are following multiple healing systems. In addition to the dominant allopathic model in the RCH Project, some NGOs have conducted training workshops on Ayurveda, others regularly organise Homeopathy camps. While judicious and appropriate use of alternative healing systems is desirable, in these organisations, there did not appear to exist any protocols or guidelines for when to use which system. Review of some training reports revealed that there no consistency in the promotion of remedies for particular symptoms. Also some of the promoted remedies may be questioned on grounds of rationality. **It is recommended that standard herbal remedies whose efficacy has been well documented be promoted, for instance, *neem* for skin infections and white discharge, prophylaxis for malaria, or then, garlic for symptoms that need antibacterial remedies. Further, community prevalent local remedies that are not documented, should be validated by ayurveds and / or botanists before being promoted. It is important to conceptualise all healing systems within a purview of Health, and to do health promotion activities accordingly.** Otherwise the ayurvedic training, homeopathy camps appear disjointed and fragmented.

Gender Mainstreaming

Both the network and the partner NGOs have been making a conscious effort to become more gender sensitive. Several partner NGOs have tried to appoint more women staff, prepared the women staff to have more responsibility, tried to change the traditional division of labour within the organization. A gender policy has been formulated and the NGOs are trying to follow it. **It is recommended that the internal and self-reviews of the partner NGOs and the network systematically undertake Gender Audits.** It is useful to assess what new gender issues emerge as older ones get resolved. It appears that the NGOs understand quite well gender discrimination as it results from sexual division of labour and differential roles in decision making. It would be

interesting to know how they feel about gender power relations and access to and control over resources.

The women staff in an exclusive meeting during this review, stated that there have been tremendous changes both within themselves as well as in their organizational cultures. **They recommended an annual gender sensitization workshop at the NGO level, so that the entire team can grapple with the gender issues together.**

It is also recommended that women staff of the NGOs be taken through a systematic management workshop, separate form the male staff, so as to build their management capacity. We suggest a separate workshop so as to help them overcome their disadvantage of fewer years of formal schooling.

Programmatically, gender mainstreaming is seen in: the efforts to work with the men and boys to increase their responsiveness to women's health needs, formation of core teams with participation of both men and women. More efforts can be made to promote male sterilisations. The role of the male field staff will be very important in this because they need to be role models for all that they advice in the community. To what extent is partner treatment being advised for infectious reproductive tract infections in women, was not very clear. This aspect has to be followed up in the community based on the analysis of health camp records. As mentioned earlier, infertility couples were not adequately followed up. This is another RH issue that requires a sensitive gender approach to work with both men and women.

It is recommended that once the network expands the scope of RH, gender issues in each RH condition be identified and what constitutes gender sensitive interventions for each condition be specified, as will as gender sensitive indicators for each. This exercise will help in programmatic mainstreaming of gender.

Strategic Approaches To HIV/AIDS Issues

Networking partners' understanding of the issues of HIV/AIDS was discussed within the existing framework and scope of RCH. More important to this was interaction with different groups in project villages regarding their understanding of HIV/AIDS related issues. Though the capacity building workshops covered the issues of HIV/AIDS, the primary understanding of HIV/AIDS both at the NGO and the community level remains limited. With the limited understanding of HIV/AIDS, it was difficult for the NGOs to initiate a dialogue with the local groups they interact with in the RCH activities. Initiating community dialogue for understanding and addressing the issues of HIV/AIDS remained out of the programmatic focus of all the network partners.

During our interaction with the male members in Kardala Village in Manthan's field area, the understanding of male responsibility about women's RH issues was not clear. But their perception about HIV/AIDS as a female disease and the use of contraception by male for its prevention was interesting. Similar types of understanding of adolescent groups emerged during the interaction in Rampura village of TSVS's field area.

Incorporation of culture-specific behaviour change messages is important in understanding the issues of stigma and discrimination at the NGO and at the community level. Using reproductive health approach is important for shaping the future work on HIV/AIDS prevention.

Efficiency of Project Management

Project Management is clearly understood at the two levels of functioning. One at the network level support to partners NGOs and the other at the NGO level implementation at the project villages. The efficiency of Project Management is dependent on the capacity of the network and the partner NGOs' understanding about the relationship that is needed, the objective of the networking and the related roles, responsibility and position of partner NGO within the network.

For all these NGOs, working in the areas of RCH is a new experience. The concept of working together for strengthening programmatic effectiveness through networking is also new. Thus, the understanding of networking management was limited to coordination of networking partners as per the project design. This was reflected in the types of correspondence from the network to the partner NGOs for facilitation of various project-related activities.

All these NGOs have substantial experience in community work in their respective geographical locations. NGO such as TSVS, Manthan, Prayatna had substantial involvement in the USAID supported PVOH (Private Voluntary Organizations in Health) project managed by SWRC, Tilonia in the '90s. That experience contributed to the effectiveness of RCH project, especially in terms of involvement of women's groups, sensitization of adolescent girls and establishing working relationship with PHC staff, ANM and PRIs. Linking NGO's other projects with the RCH activities is another possible aspect for intersectoral action in the community level.

Performance of the network in terms of plan of action, organization of key project events, exposure, conduct of financial audit and carrying out the planned activities were satisfactory. But the sharing of different project experiences and contributing to the network using the comparative advantage of each of these NGOs was not attempted. This resulted in over dependency in decision-making coordinating systems. The network coordinator has the dual responsibility of managing his own organization and coordinating the networking partners. This resulted in delay in decision-making and timely availability of reports from the networking partners.

Concept of teamwork exists in the respective NGOs for the RCH work but this could have been extended to the effectiveness of network functioning in terms of utilization of comparative advantages of each of these NGOs. This would have reduced overlapping of geographical coverage and resources. (For instance, in Beed Rampura we found that both Vihaan and Vishakha are working on the same RCH project.) Using the comparative advantages of the partners could have facilitated advocacy at different levels, establishment of Management Information System for keeping track on project progress and initiating mid-course corrections, establishing village based and village managed monitoring system. Clarity about their respective roles and responsibilities for contributing to the networking system to bring out programmatic synergy is observed to be lacking among the network partners.

These NGOs did systematic implementation of planned activities separately. Absence of networking did not benefit their respective work. For example, the presence of two partner NGOs Vihaan and Vishakha in Rampura village is a matter of concern from the perspective of establishing relationships with PHC and the village groups. These types of issues need to be sorted out at the network level at the time of planning the village selection.

Forward-looking style of leadership is observed in most of the partner NGOs. This was clear from their understanding about and expectation from the networking system for the future. The partners have developed a draft plan for the future work in RCH. Their respective sectoral strengths and capabilities are important in contributing to the future network.

Effectiveness of the networking system, is observed in their emerging understanding of the missing link within the existing RCH project, in realizing their comparative advantages in terms of division of responsibilities, participatory planning and review, development of tools and techniques, innovations, partnership management, use of multi stakeholder partnership and different levels of advocacy. Partner NGOs' interest to address issue of intersectoral cooperation, linkages with PHC and PRIs and collective preparations for future strategy and responsibility of the Network are examples of the potential effectiveness of networking system.

Capacity Building

Technical capacity of these NGOs was addressed by an external agency ARTH, Udaipur. However, the networking NGOs' individual capacity in the areas of preparation of project proposal, development of tools, techniques and indicators, strategy for project management remained limited. For example, the importance of log-frame analysis was understood but development of project specific log-frames and utilization of these for monitoring project progress and strengthening implementation was limited. In addition, the contribution of each NGOs' enhanced technical capacity to institutional development and their respective contributions to the effectiveness of the networking system are yet to be devised.

Use of IEC activities is understood by all these NGOs but their implementation during the project period remained difficult. The partnership with PRIs and government was limited to individual NGOs' relationships with these bodies, within their respective geographical locations. They could have utilized the networking system to develop and support advocacy actions at their districts.

Training of Panchayat members was limited to creating awareness and understanding the importance of RH within the institutional capacity of PRIs and experience sharing. But insufficient mechanisms were set in place to follow-up the training input. Design and development of training strategy involving PRIs is suggested for benefiting use of intersectoral action using multiple stakeholders for future.

Village based resource planning involving the PRIs as per the designed activities is suggested. This remained a major limitation among majority of these NGOs. This could have generated adequate support to intersectoral work and role clarity and responsibility well before the final phase of the project.

Relationship with PRIs needs to bring improvement in their knowledge, skills and capabilities. Involving them in organizing the health events in the project villages and monitoring the progress of RH activities local areas will contribute to sustainability.

Capacity building interventions to integrate RCH work and community mobilization were limited to understanding various issues under RCH but not translated adequately into project activities. Training support provided by these NGOs should have led to community based action plans for specific RH problems – for example, primary level advise to couples with infertility on the fertile period, when to have intercourse to increase possibility of conceiving and so on. Instead, training largely resulted in non- specific awareness generation activities, workshops, rallies and camps and campaigns etc. Content of the training that the trained NGO staff provided to various village groups was not very accurate or helpful, as was revealed through a review of some training reports. Monitoring mechanisms with women's groups and *dai*s could have been established through village-based training.

Though informal working relationships were developed with PHC staff members including ANMs, formal relationships were not established involving the PHCs and their functionaries. For instance, the importance and use of *dai*-training was not established in a formal relationship with PHC. The PHC staff's role was thought as limited to immunization work, and not understood as support during village based health events.

NGO management capacity was limited to completion of activities as planned and agreed by all the NGOs. But there is no substantive experience of managing community-based health information. There is need for development and operationalisation of effective community managed HMIS (Health Management Information System). Community needs assessment, training needs assessment for managerial effectiveness and technical interventions, mechanisms for periodic reviews and follow up are suggested as future training strategy.

Also capacity building for Networking Management and project design and log-frame for project management should be included in the future training strategy.

Institutional Collaboration Mechanism

An institutional mechanism to improve the existing system by defining a feasible role of each of these NGOs is important and these NGOs understand this. Having such a mechanism could have contributed to the institutional development of the networking system. Roles and responsibilities and institutional collaboration with Network and Partner NGOs is not clearly defined or incorporated within the Project Management strategies. This could have been utilized to strengthen the benefits of networking system in availing different levels of cooperation.

For example, the use of log-frame for strengthening of MIS in tracking the periodic changes was not utilized for monthly meetings and feedback to the NGO functionaries. Even at the NGO level, the design and monitoring of village based data and its consolidation in coordination with ANM for accuracy and mid-course measures was not utilized to track the project progress. This issue could have been addressed within the networking system for availing cooperation from PHCs and PRIs.

The use of advocacy at the network level was limited to a state level dissemination workshop with various development partners and government. The network could have been utilized to organize district level advocacy about sharing the uniqueness, innovations and importance of working as a network with the district health system. Various levels of interactions and cooperation could be generated in mapping out the roles and responsibility of partner NGOs to address issues of rights based approach using multiple stakeholders within respective geographical areas. This could have strengthened the capacity of networking system and the institutional mechanism for institutional development in terms of bringing out synergy in availing government cooperation.

Sustainability

Early signs of potential impact are understood in terms of: roles and responsibility of NGOs in the RCH project, comparative strengths and innovations of the partner NGOs and capacity of networking system to effectively utilize the partners' comparative advantages for building synergy in future.

NGOs capacity to interact and negotiate with various stakeholders is visible through the organization of village based health events, organization of village groups meetings, networking with PHC and PRIs. Experience of involvement in WDP, Shiksha Karmi Project, Lok-Jumbish, SWRC-Tilonia and the activities under PVOH supported these NGOs to emerge as potential partners for network-

ing for the work in RCH. Their interest to work with an expanded approach in making the Village Panchayat as basic unit of functioning as the future strategy confirms their enhanced understanding during this period.

The mainstreaming of various NGO specific innovations such as, sanitary napkin for adolescent girls, *amritchuran* for malnourished children, use of puppet shows in environment building, network of village based libraries, *Dai*-training, mobilization for regular immunization, effective utilization of emergency fund, gender specific approaches to reproductive health issues, relationship building with PHCs and PRIs, can be considered as early signs of impact under the scope of RCH project.

Sustainability is taken to mean continuity of the existing project even after the close of the project period by most partners. But continuity of the Network relationship, participation of community various groups are also important in managing the necessary government cooperation for meeting the ongoing demand for RCH activities. The relationship with PRIs is crucial in this aspect.

Sustainability is understood at three levels of operation within the existing scope of RCH project. These levels are organizational, that is at the NGO level, institutional that is, at the network level and behavioral, at the community level. The capacity of NGOs in understanding their role and planning sustainability within project management was limited to bringing out innovations and availing government cooperation and involving PRIs. The absence of sustainability planning at the NGO level contributes to the discomfort at abrupt cessation of some community level activities.

Similarly, the collective responsibility and contribution of the partner NGOs in managing multi-stakeholder partners at the network level could have strengthened the capacity of the network. Also, this could have generated interest in providing joint response to value based advocacy at different levels within the project period.

Initiating interventions related to behavioral sustainability involves popular participation of various community groups addressed during the project. Following indicators can be considered in this aspect.

- A male member understanding his role in promoting women's health through her life-cycle,
- Realization of adolescent girls of the importance of reproductive health and need to address issues of RTIs and STIs, sexuality and behaviour change during the period of adolescence and later.
- Community response and perception of the project and NGO in addressing health issues of women, children, and adolescent boys and girls by group formation and organization of SHGs (self-help groups).

Managing rights based approach to RH requires understanding of community perceptions about the ongoing project. Development of strategies for 'Community interface and sustainability planning' are suggested to manage sustainability of the impact as well as sustainability of the Networking system.

Section 5: Conclusion and Recommendations

Given the current context as described in the Findings section and the momentum achieved by the Network organisations in their own field areas, it is recommended that Sida continue its support for the project. Another justification for Sida to support this project is that it is in line with Sida's Health Policy. However, it is worthwhile supporting the project if larger benefits can accrue out of it. That is, apart from the benefits to the targeted villages (which are important enough in themselves), the Network's work must result in benefits for larger areas through policy and programme changes. Some challenges and constraints that are visualised are as follows:

Problems and Constraints, Challenges

1. Biggest problem is cash strapped, under staffed health system. Can any advocacy really change the reality of the health system?
2. To build an effective, synergistic network, management capacity within the Network, as well as advocacy skills, is a challenge given the present nature of the network
3. To build a rights perspective within a Network of organizations, who have for years delivered services, is a challenge. Further, based on the rights perspective, a programme of action must be developed. For instance in their future work, can the NGOs support the Mahila Samoohs, or the Kishori Samoohs to make the *amrit chooran* or the sanitary pads instead of doing it themselves?

We list below a series of Recommendations that must be carried out if the future project is to be made feasible and effective. Some recommendations were also listed in the Findings section in bold typescript. Those are reiterated here.

Recommendations related to the Network

1. The Network must develop a vision of its larger role and develop its capacities to fulfill that role. Specifically, the Network will need to be able to identify RH issues affecting grassroots communities, through research and action and use their community based data to lobby for programmatic and policy changes. External facilitation will be required for capacity building.
2. The Network will need to organize itself to provide research, documentation training, advocacy and technical support to its members. This can be done in two ways, either by having in the network itself members (individuals and / or organizations.) who have the requisite competencies, or by having support unit of 3 or 4 professionals to provide the necessary help. The structure, systems and processes that the Network will adopt should be decided.
3. Different kinds of capacities need to be built up within the Network. The rights perspective needs to be strengthened. All network members must arrive at some common understanding of the Right to Health, Right to Health Care, Reproductive Rights and Sexual Rights. And then the rights based approach has to be translated into strategies and programmes. Participatory training skills need to be developed at various levels within the network. Management skills need to be developed. Also capacity building for Networking Management and project design and log-frame for project management should be included in the future training strategy. It is recommended that an exercise be conducted to identify all training needs and a master plan be drawn up. The master plan must also include how the training quality will be monitored.
4. It is recommended that the internal and self-reviews of the partner NGOs and the network systematically undertake Gender Audits. An annual gender sensitization workshop at the NGO level should be conducted, so that the entire team can grapple with the gender issues together.

It is also recommended that women staff of the NGOs be taken through a systematic management workshop, separate form the male staff, so as to build their management capacity.

5. The network must become a part of larger health movements in India. Eg. the Medico Friend Circle, Janswaasthya Abhiyaan, and so on
6. As the Network begins to formalise itself, it must also formalise, to some extent, its relationships with various stakeholders. For instance, the state and district health authorities should receive intimation of the goals, objectives and activities of the project right at the beginning. Annual or half-yearly reviews with these authorities should be done. Sustainability planning should also be an agenda with various stakeholders so that the project activities and the impact are sustainable beyond the project period.

Recommendations for Strategies and Approaches

7. Panchayat should be the unit of programme implementation. Selection of villages should be done according to Panchayats. PRI members will need capacity building in all essential aspects of Panchayat Raj as well as in right to health and health advocacy. Women Panchayat members must be trained separately and also helped to form their own women in Panchayat forum or *manch*.
8. Similarly, the unit for advocacy should be the District. Thus rather than spreading itself too thin, the Network must restrict itself to a few districts of Rajasthan with two to three NGOs per district.
9. NGOs should regularly monitor staff situation in government health facilities in their areas and use this data to lobby for adequate staffing for quality services..

Programmatic Recommendations

10. Focus of work of the next project should be adolescent girls and boys. Rights based adolescent programmes should be designed and implemented, giving emphasis on assertiveness training and negotiation skills for girls especially, and evolving new models of masculinities for boys especially. Progressive, rights-based work with boys is very essential in the given context of right wing forces using the youth power to perpetuate their own agendas.

    Work with adolescents can be done effectively through the school health programme. This should be explored as well as the strategy of working through peer educators.
11. Interlinkages between the concepts of HEALTH, REPRODUCTIVE HEALTH. RIGHTS, GENDER and other sectors like ENVIRONMENT WATER, SANITATION, EDUCATION have to be programmatically forged. Specific and critical interventions, which lead to convergence, will need to be identified. For example, adolescent health and rights work through middle schools is one such strategic intervention.
12. Village level work should be done through a formation of Village Development Committees to promote convergence. Village based cadres eg. *dais*, peer educators etc should be paid through the VDCs as far as possible, and not by the NGOs. This will build their accountability to the people and not to the NGO.

    Decentralized and village based monitoring systems should be promoted by building capacity for maintenance of essential records at the village level.
13. It is recommended that the network expands the scope of RH, to include aspects like MTPs, infertility, violence against women, mental health concerns and so on. Once this is done gender issues in each RH condition should be identified and what constitutes gender sensitive interventions for each condition should be specified, as will as gender sensitive indicators for each. This exercise will help in programmatic mainstreaming of gender.

14. The RCH Project has been using multiple healing systems. It is important to conceptualise all healing systems within a purview of Health, and to do health promotion activities accordingly. It is recommended that standard herbal remedies whose efficacy has been well documented be promoted. Further, community prevalent local remedies that are not documented, should be validated by ayurveds and / or botanists before being promoted.
15. Incorporation of culture-specific behaviour change messages is important in understanding the issues of stigma and discrimination at the NGO and at the community level. Using reproductive health approach is important for shaping the future work on HIV/AIDS prevention.
16. For programmatic interventions, the Network must be guided by the Draft RCH II document of the Government of India. The contents of this document indicate that there may be several opportunities that the new Sida supported project could avail of. For example, the draft document talks about a village level link worker, who could be the project trained *dai* or community health worker. Using such opportunities may be a way of building sustainability into the new project. The Network NGOs may also be able to fulfill the role of the Field NGOs as listed in the document.

Management related Recommendations

17. The network partners need to learn about which data is relevant for their purpose and develop an appropriate HMIS based on this understanding. Coordination with the ANM and the AWW is required to produce sound village-based data.

    Interesting trends observed at the village level, should be examined at the network level and used to identify advocacy issues.
18. Management tools should be used regularly and appropriately. For example, the Log Frame Analysis should be used for ongoing monitoring of the project. Health Mapping in the villages can be used every year with the community-based stakeholders to assess changes due to the project.

Other Generic Recommendations

19. Information Technology can and should be used in Programme Management, both at the Network level as well as at the decentralised village level. The Network should also develop a culture of an e sharing through a list server and a web site. Both these will also help in relating with the other health rights movements, like the MFC and the PHA movement.

    Setting up village based WLL kiosks especially in Shiksha Karmi villages can bring about an IT revolution in the rural areas of Rajasthan. Through these kiosks local literate boys and girls can use computers and the Internet for health related purposes as well as for all other needs in the village.

Section 6: Lessons Learned

The experience of the Sida supported RCH Network in Rajasthan has thrown up several valuable lessons. These are

- Before any networking project, the concept of network should be clear among networking partners including donors. Otherwise valuable opportunity is lost.
- Selection of networking partners and the level of operation of the respective partners is important for the effectiveness. Therefore the criteria for selection of partners should be carefully drawn up
- This networking system has the potential to address intersectoral action for health because of the background and expertise of the existing partners.
- Capacity of network partners and network coordinator is important to manage the relationship and programme effectiveness. The initial capacity should be carefully assessed and a plan formulated to enhance the capacity.
- For value based advocacy the collective agenda and response is more important than the individual NGO's interest. Partners must remember this at all times. The norms of functioning of the Network must emphasise a commitment to collective interests over individual interests.
- Capacity building as a concept includes technical training workshops, exposure and study tours, on the job training and mentoring. Within this project, capacity building is synonymous with the technical training given by ARTH. Technical training workshops need to be sufficiently accompanied by assistance for developing managerial effectiveness.
- Creative agendas for channeling the energies of adolescent boys are important within the context of the existing vacuum, and the initiatives of rightwing forces to coopt the youth to further their divisive agendas. Also modules and methodologies are required for addressing adolescent boys reproductive and sexual health issues.
- Making changes in the constitutions and policies do not necessarily make NGOs and programs gender sensitive. Ongoing reflections and gender sensitization efforts are required in NGOs and programmes.

Annexure 1

Sida's Terms of Reference

Evaluation of "*Integrating Social Support in Reproductive and Child Health*", a project implemented in India by Network of NGOs in Rajasthan

1. Background

During 1997 Sida worked with the Government of India and Government of Rajasthan leading to the understandings that support would be provided for a decentralised RCH project in 7 districts of the state. With the nuclear sanctions the entire process came to a halt and Sida decided to concentrate support in RCH program through the NGOs since March 1998.

The RCH NGOs network, covering 100 villages spread across five districts of the state, attempts to respond to the health needs of the poor by generating a demand for health services among women, men and adolescents. Village based forum for community participation is created and links with the public health system and local governance to respond to these needs are established.

After an initial support of Rs 19,75,000 (SEK 300,000) to initiate the project, the Embassy approved a contribution of Rs 132,75,000 (SEK 2.9 million) to the project "*Integrating Social Support in Reproductive and Child Health*" from October 2000 – March 2003. To enhance the effectiveness of project interventions, Action Research & Training for Health (ARTH) have provided technical capacity to the network.

The objectives of the project are:

- To create demand for appropriate RCH services in the targeted villages through increased awareness, advocacy and sensitisation to contextual geo-cultural requirements;
- To emphasise gender sensitivity and women's equality in RCH matters;
- To educate the community on RCH issues and act as links between the community and service delivery system; and
- To strengthen PRIs to ensure availability and sustainability of services.

2. Objective of the evaluation

This evaluation has been initiated by the Embassy in compliance with Sida's Evaluation Plan 2002 and Evaluation Policy, dated 7 October 1999 (attached as Annex I).

The project will complete it first phase of implementation in March 2003. Before continuing support for the next phase, an evaluation has been planned. The evaluation will attempt to assess systematically and objectively the project's relevance, performance and success to date. The evaluation should also be forward-looking, including recommendations to ensure the sustainability of results and lessons learned that would feed into a possible next phase of the project.

The main stakeholders of this evaluation are the eight partner agencies – Aadhar Research Institute (Secretariat), Prayatna Sansthan, Social Action for Rural Advancement, Tilonia Shodh Evam Vikas Sansthan, Vihaan, Vishaka, Manthan and Atma, and the Development Co-operation Section (DCS) of the Embassy of Sweden in New Delhi.

3. Scope of the evaluation

The evaluation will cover all important aspects and components of the project as outlined in the project document and later amendments, taking into account developments since the signing of the agreement between the Secretariat, Aadhar Research Institute (ARI) and the DCS/Sida to date.

4. Issues to be addressed by the evaluation

Guided by Sida's Evaluation Policy, the evaluation team shall particularly address the following issues:

- The continued relevance of the project (approach, objectives, modalities of implementation, etc.) with regard to the prevailing context and the Convention on the Rights of the Child, Cairo, CEDAW and other relevant conventions;
- The project outputs with regard to the expected end-results;
- The effectiveness of the approach/strategy being used to produce these results;
- Gender concerns at various levels of project implementation and gender sensitivity of the project staff;
- Strategic approaches related to HIV/AIDS issues included in the program;
- The efficiency of project management, including the quality, quantity and timeliness of delivery of inputs;
- The efforts put in for capacity building and institutional development and the development of networking systems and coordination;
- The institutional collaboration between the network partners: clarity in roles and responsibilities, scope for improvement;
- Early signs of potential impact and sustainability of results, including the contribution to capacity development;

On the basis of this assessment, the evaluation team should identify problems and constraints, if any, and propose recommendations for follow-up action to consolidate project sustainability. A number of generic recommendations should also be made that have bearing beyond the project.

5. Products expected from the evaluation

The evaluation team will produce an **evaluation report** of not more than 25 pages, apart from relevant annexes, containing the following six sections (1) Cover page with date of version and name of consultants; (2) Executive summary; (3) List of contents (4) The Project: design, objectives, and results; (5) The Evaluation methodology; (6) Findings; (7) Conclusions and recommendations; and (8) Lessons learned. The report should include a list of reference material as well as list of people interviewed.

The findings and recommendations of the evaluation team should also be verbally presented to the Rajasthan RCH NGO Network and the DCS/Sida. A draft version of the evaluation report will be shared with these organisations for comments at least three days before the presentation/s. The final evaluation report will be submitted to the DCS in 5 bound hard copies, one unbound hard copy and one electronic copy (in MS Word or compatible software).

The Evaluation Team will also be required to fill out the Sida Evaluation Data Work Sheet and the Evaluation Newsletter form.

6. Methodology

As a first task, the evaluation team will, in consultation with Network Secretariat and the DCS, prepare a detailed scope of work and time schedule reflecting this ToR and present it to the DCS/ Sida for approval.

The evaluation team will carefully review all relevant documentation, including the original project document and the project progress reports.

The team will conduct interviews with relevant staff in the DCS/Sida, the Network partner NGOs, as well as other stakeholders in the activities undertaken.

7. Composition of the evaluation team

The evaluation team will be consisted of minimum two members designated jointly by the Network and the DCS/Sida.

The team should possess demonstrable skills in evaluating capacity development of organisation as well as substantive experience from dealing with RCH issues, gender issues and networking processes. Excellent (English) oral and writing skills is essential. Work experience in Rajasthan is of advantage and good knowledge and ability to apply Sida's goals and Sida's Health Policy in carrying out the evaluation is needed.

The team should ensure that the ToR is fully understood that the evaluation report is completed in accordance with this ToR.

8. Implementation arrangements

The evaluation will be carried out during three weeks in April/May 2003. It is proposed that the evaluation be carried out in four steps as follows:

- Documentation review (desk study) and preliminary consultations with the DCS/Sida and Network partners, including the development of a work plan;
- Visit to the project site, including collection of relevant written material as well as interviews with the staff of Network partners, and other stakeholders;
- Analysis of the information collected and preparation of a first draft of the report; and
- Debriefing, information validation, and preparation of the final version of the report.

Logistical arrangements for the project visit will be decided upon once a detailed work plan has been developed.

Annexure 2

Documents studied

1. Project Proposal on RCH (09/04/99)
2. Work Plan for 6 months (29/04/99)
3. Project Proposal on Integrating Social support in Reproductive and Child Health.
4. Revised Project Proposal on RCH Activities in Rajasthan (26/09/2000)
5. Narrative report May – October 1999
6. Narrative report May 1999 – July 2000
7. Narrative report October 2000 – Sept. 2002
8. Review of RCH Projects – Dr. M. Prakasamma
9. Agreed Minutes for Annual Review of the Rajasthan Network, 20-22 Nov, 2001
10. Review of Sida Supported NGO Network Project – Draft Report, November 2001
11. ARTH's Proposal 'Integrating Social Support in reproductive and Child Health' May 2001
12. ARTH's Report of Activities from July 2001 to September 2002.
13. Audit report of RCH Rajasthan, Subhash Mittal and Associates.
14. Concept Note for RCH – NGO Network, 13.02.2003.
15. Gender Policy
16. Action Plan following Financial Audit
17. Sida's Health Policy
18. Report of the Dissemination Workshop (February 4, 2003)
19. RCH II Project Implementation Plan (Draft Document), Government of India

Annexure 3

Programme followed May 1 to 15, 2003

Date	Time	Activity	Details
May 1	11.30–1 PM	Meeting between • Yasmin Zaveri Roy • Renu Khanna • Manoj	• Discussed TOR • Review up tentative programme • Collected additional documents
	8.15–9.45 PM	Manoj Renu Khanna	• Planning for meeting with network partners • Agenda of meeting with Satyajit • Interpreting TOR (Yasmin's input, issues form Annual Review reports, Financial audit report) • Format for desk review • Clarification on our roles and responsibilities • Planning for NGO visits
May 2	9.15–10.15 AM	Meeting with Satyajit Bhattachraya, Network Coordinator	• Introductions • Guiding for the evaluation • Field visit planning
	10.15–2 PM	Meeting with Network Partners	• Introductions • Guiding principles for evaluation • What aspects to be evaluated from their perspective • Their suggestions for the methodology • Finalising Programme for field visits
	2–3 PM	Developing tool for Network Partners' perceptions	
	3.30–5 PM	Further discussion with Network Partners	• How the network functions • Difference between Concept Note and Future Proposal • Feedback on capacity building
	7.30–9.30 PM	Meeting with Satyajit and Kumkum Srivastav	• Gender mainstreaming • Rajasthan's Health system • Problems with dealing Government funding • Women in Panchayats
May 3	8.15 AM–6.45 PM	Field visit to Vihaan • Renwal • Deomand • Beed Ramchandrapura	• Meeting with field staff (Mahavir, Sadanand, Deepchand, Mahesh) • Visit to Renwal PHC • Visit to Deomand – Meeting with women – Meeting with men – Meeting with dai • Visit to Beed Ramchandrapura – Meeting with ANM – Meeting with women – Meeting with 3 girls – Meeting with dai

Date	Time	Activity	Details
May 4	7.30 AM to 6.45 PM	Field visit to Aadhar Research Institute • Radoli • Bhagwatsar Kankaria • Salagrampura	• Discussions with Satyajit • Meeting with field staff • Interview of Sarpanch, Radoli Gram Panchayat • Visit to Bhagwatsar Kankaria – Women's group meeting – Adolescent girls meeting • Visit to Salagrampura – Women's group meeting – Adolescent girls meeting
May 5	7.30 AM to 6.45 PM	Field visit to Vishakha • Renwal • Mandor • Choru • Revatpura • Teekel	• Discussion with Lata and Bharat • Visit to Library Resource Center, Renwal • Meeting with field staff in Mandor field center • Meeting with adolescent girls and boys • Visit to Choru PHC, Interview with medical officer • Visit to Revatpura, meeting with women and mahila ward panch • Visit to Teekel meeting with the Panchayat members
May 6	6.30 to 8.30 Pm	• Updating field motes • Reviewing various NGO documents, records • Meeting with Satyajit	• Interview using checklist
May 7	8.00 am to 8.30 Pm	Field visit to SARA • Laxmpura • Mota ki Dhani • Khachariyavas • Khatu shmyami • Gopinathpura	• Discussion with Mota Ram • Meetings with staff at Laxmipura • Meeting with women's group, dai, adolescent boys and girls, panchayat member in Mota ki dhani • Visit to mini PHC Khachariyawas • Discussion with the doctor couple • Visit to CHC at Khatu Shyamji, discussion with lady doctor • Meeting with woman panchayat member, savings group leader male core group member in gopinathpura
May 8	6.30 am to 10.am	At SARA • Review of reports and records and resource material available • Meeting with staff	
May 8	11 am to 1 pm 2 pm 8 pm	 Arrival at ATMA Arrival at Prayatan	• Meeting with dai, review of her kit • Emergency fund incharge • Anganwadi worker • Adolescent Boys • Meeting with ATMA staff • Visit to Pratappura • Internal discussion with 2 women staff
May 9	8-10 am 10.30 to 3.00 pm	At Solavta field visits	• Staff meeting • Meeting with ANM at Sirohi • Visit to Narena government hospital • Visit to Bingolav
May 10	10.30 to 1.30	Aadhar office	• Meeting with woman staff of network on gender issues • Report writing

Date	Time	Activity	Details
May 11			• Repot writing
May 12	10.30 am to 4.30 pm	Aadhar office	• Meeting with NGO heads • Presentation of findings, discussion on network and future ideas
May 13, 14			• Report writing
May 15		Sida office	• Presentation of findings and recommendations

Annexure 4

List of persons met

S.No	Name	Details
A	**Network partners**	
	Satyajit Bhattacharya	Secretariat Coordinator
	Dr. Kumkum Srivastav	Vihaan
	Bharat	Vishakha
	Teja Ram	Manthan
	Laxmi Narain	Prayatana
	Atma Ram	Atma
	Mota Ram	SARA
	Nand Lal	Aadhar
	Chotu Lal	TSVS
B	**Staff of network organisations**	
a	**VIHAAN**	
	Mahavir	Field coordinator Renwal
	Sadanand	Field organizer
	Deep Chand	Block coordinator
	Mahesh	
b	**Aadhar Research Institute**	
	Santosh	Adolescent girls
	Savita	Core group coordinator
	NandLal	RCH project coordinator
	Ghasi Ram	Accounts of RCH Project
	Magan Singh	Plan International Project
	Mohan Lal	Night school supvsr
	Jagdish Prasad	Education section in charge
	Jai Narayan	
c	**Vishakha**	
	Lata	RCH programme coordinator
	Shiva Ram	
	Manbhar	
	Gopal	
	Kamalludin	
	Indrajit	
d	**SARA**	
	Urmila	RCH Project Coordinator
	Krishna	

S.No	Name	Details
	Jagdish	Plan International Project Coordinator
	Prabu Dayal	Night schools Coordinator
	Bhagwan Sahay	Store manager – computer operator
	Sainwan Lal	Health Work Coordinator
	Sant Lal	Accounts incharge
	Bhanwar Lal	Nagaur field centre incharge
	Birmal	Driver
	Ganpat Lal	Sikar field office incharge
e	**ATMA**	
	Milap Chand Tailor	RCH programme
	Jai Narayan	
	Hari Mohan Sharma	CRS- SACH
	Shiela Kanwar	VHW Jaisinghpura
	Mira Devi	VHW Basnivala ni dhani
	Usha Kumavat	Trainee
	Sunita	Trainee
	Bina sharma	RCH Programme
f	**Prayatna**	
	Vidya srivastav	RCH Programme
	Chandra Kanta	
	Dhan Raj Sharma	Shiksha Karmi Programme
	Pardeep kumar	Accounts
	Ram Avtar	Education
	Laxmi Narain	Plan sponsorship
	Shiv Dayal	SCF
	Purshottam	Plan Sponsorship
	Shiv Dan	Driver
	Sua Lal	Education
D	**Government Health staff**	
	Radhamani	ANM Bichhoon PHC,
	Dr. Rajendra Tamra	MO Incharge (MD) Naraina Govt Hospital
	Dr. Salil Maheswari	MO (MD Paeds)
	Dr. Anil agarwal	MO (MD Medicine)
	Moharu Lal kumavat	UDC
	Dr. Ajay Sharma	Renwal PHC
	Dr. Rajendra Rao	Chomu PHC
	Dr. Ajay Gemini	Khachariyavas PHC
	Dr. Ramesh Sharma	PHC
	Abdul Raftar	Compounder

S.No	Name	Details
	Village people	
	Devmand	
	Prem Devi	Mahila swasthaya kaarya karta
	Kanhaya Lal	Core team member
		Mahila swasthya kaarya karta
	Beed Ramchandra pura	
	Kaili Devi	Mahila swasthya kaarya karta
	Kamala	Anganwadi worker
	Sunita	Kishori group member
	Bina	
	Lalita	
	Bhagvasar Kankaria	
	Nanu Devi	**Dai**
	Gora Devi	Dai
	Ram harni Devi	CBD
	Kani Devi	CBD
	Raju devi	Mahila samooh member
	Galli Devi	Mahila samooh member
	Santi	Kishori group
	Kamjari	Kishori group
	Kajormal Jaat	Dy. Sarpanch, Radoli Panchayat Samiti
	Salagrampura	
	Manbar	Dai
	Asha Sharma	CBD
	Shakuntala	Ward Panch member
	Sunita	Night school teacher
	Urmila	Night school teacher
	Revatpura	
	Rajiji	Village leader
	Leela Devi	Ward Panch
	Rukma Devi	Dai Revatpura
	Seeta Devi	Dai Pinaach
	Mota Ki Dhani	
	Gopal Lal Sharma	School teacher
	Sushila	Panchayat member
	Krishan	Dai
	Pusepa	Adolescent girls group
	Saroj	
	Mukesh	Adolescent Boys group
	Balbir	
	Hemraj	
	Rajendra	
	Sawan	
	Gopinathpura	
	Anop Kanwar	Panchayat member
	Badrinarayan	community leader
	Prem Lata	Anganwadi helper
	Nolasia (Champa Ki Vas)	
	Ratan Lal	Coordinates emergency fund
	Nathi	Dai
	Sayar Devi	Anganwadi worker
	Gopal	Adolescent boys
	Sanjay	
	Mahender	
	Rudi devi	Grandmother of amrit chooran recipient

S.No	Name	Details
	Pratappura Sita Devi Goga Devi Soni Devi Santara Devi Manbhar Manju Suman Meena Sushila	 RCH Dai SHCH Dai Adolescent girls
	Bingolav Lalli Soni Barji Devi Motan Devi	 Group member core group member Dai Adolescent girl

Villages visited during evaluation

S.No.	*Name of Organisation*	Name of Villages	Block	District
1	AADHAR RESEARCH INSTITUTE, RADOLI	Bhagwatsar Kankria	Chaksu	Jaipur
2		Salagrampura	”	”
3	VIHAAN, JAIPUR	Beer Ramchandrapura	Phagi	Jaipur
4		Deomand	”	”
5	VISHAKHA, JAIPUR	Revatpura	Phagi	Jaipur
6		Tikel Purohitan	”	”
7	SARA, LAXMIPURA	Mota ki Dhani	Dantaramgarh	Sikar
8		Goplapura	”	”
9		Nolasiya	Kuchaman	Nagour
10	PRAYATNA Solawta	Bingolav	Dudu	Jaipur
11		Ringi	”	”
12				
13	ATMA	Pratappura	Sambhar	Jaipur
14	TILONIA SHOD EVAM VIKAS SANSTHAN	Phaloda	Silora	Ajmer
15		Rampura	”	”
16	MANTHAN	Kardala	”	”
17				

Annexure 5

Tools used

Guidelines for interview of Network Coordinator

1. What motivated you to take on the role of the network coordinator?
2. What is your assessment of the strengths and weaknesses of the network?
3. What preparations did you have to do (or are required) to fulfill the responsibilities of the network coordinator?
4. What mechanisms structures and processes one required for an effective network?
5. What problems on special challenges do you face as network coordinator?
6. What problems do you think network members have?
7. What is your assessment are the achievement of the network?
8. What are the failures or areas of empowerment?
9. What are the strengths of each organization in your perception?
10. Comment on the strengths of this project
    - Understanding of RH
    - Understanding of gender
    - Understanding of Reproductive Rights
    - Understanding of Health
11. Feedback on last annual review and action plan?
12. What are your ideas for the future?
13. Give us ideas of
    a) What we should look for in each organization and its field area?
    b) What documents can you give us to substantiate our enquiry according to the TOR?

Guidelines for feedback of Network Partners

1. What are the mission and vision statements of your organization?
2. From the perspective of your organization and field area what do think is the relevance of the RCH project?
3. What factors contributed towards the achievements of the RCH project?
4. What innovations or special features and your organization contribute to this project?
5. What obstacles / problems did you face in fulfilling objectives of the RCH project? (Programmatic problems)
6. What organizational concerns have emerged in the course of implementation of the project?
7. What lessons did your organization learn as a result of this project?
8. How did you link the RCH project with other developmental programmes of your organization?
9. How has your organization understood and implemented gender?
10. How did your link HIV/AIDS in the implementation of the RCH project? What are your plans for the future?
11. What do you think are the bases for participating in this network as a partner?
12. What Technical and Management support do your require from the network?
13. How do you understand "Sustainability"
    (A) Programmatically
    (B) Of the network
14. For this project, who all did your organization initiate a partnership with? Why? How?
14. What all was done for capacity building? What were the results and achievements?
15. What preparation do you require for the future work?

Checklist for Staff Meetings in Partner NGOs

1. Understanding of RCH Project 's objectives
2. Development of the project in their NGO
3. Strengths and achievements
4. Weaknesses and problems
5. Understanding of gender and how it was implemented
6. Capacity building efforts and future needs
7. Monitoring mechanisms for the programme
8. Documentation, records and reports
9. New strategies, special features
10. State of and relationship with government health system
11. Effects of RCH Programme on *panchayat* members
12. Experiences of being in a network
13. How do they understand sustainability
14. Ideas for the future

Also look at training reports, village registers, resource material available, correspondence with government health system.

Checklist to be used in the Village Visits

1. Meet the *dai*, core group members, adolescent girls, adolescent boys, persons who manage the emergency fund.
2. Talk to the *mahila samooh* members, men of the village, *panchayat* members, *anganwadi* workers, CBD, SHG members
3. See *dai's* kit, school medicine kit, if there is a school health programme going on in the village
4. See nearest PHC, Sub center, CHC, if possible

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