

An Evaluation Study On Advocacy of Safe Motherhood under CHCMI



Prepared for
Department of Panchayats
&
Rural Development,
Government of West Bengal

*Achin Chakraborty
Subrata Mukherjee
Bidhan Kanti Das*



Institute of Development Studies Kolkata
Calcutta University Alipore Campus
1, Reformatory Street, 5th Floor
Kolkata 700027

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Achin Chakraborty

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Bidhan Kanti Das

Institute of Development Studies Kolkata
Calcutta University Alipore Campus
1, Reformatory Street, 5th Floor
Kolkata 700027

Tel + 91 33 2448 8178/5970

Fax +91 33 2448 1364

Email: idsk1@vsnl.net

URL: www.idsk.org

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Field Investigators

Bankura

Bulu Karmakar
Apurba Baul

Birbhum

Shibani Ray
Rajendra Prasad Sen

Dakshin Dinajpur

Tanusree Paul
Atanu Sarkar

Malda

Sharmila Deb
Kaushik Bhattacharya

Murshidabad

Rita Baral
Manab Bhatta

Purulia

Sathi Das
Mrinal Kanti Routh

Research Assistants

Arpita Lahiri
Moloy Banerjee

Photos

Subrata Mukherjee

Cover Design

Sanchari Guha Samanta

Foreword

The health of mothers and their children is the foundation of the health of the nation. Yet in many countries, including India mothers' health has a low priority in many households and in government plans. The initiative of the Department of Panchayats and Rural Development (P& RD), Government of West Bengal in monitoring the health of the mothers and their children with support from the Department of Health and Family Welfare (H & FW), Government of West Bengal and UNICEF should, therefore, be welcomed by every person interested in the welfare of the Indian people and in particular, the people of West Bengal.

The Institute of Development Studies Kolkata thanks the Department of P& RD, Government of West Bengal for entrusting it with an Evaluation Study on **Advocacy of Safe Motherhood under Community Health Care Management Initiative (CHCMI)** since such a study was in absolute consonance with the objective of the Institute. The CHCMI was carried out in six districts of West Bengal, namely, Birbhum, Uttar Dinajpur, Dakshin Dinajpur, Malda, Murshidabad and Purulia. In addition, the district of Bankura had started CHCMI on its own. All the seven districts were covered by the evaluation study. The basic unit for implementing the CHCMI is the Gram Panchayat (GP). This evaluation study was carried out by Professor Achin Chakraborty, Dr. Subrata Mukherjee and Dr. Bidhan Kanti Das with the help of many persons and departments whom they have acknowledged in a separate place. They remain agnostic about why some GPs that were covered under the CHCMI performed better than other GPs which were also similarly covered. That agnosticism is warranted by the limited duration of the CHCMI and the even more limited duration of the period of evaluation. But several recommendations come out from this limited evaluation.

First, every district should have a Programme Coordinator for the CHCMI because the GPs of the two districts of Murshidabad and Birbhum, which did not have Programme Coordinators, performed worse on average than the GPs of the other districts with Programme Coordinators.

Second, coordination between the different departments of the governments both at the state and the central levels will measurably improve the outcome of the CHCMI as indeed of many other programmes of the government. In the instant case, it is the cooperation between the Departments of P & RD and H & FW that has been critical in successful implementation of the CHCMI. Similar coordination between the P & RD and H & FW Departments, and the National Rural Health Mission of the central government can be highly synergistic for

implementing the CHCMI and a Safe Motherhood Programme. It is obvious that more financial provision is needed for the Safe Motherhood and CHCMI programmes , which will also benefit the nurturing and education of children .

Financial provision must be seen as a matter of continuous and dependable support for such programmes and not as sporadic injection of funds for particular programmes as and when higher echelons of the political establishment wake up to some emergency. I believe that the very interrupted flow of funds, and spasmodic nature of interests of the politicians and bureaucrats in education and health oriented programmes are among the causes of the apparent apathy or cynicism of many functionaries of Panchayati Raj Institutions (PRI) and ground level operators of line departments. However, many other social factors contribute to such dysfunctional attitudes and resulting behaviour patterns.

As Professor Chakraborty, and Drs Mukherjee and Das emphasize, financial constraints cannot be an accepted alibi for non-performance in every case. Sensitization on a continuous basis is needed in order to get the PRIs and the ordinary people to believe in a sustainably improving future for all the people. I hope that this evaluation report will help policy makers and PRIs and ground level workers in believing in an achievable improvement in the critical indices of nutrition, health and survival.

Amiya Kumar Bagchi

Director

Institute of Development Studies Kolkata

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Executive Summary

1. The report presents the findings of the evaluate study on advocacy of safe motherhood under Community Health Care Management Initiative (CHCMI). The programme was launched in 2004 in six districts, viz. Uttar Dinajpur, Dakshin Dinajpur, Maldah, Murshidabad, Purulia and Birbhum, with the overall aim of promoting community involvement in improving people's health.
2. CHCMI has a well-formulated set of objectives. The monitoring initiative is supposed to be based on a comprehensive *population-based* set of data. The data generated by the government departmental sources are essentially supply side data on facilities and the numbers they serve. CHCMI can reorient this by focusing on population-oriented data base.
3. The study is based on primary data collected from six districts: Dakshin Dinajpur, Malda, Murshidabad, Birbhum, Purulia and Bankura. From each district, six GPs were selected from those which had prepared Action Plans on CHCMI ('focus group'), and three GPs were selected at random as 'control' where Action Plans are yet to be prepared. Altogether fifty four GPs were thus selected. Separate questionnaires for the following informants were used: GP *Sachib, Sanchalak* (Convener) of *Swastha O Siksha Sthae Committee* of GP, ANM, *Dai(s)*, ICDS supervisor(s), and ten randomly selected women who are currently pregnant or have children aged below one year. Both the process of implementation and the outcome of the initiative have been analysed.
4. A composite index of achievement on implementation ('process score') was constructed from select indicators and GPs were ranked. There are well-performing GPs and poorly performing GPs in all the study districts, and none of the districts seems to have a disproportionate share of either. Among the top twenty GPs fifteen belong to the focus group and five belong to the control group. It implies that preparation of the Action Plan is a necessary first step in the implementation process, and the GPs that have prepared their Action Plans are more likely to make progress on other parts of the implementation process.

5. No common explanation can be found as to why some GPs have taken more interest in CHCMI than others. It ranges from motivated GP leadership combined with active SHGs to existence of a good NGO as facilitating agent.
6. The correlation between the process score and an outcome indicator, namely, the percentage of institutional deliveries, is found to be positive and not too low (0.39), which shows that a GP with a high process score is likely to show a high percentage of institutional births.
7. The most prominent element of CHCMI is the 'Last Saturday Meetings' that the GPs hold every month to discuss public health issues. The meetings are being held regularly in all the 54 GPs. The minutes of the recently held meetings show that a variety of health related issues, most of which on safe motherhood, have been discussed. However, there are indications that not all the GPs and GP members are equally involved in the meetings. In most of the meetings either the *Pradhan*, or *Upa-Pradhan*, or the *Sanchalak* is present, besides the almost regular others from the Health Department, and sometimes ICDS. In a very few GPs more than one GP member was present at a time in the meeting.
8. The proceedings of the meetings in most cases are recorded in very general terms such as "people should be made aware of the health and hygiene practices". If specific points are not noted, it is not possible to record in the subsequent meetings the 'actions taken'. However, no matter how casually they are done, the last Saturday meetings undoubtedly have influenced the PRI functionaries. They now at least feel the importance of having information on birth and death, safe motherhood and other health related information including child under-nutrition.
9. GPs are supposed to set up a Sadar Sub-Centre with certain facilities close to the GP office. In 18 out of 54 study GPs were the Sadar Sub-Centre set up. Out of these 18 only 7 have electricity and 6 have water facility. In none of them child delivery has taken place, even though the idea was to equip them for child delivery.
10. In 40 GPs information on institutional delivery was available. Only 12 GPs could provide information on number of deliveries attended by trained Dais, and 24 GPs could report how many trained Dais the GP had. In the data compilation and transmission process many GP functionaries are yet to take active interest. Even though 68 percent *Sanchalaks*

said baseline surveys by SHGs were conducted in their GPs, most of them failed to say anything about the findings of the surveys.

11. On the outcome side, when asked about what the ideal age at marriage is, 32 percent of women reported an age less than 18. There is no significant difference between the focus and control GPs on this. However, if we focus only on the non-literates among them, women in focus GPs seem more aware than their counterpart in control GPs. Similarly, the percentage of illiterate women who said that a family should have two or fewer children is 51 in focus GPs compared to 43 in control GPs.
12. The ANMs believe that CHCMI has made moderate to high improvement in several areas. But in reducing early marriage, about 40 percent said it has made very little or no improvement, which seems reasonable since the problem of early marriage is due to a complex of factors in which awareness perhaps plays only a partial role.
13. In our overall assessment, the record of success of CHCMI has so far been somewhat mixed, which is not surprising, since it is too early to have the full effect of the initiative felt. The amount of work that has gone into planning and designing the initiative is quite remarkable. If one goes through the series of notifications containing detailed instructions on various components of CHCMI one can hardly doubt the internal consistency of the design and the assumptions on which various components have been built. The study, however, identifies a few key areas where some rethinking combined with a bit more effort at implementation can bring about better results.

Suggestions:

- i) The main challenge is to motivate those PRI functionaries who are yet to take active interest. At the core is of course the general lack of capacity to comprehend and implement various instructions flowing down from above, which is not specific to CHCMI. Apart from the general capacity building, which is perhaps beyond the scope of CHCMI, sensitisation workshops should be strengthened by involving *experienced motivators*.

- ii) However, sensitization alone cannot be effective unless they are combined with some incentives. While in the orientation programmes successful cases should be repeatedly mentioned to instill a sense of competition among the GP functionaries, a small number of specific targets can be thought of, which are somewhat feasible to attain. The GP may be rewarded if certain targets are reached.
- iii) To institutionalize the initiative adequate financial provisioning is necessary. The overall financial allocation for the programme has so far been rather small, and much of the resources had to be managed from sources other than the standard earmarked government budgetary sources. Some of the stated goals of the National Rural Health Mission are quite in line with the objectives of CHCMI. While the NRHM has made substantial financial allocation to achieve the stated objectives, CHCMI provides a kind of blueprint for working towards these objectives without financial backing. The complementarities between the two are so obvious that it would be unfortunate if it remained unexploited for a lack of initiative at the upper echelons of the government to transcend the departmental boundaries.
- iv) Money is needed for financing additional manpower needed to build capacity at various levels. There is clear indication that the presence of a Programme Coordinator in a district makes significant difference, as it is evident from the record of progress that Murshidabad and Birbhum have made. Neither has a Programme Coordinator, and in terms of our process scores they lag behind others, despite sincere efforts by the Secretary to Zilla Parishad in the former and the Nodal Medical Officer in the latter.
- v) Money is also needed to sustain motivation of the SHGs as well. An honorarium is more a symbol of recognition than anything else. It is almost impossible for anyone to keep up motivation on a sustained basis if one's work is not recognized as valuable.
- vi) SHG members may be motivated by the recognition that they are doing valuable work for the community. But this feeling of pride and self-respect has to be nurtured by the GP leadership. Some GP members tend to think of the SHG members as inferior beings incapable of delivering the job they are expected to. The sensitization programmes should address this too.

- vii) The cascade mode of training and sensitization does not seem to have been working the way it should be. This does not mean that the cascade mode itself is flawed. This mode of training would be more effective if the goal of training was to impart *well-defined technical knowledge*. But in the case of CHCMI the training programmes must be aimed at arousing interest in the GP level functionaries about community orientation in matters of people's health. The district coordinators or the persons in charge of organizing the training programmes should be given the freedom to deviate from the norm about who can be the district level trainers and invite people who are known for their abilities to motivate. A CMOH – II, for example, having a good stock of knowledge on safe motherhood but poor ability to communicate is no better than a well-respected local school teacher who knows how to motivate and sensitise. But a strategic balance has to be made. Involving CMOHs and DPOs of ICDS in the training programmes makes good strategic sense, for CHCMI cannot succeed without the involvement of these officials from different departments.
- viii) In Blocks the Joint BDOs are usually in charge of CHCMI. This middle tier seems the weakest link in the chain, as the Joint BDOs seem rather overburdened with various other responsibilities. A Block level coordinator similar to the District Coordinator may be a possible solution.
- ix) The data on population health collected and compiled at different levels must attain the desired standard of quality. With more effort in monitoring at different levels it is possible and most desirable to improve the quality of data. More importantly, the GPs are yet to be sensitized about the difference between the nature of data that the health department would provide and the kind of data they need for planning action. The crucial difference is between 'client oriented' and 'population oriented' data. GPs must be sensitized to keep as much information as possible on the *excluded* people.
- x) In one district, the *Zilla Parishad* on its own initiative conducted a small survey of children and found that the data on undernutrition routinely reported by ICDS centres frequently suffer from gross underestimation. The ZP then introduced a nutrition supplement programme and in six months' time obtained impressive results. This type of questioning of the data received from ICDS and Health Department sources and reworking on them for effective intervention must be encouraged in other districts.

Chapter 1

Introduction

The Panchayats and Rural Development Department (P&RD), Government of West Bengal, launched the Community Health Care Management Initiative (CHCMI) with support from UNICEF and the Department of Health and Family Welfare, Government of West Bengal, in 2004, with the overall aim of promoting community involvement in improving people's health. It has been three and a half years since the initiative was formally launched. Even though the impact of such an initiative should ideally be judged in terms of its consequences on people's health, three-and-a-half years seem rather short for the intervention to have its full effect, especially because in this kind of programme a good deal of time is required for the programme to be implanted. However, one can take a rigorous analytical look at the achievements and pitfalls at this point in order to inform the policy makers while planning the future course of action in the area of decentralized governance and health.

The CHCMI follows a well-formulated set of objectives. If the ultimate objective is to improve people's health, there is no obvious way in which strategies can be designed to achieve that goal. Until recently the focus of the government's health policy had almost exclusively been on the financial allocation through government departments, such as the department of health and family welfare, to directly provide health care services of curative as well as preventive and promotive kind, on the presumption that it would be automatically translated into improved health of the people. With the advent of the Panchayati Raj as the formal institutional form of decentralized governance it was increasingly realised that the Panchayati Raj Institutions (PRI) could be involved in delivery of public health services. Yet the conventional wisdom has so far not gone beyond using the Panchayats only for occasional campaigns such as Pulse Polio programmes which require mass participation.

Perhaps for the first time in the history of decentralised governance in West Bengal such a comprehensive programme as CHCMI has been planned with the aim of involving the community in monitoring its own health. To involve the community, specific steps had to be designed, the first and foremost of which was identification of the key agency at the local community level. The key agency here is the elected *Gram Panchayat* (GP), and the specific steps include regular meetings of GP functionaries with health care delivery workers,

including ICDS workers and supervisors, training GP functionaries to sensitise them about health issues and develop capacities to manage the system of monitoring. The meetings are held on the last Saturday of every month, and are supposed to deliberate on the important health issues and concrete steps that need to be taken to address those issues. The discussions, and the decisions that follow, must be based on quantifiable data on nutritional status, mortality, morbidity, different aspects of safe motherhood, and various public health issues such as sanitation, drinking water and so on. Special emphasis has been on safe-motherhood-related awareness generation and capacity building in the community.

The most important aspect of CHCMI is that the monitoring initiative is supposed to be based on a comprehensive *population-based* set of data. The data generated by the government departmental sources are essentially supply side data on facilities and the numbers they serve. Solely from the information on how many have availed the government facilities it is impossible to draw a complete health profile of a population, and hence make specific plans covering the whole population. CHCMI seeks to remedy this by focusing on the need for population-oriented data base. To achieve this, progress has to be made in the direction of institutionalization of the system of monitoring, which, in turn, requires identification of key functionaries and assignment of specific tasks and responsibilities. To what extent CHCMI has progressed in this direction is what the present study aims to assess.

In the next Chapter we discuss the methodological issues and study design. As we analyse both the process of implementation of CHCMI and its possible outcome, we first present our assessment of the process in Chapter 3 and the outcome of the initiative is discussed in Chapter 4. In Chapter 5 we present overall assessment, and based on our findings make several suggestions for improvement.

Methodological Issues and Study Design

2.1 Methodological Issues:

An evaluative study of this kind has to negotiate with various constraints at different stages. Ideally, one should go about comparing the present scenario with the situation prevailed before the initiative started. But in the absence of any comparable baseline survey it is not possible to track the effects of the initiative over time. We therefore adopt a combination of strategies based exclusively on the cross-sectional data that we have collected from the field.

Instead of comparing outcomes at two different points in time, one could compare two sets of *Gram Panchayats* – one where the programme has been initiated and the other where it is has not. But formally the programme has been implemented in all the GPs in six districts, viz. Uttar Dinajpur, Dakshin Dinajpur, Malda, Murshidabad, Birbhum and Purulia. However, even within these districts different GPs are at different stages of implementation. An important component of the first phase is preparation of a plan of action on the health issues in the GP. The P&RD Department maintains a list of GPs where Action Plans have been prepared. One can therefore make an attempt to compare the set of GPs that have prepared the Action Plans early on with the others where it has not been done, or has been done only very recently.

Besides, since the process aspect of CHCMI is no less important than the outcome it is supposed to lead to, we set our evaluative gaze on the processes as well. However, even though it is generally presumed at the planning and policy level that if all the elements of a programme such as CHCMI are in place there is no reason why the expected outcome should not follow, the reality may be different. One should not ignore the possibility that good outcomes in terms of the parameters of safe motherhood may have very little to do with CHCMI, and contrarily, bad outcomes may be due to a variety of reasons beyond the limits of CHCMI. Therefore it would be interesting to find out how close is the correspondence between the parameters of successful implementation in terms of the processes and the outcome indicators.

2.2 Study Design

After consulting the key officials of the P&RD Department we decided to take up the following six districts for in-depth study: Dakshin Dinajpur, Malda, Murshidabad, Birbhum, Purulia and Bankura. These are the districts in which a good number of GPs prepared their Action Plans on CHCMI. Among the six, Bankura started the programme on its own initiative and was not among the six initial focus districts. The five districts (excluding Bankura), together with Uttar Dinajpur, formed the initial focus districts for intervention. In terms of the indicators of human development those six districts trail behind others. Between Uttar Dinajpur, which is one of the initial focus districts, and Bankura, which initiated the programme on its own even though the district was not among the initial focus districts, we decided to include the latter because we thought it would be interesting to contrast the experience of Bankura with the five others. However, the study team visited all the seven districts, including Uttar Dinajpur, and one or two block offices and *Gram Panchayats* in each district, and spoke to the key informants at the district, block and GP levels.

In each of the study districts, six GPs have been selected from among the GPs that have prepared Action Plans (we call them ‘focus group’ GPs), and three GPs have been selected at random as ‘control’ where Action Plans are yet to be prepared. These control GPs are selected from those Blocks which the first set of six GPs belong to. Thus, from six districts we took altogether fifty four GPs. In each GP, separate questionnaires for the following informants have been used to collect detailed information:

1. GP *Sachib*
2. *Sanchalak* (Convener) of *Swastha O Siksha Sthae Committee* of GP
3. ANM
4. *Dai(s)*
5. ICDS supervisor(s)
6. Ten randomly selected women who are currently pregnant or have children aged below one year

The questionnaire for *Sachib* collects objective information on health related and organizational aspects, and that for *Swasthya Sanchalak* focuses more on his/her awareness of population health matters. The questionnaires for ANMs and *Dais* are designed to capture the quality and availability of services related to safe motherhood and how much of it could be attributed to CHCMI. ICDS supervisors’ responses would give us some idea about the nature

of involvement by them in CHCMI and what they think of the GP functionaries' role in it. The questionnaire for women beneficiaries is designed to capture directly the outcome of the intervention. Although ideally one should select the sample beneficiaries by random sampling method from the entire women population, we compromised on that realizing the difficulty in drawing a complete list of all women in the reference group in a GP. Since our focus group consists of the currently pregnant women and mothers who have children less than one year old, we had to depend on ANMs for a list of such women. The investigators were instructed to select randomly from the names provided by the ANM. The ANM's list, we suspect, may be a bit biased towards women who are more likely to go for complete ante-natal care. All six types of sample questionnaires are given in Appendix.

MAP 2.1 :
STUDY DISTRICTS



Chapter 3

The Process of Implementation

3.1 The Process and the Outcome:

The information that we collected through questionnaires can be used to understand two distinct but interconnected aspects of CHCMI. As the key agency for implementation is the *Gram Panchayat*, each GP can be assessed in terms of a number of indicators, which would capture the process of implementation, i.e. to what extent the GP has succeeded in implementing CHCMI. However, from the indicators of the process of implementation it is not possible to assess how the initiative has in fact impacted on the ultimate beneficiaries, viz. mothers and children, who are supposed to benefit from the safe motherhood programme within CHCMI. For the ultimate outcome, we need to look at the beneficiaries' responses to our questions on various aspects of safe motherhood. In what follows, we first analyse the performance of GPs in terms of certain process indicators, and then in the next chapter we analyse the outcome.

3.2 The Process Indicators

We have constructed a set of *process* indicators from the information collected from the GPs. We confine ourselves to the following eight indicators, even though the set could be extended. The indicators are:

- (1) Whether the *Sadar* sub-centre has been set up (0 if 'no', 1 if 'yes'),
- (2) Awareness-related posters displayed at GP and *Sadar* sub-centre (0 if 'none', 1 if 'few', 2 if 'adequate')
- (3) Whether a list of trained dais is maintained (0 if 'no', 1 if 'yes')
- (4) Whether any information on untrained dais is kept (0 if 'no', 1 'yes')
- (5) Whether the *Sanchalak* knows the main objectives of CHCMI (0 if 'not at all', 1 if 'somewhat', 2 if 'well')
- (6) Whether the baseline survey conducted in the GP (0 if *Sanchalak* can't say, 1 if not conducted, 2 if yes)
- (7) Whether information on institutional birth is available at GP (not somewhere else or with ANM) (0 if 'no', 1 if 'yes')

- (8) Whether ANM gets GP's cooperation in discharging her duties (0 if 'not at all', 1 if 'a little', 2 if 'very much')

For each GP the scores for seven indicators were added and the GPs were ranked according to the total scores. Let us call the total score the 'process score'. The complete ranking of all GPs according to the process score is given in Table A1 in the Appendix. Before we look at the ranking, we discuss some of the process indicators separately and make a few observations.

3.3 Last Saturday Meetings

The most important process indicator would have been the one related to the last Saturday meetings. The most prominent identifiable element of CHCMI is this meeting that the GPs have to hold on the last Saturday of every month to discuss the matters related to health and nutrition. The needed actions are supposed to flow out of the discussions in the last Saturday meetings. The deliberations are expected to be based on quantitative information on various aspects of people's health. According to the responses we got from the GPs, the last Saturday meetings are held in all the 54 GPs. It does not make sense to retain an indicator that takes the same value for all the entities. Therefore we dropped it from our select set of process indicators that we have used to rank GPs.

The minutes of the recently held meetings show that a variety of health related issues have been discussed. We collected copies of the minutes of the most recently held meetings in three consecutive months. There are some indications that not all the GPs and GP members are equally involved and enthusiastic about the meetings. A close look at the minutes of the meetings led to the following observations.

- (1) In most of the meetings either the *Pradhan*, or *Upa-Pradhan*, or the *Sanchalak* is present, besides the almost regular others from the Health Department, and sometimes the ICDS supervisors and/or workers. In a very few GPs did we find that more than one GP member was present in the same meeting.
- (2) We often heard complaints from the ANM, health workers and ICDS workers, who usually attend the meetings, that the GP members do not show much interest in the meetings. In the minutes of one meeting the *Sachib* even put it on record that the GP members should be told to be present in the meetings.

- (3) The proceedings of the meetings in most cases are recorded in very general terms. Some examples are “people should be made aware of the health and hygiene practices”, “number of institutional deliveries has to be increased”, and so on.
- (4) The specific points, if they figure in the minutes at all, are usually on issues like the delay in getting the money for *Janani Suraksha Yojana*, or construction of the ‘platform’ for some tube well.
- (5) In many cases, it seems that in three consecutive meetings the same general statements have been made. If specific points are not made, it is not possible to record in the subsequent meetings the ‘actions taken’.

However, no matter how casually they are done, the last Saturday meetings undoubtedly leave some imprint on the collective consciousness of the PRI functionaries. They now at least feel the importance of having information on birth and death, other health related information including child under-nutrition. Pregnancy and delivery related issues, which earlier used to be seen from government programmatic viewpoint, could hardly be addressed effectively. As a result, it is the woman who had to bear all the contingent risks due to a general lack of awareness and needed support. CHCMI has brought to the focal point the need for treating safe motherhood related issues as community issues.

3.4 Sadar Sub-Centre:

Every GP is supposed to set up a Sadar (headquarter) Sub-Centre at a convenient place adjacent to or close to the GP office. The idea is that eventually the Sadar Sub-Centre (SSC) becomes an important facility for service delivery, being closely monitored by the GP. The SSC is supposed to have at least two large rooms – one for health check up and the other for waiting. There must be electricity, water and toilet facilities, and at least two health workers – one male and one female. Among the 54 GPs only 18 have been able to set up the Sadar Sub-Centre, and in 15 GPs they are being set up¹. In Purulia, none among the nine GPs has been able to set up SSC, even though in three GPs they are being set up. Similarly, in Murshidabad, although none of the focus GPs has set up SSC, in 4 GPs they are being set up. Table 3.1 gives a comprehensive district-wise account of Sadar Sub-Centres. In a good number of GPs that have set up SSCs, the minimum facilities such as water and electricity are not there. Only

¹ These 18 include the cases where the PHC or BPHC is located so close to the GP that there is no need for setting up the SSC.

seven have electricity and six have water facility. Even though SSCs are supposed to provide child delivery services among others, most of them do not seem to be minimally equipped to deal with child delivery cases. What is puzzling is that if we look at the status of Sadar Sub-centre separately for ‘focus group’ GPs and ‘control’ GPs, the latter group seems to have better record than the former. But as it will be discussed later, this is not generally true for other indicators.

Table 3.1: Status of Sadar Sub-Centres in six study districts

District Name	GP Type *	Set up SSC	SSC being set up	have two rooms	have a large table	have separate toilet	have water facility	have electricity	have a male health worker	have female health worker
Dakhshin Dinajpur	FG	2	3	2	2	2	2	2	2	2
	CG	0	1	0	0	0	0	0	0	0
Malda	FG	4	0	4	2	4	1	1	4	4
	CG	3	0	1	2	1	1	1	3	3
Murshidabad	FG	0	2	0	0	0	0	0	0	0
	CG	1	2	0	0	0	1	1	1	0
Birbhum	FG	2	1	1	1	1	0	0	1	1
	CG	1	1	0	0	0	0	0	0	0
Purulia	FG	0	2	0	0	0	0	0	0	0
	CG	0	1	0	0	0	0	0	0	0
Bankura	FG	3	2	3	3	2	1	1	0	3
	CG	2	0	1	2	1	0	1	0	2
Total	FG	11	10	10	8	9	4	4	7	10
	CG	7	5	2	4	2	2	3	4	5

*FG: Focus group GP; CG: Control group GP

Source: Primary survey

In 11 out of 54 GPs no awareness-related posters were displayed either at GP or Sadar Sub-Centre, whereas in 10 GPs they were found to be adequate. In the rest of the GPs (33) something or the other is found but does not seem adequate (adequacy is judged in relation to the best among them).

3.5 Keeping track of data

One indication of the involvement of the GP is that whether it keeps track of the safe-motherhood-related aspects such as the number of births occurred in institutions, the number attended by trained dais and the births neither occurred in institutions nor attended by trained *Dais*. In 41 GPs among the total 54, information on the percentage of institutional deliveries was available. However, only 12 GPs could provide information on the number of deliveries

attended by trained *Dais*. 24 GPs could report the number of trained *Dais* they have in their GPs. These gaps in information are puzzling, since all the GPs are believed to have been sending monthly reports containing all this information to the respective Block offices, and the data are compiled and sent to the District Public Health Cell every month. Of course the GPs, who could provide the figures, did it from the monthly reports they send to the Block. The common response of the GPs that could not provide the data was that they send the data to the Block office every month, and we need to contact the latter to get the data. Then we had to tell them that our interest was not so much in the data as in the awareness of the GP functionaries that the data are meant primarily for their own use, so that they can take action on their basis. One can make a couple of observations here.

- (1) In the data compilation and transmission process the GP functionaries are yet to take an active interest. One indication of the lack of involvement is that it is usually the *Sachib* or some other GP staff who provides the information on the status of CHCMI in the GP. The *Pradhan* and other members are often found to be rather poorly informed about CHCMI than the *Sachib*, except in some specific cases where the *Pradhan* herself is an *Anganwadi* worker, or a teacher; or there is an NGO already working in the GP on child and mother health related issues. In some GPs, the CHCMI related details are usually tucked in the stack of files that the *Sachib* is supposed to maintain, in the same manner as any other top down scheme.
- (2) In some cases the GP *Sachib* or *Pradhan* referred our investigators to the ANM or the Health Supervisor for information, completely oblivious of the fact that it goes contrary to the most basic objective of CHCMI which requires that the GPs themselves manage all this information. How can the GPs monitor people's health if they do not 'own' the data?
- (3) However, the data gaps at the GP level for such items as the percentage of institutional births do not pose a serious problem since the ANMs and Health Supervisors have been maintaining these pieces of information in some form. What is needed is a sense of 'ownership' on the part of the GP, which can be improved with more sensitisation drive. But what seems to be more difficult is tracking births which are neither occurring in institutions nor attended by trained *dais*. None of the GPs had any clue about the extent of this category of births.
- (4) Some GPs handed down to us copies of the data format that the Department of Health & Family Welfare has been using to keep record of treatment of various ailments in

government facilities. It seems that orientation of the GP functionaries has a long way to go.

- (5) In course of our discussions with the officials in charge of data compilation at the Block level we often heard the complaint that the GPs are not serious about the numbers they send. The Block officials have had heard time matching various totals.
- (6) Similar complaints against the Block and *Panchayat Samity* (PS) functionaries were heard from the District Coordinators. The PS functionaries do not seem to show any interest in the entire initiative, as it is evident that not much discussion or deliberation takes place around the data coming from GPs. The Block level functionaries simply compile the data and forward the compiled numbers to the district.

3.6 Baseline Survey

In each *Gram Sansad* two/three Self-Help Groups (SHG) were supposed to be given the task of conducting surveys of the families. The objective was to generate family-unit level data for planning and monitoring people's health. The SHGs are supposed to collect data on health care practices, disease prevalence, mortality and morbidity pattern, sanitation, immunization, nutritional status of children, adolescent girls, pregnant and lactating women, and data on the existing health care facilities as well. The baseline surveys by SHGs are seen by their planners not only as an instrument for planning but also as a vehicle for community empowerment.

Although 68 percent of all the *Sanchalaks* said that the 'baseline surveys' were conducted in their GPs, our investigators noted that many of them had difficulty in telling what they were all about. While in 18 percent GPs the *Sanchalak* said the survey was not conducted, in 14 percent GPs the *Sanchalak* could not say whether the survey was conducted. Even though the data collected by the SHGs are far short of the expected quality, the idea of involving the women from the community to generate data that are considered valuable for the community is in itself commendable. However, it is difficult to sustain the motivation of the SHGs unless they are rewarded in some form for the work they are expected to do. The GP functionaries are well aware of the problem. The district level functionaries responsible for implementation of CHCMI hinted at a different kind of problem. If the GP functionaries themselves are not sensitised enough about the value of the services of the SHG members they can hardly act as motivating agents.

3.7 What *Sanchalaks* say

The lack of a sense of ‘ownership’ among the people’s representatives is further evident from the responses of the *Sanchalaks* of the *Swastha Sthae Committees* of the GPs. We asked the *Sanchalaks* about the objectives of CHCMI. Even though 86 percent of them said ‘yes’ when asked if they knew the objectives, quite a few of them could not spell out anything specific². When asked to identify the objectives of CHCMI, the *Sanchalaks* in most GPs gave very general responses, such as, ‘development of people’ or ‘to improve education and health’ etc. That the idea of CHCMI is a good one is generally shared by the PRI functionaries in most GPs, even though a good number of them showed difficulty in identifying the distinctive features of the programme. In terms of quality of their responses on the objectives of CHCMI we classified them into three categories – 2 for ‘good’, 1 for ‘somewhat close’ and 0 for no response or responses quite off the mark. Whereas 15 *Sanchalaks* either could not say anything or said something that was far off the mark, 24 *Sanchalaks* said things somewhat close to the officially stated objectives, and only 15 out of the total 54 gave correct answers.

To make the *Sanchalak* speak is often a frustrating experience. We came across three cases where the *Sanchalak* did not say a word on CHCMI. Even though our investigators were instructed to make sure that the *Sanchalak* was not being helped by any other person while answering questions. But it was not entirely possible, as the *Sanchalak* often seemed at loss in the absence of the *Sachib*. In most cases, the *Sanchalak* passed on the questions to the *Sachib* or the Executive Assistant.

While judging the performance of CHCMI in terms of its impact, 14 percent of the *Sanchalaks* said CHCMI had made ‘substantial improvement’ and 42 percent said the initiative had made ‘moderate improvement’ in the area of population health. This leaves 44 percent who could see ‘no improvement’ or ‘very little improvement’, or who could not say anything about the impact of CHCMI.

3.8 Views of ANM and ICDS Supervisor on GP:

We included in the set of indicators the views of the ANMs, as they are among the key persons with whom the GP functionaries are supposed to work in full cooperation to realize

² To avoid miscommunication our investigators were instructed to say in Benagali *Jano Udyogey Jano Swasthya*, and if the respondent is still unable to relate, the investigator was supposed to provide some hints like ‘last Saturday meeting’, Panchayat department’s instructions, and so on

the goals of CHCMI. We also collected views of ICDS Supervisors. Since we managed to get the ICDS Supervisors questionnaires only for 42 GPs we could not include their views in the set of process indicators. In 13 GPs, or a little less than one-fourths of the GPs, ANMs said they get very little cooperation from the GP.

Now that the entire ICDS programme is under scanner for its generally lackadaisical performance, it is almost a commonplace view that ICDS functionaries have not had the habit of working in cooperation with the GP. Contrary to this commonplace view, the ICDS supervisors and/or workers are found present in the last Saturday meetings in most of the GPs, barring only a few. It is the ICDS Supervisors who join the ANMs and health workers to express their unhappiness about the lack of involvement of the GP members in CHCMI.

The problem of lack of coordination between the PRIs and the relevant line departments such as the Department of Health and Family Welfare and the Department of Social Welfare (which controls ICDS) repeatedly surfaced in the discussions. However, there is no general pattern. The nature and degree of participation and cooperation by different departmental functionaries at the local level varies from block to block, which defies any generalisation. We heard PRI representatives complaining against the health department officials and doctors about lack of interest in the initiative. We also hear from a block official that PRI representatives do not show much enthusiasm in attending the PS level meetings on CHCMI, even though the BMOH is not as indifferent. In other words, it is not generally the case that PRI representatives have greeted the programme with the expected degree of enthusiasm and the line departments are less than willing to get involved. Table 3.2 summarises the views of ICDS Supervisors on their relationship with the GP.

Table 3.2: Views of ICDS Supervisors on the Gram Panchayat functionaries

Have you ever discussed any problem with any GP functionary?	Yes = 41	No = 1	
Do you think it makes sense to discuss problems of ICDS with them?	Yes = 21	No = 9	Don't know = 12
Do you think that the GP has a role to play in child nutrition?	Yes = 30	No = 9	Don't know = 3
How much interest does the GP show in the functioning of ICDS	Very much = 6	Not so much = 31	Not at all = 5
Do you think GP members keep themselves informed about functioning of Anganwadi centres?	Very much = 10	Not so much = 26	Not at all = 6

Source: Primary survey

3.9 Process scores

As far as the process of implementation goes, there are well-performing GPs and poorly performing GPs in all the study districts, and none of the districts seems to have a disproportionate share of either. For example, two GPs in Birbhum are among the top five but four others are among the bottom five. Similarly, while two Dakshin Dinajpur GPs are among the top five, three others rank among the bottom fifteen. However, we should exercise caution in invoking a tournament-like interpretation. Needless to say, the method of ranking GPs according to the process scores, based only on eight indicators on which we have data for all the 54 GPs, is far from perfect. We use the process scores just to explore if there is any correlation between the process scores and an indicator of the outcome, namely the percentage of births in institutions.

Among the top twenty GPs fifteen belong to the focus group and five belong to the control group. The bottom ten GPs are mixed in perfectly equal proportions – five from the control group and five from the focus group GPs. What it implies is that, while preparation of the Action Plan is a necessary first step in the implementation process, and the GPs that have prepared their Action Plans are more likely to make progress on other parts of the implementation process, there is no automatic connection between the two. On closer scrutiny, it was found that in a good number of GPs the *Sanchalak* has very little to say on the Action Plans. A number of GPs were helped by certain NGO facilitators in preparing the Plan. In some cases, however, the GP does not seem to ‘own’ it – the Plan paper is kept in the safe custody of the NGO and the GP does not seem to have any clue as to what its contents are. In some other GPs, we were told that the Action Plans had been duly sent to the Block. In one GP, the *Sanchalak* said the Action Plan was perhaps with the BMOH ! Clearly, he does not know that the BMOH should have no business with the Action Plan.

The top three GPs in terms of process score are Abinashpur in Birbhum, Shibpur in Dakshin Dinajpur and Ghurisha in Birbhum. An analysis of the first two GPs reveals that both are among the first to prepare their Action Plans (See Boxes 1 & 2 below). However, Ghurisha is a control GP, which is a bit surprising. One could speculate that Ghurisha might be showing the influences of a parallel programme, such as Strengthening Rural Decentralisation (SRD), which has been running in a number of GPs with seemingly similar goals.

From the process scores can we find anything interesting about Bankura which would put the district in contrast vis-à-vis other districts? Let us recall that Bankura was not among the CHCMI focus districts. CHCMI initially started in four GPs in Bankura on pilot basis mainly on the initiative of the Nodal Medical Officer, even though the district was not among the six focus districts. Now, out of 22 blocks, 12/13 blocks regularly send reports on CHCMI to the district office. Although among the top twenty GPs there are four GPs from Bankura, the progress in implementation in the district is rather modest

Out of 54 GPs information on institutional birth is not available for 14 GPs as they could not provide the data. We took the 40 GPs which could provide this information and tried to correlate with the GPs' scores on how active they have been in implementing CHCMI. The correlation coefficient between the two turned out to be positive, although not too high. The value of the correlation coefficient was pulled down by three outliers. If we excluded these three outliers, the value would substantially increase. Figure 3.1 shows the scatter diagram for the two variables – process score and percentage of institutional deliveries – excluding the three outliers. The correlation coefficient is 0.39. We can therefore say with some confidence that a GP with a high process score is likely to show a high percentage of institutional births. Caution has to be exercised once again. The correlation between the two does not conclusively establish that the implementation of CHCMI has indeed 'caused' high percentage of institutional delivery unless and until we clearly identify other factors that might have influenced the outcome.

Interestingly, a fairly good percentage (40) of *Dais* felt that the demand for Dai service is not declining, although we observe high district-wise variations in Dai responses. The *Dais* claim that women are reluctant to go for institutional delivery for they fear that the government health personnel would not be as sensitive as the *Dais*.

Figure 3.1: Relationship between process score and institutional birth



Box 1

Motivated leadership as key to success: How Shibpur Gram Panchayat has done it

Shibpur Gram Panchayat in Bansihari Block of South Dinajpur District is one of the best performing GPs in terms of implementation of CHCMI. There are 14 villages in this GP, inhabited by 33,500 persons among whom 29 percent belong to the Scheduled Castes, 22 percent to minorities and 17 percent to the Scheduled Tribes. People are mostly dependent on agriculture, cultivators and agricultural labour together constituting 70 percent of all workers.

The GP is endowed with a group of highly motivated people. The *Sanchalak* and other members, including the *Pradhan* and *Upa-Pradhan*, all show a high degree of enthusiasm in making CHCMI a success. The base-line survey was organized with a high degree of active participation by SHG members. A team was formed with one member each from 72 SHGs. They were trained at the GP on how to conduct the survey. The team collected *Sansad*-wise data with active help from *Anganwadi* workers. A sub-group of the team members were given training on data compilation who compiled the data. The members then engaged in preparing an action plan with the help of the GP staff. The action plan is quite impressive, containing very detailed information on problems of health, of early marriage, and so on, with the causes analysed and possible ways to mitigate them.

The base-line survey revealed that half of the families had no sanitation facilities. The other issues of concern were low rate of institutional deliveries (30%), prevalence of under-age marriage, incomplete vaccination among children (20%), parents considering vaccination for measles not important, very high percentage of mothers having had only one antenatal check up (71%), 7 percent mothers not going for any check up, high percentage of untrained traditional birth attendants (25%), and very low female death registration. The GP members immediately realized the necessity of making public health an important agenda.

In addition to the last Saturday meetings, the *Shiksha O Janaswastya Upa Samity* of Shibpur GP meets almost every month to discuss progress on health status, what action can be taken and the information feedback system. As a result, some positive results can be seen, such as increased sanitation, increase in institutional deliveries, increased birth and death registration. To provide some basic health services at the village level, one member from each SHG in each *Sansad* has been selected as 'Depot Keeper' who keeps a stock of delivery related and family planning kits for easy access. Furthermore, on 2nd Monday in every month a meeting at the sub-centre level is held to analyse the progress report prepared by select SHG members. *Anganwadi* workers are especially invited to attend this meeting, besides the workers of the concerned sub-centre. Documentary video shows, plays etc are occasionally organized to create awareness among people about the ill effects of early marriage, home delivery and other health problems. The GP has even prepared a handbook on public health related information and their remedial measures for the members of the local SHGs.

The key to success thus seems to be a highly motivated leadership at the GP level, capable of involving members of SHGs and community in general and achieving a high degree of coordination between the GP and the health department and ICDS.

Box 2
NGO as facilitating agent: How Abinashpur GP did it?

Abinashpur GP in Suri II block of Birbhum district has 10 gram *Sanshads* for 13 villages under its jurisdiction. Out of the 13 villages, 5 are Integrated Tribal Development Project villages. This GP has a total population of 11,954 (as per 2001 Census) out of which 34 percent belong to SCs and 32 percent to STs. There are 17 Anganwadi centres. The GP tries to ensure 'spot feeding' at the centres.

The base-line survey in this GP had been conducted even before CHCMI was formally launched in other GPs in the district. The Action Plan was prepared with active assistance from CARE – an NGO working in the area. The NGO organized training for members of the SHGs, GP members and officials on survey procedure, compilation of data and how to write report. The action plan has very detailed information on problems of public health, education, early marriage, and so on. The action plan clearly spells out the possible ways to address the problems that emerged out of the survey, and how the responsibilities for action and financial sources can be fixed.

From the base line survey, several important issues emerged, such as problems of drinking water sources, status of sanitation facility and drainage system, prevalence of marriage at below 18, early pregnancy, very low rate of institutional deliveries, incomplete vaccination in children, family planning, fewer than normal prenatal and post natal check up, incomplete birth and death registration, problem of malnutrition and basic infrastructure. The GP seems to be good at keeping records and information dissemination is one among its important activities. For example, at the entrance of the GP office, the chart on the public health status in the GP is prominently displayed with most of the cells filled in.

As far as achievements go, the condition of antenatal care is now satisfactory in this GP. Most of the pregnant women are getting up to the third check up. A part of the money for *Janani Surakshya Yojana* is given to the mothers to improve their nutrition. This is one of the very few GPs where the expenditure on specific items of public health is clearly identified and easily obtainable. In the last financial year (2006-07) this GP spent around 25 per cent of its untied and finance commission's funds on public health. Furthermore, this GP has provided a Trolley Van to one person in each village with an innovative arrangement. The person is responsible for carrying the patient to the nearest facility whenever such need arises, and during the rest of the time he can earn a livelihood by using the van for transportation.

Picture 3.1: A poster of CHCMI: clearly displays five major goals to accomplish.

পথ দেখাচ্ছে পঞ্চায়েত

জন উদ্যোগে জনস্বাস্থ্য

এক সাথে পাঁচ কাজ

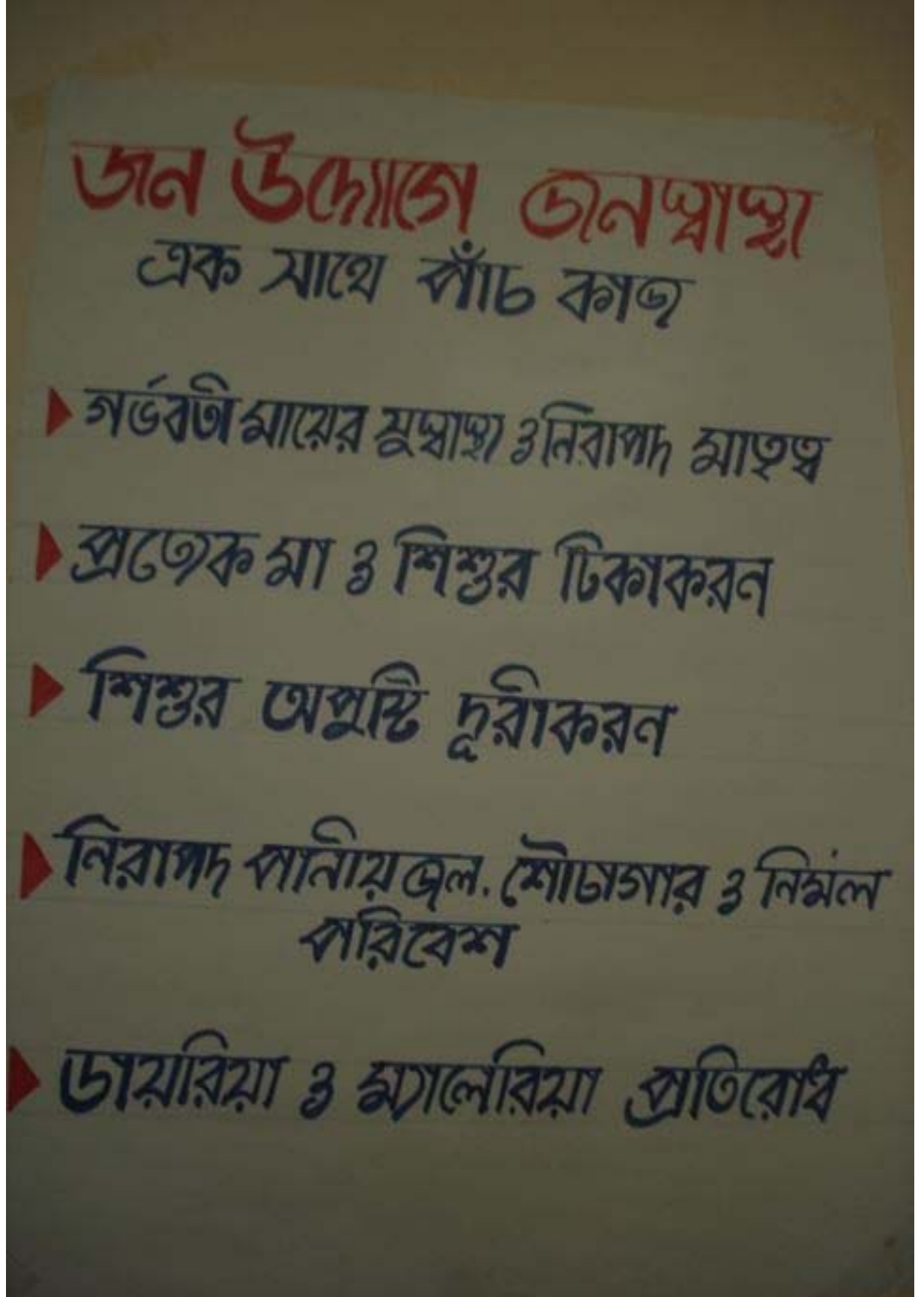
- গর্ভবতী মায়ের সুস্বাস্থ্য ও নিরাপদ মাতৃত্ব
- প্রত্যেক মা ও শিশুর টিকাকরণ
- শিশুর অপুষ্টি দূরীকরণ
- নিরাপদ পানীয় জল, শৌচাগার ও নির্মল পরিবেশ
- ডায়রিয়া ও ম্যালেরিয়া প্রতিরোধ

গ্রাম পঞ্চায়েত
সদর স্বাস্থ্য উপকেন্দ্র

নিজেদের স্বাস্থ্য নিজেরাই গড়ব

unicef

Picture 3.2: A hand-written poster of CHCMI.



Picture 3.3: Now many *Gram Panchayats* maintain basic important information on public health related to the *Gram Panchayat* - both an outcome as well as input of CHCMI. However, this cannot be said for all panchayats that the study team has visited.

গ্রামপঞ্চায়েতের জনস্বাস্থ্য তথ্য		সাল: ২০০৬-২০০৭																			
২১০	০৩	০	০১	০২	০৩	০২	০১	১৭	০২	২৭৩	১৫	২২	১৪	০	০৪	৫	৪	৬	১১	০	০
১৭	০৬	০	০২	০১	০৩	০১	০২	০২	০২	২৪	১৪	১১	০	০৪	৫	৪	৬	১১	০	০	
১২	০	০০	০৩	০৩	০৩	০১	০৫	০৫	৩০	২৬	২৩	০	০৪	৭	১০	৪	৬	১১	০	০	
১৪	০	০০	০৪	০৪	০২	০০	৩৭	০৪	১৯	২৬	২০	০	০৫	১৩	১৩	৪	৬	১১	০	০	
১৫	০	০২	০২	০৪	০১	০২	৩৬	০৩	২৭	২৬	৩৬	০৯	০	০২	১৩	৪	৬	১১	০	০	
১৬	০	০০	১০	১০	০৫	০০	৪৫	০৪	২২	১৫	১৪	০	-	১৩	১৩	৪	৬	১১	০	০	
২০	০	০০	০২	০২	০২	০০	৪০	০৬	২৭	২৮	১৮	০	০৭	১৬	১৩	৪	৬	১১	০	০	

Picture 3.4: Shibpur is found to be one of the best performing Gram Panchayats in implementing CHCMI.



Picture 3.5: The Sadar Sub-centre adjacent to the Bahin Gram Panchayat office in Uttar Dinajpur. Not many GPs are blessed with this unique feature of having the GP office and Sadar Sub-centre in the same compound.



Picture 3.6: Implementation of NREGS has become a priority for the Panchayats. Some are saying that NREGS is affecting other activities of the Panchayat including CHCMI.

- বাবুগ্রাম গ্রাম পঞ্চায়েত - NREGS - বাবু গ্রাম পঞ্চায়েত -	
২০০৬-০৭ আর্থিক বৎসরে বার্ষিক পরিকল্পনার আওতাধীন প্রকল্প সমূহের বিবরণ.	
প্রকল্পের নাম :-	টাকার পরিমাণ
• পুকুর সংস্কার, আমনা গড়িয়া, বাবুগ্রাম-	১০৬০০০-০০
• " " লাক্সানে বাঁধ " "	১০৬০০০-০০
• " " বিয়ানা বাঁধ " "	১০৬০০০-০০
• " " তেলিত বাঁধ " "	১০৬০০০-০০
• " " গাছিয়া পুকুর গোবিন্দপুর	১০৬০০০-০০
• " " আলকানন্দবাঁধ, শ্যামসুক্করপুর	১০৬০০০-০০
- প্রকল্পের নাম :-	
টাকার পরিমাণ	
• পুকুর সংস্কার, কলাগড়িয়া, শ্যামসুক্করপুর	১০৬০০০-০০
• " " বড়া বাঁধ, বাবুগ্রামেডি	১০৬০০০-০০
• " " " " বাগতবাড়ি	১০৬০০০-০০
• " " মিমডতুরা বাঁধ, একুজঙ্গা	১০৬০০০-০০
• " " নামো বাঁধ " "	১০৬০০০-০০
• " " উপর বহড় বাঁধ, ডুমুরাকুড়ি	১০৬০০০-০০

Chapter 4

More on Outcome: The Target Beneficiaries

The main targeted beneficiaries of CHCMI, with its special focus on safe motherhood, are women belonging to reproductive age group including adolescent girls. CHCMI has laid special emphasis on the capacity building exercises as well as awareness generation for safe motherhood practices at the community level. To achieve these goals, orientation programmes for the PRI members and traditional birth attendants (*dai*) have been organised all over the state with support from UNICEF and the Department of Health and Family Welfare. The traditional birth attendants have been oriented to follow the best practices, and the community members have been made aware of the practices as well. The present chapter attempts to assess the extent to which CHCMI and its associated awareness campaign programmes have been able to affect various outcome indicators pertaining to the beneficiaries (mothers and pregnant women) at the community level, by using data from our field survey.

4.1 Brief profile of the sample beneficiaries

Our survey of women beneficiaries includes 10 women (approximately 5 pregnant women and 5 mothers of less-than-one-year-old child) from each study GP. Within a GP, wherever possible, attempts were made to select women from the village rather far away from the GP office. The logic is that if the women living in areas far away from the GP have been benefited, it gives a clear indication of the overall reach of the programme/scheme. Since we selected nine GPs from each survey district and 10 women were selected from each GP, a total number of 542 women were surveyed from six districts.¹

Although attempts were made to select equal number of pregnant women and mothers with less than one year old child, the sample of 542 women consists of 47 per cent pregnant women and 53 per cent mothers. Among the pregnant women, 62 per cent are pregnant for more than 6 months. The reported age of the surveyed women ranges between 14 years and 40 years with a median age of 21 years (mean age is 22 years). Only 9.5 per cent of our sample consists of mothers and pregnant women aged less than 18 years, which is the legal minimum age for getting married for a woman. This is far less than what we find from the larges scale sample surveys, such as the Reproductive & Child Health Survey (RCH – II), for

¹A total number of 92 women were surveyed in Bankura district due to some unavoidable reason.

any of the six districts. In the Appendix Table A3 a couple of indicators for the six districts are presented for reference.

With regard to religious composition of our sample beneficiaries, 83 per cent of them are Hindu, 15 per cent of them are Muslim and the remaining 2 per cent belong to other religions. Out of all Hindu respondents, the percentage shares of general castes, other backward castes, scheduled castes and scheduled tribes are 29 per cent, 8 per cent, 49 per cent and 15 per cent respectively. This indicates that our sample has good representation from the socially disadvantaged classes.

As far as household's major occupation or major source of income is concerned, we have followed National Sample Survey Organization (NSSO) classification of households' occupational categories. The distribution of sample women by their household's major source of income is presented in Table 4.1. The table shows that nearly half of our sample women (48 per cent) are from households whose major source of income is agriculture-related activities. However, majority of them are from agricultural labourer households. The table also shows that as high as 30 per cent of the beneficiaries are from other labourer households, mostly casual labourers. Taking together, agricultural and non-agricultural labour households account for 61 per cent of the total sample beneficiaries. Only 8 per cent of the women are from households engaged in salaried or regular wage employment.

Table 4.1: Distribution of sample beneficiaries by their households' major source of income

Household's major occupation	No of beneficiaries	Percent
Self employed in agriculture	90	17
Agricultural labour	167	31
Self employed in non-agriculture	78	14
Other labour	165	30
Others	42	8
Total	542	100

Source: Primary Survey

We mentioned in the earlier chapter that we had selected two types of GPs from each district. Out of the nine GPs selected from each district, six belong to that category of GP which submitted *Action Plan* as a part of CHCMI ('focus group'). Another three GPs belong to the 'control group'. Throughout our analysis we try to see the contrast of these two types of GPs in terms of various process and outcome indicators for the women beneficiaries.

The educational levels of the sample respondents are presented in Table 4.2. 63 per cent of the sample respondents are literate, which means, they can read and write. Almost 80 per cent of the literate respondents have crossed the boundary of primary school. The mean and median years of schooling are almost the same in both focus and control GPs indicating similar education profiles of the women in two types of GPs.

Table 4.2: Education profiles of the sample women in focus and control GPs

	Focus GP	Control GP	Total
<i>Percentage of women who can read and write</i>	63	64	63
<i>Percentage distribution of literate women by years of schooling completed</i>			
1-4	21	21	21
5-8	49	41	47
9 and above	29	38	32
<i>Mean and median years of schooling for all women (including illiterate)</i>			
Mean years of schooling	4.5	4.7	4.6
Median years of schooling	5	5	5

Source: Primary Survey

The widespread prevalence of under-18 marriage is evident from the information of sample women's age at marriage. Among the respondents, 53 per cent got married before reaching the age 18 (287 out of 539). Curiously, the corresponding figures are 56 per cent and 48 per cent in the focus and control GPs respectively, which is clearly not in line with our expectations.

4.2 Awareness of safe motherhood

One of the important objectives of CHCMI is to raise awareness among women, especially among the women who have not had the advantage of going to school, on the crucial aspects of reproductive health. Women with better awareness are expected to have clearer ideas about minimum age of marriage, ideal family size or maximum number of children a couple should have, minimum time gap between two births, and so on. Although the situation seems to have improved significantly after the initiation of various family welfare programmes from time to time by the governments, it still remains far from a reasonably expected standard. As high as 32 per cent of the women reported an age ideal for marriage which is less than 18 years – the legal minimum age for getting married for women. There is not much difference between the focus and control GPs in this regard. However, if we focus only on the illiterate women, the corresponding figures are 52 per cent and 65 per cent in focus and control GPs respectively.

Therefore, it seems that education, or the ability to at least read and write, seems to play a more instrumental role in increasing awareness among women regarding the ideal age for getting married.

With regard to the maximum number of children a couple should have, we find an unimpressive picture too. Only 68 per cent of the women said that a couple should ideally have one or two children. The remaining 32 percent women either reported more than two or do not have clear idea about the ideal/maximum number of children a family should have. Further, there is no difference between the focus and control GPs. However, if we consider only the illiterate women, the focus GPs seem to have done better than the control GPs. The percentage of illiterate women who have said that a family should have two or fewer children is 51 in focus GPs compared to 43 in control GPs. Similarly, a high percentage of women do not have clear idea about the minimum gap between two births. The percentage of women who think the minimum gap between two births is less than three years or do not have clear idea about minimum gap between two births is as high as 44 per cent. There is no significant difference between the focus and control GPs.

As far as awareness of safe motherhood is concerned, only 39 per cent of the sample women (38 per cent in focus GPs and 41 per cent in control GPs) have knowledge of any orientation programme on birth preparedness to increase awareness on safe motherhood and safe delivery. However, a high percentage of women (73) have reported that somebody from Sub-centre or Panchayat visited them and advised them on how to prepare for safe delivery.

As far as the source of drinking water is concerned, more than 90 per cent of the women have reported that their source of drinking water is either tube well or hand pump or tap, which can roughly be considered as 'safe' for drinking. However, only 23 per cent of the women have reported that they purify water before drinking. There is no difference between focus GP and control GP with regard to women's habit of purifying water before drinking. Access to toilet facility also shows similar unimpressive picture. Only 28 per cent of the women are staying in houses having toilet facility (27 per cent in focus GPs and 29 per cent in control GPs). Out of those who do not have toilet facility, only 65 per cent know that it is possible to build safe toilet at cheaper cost with financial assistance from Panchayat or block. The corresponding figures are 66 per cent and 63 per cent in focus and control GPs indicating marginally better level of awareness among the women in focus GPs compared to control GPs.

4.3 Antenatal Care

There is overwhelming evidence that antenatal care has reached most of the target beneficiaries. Around 97 per cent of the women clearly have said that their pregnancy is /was registered with ANMs. Those who reported registration of their pregnancy with ANM, almost 99 per cent said that they had received a card showing their registration. 96 per cent of the women reported antenatal check up (97 per cent in focus GPs and 95 per cent in control GPs).²

It is customary for many communities that the woman goes to her maternal home for childbirth. Our survey found that almost 88 per cent of the women stayed (or likely to stay, for the pregnant women) most of their pregnancy period in their own village. The survey reveals that a high proportion of women received the first antenatal care only when they were pregnant for 3-4 months (Table 4.3). Sub-centres were found to be the major source for antenatal check up by the women (see Appendix Table A2).

Table 4.3: Percentage distribution of women by months of pregnancy when they received the first antenatal care.

Months of pregnancy	Focus GP	Control GP	Total
within 2 months of pregnancy	24	28	26
3-4 months of pregnancy	55	42	51
more than 4 months of pregnancy	19	27	22
no care during pregnancy	1	3	2
Total	24	28	26

Source: Primary Survey

Depending upon the stage of pregnancy, a pregnant woman is supposed to undergo a set of medical examinations as a part of the antenatal care. For example, urine and blood samples are examined, blood pressure is measured, and abdomen is checked. Along with these tests, women are informed about the expected date of delivery, safe place for delivery, proper nutrition during pregnancy period and where to go in case of pregnancy complication. Women are also made aware of the following signs of pregnancy complications: vaginal bleeding, convulsions, and prolonged labour. To what extent the antenatal care received by the surveyed women (as remembered by the women themselves) covered the above-mentioned aspects of care is presented in Table 4.4 and Figures 4.1- 4.3.

² Out of 19 cases where women did not register their pregnancy with ANMs, we have information from 16 women about their reasons for not having antenatal check up. 3 women felt it was not necessary, 2 felt cost too much or the facility too far, 6 did not go anticipating poor quality of service, 2 did not find time to go and 2 did not go because of the lack of knowledge.

Table 4.4: Medical examination services and pregnancy related information provided to the pregnant women during antenatal care.

	Focus GP	Control GP	Total
Percentage of women weighed	94	94	94
Percentage of women whose blood pressure was measured	83	78	82
Percentage of women whose urine sample was taken	56	63	59
Percentage of women whose blood sample was taken	54	57	55
Percentage of women whose abdomen was checked	73	73	73
Percentage of women who were about told expected date of delivery	83	83	83
Percentage of women who were about safe place for delivery	87	91	88
Percentage of women who where told about proper nutrition during pregnancy	90	89	89
Percentage of women who were told where to go in case of pregnancy complication	81	81	81
<i>Percentage of women who were told about the following signs of pregnancy complication during antenatal care visits</i>			
Vaginal bleeding	49	43	47
Convulsions	57	42	51
Prolonged labour	51	42	48
<i>Percentage of women who received advice on the following during the antenatal visits keeping the baby warm</i>			
Breast feeding	72	70	71
Keeping the baby warm	74	71	73
Need for cleanliness at the time of delivery	78	74	77
Family planning or delaying your next child	73	71	72

Source: primary survey

Figure 4.1: Percentage of women underwent different examination during pregnancy

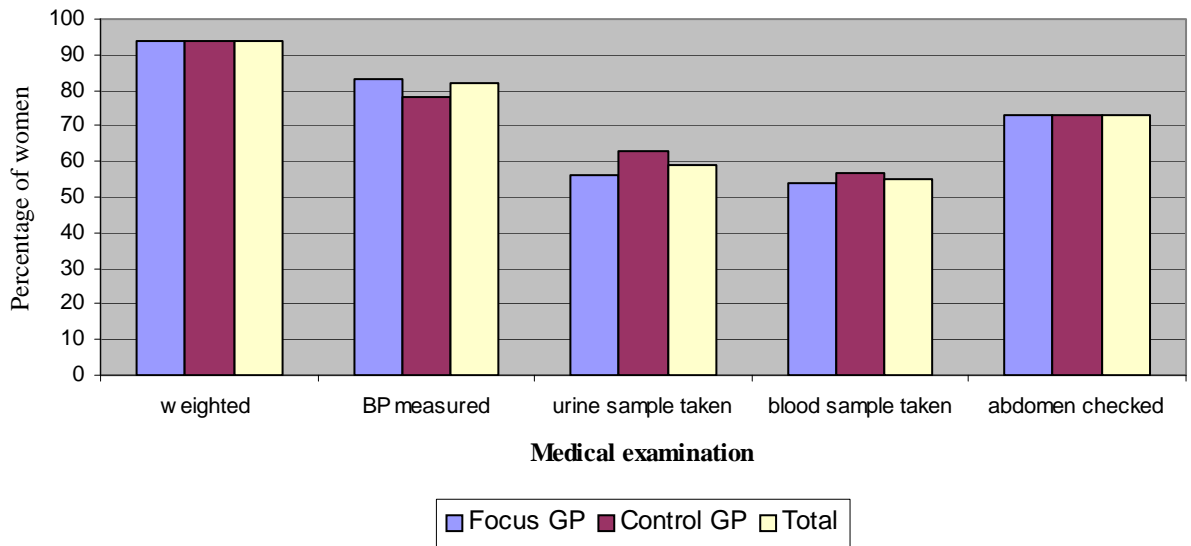


Figure 4.2: Percentage of women who were advised on the following complication during their pregnancy

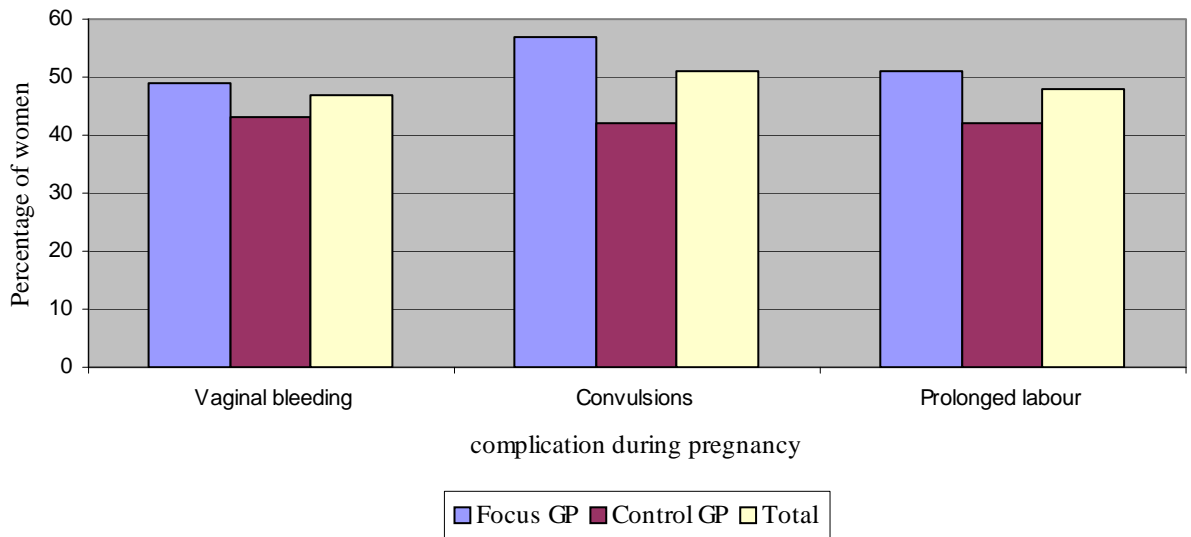
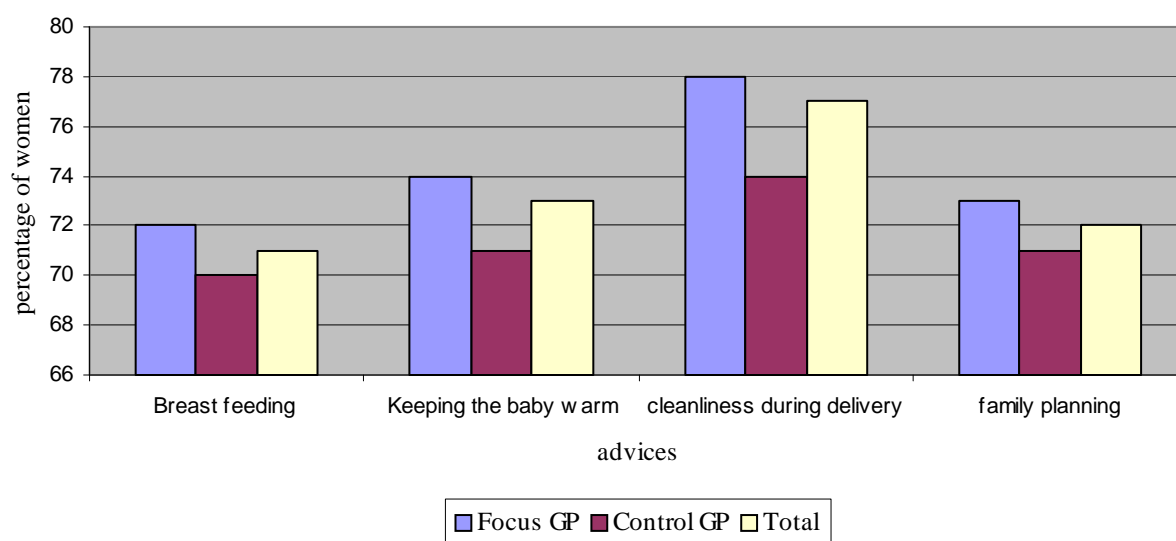


Figure 4.3: Percentage of women who received advices on delivery and post-delivery matters



4.4 Delivery, postnatal and child care

Our study finds lower incidence of home delivery among the surveyed mothers in six districts compared to other available secondary sources based on large-scale surveys, such as RCH – II (Compare Table 4.5 with Appendix Table A3). There could be two reasons for the difference in estimated numbers. It may be that the percentage of institutional deliveries has in fact increased between the time of RCH survey and our survey. But a more plausible explanation would be entirely methodological. Our sample is rather small, as it was not designed to estimate the district level percentages in a statistically robust way. As we mentioned in Chapter 2, the way we drew the sample of ten respondents from each GP with the help of ANM had scope for bias.

Table 4.5: Percentage distribution of birth by place of delivery

	Focus GP	Control GP	Total
Home	33	34	33
Sub-Centre	1	1	1
PHC/BPHC/Government hospital	60	61	60
Private doctor's clinic / nursing home	6	4	6

Source: Primary Survey

Table 4.6 gives the distribution of home deliveries according to the reasons for going for it. We have information from 86 women about their reasons for not going to institutional delivery. It is observed that the major reason for home delivery is high cost or poor accessibility, contrary to other factors. For example, ‘not enough time to go to hospital’ indicates that the facility is quite far from the village and/or there are not appropriate transport facilities. However, it is important to note that as high as 30 per cent of these women preferred home delivery for reasons which are not related to high cost, poor quality, poor accessibility or lack of transport facilities.

Table 4.6: Reasons for home delivery

Reasons for home delivery	Percent
Not necessary	15.12 (13)
Not customary	5.81 (5)
Cost too much and facility too far – no transport	36.01 (31)
Poor quality service	9.3 (8)
Not enough time to go to hospital	24.42 (21)
Family did not allow	2.33 (2)
Lack of knowledge	3.49 (3)
Others (e.g. afraid)	3.49 (3)
Total	100 (86)

Note: figures in the parentheses indicate number of cases
Source: Primary Survey

4.5 Perceived outcome in ANM’s view

How much improvement has CHCMI made in the area of safe motherhood according to the ANMs we surveyed? Table 4.7 presents their views on five aspects of safe motherhood, viz. reducing early marriage and repeated birth, improving pregnant women and lactating mothers’ nutritional status, increasing the percentage of infants born in institutions or attended by trained dais, referring complicated delivery cases to health centres or hospitals. It turns out that most of the ANMs believe that CHCMI has made moderate to high improvement in all the five areas. However, in reducing early marriage and repeated birth CHCMI has been less successful, according to them. About 40 percent said it has made very little or no improvement in this particular aspect, which seems reasonable since the problem of early marriage is due to a complex of factors in which awareness perhaps plays only a modest role.

Table 4.7: Impact of CHCMI according to ANM

	High improvement	Moderate improvement	Low improvement	No improvement	Cannot say
Reducing early marriage and repeated birth	5.6	54.2	26.4	11.1	2.8
Improving pregnant women's and lactating mothers' nutritional status	11.3	60.6	26.8	1.4	--
Bringing more and more women under antenatal and post natal care	56.9	38.9	4.2	--	--
Bringing more and more women under institutional delivery or delivery attended by trained dai	39.4	43.7	16.9	--	--
Referring complicated delivery cases to health centre or hospitals	50.0	35.7	11.4	1.4	1.4

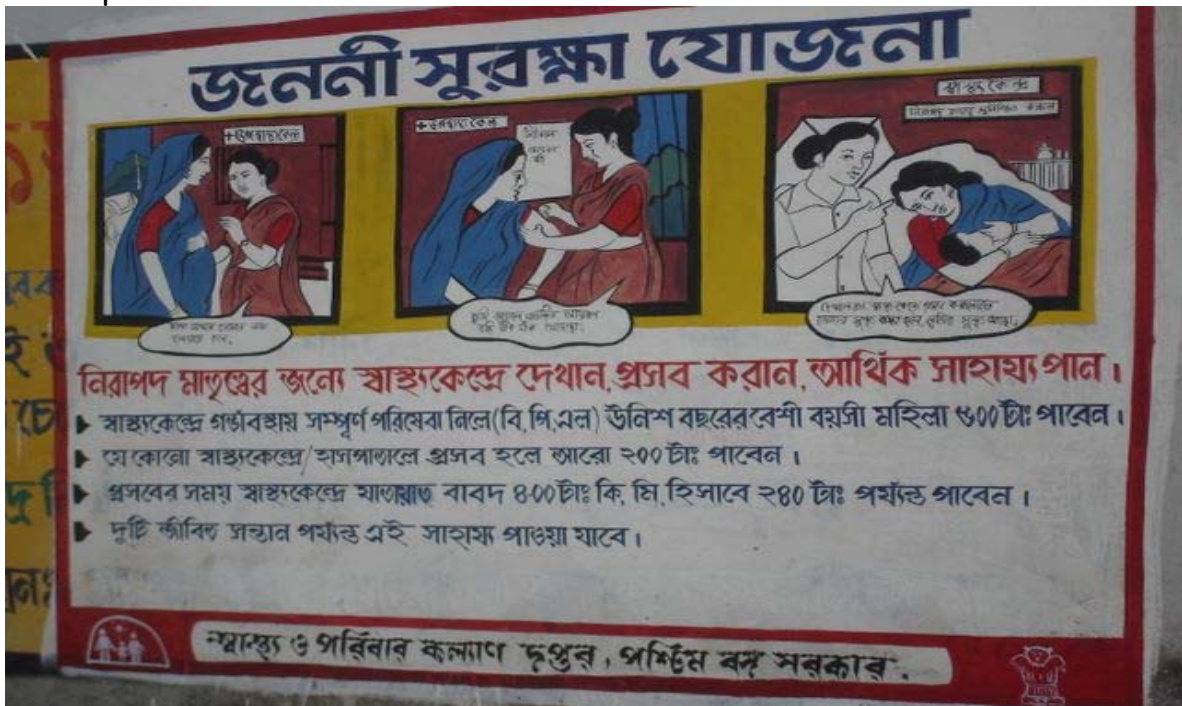
Source: Primary Survey

Picture 4.1: A poster for promoting Safe Motherhood.



Picture 4.2: Many feel that the *Gram Panchayats* should be given some power to relax the strict conditions that a beneficiary of *Janani Suraksha Yojana*

needs to satisfy, in order to bring more and more poor mothers under its purview.



Picture 4.3: Despite the aggressive awareness campaigning, many women do not know that it is possible to build toilet in their houses at very low cost with the assistance from Panchayat.



Picture 4.4: Posters on various components of safe motherhood displayed on the wall of Sub-centre at Pranjul (Dakshin Dinajpur).



Picture 4.5: There are plenty of awareness campaign materials on safe drinking water displayed on the walls of health centres and panchayat offices. Villagers do not seem to have taken much notice of them.



Chapter 5

Comprehensive Assessment and Suggestions for Improvement

Although the unavoidable methodological limitations of the study restrain us from making any firm conclusions, we noted in Chapter 3 that by and large the GPs that have made better progress in terms of certain parameters of success at implementation are also the ones which have achieved better outcome in terms of institutional birth. Of course there are cases contrary to this general pattern, and it would be more illuminating if we could further probe into those cases in greater detail. But given the time limit we could not pursue that line. Furthermore, there are other influences at work too. A parallel programme called Strengthening Rural Decentralisation (SRD) with seemingly similar goals is also running in a number of GPs. It is methodologically challenging to isolate the effects of various overlapping programmes. However, in what follows we shall supplement our quantitative analysis presented earlier with the qualitative information we gathered from the key persons at the district, block and GP levels (without mentioning their names).

In our assessment, the record of success of CHCMI has so far been somewhat mixed. It is no surprise that there are good GPs, not so good GPs and bad GPs. However, in no way should this raise any doubt about the strength of the core idea of the programme. Our study identifies a few key areas where some rethinking combined with a bit more effort at implementation can bring about better results.

The amount of work that has gone into planning and designing the initiative is quite remarkable. If one goes through the series of notifications containing detailed instructions on various components of CHCMI one can hardly doubt the internal consistency of the design of the initiative and the assumptions on which various components of the programme have been built.

As we noted at the outset, the key element in the conceptualisation of CHCMI is community involvement and community-based monitoring system, which is rather intangible as an outcome of an effort. Government actions favoured by the political class generally tend to be biased towards areas where the ratio of visibility to effort is high. On this count CHCMI scores low – the level of collective effort it requires is rather high while the outcome is far less visible than roads, flyovers or direct show of patronage by doling out freebies. The

protagonists of the initiative must therefore be ready to face all the challenges, many of which are the direct fallout of a kind of inertia on the part of the key agents of change.

The key agents of change are those who represent PRIs. But unfortunately many PRI functionaries are yet to take an active interest in the initiative. And this seems to be the main challenge that CHCMI is facing. At the core of the problem is of course the general lack of capacity to comprehend and implement various instructions flowing down from above, which has nothing specific to do with CHCMI. Apart from the general capacity building, which is perhaps beyond the scope of CHCMI, sensitisation workshops can be strengthened with experienced motivators. However, sensitisation alone cannot be effective unless they are combined with some incentives. There should be a combination of sensitisation drive and built-in incentives. While in the orientation programmes successful cases should be repeatedly mentioned to instil a sense of competition among the GP functionaries, one can think of putting down a small number of specific targets for GPs. The GP may be rewarded if certain targets are reached.

The problem of lack of coordination between the PRIs and the relevant line departments such as the Department of Health and Family Welfare and the Department of Social Welfare (which controls ICDS) repeatedly surfaced in the discussions. However, there is no general pattern. The nature and degree of participation and cooperation by different departmental functionaries at the local level varies from block to block, which defies any generalisation. We heard several PRI representatives complaining against the health department officials and doctors about lack of interest in the initiative. On the other hand, we also heard from several ANMs and health workers that Panchayat members show little interest in attending CHCMI meetings.

To institutionalise the initiative and establish it on a firm basis adequate financial provisioning is necessary. The overall financial allocation for the programme has so far been rather small, and much of the resources had to be managed from sources other than the standard earmarked government budgetary sources. Only in the current year's budget an amount has been earmarked for the specific purpose of CHCMI, but the amount is in no way close to the estimated need. This shows that one of the most important steps in the institutionalisation process is yet to be taken. Some of the stated goals of the Centrally sponsored National Rural Health Mission are quite in line with the objectives of CHCMI. While the NRHM has made

substantial financial allocation to achieve the stated objectives, CHCMI provides a kind of structural mechanism for working towards these objectives. The complementarities between the two are so obvious that it would be unfortunate if it remained unexploited for a lack of initiative at the upper echelons of the government to transcend the departmental boundaries.

Money is needed for employing additional manpower to build capacity at various levels. There is clear indication that the presence of a Programme Coordinator in a district makes significant difference, as is evident from the progress report of Murshidabad and Birbhum. Neither has a Programme Coordinator, and in terms of our process scores they lag behind others.

Money is also needed to sustain motivation of the SHGs as well. A large portion of this little amount that has been spent for organizing training programmes. The members of the select Self-Help Groups (SHG), who have an important role to play in the programme, are provided with only a token amount. Even that little amount has not been paid in many GPs for lack of funds. An honorarium is more a symbol of recognition than anything else. It is almost impossible for anyone to keep up motivation on a sustained basis if one's work is not recognised as valuable.

However, there is a flip side to this constant attention to the need for more financial resources, which we should not ignore. The PRIs at all levels are too ready to grab this opportunity to blame the lack of money for the lack of success in implementation. We should make it clear that much of the money is needed to sustain the capacity building effort, which cuts across the three tiers of PRIs. However, implementation of CHCMI at the GP level should not require a huge amount of money, and GPs do have the means in the form of untied funds to support the initiative. It seems that GPs are yet to be sensitised about the need for reprioritising their allocation decisions, giving more importance to such initiatives as CHCMI whose immediate outcome is not as tangible as a tube-well or a metalled road. Many of the PRI representatives, tend to think of themselves as dispensers of patronage. Since the whole idea of CHCMI is to break away from this mental model that the members of the political class share, it seems a long way to go. Yet, there are visible signs of change in quite a few GPs where CHCMI has been initiated with a good deal of seriousness. In most such cases, there are some identifiable catalytic factors, ranging from the leadership quality of individual PRI functionaries to existence of good NGOs as facilitating agents.

That the SHGs cannot be motivated to get involved without financial incentive is not entirely true, even though the GP functionaries often expressed such feeling. SHG members may be motivated by the recognition that they are doing valuable work for the community. But this feeling of pride and self-respect has to be nurtured by the GP leadership. Some GP members tend to think of the SHG members as inferior beings incapable of carrying out their assigned tasks. It seems that the effects of the cascade mode of training and sensitisation tend to wither away as they flow down the successive tiers. This does not mean that the cascade mode itself is flawed. This mode of training, we believe, can be effective if the goal of training is to impart well-defined technical knowledge. But in the case of CHCMI the training programmes must be aimed at arousing interest in the GP level functionaries about community orientation in matters of people's health. The district level and block level trainers have been entrusted with the job apparently because of their position in the hierarchy of district administration, not by virtue of their ability to motivate. The district coordinators or the persons in charge of organizing the training programmes seem to have realised this problem. They often deviate from the norm about who can be the district level trainers and invite people who are known for their abilities to motivate. A CMOH – II, for example, possessing good knowledge on safe motherhood but poor ability to communicate would be less useful than a well-respected local school teacher who knows how to motivate and sensitise. The district coordinators should be encouraged to reorganize the training programmes keeping this in mind. But there is a dilemma here. Involving CMOHs and DPOs of ICDS in the training programmes makes good strategic sense, for CHCMI cannot succeed without the involvement of these officials from different departments.

The data on population health collected and compiled at different levels are yet to attain the desired standard of quality. The District Coordinators and Nodal Medical Officers expressed their frustration with data. As we discussed in detail in Chapter 3, the data reported by GPs and sent to Blocks every month and the compiled data sent from Blocks to the District are full of discrepancies, and therefore almost useless. With a little more effort in monitoring at different levels it is possible to improve the quality of data. More importantly, the GPs are yet to be sensitised about the difference between the nature of data that the health department people would provide and the kind of data they need for planning action. The crucial difference is between 'client oriented' and 'population oriented' data. It is not enough for people's representatives to keep information only on people who have accessed government

service providers, it is equally, or even more, important to keep information about the excluded.

In one district, the Zilla Parishad on its own initiative conducted a small survey of children and found that the data on undernourished routinely reported by ICDS centres frequently suffer from gross underestimation. The ZP then introduced a nutrition supplement programme and in six months' time obtained impressive results. This type of questioning of the data received from ICDS and Health Department sources and reworking on them for effective intervention is rarely found among PRIs in other districts.

All these problems seem interconnected. If the PRIs take active interest in the initiative, different elements of the programme – from awareness generation to information dissemination, from infrastructure to ensure safe motherhood to routine collection and compilation of data for better planning – all of them should follow. One of the positive effects of the initiative is that most PRI representatives now appreciate the idea that people's health is not exclusively the responsibility of the health department.

Appendix

Table A1: Ranking of *Gram Panchayats* based on 8 indicators

<i>GP</i>	<i>district</i>	<i>Sadar SC</i>	<i>Awareness</i>	<i>dai list</i>	<i>untrained dai</i>	<i>objectives of CHCMI</i>	<i>baseline Survey</i>	<i>Coop from ANM</i>	<i>Info on inst. Birth</i>	<i>total scores</i>	<i>Focus / control</i>
Abinashpur	Birbhum	2	2	1	0	2	2	2	1	12	focus
Shibpur	D. Dinajpur	2	2	1	0	2	2	2	1	12	focus
Ghurisha	Birbhum	2	1	1	1	2	2	2	1	12	control
Brajaballavpur	D. Dinajpur	1	2	0	1	2	2	2	1	11	focus
Sanka	Purulia	1	1	1	1	2	2	2	1	11	focus
Santuri	Purulia	1	1	1	1	2	1	2	1	10	control
Bulbulchandi	Malda	2	1	1	1	2	0	2	1	10	focus
Kuswadi	Bankura	2	1	1	0	1	2	2	1	10	control
Binshira	D. Dinajpur	1	1	0	1	2	2	2	1	10	focus
Bhabuk	Malda	2	1	1	1	1	2	0	1	9	focus
Safanagar	D. Dinajpur	1	1	0	1	1	2	2	1	9	focus
Gajole-I	Malda	2	2	1	0	2	1	0	1	9	control
Natundih	Purulia	1	1	1	0	1	2	2	1	9	focus
Bhour	D. Dinajpur	2	1	0	1	1	2	1	1	9	focus
Achuri	Bankura	1	1	0	1	1	2	2	1	9	focus
Babugram	Purulia	0	2	1	0	1	2	2	1	9	focus
Jamkuri	Bankura	2	1	1	1	0	2	2	0	9	focus
Khajura	Purulia	0	2	1	0	1	1	2	1	8	control
Muchia	Malda	2	1	1	1	0	1	1	1	8	control
Balitora	Purulia	0	1	1	0	2	1	2	1	8	focus
Kantukra	Malda	0	2	0	1	1	2	1	1	8	focus
Damdama	Birbhum	0	1	1	0	2	2	1	1	8	focus
Gajole-II	Malda	2	1	0	1	1	2	0	1	8	control
Muradi	Purulia	0	1	1	0	1	2	2	1	8	focus
Natungram	Murshidabad	1	0	1	0	1	2	2	1	8	control
Niallishpara-Goaljan	Murshidabad	0	1	1	0	1	2	2	1	8	focus
Rowtora	Bankura	2	1	0	0	1	2	2	0	8	focus

Table continues ...

<i>GP</i>	<i>district</i>	<i>Sadar SC</i>	<i>Awareness</i>	<i>dai list</i>	<i>untrained dai</i>	<i>objectives of CHCMI</i>	<i>baseline Survey</i>	<i>Coop from ANM</i>	<i>Info on inst. Birth</i>	<i>total scores</i>	<i>Focus / control</i>
Boro	Purulia	0	2	1	0	1	1	2	1	8	control
Kusumba	Birbhum	2	1	0	0	1	2	0	1	7	focus
Kenjakura	Bankura	1	0	0	1	1	2	2	0	7	focus
Bairagachi-II	Malda	0	1	1	1	1	2	0	1	7	focus
Bahadurpur	Murshidabad	1	1	0	0	1	2	2	0	7	focus
Jaideb-Kenduli	Birbhum	0	0	1	1	2	2	0	1	7	focus
Ramchandrapur-Kotaldih	Purulia	0	1	1	0	2	0	2	1	7	focus
Ramkrishnapur	D. Dinajpur	0	1	0	1	1	1	2	1	7	control
Ellahabad	D. Dinajpur	1	0	0	1	2	1	0	1	6	control
Rudra	Bankura	2	1	0	0	1	0	2	0	6	control
Habibpur	Malda	2	2	1	0	0	0	0	1	6	focus
Prashadpur	Murshidabad	1	1	0	0	0	2	2	0	6	focus
Narayanpur	Bankura	2	1	0	1	0	0	2	0	6	focus
Radharghat	Murshidabad	2	0	0	0	0	2	2	0	6	control
Satui-Chwrigacha	Murshidabad	0	0	0	0	0	2	2	1	5	focus
Panjul	D. Dinajpur	0	1	0	1	0	1	2	0	5	control
Jagadalla-I	Bankura	0	1	0	1	1	0	2	0	5	control
Mahishbathani	Malda	2	1	0	1	0	0	0	1	5	focus
Amritkhand	D. Dinajpur	0	2	0	0	1	2	0	0	5	focus
Kendua	Birbhum	0	1	0	0	1	2	0	1	5	focus
Puddi	Bankura	0	0	0	0	1	2	2	0	5	focus
Dahapara	Murshidabad	0	0	0	0	0	2	2	1	5	focus
Bhabta	Murshidabad	1	1	0	0	0	0	2	0	4	control
Mahula-I	Murshidabad	0	1	0	0	0	2	1	0	4	focus
Kharun	Birbhum	0	0	0	1	0	0	2	1	4	focus
Bonshanka	Birbhum	1	0	0	1	0	0	0	1	3	control
Illambazar	Birbhum	0	0	0	0	0	0	0	1	1	control

Source: Primary Survey

Table A 2: Utilisation of antenatal care by sources of care

Sources of antenatal care	Per cent
At home	3.2 (17)
Government hospital/BPHC/PHC	16.7 (88)
Sub-Centre	41.1 (216)
ICDS centre	3.4 (18)
Nursing home/private doctor /private clinic	7.4 (39)
Government hospital/BPHC/PHC and Sub-Centre	11.4 (60)
Government hospital/BPHC/PHC and + Nursing home/private doctor /private clinic	2.1 (11)
Sub-Centre and Nursing home/private doctor /private clinic	13.9 (73)
Others	0.8 (4)
Total	100.0

Note: figures in the parentheses indicate number of cases

Source: Own primary survey

Table A3: Two indicators of safe motherhood for six districts from Reproductive & Child Health (RCH – II) Survey

District	Percentage delivered at home	Percentage of women married at less than 18
Bankura	36.9	54.0
Birbhum	51.9	59.8
Dakshin Dinajpur	55.1	57.6
Maldah	72.6	65.9
Murshidabad	64.4	54.8
Purulia	51.1	51.2

Source: RCH - II

Survey Questionnaires

1. Questionnaire for the *Gram Panchayats* and *Panchayat* members
2. Questionnaire for ANMs
3. Questionnaire for the trained *dai* or traditional birth attendant
4. Questionnaire for the ICDS supervisors
5. Questionnaire for the beneficiaries

**Community Health Care Management Initiative undertaken by Panchayati Raj Institutions with Thrust on Advocacy on Safe Motherhood****An Evaluation Study undertaken by
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for the purpose of
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Respondent: A competent Panchayat officer (Sachib)**

0	Serial number of the questionnaire	
1	Name of the district (use code)	
2	Name of the block (use code)	
3	Name of the Gram Panchayat ¹ (use code)	
4	Population size ²	
5	SC population	
6	ST population	
7	Hindu Population	
8	Muslim population	
9	Other population	
10	Literacy rate	
11	Number of Anganwadi centres	
12	Nearest BPHC/Hospital (note the distance in km)	
13	No of sub-centres	
14	When was CHCMI initiated? (mm/yy)	
15	When did the UNICEF-PRD initiated safe motherhood programme start? (mm/yy)	
16	Has the Sadar Sub-Centre been set up? (yes – 1; no but process of setting up started – 2, no – 3)	
16_1	Does it have two rooms (yes – 1; no – 2)	
16_2	Does it have large table? (yes – 1; no – 2)	
16_3	Does it have separate toilet (yes – 1; no – 2)	
16_4	Does it have water facility? (yes – 1; no – 2)	
16_5	Does it have electricity? (yes – 1; no – 2)	
16_6	Does it have a male health worker? (yes – 1; no – 2)	
16_7	Does it have one female worker? (yes – 1; no – 2)	
17	Are the awareness related posters displayed at GP (Adequate – 1; few – 2; none – 3)	
18	Are the awareness related posters displayed at Sadar Sub-Centre? (Adequate – 1; few – 2; none – 3)	
19	Did the Last Saturday meeting take place in	
19_1	January (yes – 1; no – 2)	

19_2	February (<i>yes – 1; no – 2</i>)	
19_3	March (<i>yes – 1; no – 2</i>)	
20	What issues did you discuss in the last meeting? <i>First note down his/her answer, then request for a copy of the minutes</i>	
21	Participants in the meetings <i>Note down from the minutes</i>	
21_1		
21_2		
21_3		
21_4		
21_5		
21_6		
21_7		
21_8		
21_9		
21_10		
22	Total number of birth in last one year (April 06 – March 07)	
23	Number of institutional birth I last one year (April 06 – March 07)	
24	Number of birth attended by trained DAI in last one year (April 06 – March 07)	
25	Number of births neither in institutions nor attended by trained DAI in last one year (April 06 – March 07)	
26	Do you keep a list of trained DAI in your GP? (<i>yes – 1; no – 2</i>)	
27	If yes, how many trained DAI are there in the GP?	
28	Do you have untrained DAI in your GP? (<i>yes – 1; no – 2</i>)	
29	If yes, how many untrained DAI are there in your GP?	
30	Total money (in rupees) spent by the Panchayat during last one year on Safe Motherhood related issues (April 06 – March 07)	
31	Money (in rupees) spent on activities related to public health during last one year (April 2006 – March 2007)	
32	What percentage of money available from untied and Finance Commission funds was spent on public health during last financial year (April 06 – March 07)?	
33	Does this GP spend money to provide additional food supplies for the malnourished children in the Panchayat area to reduce malnutrition? (<i>yes – 1; no – 2</i>)	

Important Notes

1. Also note down the names of all the villages within the GP.
2. Questions 4-11 can be obtained from a kind of data-sheet that many GPs maintain. Request a copy of that.
3. Fill in ‘Public Health Related Information of the Gram Panchayat’ schedule.



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Questionnaire for Panchayat Member who is also a member of Swasthya Sthae Samiti

**we have to make sure that the member took part in the orientation programme*

***Ask him/her separately – not in presence of Sachib.*

0	Serial number of the questionnaire	
1	Name of the district (use code)	
2	Name of the block (use code)	
3	Name of the Gram Panchayat ¹ (use code)	
4	Name of the Panchayat Member	
5	Sex (<i>male – 1; Female – 2</i>)	
6	Age (years)	
7	Education (in years)	
8	Occupation	
9	Do you know the main objectives of CHCMI? (<i>Yes – 1; No – 2</i>)	
10	What are the objectives of CHCMI? (<i>Mention 2 objectives which you think important</i>)	
10_1		
10_2		
11	Did you attend any orientation programme organised by the management units of CHCMI at the district or block level? (<i>Yes – 1; no – 2</i>)	
12	Did the training programme cover the following areas?	
12_1	How to reduce early marriage and repeated birth (<i>Yes – 1; No – 2; Don't remember - 3</i>)	
12_2	How to improve woman's poor nutritional status (<i>Yes – 1; No – 2; Don't remember - 3</i>)	
12_3	How to bring more and more women (pregnant) under antenatal care (<i>Yes – 1; No – 2; Don't remember - 3</i>)	
12_4	How to bring more and more women (pregnant) under skilled birth attendant? (<i>Yes – 1; No – 2; Don't remember - 3</i>)	
12_5	How to reduce delays in getting help if things go wrong during delivery? (<i>Yes – 1; No – 2; Don't remember - 3</i>)	

13	Was there any Gram Sansad meeting held after the initiation of CHCMI to prepare Action Plan? (<i>yes - 1; no - 2; don't know - 3</i>)	
14	Who all helped to prepare the Action Plan? (<i>Note in your diary the process of Plan preparation</i>)	
14_1		
14_2		
14_3		
14_4		
14_5		
15	What mother and child health related awareness programmes were organised in your GP in the past 6 months? (<i>needs to be specific</i>)	
15_1		
15_2		
15_3		
16	Have you ever conducted or participated in an awareness generation programme in your GP on birth preparedness and safe delivery? (<i>yes - 1; no - 2</i>)	
17	What specific steps have been taken to build capacity to monitor public health?	
17_1		
17_2		
17_3		
18	Was a baseline survey conducted in your GP (the ones SHGs are supposed to do)? (<i>yes - 1; no - 2; don't know - 3</i>) Make sure that they understand correctly what we mean by baseline survey; ask for a copy of the survey report	
19	What are the main highlights (3 important findings) of that survey?	
19_1		
19_2		
19_3		
20	What steps have your Panchayat taken to monitor the system of public health on a regular basis?	
20_1		
20_2		
20_3		
21	What aspects of public health are monitored?	
21_1		
21_2		
21_3		
21_4		
21_5		
22	What, according to you, is the most important public health issue in your GP?	
23	Do you think that CHCMI has made any improvement in the health scenario of the Gram Panchayat? (<i>substantial improvement - 1; moderate improvement - 2; little improvement - 3; no improvement - 4; cannot say - 5</i>)	
24	If it has made improvement, tell us three important areas in which it has made improvement.	

24_1		
24_2		
24_3		
25	If it has made little or no improvement, why?	
26	Have you found any coordination problem with different line departments in implementing the CHCMI? (yes – 1; no – 2)	
27	What types of problems?	
28	Do you feel that CHCMI is an additional burden on the GP, given that more important problems need immediate attention? (yes – 1; no – 2; don't know – 3)	
29	If yes, tell us three important problems which need immediate attention.	
29_1		
29_2		
29_3		
30	In your opinion, CHCMI can be effective in solving most public health problems/cannot be unless and until	
31	According to you, what should be three important steps to improve safe motherhood?	
31_1		
31_2		
31_3		
32	Investigator's signature	
33	Date (dd/mm)	



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Questionnaire for ANM

0	Serial number of the questionnaire	
1	Name of the district (use code)	
2	Name of the block (use code)	
3	Name of the Gram Panchayat (use code)	
4	Name of the ANM	
5	Age (years)	
6	How many years she has been working as ANM?	
7	Did you attend the last Saturday meeting held in	
7_1	January (<i>Yes – 1; No - 2</i>)	
7_2	February (<i>Yes – 1; No - 2</i>)	
7_3	March (<i>Yes – 1; No - 2</i>)	
8	Do you get enough chance to say what you want to say in the Saturday meeting? (<i>Yes, always – 1; most of the time – 2; sometimes – 3; very few times – 4; not at all - 5</i>)	
9	Were the following issues discussed in the last Saturday meeting	
9_1	Improve safe delivery (yes -1; no – 2; don't remember – 3)	
9_2	Improving child death (yes -1; no – 2; don't remember – 3)	
9_3	Reducing under-age marriage (yes – 1; no – 2; don't remember – 3)	
9_4	Improving immunisation coverage of children (yes – 1; no – 2; don't remember – 3)	
9_5	Reducing child malnutrition (yes – 1; no – 2; don't remember – 3)	
9_6	Family planning (yes – 1; no – 2; don't remember – 3)	
9_7	Improving the situation of drinking water (yes – 1; no – 2; don't remember – 3)	
9_8	Improving the sanitation and toilet (yes – 1; no – 2; don't remember – 3)	
9_9	Improving health infrastructure (yes – 1; no – 2; don't remember – 3)	
10	Did you participate in any orientation programme (to promote safe delivery) in last two years in which officials from block or district participated? (<i>yes – 1; no – 2; don't know – 3</i>)	
11	If yes, how many months ago (rough figure)?	

12	Were the following things were covered in that orientation programme?	
12_1	How to reduce early marriage and repeated birth (Yes – 1; No – 2; Don't remember - 3)	
12_2	How to improve woman's poor nutritional status (Yes – 1; No – 2; Don't remember - 3)	
12_3	How to bring more and more women (pregnant) under antenatal care (Yes – 1; No – 2; Don't remember - 3)	
12_4	How to bring more and more women (pregnant) under skilled birth attendant? (Yes – 1; No – 2; Don't remember - 3)	
12_5	How to reduce delays in getting help if things go wrong during delivery? (Yes – 1; No – 2; Don't remember - 3)	
13	Do all pregnant women possess card in the area you cover? (Yes – 1; No – 2; Don't know - 3)	
14	If no, can you tell us roughly what percentage do not have card?	
15	Do all mothers (with less than one year old child) possess card in the area you cover? (yes – 1; no – 2; don't know – 3)	
16	If no, can you tell us roughly what percentage do not have card?	
17	Do you think that CHCMI has brought perceptible improvement in the following areas:	
17_1	Reducing early marriage and repeated birth (high improvement – 1; moderate improvement – 2; low improvement – 3; no improvement – 4; cannot say – 5)	
17_2	Improving pregnant women and lactating mothers' nutritional status? (high improvement – 1; moderate improvement – 2; low improvement – 3; no improvement – 4; cannot say – 5)	
17_3	Bringing more and more women under antenatal and post natal care (high improvement – 1; moderate improvement – 2; low improvement – 3; no improvement – 4; cannot say – 5)	
17_4	Bringing more and more women under institutional delivery or delivery attended by trained DAI? (high improvement – 1; moderate improvement – 2; low improvement – 3; no improvement – 4; cannot say – 5)	
17_5	Referring complicated delivery cases to health centre or hospitals? (high improvement – 1; moderate improvement – 2; low improvement – 3; no improvement – 4; cannot say – 5)	
18	Do you think that your work burden has increased significantly due to the introduction of CHCMI? (significant increase in work burden – 1; moderate increase in work burden – 2; low increase in work burden – 3; no increase in work burden – 4; cannot say – 5)	
19	Do you get enough cooperation from Panchayat in discharging your duties? (Yes, always – 1; most of the time – 2; sometimes – 3; very few times – 4; not at all - 5)	
20	Investigator's signature	
21	Date (dd/mm)	



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Questionnaire for dai /Traditional Birth Attendant

0	Serial number of the questionnaire	
1	Name of the district (use code)	
2	Name of the block (use code)	
3	Name of the Gram Panchayat (use code)	
4	Name of the DAI/TBA	
5	Age (years)	
6	How many years she has been working as a DAI/TBA?	
7	Did you attend the last Saturday meeting held in	
7_1	January (Yes – 1; No - 2)	
7_2	February (Yes – 1; No - 2)	
7_3	March (Yes – 1; No - 2)	
8	Do you get enough chance to say what you want to say in the Saturday meeting? (Yes, always – 1; most of the time – 2; sometimes – 3; very few times – 4; not at all - 5)	
9	Did you participate in any orientation programme/training programme (to promote safe delivery) in last two years in which officials/doctors/health staff from block or district gave training? (yes – 1; no – 2; don't remember – 3)	
10	If yes, how many months ago (rough figure)?	
11	From this training programme did you learn anything new to improve safe delivery? (yes – 1; no – 2; don't remember – 3)	
12	Do you get any help from Panchayat or Health department in terms of money and equipment? (Yes, always – 1; sometimes – 2; rarely 3; no help at all – 4)	
13	How many birth you have attended in last one year?	
14	Did you find any of these cases complicated and referred to nearest health centre or hospital? (yes – 1; no – 2)	
15	If yes, how many?	
16	Do you earn enough money from DAI's work? (yes – 1; no – 2, don't know - 3)	
17	Do you think that demand for DAI is coming down in your area? (yes – 1; no – 2; don't know - 3)	
18	If you have a daughter, will you prefer your daughter to do DAI's work? (yes – 1; no – 2)	
19	Investigator's signature	
20	Date (dd/mm)	



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Questionnaire for ICDS Supervisor

1	Serial number of the questionnaire		
2	Name of the district (use code)		
3	Name of the block (use code)		
4	Name of the <i>Gram Panchayat</i> (use code)		
5	How many <i>Anganwadi</i> centres are under your supervision?		
6	Name three major problems facing the centres in your area.		
6_1	Problem 1		
6_2	Problem 2		
6_3	Problem 3		
7	Have you ever discussed any of these problems with Pradhan / member / panchayat officials? (yes – 1; No – 2)		
8	If yes, with whom? (<i>Mention three designations</i>)		
8_1	1		
8_2	2		
8_3	3		
9	Do you think it makes sense to discuss problems of ICDS with Pradhan/members/panchayat officials? (Yes – 1; no – 2; don't know/depends/ don't want to reveal – 3)		
10	Do you think that <i>Gram Panchayats</i> have a role to play in child nutrition? (yes – 1; no – 2; don't know – 3)		
11	If yes, specify what they can do to improve child nutrition.		
12	How much interest does the <i>Gram Panchayat</i> show in the functioning of ICDS? (Very much - 1; not so much – 2; not at all – 3; can't say – 4)		
13	In the past one month, did you attend any meeting called by the <i>Gram Panchayat</i> ? [Please note if he mentions <i>Last Saturday</i> meeting] (Yes – 1; no – 2, don't know – 3)		
14	If yes, what were they on? (<i>mention three important points which were discussed in the meeting</i>)		

14_1	1	
14_2	2	
14_3	3	
15	In the past one month did you attend any meeting called by the <i>Panchayat Samity/Block</i> ? (<i>yes – 1; no – 2; don't remember – 3</i>)	
16	If yes, what were they on? (<i>mention three important points which were discussed in the meeting</i>)	
16_1	1	
16_2	2	
16_3	3	
17	In the past one month, did you attend any meeting called by the Zilla Parishad? (<i>yes – 1; no – 2; don't remember – 3</i>)	
18	If yes, what are they on? (<i>mention three important points which were discussed in the meeting</i>)	
18_1	1	
18_2	2	
18_3	3	
19	Do you think <i>Panchayat</i> members keep themselves informed about the functioning of <i>Anganwadi</i> centres? (<i>Very much – 1; /not so much – 2; not at all – 3; can't say – 3</i>)	
20	Do <i>Anganwadi</i> workers regularly pass on the information on nutritional status to <i>Gram Panchayat(s)</i> ? (<i>yes regularly – 1; not regularly – 2; never – 3; don't know/ can't say – 4</i>)	
21	Is there any official instruction that they should do so? (<i>yes – 1; no – 2; don't know – 3</i>)	
22	Have you heard about a programme called Community Health Care Management Initiative (<i>JONO UDDYOGE JONO SWASTHYER PROYASH</i>)? (<i>yes – 1; no – 2</i>)	
23	If yes, what is it all about?	
24	If yes, what role does ICDS play in that?	
25	Do you think that ICDS workers and supervisors are so burdened with their own work that attending meetings called by <i>Gram Panchayats</i> would adversely affect their work? (<i>Yes – 1; no – 2; cannot comment – 3</i>)	
Signature of investigators		
1		
2		
Date of the interview (dd/mm)		



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Questionnaire for Beneficiaries (current and potential mothers)

* Select those women who have child of less than 1 year old or those women who are currently pregnant.

** Choose those pregnant women who are pregnant for six months or more)

A. Identification information

A0	Serial number of the questionnaire	
A1	Name of the district (use code)	
A2	Name of the block (use code)	
A3	Name of the Gram Panchayat (use code)	
A4	Name of the village	
A5	Approximate distance (in KM) of the village from the <i>Gram Panchayat</i> office (ask GP official)	
A6	Is the GP covered under P&RD-UNICEF intervention? (yes – 1; no - 2) copy from GP level questionnaire	
A7	Is the GP covered under any other intervention programme? (yes – 1; no - 2) copy from GP level questionnaire	

B. General information about the respondent

B1	Name of the respondent	
B2	Age (years)	
B3	Caste (<i>general – 1; OBC – 2; Scheduled Caste – 3; Scheduled Tribe – 4</i>)	
B4	Religion (<i>Hindu – 1; Muslim – 2; others – 3</i>)	
B5	Household occupational category (depending upon the main source of income for the family) (<i>self employed in agriculture – 1; agricultural labour – 2; self employed in non-agriculture; other labour – 4; others – 5</i>)	
B6	Specify	
B7	Education: can you read and write? (yes – 1; no – 2)	
B8	In case she can read and write, ask how many years of schooling she has completed?	
B9	Age at marriage (years)	

B10	Beneficiary status of the women (<i>mother with less than one year old child – 1; currently pregnant – 2</i>)	
B11	No of children	
B12	Age of the youngest child (in months)	
B13	<u>Pregnant women</u> : how many months pregnant are you?	

C. Some awareness related questions

C1	According to you, what should be the minimum age for getting married? (<i>record the minimum age as responded; do not record range; write 99 in case she is not able to tell</i>)	
C2	According to you, maximum how many children a woman should give birth to? (<i>record 99 in case she is not able to give any answer</i>)	
C3	According to you, what should be the minimum gap between two births? (<i>record 99 in case she is not able to give any answer</i>)	
C4	What is the source of your drinking water? (<i>tube well/hand pump – 1; tap – 2; pucca well – 3; kutcha well /tank / pond / canal / river – 4; others – 5</i>)	
C5	Do you purify water before drinking? (<i>yes – 1; no – 2</i>)	
C6	How do you purify water? (<i>Boiling – 1; filter including charcoal or clean cloth – 2; others – 3</i>)	
C7	Do you have toilet facility in your house? (<i>yes – 1; no – 2</i>)	
C8	If yes, what types of toilet facility do you have? (<i>septic tank/flush system – 1; others – 2</i>)	
C9	Do you know that it is possible to build safe toilet at cheaper cost with financial assistance from <i>Panchayat</i> or block? (<i>yes – 1; no – 2</i>)	
C10	Did anybody from Panchayat or Sub-centre visit you and advise you how to prepare for safe delivery? (<i>yes – 1; no – 2; don't remember – 3</i>)	
C11	Are you aware of any orientation programme on birth preparedness to increase awareness on safe motherhood and safe delivery? (<i>Yes – 1; no – 2</i>)	
C12	Are you aware of any government programme or schemes which are meant for the benefit of women and children including adolescent girls? (<i>Yes – 1; no – 2</i>)	

D Antenatal Care

D1	<u>Mother</u> : did you stay most of the time of your pregnancy in this village? <u>Pregnant women</u> : are you staying most of the time during your pregnancy in this village? (<i>yes – 1; no – 2; don't know – 3</i>) Note: (1) Women generally go to their parental house in the pregnancy period and stay till the delivery or till the child becomes few weeks/months old. (2) don't know can be an option for currently pregnant women.	
D2	If no,	

	<p><u>Mother</u>: where did you stay most of your pregnancy period? <u>Pregnant women</u>: where are you going to stay most of your pregnancy period? (Parental home – 1; other place – 2)</p>	
D3	Name of the village where parental home or other place is located	
D4	Name of the district	
D5	Name of the Block	
D6	Name of the Gram Panchyat	
D7	<p>Is this Gram Panchayat covered by P&RD – UNICEF initiative? (yes – 1; no – 2) Note: Investigator will have to find this from the list of Gram Panchayat actively covered under P&RD – UNICEF intervention.</p>	
D8	<p>Was/is your pregnancy registered with ANM? (yes – 1; no – 2; don't know – 3)</p>	
D9	<p>Did you get a card from the ANM showing your registration? (yes – 1; no – 2, don't know/don't remember – 3)</p>	
D10	<p>Did you see anyone for <i>antenatal</i> check up (medical check up by a health staff or doctor during pregnancy before delivery)? (yes – 1, no – 2, don't know / don't remember – 3)</p>	
D11	<p>If yes, whom did you see? (doctor – 1; ANM/Nurse/Midwife/LHV – 2; other health personnel – 3; DAI/TBA – 4; Aganwadi worker – 5; Others – 6)</p>	
D12	In case of 'others', specify.	
D13	<p>If no, why? (not necessary – 1; not customary – 2; cost too much – 3; too far – no transport – 3; poor quality service – 4; no time to go – 5; family did not allow – 6; lack of knowledge – 7, others – 8)</p>	
D14	If others, specify.	
D15	<p>Where did/do you get antenatal care for this pregnancy? (at home – 1; government hospital/BPHC/PHC – 2; sub- centre / government dispensary – 3; ICDS centre – 4; Nursing home / Private doctor/private clinic – 5; NGO/Trust – 6; others – 7)</p>	
D16	If 'others', specify?	
D17	How many months pregnant were you when you received the first antenatal care?	
D18	<p><u>Mother</u>: how many times did you receive antenatal care during your pregnancy? <u>Pregnant women</u>: how many antenatal check ups have you received so far?</p>	
D19	As a part of the antenatal care during the pregnancy, were the following done at least once?	
D20	<p>Were you weighted? (yes – 1; no – 2; don't know/don't remember – 3)</p>	
D21	<p>Was your blood pressure measured? (yes – 1; no – 2; don't know / don't remember – 3)</p>	
D22	<p>Did you give urine sample? (yes – 1, no – 2; don't know/don't remember - 3)</p>	
D23	Did you give blood sample?	

	<i>(yes – 1; no – 2; don't know / don't remember – 3)</i>	
D24	Was your abdomen checked? <i>(yes – 1; no – 2; don't know / don't remember – 3)</i>	
D25	<u>Mother:</u> Were you told your expected delivery date? <u>Pregnant women:</u> Are you told your expected delivery date? <i>(yes – 1; no – 2; don't know / don't remember – 3)</i>	
D26	<u>Mother:</u> Were you advised to deliver in a hospital or a health facility? <u>Pregnant women:</u> Are you advised to deliver in a hospital or a health facility? <i>(yes – 1; no – 2; don't know / don't remember – 3)</i>	
D27	<u>Mother:</u> Were you advised about proper nutrition during pregnancy? <u>Pregnant women:</u> Are you advised about proper nutrition during pregnancy? <i>(yes – 1; no – 2; don't know / don't remember – 3)</i>	
D28	During (any of) your antenatal care visit(s), were you told about the following signs of pregnancy complications?	
D28_1	Vaginal bleeding <i>(yes – 1; no – 2; don't remember – 3)</i>	
D28_2	Convulsions <i>(yes – 1; no – 2; don't remember – 3)</i>	
D28_3	Prolonged labour <i>(yes – 1; no – 2; don't remember – 3)</i>	
D29	<u>Mother:</u> Were you told where to go if you had a pregnancy complication ? <u>Pregnant women:</u> Are you told where to go if you have a pregnancy complication? <i>(Yes – 1; no – 2; don't remember – 3)</i>	
D30	Name of the place <i>(government hospital/BPHC/PHC – 1; sub- centre / government dispensary –23; ICDS centre – 3; Nursing home / Private doctor/private clinic – 4; NGO/Trust – 5; others – 6)</i>	
D31	If 'others, specify the name of the place.	
D32	During the pregnancy, were you given an injection to protect you and your baby from tetanus? <i>(Yes – 1; no – 2; don't know/don't remember – 3)</i>	
D33	During the pregnancy were you given or did you buy iron folic tablet or syrup? <i>(Yes – 1; no – 2; don't know/don't remember – 3)</i>	
D34	During your pregnancy did you take any drug to get rid of worm in your intestine? <i>(Yes – 1; no – 2; don't know/don't remember – 3)</i>	
D35	During your pregnancy did you receive any supplementary nutrition from the Anganwadi Centre? <i>Yes – 1; no – 2; don't remember - 3</i>	
D36	<u>Mother:</u> During the last three months of your pregnancy did you meet any ANM / Lady Health Visitor / Anganwadi worker / other community health worker / DAI and discussed about your pregnancy and delivery? <u>Pregnant mother:</u> Since you became pregnant, have you met any ANM/Lady Health Visitor / Anganwadi worker /other community health worker /DAI and discussed about your pregnancy and delivery?	

	<i>(Yes – 1; no – 2; don't remember – 3)</i>	
D37	If yes, whom did you meet? <i>(ANM – 1; Lady Health Visitor – 2; Other community health worker – 3; Aganwadi or ICDS worker – 4; DAI – 5; others – 6)</i>	
D38	If others, specify?	
D39	During any of these meetings, did you get any advice on any of the following:	
D40	Breast feeding <i>(yes – 1; no – 2; don't remember – 3)</i>	
D41	Keeping the baby warm <i>(yes – 1; no – 2; don't remember – 3)</i>	
D42	The need for cleanliness at the time of delivery <i>(yes – 1; no – 2; don't remember – 3)</i>	
D43	Family planning or delaying your next child <i>(yes – 1; no – 2; don't remember – 3)</i>	

E Child birth and post-child birth health care (Ask to Mother only)

E1	Did you go to your parental home at the time of delivery? <i>(Yes – 1; no – 2; don't know – 3)</i>	
E2	When your child was born, was he/she large, normal or small? <i>(large – 1; normal – 2; small – 3; don't know – 4)</i>	
E3	Was he/she weighted at the time of birth? <i>(Yes – 1; no – 2; don't remember – 3)</i>	
E4	Who assisted the delivery of <<NAME OF THE CHILD>>	
E4_1		
E4_2		
E4_3		
E5	Where did you give birth to <<NAME OF THE CHILD>> <i>(Home – 1; Sub-Centre/clinic – 2; PHC/BPHC/government hospital – 3; private doctor's clinic/ nursing home – 4; NGO's clinic – 5; others – 6)</i>	
E6	If others specify, the name of the place.	
E7	In case you had a home delivery, why did you not deliver in a health facility? <i>(not necessary – 1; not customary – 2; cost too much – 3; too far – no transport – 3; poor quality service – 4; no time to go – 5; family did not allow – 6; lack of knowledge – 7, others – 8)</i>	
E8	If others, specify.	
E9	Was delivered by caesarean section? <i>(yes – 1; no – 2; don't know – 3)</i>	
E10	In case of institutional birth: before you were discharged after birth of <<NAME OF THE CHILD>> did any health personnel check on your health? <i>(yes – 1; no – 2; don't know - 3)</i>	
E11	How long (days) after the delivery did the first check up take place? Note: whatever be the reply, the investigators will have to convert into days and record.	
E12	Who checked on your health at that time? <i>(doctor – 1; nurse – 2; other health staff – 3; others 4)</i>	
E13	If others, specify.	

E14	In the two months after you were discharged, did any ANM/Lady Health Visitor / anganwadi worker, DAI check on your health? (yes – 1; no – 2; don't remember – 3)	
E15	Who checked? (ANM – 1; Lady Health Visitor – 2; Anganwadi worker – 3; DAI/ TBA – 4; Others - 5)	
E16	If others, specify.	

F Children's Health (ask to Mothers only)

F1	Do you have a card where all vaccinations of <<NAME OF THE CHILD>> are written? (Yes, seen – 1; Yes, not seen – 2; no card – 3) Note: Request the mother to show the card.	
F2	Did your son/daughter have diarrhoea or loose motion in last three months? (yes – 1; no – 2; don't know – 3)	
F3	Did your child receive the following vaccination?	
F4	Polio (excluding pulse polio) (yes – 1; no – 2; don't know – 3)	
F5	DPT (yes – 1; no – 2; don't know – 3)	
F6	Measles (yes – 1; no – 2; don't know – 3)	

G Signature of investigator and date of survey

	Signature of investigators	Date (dd/mm)
G1		
G2		