End Line Evaluation of MACHAN (GPAF IMP 056) Program

KPMG

Final Report

March 2016

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Acronyms

Acronym	Explanation
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BFM	Beneficiary Feedback Mechanism
CA	Change Agents
CBO	Community Based Organisation
CINI	Child in Need Institute
FGD	Focus Group Discussion
GPAF	Global Poverty Action Fund
HHW	Honorary Health Workers
ICDS	Integrated Child Development Scheme
IFA	Iron-Folic Acid
JSY	Janani Suraksha Yojana
KII	Key Informant Interviews
KMC	Kolkata Municipal Corporation
MACHAN	Maternal and Child Health and Nutrition
MAM	Moderate Acute Malnourished
MCH	Maternal and Child Health
MCP	Mother Child Protection
MIS	Management Information System
MUAC	Mid Upper Arm Circumference
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NREP	Nutrition Rehabilitation Education Programme
PHC	Primary Health Centers
PNC	Post Natal Care
SAM	Severe Acute Malnourished
SHG	Self Help Group
ULB	Urban Local Body
VHND	Village Health & Nutrition Day

1. Executive Summary

India has far to go to fulfil the MDG and SDG commitments, especially in the area of maternal and child health. The continuing practices of child marriage and teenage pregnancies along with unavailability of antenatal and postnatal care, poor child care practices as well as inadequate and poor quality health infrastructure have contributed to maternal and infant deaths. While India has achieved some success in maternal health, visible in the fall of maternal mortality rate from 212 deaths per 100,000 lives in 2007[1] to 167 deaths in 2013, it is still lagging behind the MDG target of 109[2] deaths per 100,000 lives. Further, an estimated 12.7 lakh children die every year before completing 5 years of age with 81% of the under-five child morality taking place within one year of the birth[3]. As per the fourth National Family Health Survey (NFHS-4) conducted during 2015-16, IMR and U5MR rates in West Bengal are 27 and 32 respectively. This can be attributed to poor health indicators for mothers such as pregnancy complications arising due to being an underage mother (18.3% women aged 15-19 years in West Bengal are mothers or pregnant), only 21.8% of mothers having received full antenatal care and only 28.1% of the mothers having consumed IFA for 100days.

While Kolkata is among the better performing districts in West Bengal with respect to maternal and child health indicators, however it is yet lagging behind with respect to some key MCH indicators. As per NFHS-4 only 32.9% of the mothers have received complete antenatal care. Further, only 33.1% of the children born receive a health checkup from a skilled health personnel within the first two days of birth, and nearly 70% of children aged 6-59 months are anaemic., North Dinajpur on the other hand is among the worst performing districts in terms of maternal and child health indicators in West Bengal. As per a study conducted, of 19 of the 20 districts in West Bengal on the on MDG-5 status on maternal health[4], North Dinajpur ranked among the lowest as per the MDG-5 status index. While the state's average is 23.8% for unmarried women belonging to the reproductive age group (15-49) and having knowledge about emergency contraception, the same stands at 9.8%in North Dinajpur making it the worst performing district.

In order to address the maternal and child heath situation, the Child in Need Institute (CINI), an Indian non-government organisation (NGO), had undertaken the Maternal and Child Health and Nutrition (MACHAN – local name of the project) which is a collaborative project of CINI India and ChildHope UK under Global Poverty Action Fund (GPAF) from UKAID (DFID UK). CINI works to improve outcomes for the most vulnerable communities i.e. women, adolescents and children in India in the areas of health, nutrition, education and protection.

The MACHAN project was implemented in Borough VII of Kolkata Municipal Corporation and Goalpokhar I Block of North Dinajpur, catering to 41,990 vulnerable women and children aged 0-2 years. The project was expected to improve pregnant women and young mothers' knowledge and awareness on maternal, child health and social welfare schemes leading to better decision making, health seeking behaviour and optimal utilization of existing health and nutrition services to reduce infant and maternal mortality. The

[1]http://unicef.in/Whatwedo/1/Maternal-Health
[2]2013 figures from Millennium Development Goals India Country Report 2015, MOSPI
[3] http://nrhm.gov.in/nrhm-components/rmnch-a/child-health-immunization.html
[4]http://indiansss.org/pdf/pdfset-17/issueset-18/9_Article64_73.pdf

key objectives of the project were to **Improve maternal and child health and nutrition during first 1000 days of life** aiming at reducing **maternal and child mortality.**

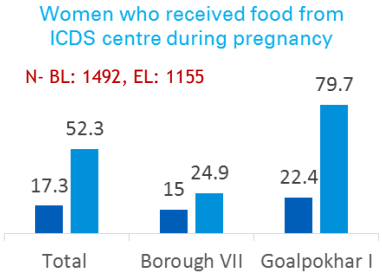
KPMG India was engaged by CINI to conduct the end-line evaluation. The **key objectives** of the evaluation were:

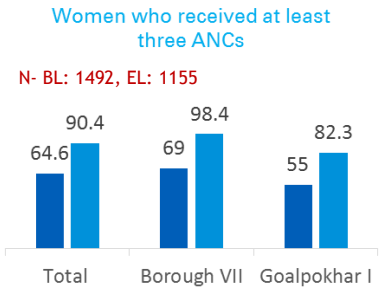
- Assess if the project design (needs and delivery) was appropriate and relevant to the needs of women and children.
- Assess the impact of the project on the beneficiaries (women and children) and key stakeholders, e.g. health workers, change agents, local CBO's/SHGs, local government officials, etc.
- Appraise the sustainability of the project outputs.
- Identify lessons learned from project implementation and best practices, suggesting reasons for particular successes and/or failures.

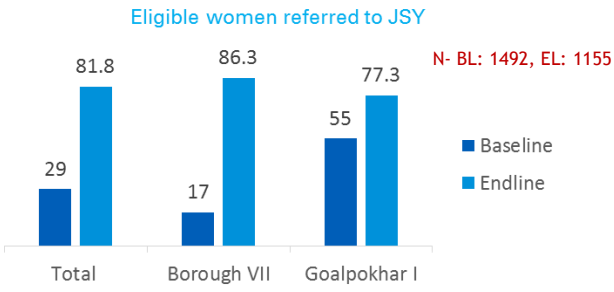
A **mixed-method (quantitative and qualitative) methodology** was applied for the purpose of the end-line evaluation. For the quantitative component of the end-line study the target group were mothers with **children** in the age group of **6-24 months.** The sample size covered was **1,155households,** (**578** in Borough VII and **577**in Goalpokhar 1) and **41change agents** (21 in Borough VII and 20 in Goalpokhar 1). The qualitative component sample included **ICDS supervisors, AWWs, SHGs and councilors, club members.**

The following below highlight some of the key findings from the end-line evaluation on the five core focus areas:

ANTENATAL CARE





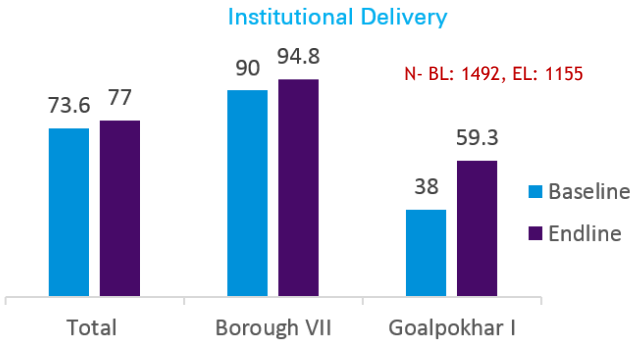


25% increase has been observed in the proportion of women getting **at least 3 ANC checkup,** from the baseline to the end line. The MACHAN project has focused on improving pregnant women's knowledge about antenatal care, pregnancy complications, consumption of IFA tablets etc.

Involving male members of the community, to support women during pregnancy, **with the help of Change Agents and supervisors** has been an important facilitating factor.

61% increase in access to JSY as well as **35% increase in ICDS food** for eligible mothers has been observed. **Advocacy with government bodies and AWWs** has resulted in a strengthened link between such social welfare schemes and women, to address MCH issues.

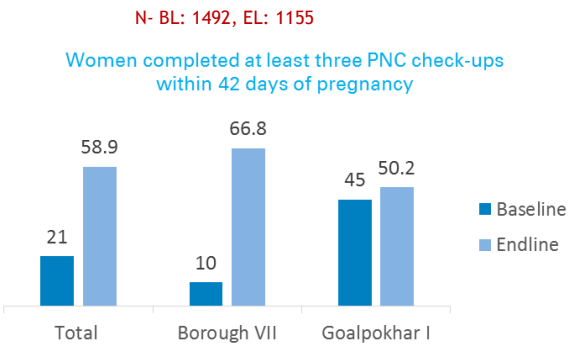
DELIVERY

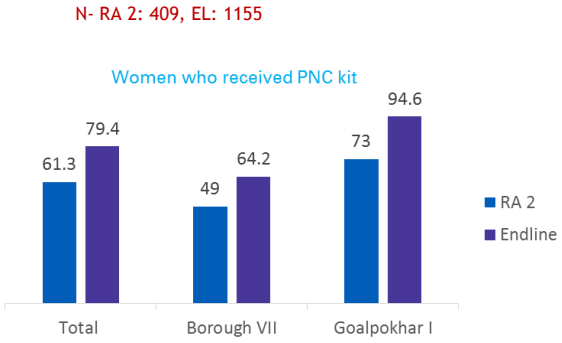


A **20% increase in proportion of women being assisted by skilled health persons** during their delivery, has been observed during the end line evaluation.

Community based feedback systems were introduced in the target locations to **identify and bridge any gaps in service delivery**. Further, **Change Agents** were engaged to **sensitize women** on the importance of institutional delivery and alternatively importance of skilled health persons assisting in home births.

POSTNATAL CARE





Number of women receiving **PNC kits increased from 61.3% to 79.4%**indicating completion of atleast 3 PNC checkups after discharge (**increased from 21%to 58.5%**). **ICDS food delivery also increased by 6%.**

MACHAN aimed to increase PNC coverage by improvements in awareness about PNC among pregnant women and young mothers, knowledge about PNC kits, counselling on health practices, increase in consumption of supplementary rations.

Engagement of the community members and Change Agents has been critical in **behavior change communication** amongst the women. Further, **collaborative initiatives** were taken, by involving representatives of ICDS and AWWs to review community feedback on government services, and put in place action plans to ensure better health service delivery.

BREAST FEEDING AND CHILD CARE

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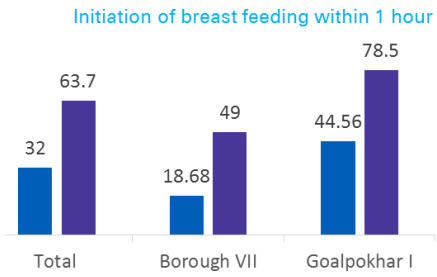

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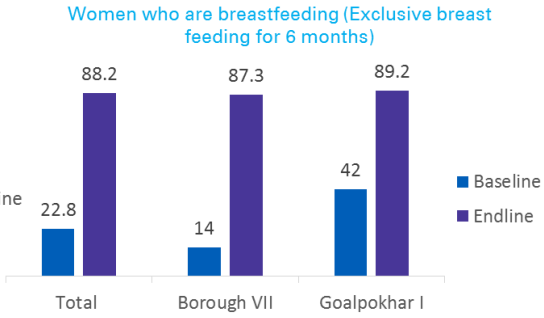

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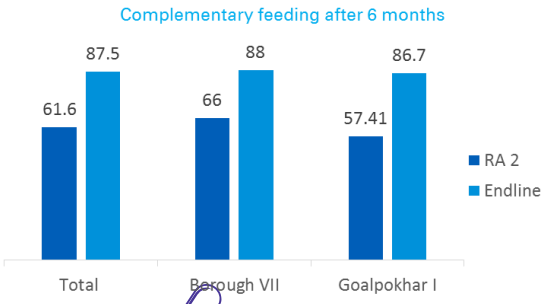


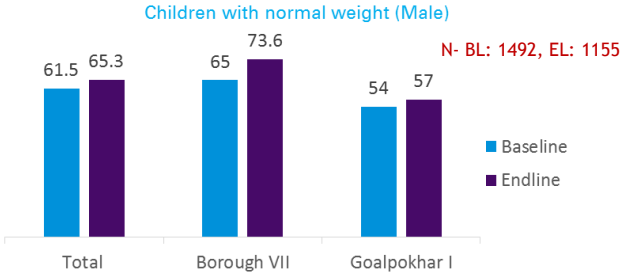
Exclusive breastfeeding for 6 months witnessed a significant increase form **22.8% to 88.2%.**

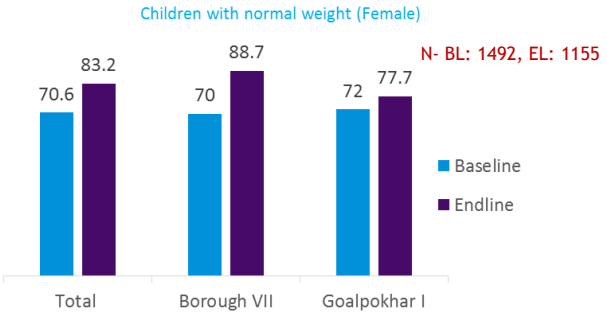
Another core focus area under MACHAN was improved infant care and breast feeding practices. **Counselling sessions, trainings and workshops** were regularly conducted by **CINI staff and Change Agents**, in collaboration with government **representatives such as AWWs and ICDS supervisors** to initiate behavior change and sensitization of women on the meaning and importance of exclusive breastfeeding, colostrum feeding etc.

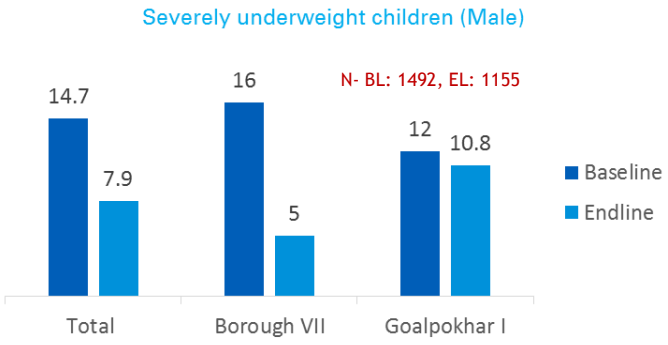
NUTRITIONAL STATUS

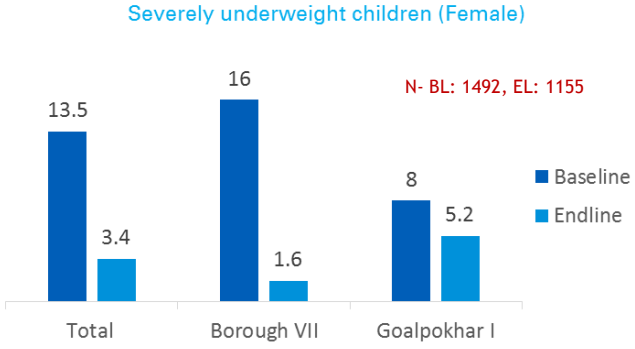
Significant **drop in the number of Severely Malnourished children** was observed especially in Kolkata**. 16% to 1.6% for girls in Borough VII and 8% to 5.2% in Goalpokhar 1**.

The high magnitude of malnutrition in children was addressed through Nutritional Rehabilitation Educational Programme **(NREP) sessions.** The sessions are knowledge dissemination platforms conducted for mothers for malnourished children on how to care for and feed the children i.e. exclusive feeding, complementary feeding, growth monitoring, hand washing etc.









Based on the end-line findings, the following are the **key recommendations:**

- **Extension of the programme:** Majority of the stakeholders (Government officials, elected representatives and CBOs) categorically mentioned that for any nutritional intervention to have a significant impact, it should have a duration of at least 5 years. It is therefore recommended that the CINI program should be extended for at least 2 more years.

- **Leveraging Government Programmes:** Alternate models of implementing few crucial components of the programme (like other funding sources) should also be explored. CINI can work on leveraging existing government schemes. There is a huge shortage of manpower in the Government as highlighted by the interviewed Government respondents.

- **Greater advocacy at state level:** The CINI programme has some innovative best practices like Self-monitoring calendar, Beneficiary Feedback Mechanism, NREP which have proved to be very useful. These innovations could be taken up at a larger level through advocacy at the state level. This will help in scaling up and sustainability.

- **Holistic approach to attract CSR funds:** Funding from CSR needs to be explored to a larger extent and brand CINI needs to be marketed for enhancing fund flow and implementing similar projects in future. However, it has been our experience that Corporates and PSUs are inclined towards investing in programs where there are tangible benefits which are visible and preferably in an around operating locations. Interventions that improve maternal and child health can be implemented along with other interventions on areas such as livelihood, skill development, enterprise development where there is already some amount of community mobilization

- **Linkage with ANMs, AWWs and ASHAs:** The sustainability of the program results is highly dependent on linkages with grass root level health workers. It is important that they take ownership of the program learnings. CINI should ensure there is a proper knowledge transfer to these stakeholders before exiting.

- **Motivating the CBOs to take ownership:** One major success of the programme was the investment by the Community based organization like local clubs, and SHGs etc in few of the program activities like meetings and infrastructure support. The community should be further motivated to take up ownership of few critical activities. The CBOs/ULBs/PRIs can also play a crucial role in ensuring accountability of duty bearers in providing quality services.

- **Incentivising Post natal care:** Though there has been a improvement in PNC indicator, the overall PNC coverage is low. Greater communication efforts for PNC should be put in future programs. Incentivizing PNC should be explored.

2. Introduction

2.1. Background: MCH in India and West Bengal

The Millennium Development Goals (MDGs), committed to countries halving extreme income poverty and to achieving improved health outcomes by 2015. Three of the eight MDG goals were health-related; calling for a two-thirds reduction in child mortality, a three-quarters reduction in maternal mortality, and a halt to the spread of HIV/AIDS, malaria and tuberculosis.

The Sustainable Development Goals (SDGs), are now succeeding the MDGs, where MDG 4 and 5 focusing on health are now covered under SDG-3; "ensure healthy lives and promote well-being for all at all age". In order to meet the new global target of **zero preventable child deaths and a much sharper reduction in maternal deaths by 2030**[5]**,** committed and sustained efforts on improving child and maternal health will be required.

While efforts have been made to achieve the MDG objectives, India has far to go to fulfil these commitments, especially in the area of maternal and child health. The continuing practices of child marriage and teenage pregnancies in rural areas, put women at a higher risk of dying of child birth. Inadequacy of antenatal and postnatal care, poor child care practices as well as inadequate and poor quality health infrastructure have contributed to maternal and infant deaths.

Maternal and child health are areas of concern globally, and is an important tenet of the Indian government's health policy. While efforts are being made to improve the maternal and child health indicators through large scale interventions targeting improvement and increased coverage of high quality health services, yet India has been ranked among the worst performing countries (137 among 178 countries)[6]. Globally 800 women die every day of preventable causes related to pregnancy and childbirth, and 20% of these women are from India. While India has achieved some success in maternal health, visible in the fall of maternal mortality rate from 212 deaths per 100,000 lives in 2007[7] to 167 deaths in 2013, it is still lagging behind the MDG target of 109[8] deaths per 100,000 lives. With respect to child health, India's performance has been lagging. In India, an estimated 26 millions of children are born every year, with the share of children (0-6 years) accounting for 13% of the country's total population (Census 2011). However, an estimated 12.7 lakh children die every year before completing 5 years of age with 81% of the under-five child morality taking place within one year of the birth.

West Bengal is the fourth most populous state in India after Uttar Pradesh, Maharashtra and Bihar. The situation in West Bengal, though generally better than the average in India, requires significant improvement. As per the third National Family Health Survey (NFHS-5) conducted during 2015-16, the

[5]http://www.unic.org.in/items/India_and_the_MDGs_small_web.pdf
[6]Report: Trends in maternal mortality: 1990 to 2013
[7]http://unicef.in/Whatwedo/1/Maternal-Health
[8]2013 figures from Millennium Development Goals India Country Report 2015, MOSPI

state has 40.3% of women of the age group 20-24 married before the age of 18 years. This puts them at high risk of pregnancy related complications. The same is as high as 46.2% in rural areas. Also, 18.3% (20.6% in rural areas) of all women aged 15-19 years were already mothers or pregnant at the time of survey. As per Census 2011, Infant Mortality Rate (IMR) in West Bengal was 33, which was higher than the MDG goal for IMR of 27 deaths per 1000 live births. Though MMR of the state is better than most of the states but it is the only state where the MMR increased between the period 2004-06 (141) and 2007-09 (145) (SRS, 2011). Some of the reasons contributing to high MMR include lag in institutional delivery (which has reached nearly 100% in several states compared to around 75.2% at the end of the year 2015-16 in the state), lack of training of all nurses, poor status of nutrition, high incidence of anemia and as well as early age at first birth of the child.

While Kolkata is among the better performing districts in West Bengal, with respect to maternal and child health indicators, North Dinajpur on the other hand is among the worst performing districts. As per a study conducted, of 19 of the 20 districts in West Bengal on the on MDG-5 status on maternal health[9], North Dinajpur ranked among the lowest as per the MDG-5 status index. While the state's average is 23.8% for unmarried women belonging to the reproductive age group (15-49) and having knowledge about emergency contraception, the same stands at 9.8%in North Dinajpur making it the worst performing district.

According to the 2010 HDR Report, North Dinajpur located along the Indo-Bangladesh border, is one among whose backwardness is directly related to its geographical situation. It is placed among the least developed districts in West Bengal as well as in India, with high levels of illiteracy, low health-care and livelihood access and wide-spread rural poverty.

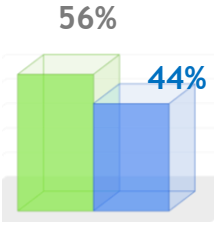
The below given table represents some of the important MCH indicators for North Dinajpur, Kolkata and West Bengal. Table 1 represents the key MCH indicators of both the districts as per NFHS-4

Table 1: MCH indicators for West Bengal, North Dinajpur and Kolkata (Source: NFHS-4)

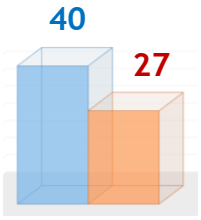
Maternal and Child Health Indicators[10]	North Dinajpur (%)	Kolkata (%)	West Bengal (%)
Mothers who had at least four ANC visits	43.1	84.8	76.5
Delivery attended by skill birth attendants	58.4	97.6	81.7
Institutional delivery	47.0	95.0	75.2
Mothers who received post-natal care within 48 hours of Institutional delivery	46.3	83.1	61.1
Exclusive breast feeding	67.8	-	52.3
Children under 5 who are under weight	34.7	19.6	31.5

[9]http://indiansss.org/pdf/pdfset-17/issueset-18/9_Article64_73.pdf
[10] National Family Health Survey-4 statistics

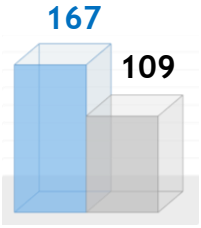
Facts in India



Neo-natal deaths account for 56% of U5MR in India which is much higher than the global avg. of 44%



IMR is 40 against the target of 27 per 1000 live births by 2015



MMR status in India is 167 against the MDG target of 109 per 100,000 live births

2.2. Introduction to Child in Need Institute

Child in Need Institute (CINI) is an Indian non-government organisation (NGO) working to improve outcomes for the most vulnerable communities i.e. women, adolescents and children in India in the areas of health, nutrition, education and protection. CINI connects with multiple institutions including government and donors to promote sustainable development. Apart from projects such as Aanchal and MACHAN in West Bengal, CINI has also dedicated its efforts to improving maternal and child health in other states such as Jharkhand and Odisha, working with institutions like Essar Foundation and Oxfam.

From a small beginning in 1974, **Child In Need Institute (CINI)** has grown into a vibrant institution with various thematic divisions and units. Currently, it covers 7,00,000 population across multiple states in India. It is guided by its mission of ***Sustainable development in health, nutrition, education and protection of child, adolescent and woman in need.*** CINI is recognized as a pioneer in the fields of reproductive and child health and combating malnutrition. It has developed considerable expertise in working on education and protection issues also.

2.3. Overview of Project Machan

Maternal and Child Health and Nutrition (MACHAN – local name of the project) is a collaborative project of CINI India and ChildHope UK under Global Poverty Action Fund (GPAF) from UKAID (DFID UK). This project is being implemented in Borough VII of Kolkata Municipal Corporation and Goalpokhar I Block of Uttar Dinajpur, catering to 41,990 vulnerable women and children aged 0-2 years. The project is expected to improve pregnant women and young mothers' knowledge and awareness on maternal, child health and social welfare schemes leading to better decision making, health seeking behaviour and optimal utilization of existing health and nutrition services to reduce infant and maternal mortality.

The key objectives of the project were as follows:

- **Improve maternal health** of pregnant women, lactating mothers and improve nutrition of children under two years of age in nine municipal wards (all slum settlements) of Borough VII of Kolkata District and one block (Goalpokhar 1) of North Dinajpur.

- **Reduce maternal and child mortality** (MDG 4 and 5) in two project locations catering to 41,990 mothers and their children up to 2 years of age

1.1. **The outcome of the project** is 'Improved maternal health of pregnant women, lactating mothers and improved nutrition of children under two years of age in nine municipal wards (all slum settlements) of Borough VII of Kolkata District and one block (Goalpokhar 1) of North Dinajpur District of West Bengal'. Following are the **five outputs** of the project as per the project Logframe (M&E framework):

1. Women acquire the knowledge and skills to act as volunteer Change Agents (CAs) and promote essential MCH services and increase MCH awareness among community members.
2. Enhanced capacity of key stakeholders and service providers (CINI staff, govt Integrated Child Development Services ICDS and National Rural Health Mission supervisors) enables quality service delivery.
3. Increased access to essential Ante and Post Natal Care (ANC & PNC) services for mothers and child nutrition services for 0-2 year olds
4. Increased knowledge of and referral to the govt-funded Janani Suraksha Yojana (JSY) scheme for pregnant women in the target communities.
5. Increased awareness, involvement and coordination of stakeholders in Janani Suraksha Yojana (JSY), Ante and Post Natal Care (ANC & PNC) services and Integrated Child Development Services (ICDS)

2.4. Partnership between CINI and ChildHope UK

ChildHope UK has been working with CINI for a long time on the issues around street and working children, and have a lot of mutual respect for each other. GPAF was the first opportunity for them to work together on a large multiyear Maternal and Child Health Project. ChildHope had the experience of working on numerous DFID projects though had limited experience on MCH, at the same time had significant learnings to share on issues related to child protection. However, this was the first UKAid project for CINI, though they had a lot of expertise and experience on MCH. CINI also had a good ground level presence in West Bengal and share good relationship with key stakeholders like Government officials, elected representatives and the community. So the partnership had a good balance. ChildHope experience was particularly useful is complying with DFID's guideline for project management, logframe development, yearend financial process, risk management and ensuring quality financial and narrative reporting. Regular communication on skype (every quarter), emails, phone calls and field visits ensured project was on track.

Various opportunities were facilitated for CINI staff member to be part of capacity building programmes and ChildHope International Civil Society Network. Reference to UK based donors and learning networks such as the Consortium for Street Children (CSC) was also provided by ChildHope UK. Overall, the project was a learning experience for both CINI and ChildHope UK as highlighted by the program staff from both the organizations.

2.5. Selection of KPMG

KPMG was selected through a competitive bidding process. The advertisement for the study was published on devnetjobsindia.org and more than 35 agencies applied for this assignment. KPMG was called for a presentation based on the technical proposal along with 2 other agencies. Based on the score achieved

in the technical proposal, presentation and the financial presentation, KPMG was selected for conducting this evaluation.

2.6. Target group (beneficiaries and key stakeholders):

The direct target groups include 41,990 disadvantaged women and children (0-2 years) from the 9 wards of the urban slum, Borough VII of Kolkata and rural Goalpokhar 1 blocks of North Dinajpur district in West Bengal. The target group includes (i) Women eligible under JSY, (iii) Women during post-natal period (from delivery to 42 days), (iv) Children in the 0-2 years age group with special emphasis on girls (v) Vulnerable and poor adolescent girls (15-18 years), young women (19-24 years) (mostly in the urban slums) to be empowered and acting as community 'Change Agents (vi) Older women (mostly from rural areas) to be empowered and acting as community 'Change Agents'. Change Agents are women from the community, who will act towards transformation of the community from within. The Change Agents are trained by the CINI staff on maternal and health related issues and they work closely with field level health functionaries of the Government.

The project is expected to indirectly benefit the following groups within the same communities: (i) Women ineligible for JSY because of having two or more children (ii) Adolescents (15-18 years) and young people (19-24 years); peers of Change Agents targeted with information (iii) Male and female caregivers of children in the wider community (iv) Children of mothers not included in the direct target group

2.7. Objective of Evaluation

The end-line evaluation was conducted keeping in my mind five key objectives:

- Assessing the performance of the project based on the pre-defined program indicators with the log frame as the reference
- Assessing the effectiveness of the different components of the program- Engagement of community level groups, Behaviour Change Component (BCC), tracking of community level health behaviour, working with the Government Departments and capacity of the program staff
- Assessing the knowledge level of the caregivers and mothers on infant and young feeding indicators with the program training modules as a reference
- Assessing the linkages with Government care providers like the ANMs, ASHAs, municipalities and communities
- Identifying the lessons learnt from the project based on what worked and what did not work and assessing the reasons for success or failure

Three rounds of surveys were done before the end line study. A baseline study was conducted in May, 2013. It was followed by 2 Rapid Assessments in March, 2014 and March, 2015 respectively. The end line study was launched in the first week of January, 2016. The baseline and Rapid Assessment 1 covered only few key indicators. However, Rapid Assessment 2 and end line covered a more extensive list of indicators. In this report, most of the indicators of the end line are compared with the baseline as the figures from other two rounds are not available. We have however presented figures from baseline wherever it is available.

2.8. Methodology

2.8.1. Sampling

The sample size for the end-line was calculated at 95 percent confidence and 80 percent power value. For the quantitative component, the end-line study covered **1155** households, with **578** households being covered in Borough VII and **577** households being covered in Goalpokhar 1. We will cover households with children in the age group of 6-24 months. **41** quantitative interviews were also conducted with Change Agents, with 21 Change Agents being covered in Borough VII and 20 Change Agents being covered in Goalpokhar 1.

The process of selecting the households is as defined below:

Step 1: Purposive selection of CINI agents based on number of children in the target age group they are catering to. We selected 138 CINI agents from across both the project areas to ensure proportionate representation from each of the wards and gram panchayats.

Step 2: Based on the list of households received from the CINI agents, we then randomly select mothers per CINI agent, with a child in the 6-24 months age group.

In addition to the quantitative interviews, we also conducted qualitative interviews with the key stakeholders to understand the non-tangible benefits of the program. The focus of the qualitative interviews was to understand whether the community is willing to take ownership of the program results and whether they think the program has led to overall improvement of the maternal and child health conditions of the project geography.

2.8.2. Sample Size: Quantitative

The tables below reflect the number of beneficiary households i.e. mothers with children between 6 months and 24 months of age and Change Agents that were reached out during the end-line study.

Table 2: Sample Size Quantitative (End line)

Districts	End Line			
	Number of Wards/GPs	No of Change Agents	Mother's sample size	Change Agent-Sample size
North Dinajpur (Goalpokhar 1)	13	42	577	20
Kolkata (Borough VII)	9	97	578	21
Total			**1155**	

2.8.3. Sample Size: Qualitative

The table below reflects the number of qualitative interviews conducted under this study, in the form of Key Informant Interviews (KII), In-depth Interviews (IDI) and Focus Group Discussions (FGD), with involved stakeholders such as government workers, Change Agents, club members etc.

Table 3: Sample Size Qualitative

Sample	Method	End Line	
		Kolkata	North Dinajpur
AWW	FGD	1	1
ANM	FGD	-	1
MOIC	In-Depth/KII	2	1
CDPO	In-Depth/KII	1	2
ICDS Supervisors	In-Depth /KII	1	-
Honorary Health Worker (urban)	FGD	1	-
SHG	FGD	2	1
Club Members	FGD	1	1
Panchayat Pradhan	FGD		1
Councillor	In-Depth/KII	1	

3. Results and Impacts of H

This chapter highlights the findings on the knowledge, attitude and practice of the survey households/ women with respect to maternal and child health and nutrition. The section starts with a description of the households' characteristics in terms of age of respondents, marital status, caste, religion, literacy levels, age of marriage, number of children, gender of children, age of first pregnancy etc. This is then followed by findings with respect to women's practices towards antenatal and post-natal care, anthropometric details and child care, and their knowledge about the MACHAN project.

3.1. Background Information

The respondents for the end-line are women with children between 0 to 2 years of age. Most of the women were reported to belong to the General social category which was 73.4% in Borough VII and 63.1% in Goalpokhar 1, followed by Scheduled Caste respondents which are slightly lower in Borough VII (14.2%) as compared to Goalpokhar 1 (20.1%). Overall, majority of the respondents in Borough VII have completed their education till secondary level (39.8%) followed by those who have completed their primary level education (25.3%). However, in Goalpokhar 1, the majority of the respondents mentioned that they are illiterate (31.9%) followed by those who are semi-literate (people whoc could only read and write (30.8%).

Distribution of respondents by age

The age distribution of the study population, is comparable across the respondent groups for the Rapid Assessment-2 (RA2) and the end-line. Table 4 below, shows the distribution of the respondents by age. The majority of respondents surveyed during the end-line fall within the age group of 25 to 34 years, with the average age at 24.31 years in Borough VII and 25.99 years in Goalpokhar 1. Further, the overall percentage of early pregnancies has reduced when compared to the RA2 period i.e. from 3.18% to 2.60%. This decrease has resulted from a decreasing trend in Goalpokhar 1 (2% fall), while Borough VII reflects an increase in underage mothers by 1%.

Table 4: Distribution of respondents by age (BASE: ALL)

Age in years	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
15to18	3.18	2.50	3.83	2.60	3.46	1.73
19-24	44.99	52.00	38.28	43.81	51.04	36.57
25-34	46.70	40.50	52.63	48.92	42.21	55.63
35-44	4.89	5.00	4.78	4.68	3.29	6.07
Don't know/Can't say	0.24	-	0.48	-	-	-
Average	**25.27**	**24.69**	**25.83**	**25.15**	**24.31**	**25.99**

Distribution of respondents by marital status

99.5% women in Borough VII and 99.8% women in Goalpokhar 1 are 'currently married'. This is represented in Table 5 below. A very small percentage of respondents are separated, divorced or widowed.

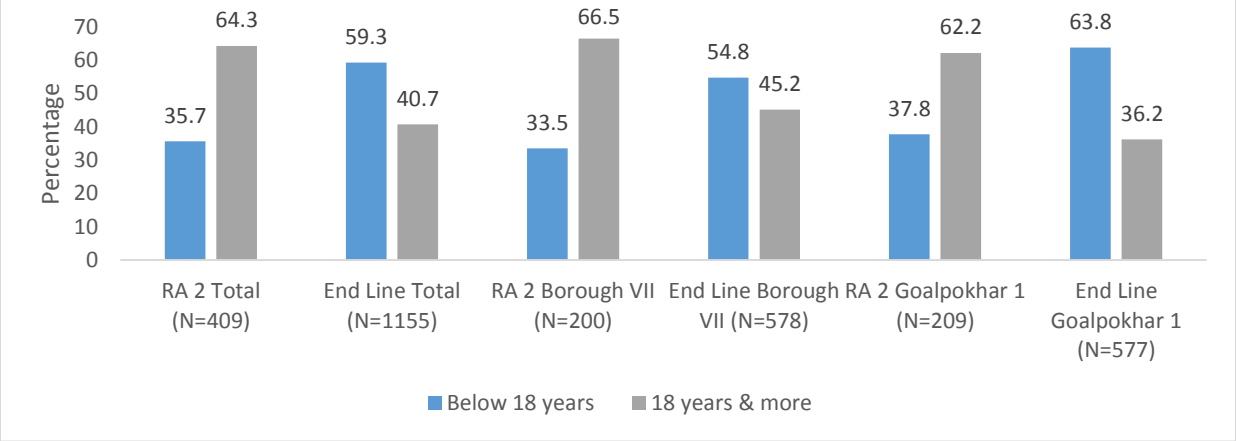
Table 5: Distribution of respondents by marital status (BASE: ALL)

Marital status	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Currently married	98.78	98.50	99.04	99.7	99.5	99.8
Separated/Divorced/ Deserted	0.24	0.50	-	0.2	0.3	-
Widowed	0.73	1.00	0.48	0.2	0.2	0.2

Distribution of respondents by age at marriage

The distribution of respondents by age at marriage (given in Figure 1) highlights that a significant proportion of respondents in Borough VII (54.8%) and Goalpokhar 1 (63.8%) get married under 18 years. The proportion of women getting married under 18 years has increased from the time of RA2 from 35.7% to 59.3%. Early marriage results in vulnerabilities in pregnancy related experiences such as early or unplanned pregnancies, pregnancy related complication etc. Though, MACHAN directly did not address early marriage, the project focused on preventive measures for pregnancy complications.

Figure 1: Distribution of respondents by age at marriage (BASE: ALL)



Distribution of respondents by number of children

The distribution of respondents by number of children, given in Table 6, shows that most respondents have one child in Borough VII (45.7%) and in Goalpokhar 1 (29.6%). The average number of children is found to be higher in Goalpokhar 1 than in Borough VII. This is comparable to the trend during the RA2 study.

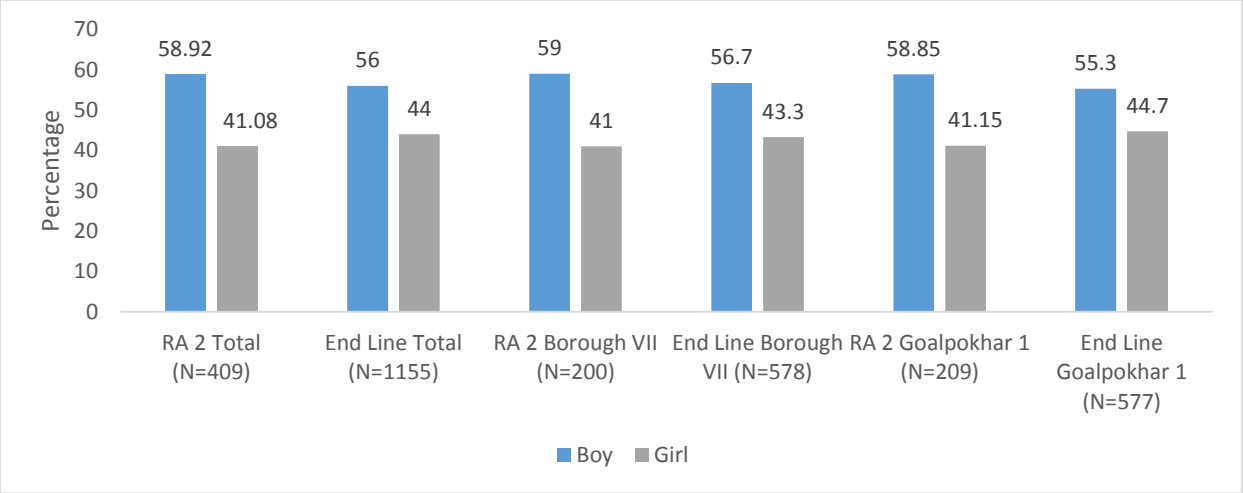
Table 6: Distribution of respondents by number of children (BASE: ALL)

Number of children	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
1	40.58	52.50	29.19	37.7	45.7	29.6
2	31.30	32.00	30.62	33.0	37.7	28.2
3	12.71	10.00	15.31	13.0	10.6	15.4
4	7.33	4.00	10.53	8.9	4.0	13.9
5	5.62	1.50	9.57	3.7	1.2	6.2
6	1.22	-	2.39	2.5	0.7	4.3
7	0.98	-	1.91	0.5	0.2	0.9
8	0.24	-	0.48	0.5		1.0
Average ±SD	2.15 ±1.36	1.70 ±0.92	2.58 ±1.56	2.21±1.40	1.80±0.97	2.63±1.63

Distribution of respondents by gender of last child

The distribution of respondents by gender of last child reflects that all together 56% of the respondents reported that their last child was a boy and the trend has remained the same since the period of the RA2. Figure 2 presents the distribution of respondents by gender of last child.

Figure 2: Distribution of respondents by gender of last child (BASE: ALL)



Further, when asked about the mortality and disability related questions of the last child, 100% of the respondents of the survey reported that their last child is still alive. Majority of respondents in Borough VII and Goalpokhar 1 did not have any differently abled children. The total percentage of differently abled children were 0.4% amongst the respondents.

3.2. Antenatal Care

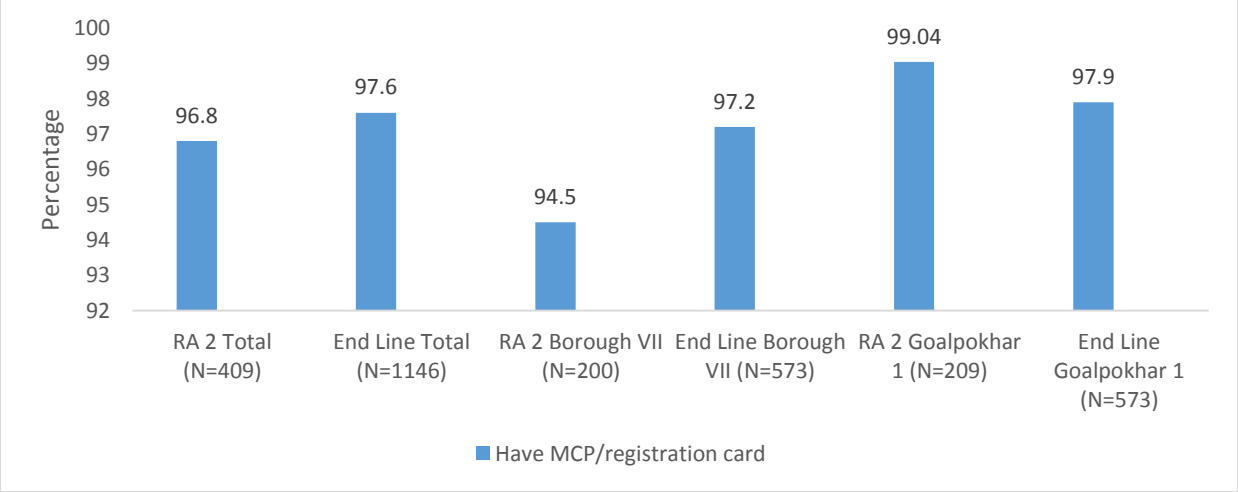
This section of the report presents the end-line survey findings related to quality and coverage of antenatal care (ANC) in the project areas. Some of the indicators related to ANC include knowledge of ANC, frequency of ANC check-ups, behaviour change towards consumption of Iron folate supplements during pregnancy etc.

Pregnancy Registration

Across the urban as well as rural setting, findings show that majority of the women registered their pregnancy by the 3rd month. However, it was observed that the practice of registering by the third month was higher in Goalpokhar 1 (69.7%) as compared to 40.8% in Borough VII.

Among the respondents in Borough VII who register their pregnancy, 90% of them register at government hospitals, while majority of the respondents register at sub-centres in Goalpokhar 1 (83.4%). The prevalence of registering at private hospitals and clinics is 7.5% in Borough VII but only 0.5% in Goalpokhar 1. The choice of place of registering their pregnancy is mostly dependent on ease of accessibility to the place. The study reflected that overall most of the respondents have Mother and Child Protection/ registration cards and has shown a positive trend since the RA2 study. In Borough VII, 97.2% of the mothers and in Goalpokhar 1 97.9% of the women have MCP/ registration cards. Distribution of respondents by having MCP or registration cards is given in Figure 3.

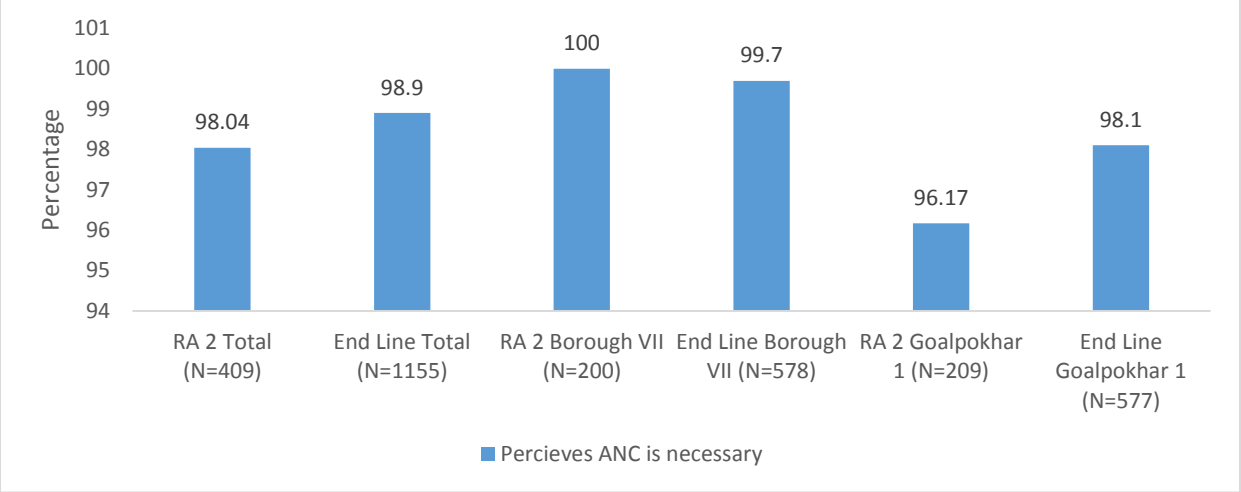
Figure 3: Distribution of respondents by having MCP or registration cards (BASE: ALL)



Perception of Antenatal care

The majority of the respondents of the study consider ANC as necessary during pregnancy. 96.17% of the respondents in Borough VII and 98.1% of the respondents in Goalpokhar 1 consider ANC necessary. Figure 4 presents the distribution of respondents by their perception of ANC. High percentages of MCP cards and ANC check-ups reflect a positive trend in the behavior of the respondents towards antenatal care. The overall proportion was observed to be similar to that reported during the RA2 study.

Figure 4: Distribution of respondents by their perception if ANC is necessary (BASE: ALL)



When asked about the reasons why ANC is necessary, majority of the respondents mentioned 'to know the health of the mother' as the main reason. In Borough VII, ANC is considered necessary to know the health of the mother (91%) followed by knowing the health of the child (78.1%). The same is the case for Goalpokhar 1 where the statistics are 84.1% and 78.3% respectively. Table 7 represents the distribution of the respondents by reasons they think ANC is necessary.

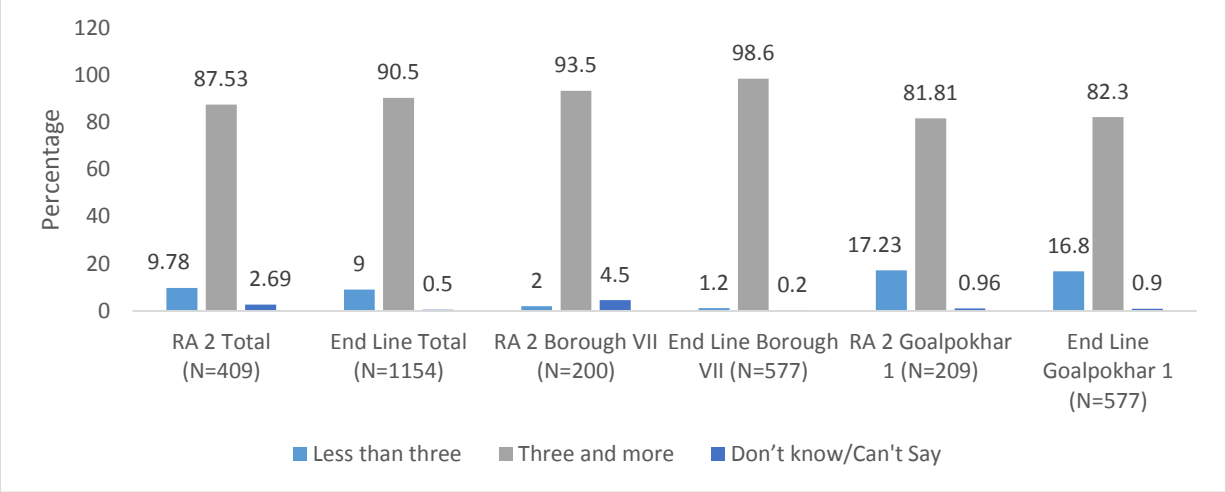
Table 7: Distribution of respondents by the reasons they think ANC is necessary (BASE: Those who mentioned ANC is necessary)

Reasons	Rapid Assessment 2 (%)			End Line		
	Total (N=401)	Borough VII (N=200)	Goalpokhar 1 (N=201)	Total (N=1142)	Borough VII (N=576)	Goalpokhar 1 (N=566)
To know the health of the mother	93.77	93.00	94.53	87.6	91.0	84.1
To know the health of the child	72.57	81.00	64.18	78.2	78.1	78.3
It is customary	1.25	1.50	1.00	2.3	3.6	0.9
Other	0.50	1.00	-	-	-	1.6

Practice related to Ante natal care

With respect to the actual practice of receiving ANC check-ups, it was observed that majority of the respondents across Borough VII (98.6%) and Goalpokhar 1 (82.3%) have received three or more ANC check-ups. This is consistent as against the proportion of women perceive ANC as necessary. These findings show a significant improvement compared to the Baseline figures where only 59.20% of the respondents were getting the mandated 3 ANC checkups in the rural setting and 88.60% were getting three ANC checkups in the urban areas. Figure 6 gives the distribution of respondents by number of ANC received during last pregnancy.

Figure 5: Distribution of respondents by number of ANC received during last pregnancy (BASE: ALL)



Advice on Antenatal care

On being asked about receiving any advice during their last pregnancy, 96.9% and 97.1% respondents in Borough VII and Goalpokhar 1 respectively mentioned receiving advice. Most respondents (79.7%) stated that they received advice during their last pregnancy from Change Agents. In Borough VII (76.3%) and Goalpokhar 1 (83.2%) majority of the respondents received advice from Change Agents, which was followed by doctors (63.9%) in Borough VII, while in Goalpokhar 1 it was followed by Accredited Social Health Activists (ASHA) workers (62.1%). The findings show the importance of Change Agents in the community at large, and significant role they have played in behavior change communication and driving better health practices by supporting government workers such as ASHAs. Table 8 presents distribution of respondents by whom they got advice.

Table 8: Distribution of respondents by from whom they got advice (BASE: Those who received advice during last pregnancy)

Source of advice	Rapid Assessment 2 (%)			End Line		
	Total (N=386)	Borough VII (N=192)	Goalpokhar 1 (N=194)	Total (N=1120)	Borough VII (N=560)	Goalpokhar 1 (N=560)
Doctor	59.59	86.46	32.99	41.4	63.9	18.9
ANM	17.10	3.13	30.93	17.9	7.9	27.9
AWW	27.72	23.96	31.44	15.1	9.8	20.4
ASHA	33.42	1.04	65.46	31.3	0.4	62.1
HHW	1.55	0.52	2.58	2.1	1.1	3.0
Change Agents	47.93	39.58	56.19	79.7	76.3	83.2
CINI Supervisors	11.66	10.42	12.89	1.5	1.8	1.3
Family members	13.73	16.67	10.82	21.3	33.6	8.9
Others	0.52	1.04	-	-	-	-

Knowledge of pregnancy related complication

When asked about their knowledge regarding pregnancy related complications, it was noted that overall only 45.5% of the respondents knew of pregnancy related complications. In Borough VII 58.5% and in Goalpokhar 1 50.4% of the respondents were aware of complications. Majority of respondents were aware of Oedema as a major pregnancy related complication, 48.5% in Borough VII and 69.8% in Goalpokhar 1. This was followed by knowledge about prolonged labour (39.1% in Borough VII and 47.8% in Goalpokhar 1). In Borough VII 71.3% also stated mentioned 'other' pregnancy related complications of which vomiting was the highest proportion. Table 9 reflects the distribution of respondents by their knowledge about the kind of pregnancy complications.

Table 9: Distribution of respondents by their knowledge about kind of complication of pregnancy (BASE: Those who mentioned to know about complications of pregnancy)

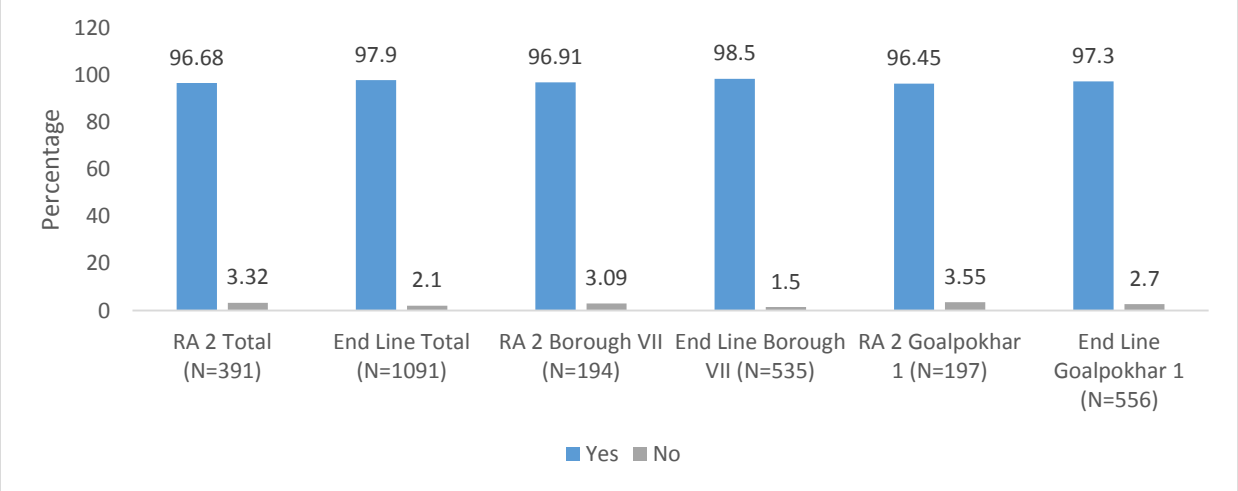
Complications of pregnancy	Rapid Assessment 2 (%)			End Line		
	Total (N=215)	Borough VII (N=119)	Goalpokhar 1 (N=96)	Total (N=629)	Borough VII (N=338)	Goalpokhar 1 (N=291)
Vaginal bleeding	50.23	47.06	54.17	14.0	14.2	13.7
Prolonged labour	40.93	36.13	46.88	43.1	39.1	47.8
Convulsions	35.35	29.41	42.71	11.8	8.3	15.8
Oedema	54.42	52.10	57.29	58.3	48.5	69.8
Others	10.23	14.29	5.21	52.0	71.3	29.6

Source of knowledge on pregnancy complications

As in the case of advice during pregnancy, most respondents mentioned Change Agents as their source of knowledge regarding complications of pregnancy. Compared to the RA2 period, there has been a visible improvement in the role played by Change Agents. While during RA2 only 30.25% mentioned Change Agents as their source of knowledge, this increased to 71.7% during the end line. The same was seen in Goalpokhar 1, where the proportion increased from 28.13%to 70.1%, highlighting the significance of Change Agents in knowledge dissemination. In Borough VII the next highest proportion is family members (49.4%) while in Goalpokhar 1 its ASHA workers (45%).

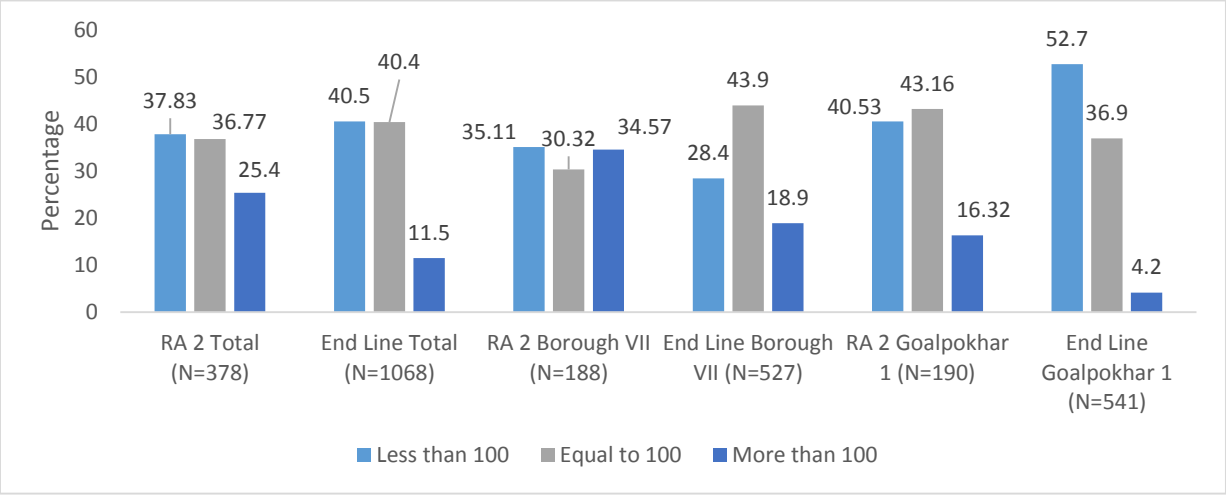
IFA consumption The reported percentage of respondents consuming IFA tablets during their pregnancy has increased from 96.9% to 98.5% in Borough VII and from 96.45% to 97.3% in Goalpokhar 1). Figure 6 shows the distribution of respondents by whether they consumed IFA during their last pregnancy.

Figure 6: Distribution of respondents by whether they consumed IFA during their last pregnancy (BASE: those who mentioned to receive IFA)



Among the respondents who did consume IFA during their last pregnancy, majority of the respondents in Borough VII (43.9%) consumed 100 IFA tablets as compared to 30.32% during the RA2 period, showing a significant improvement in their knowledge of consuming 100 IFA tablets during pregnancy. In Goalpokhar 1, majority of the respondents (52.7%) consumed less than 100 IFA tablets with 36.9% consuming 100 IFA tablets. This reflects a fall in proportion as compared to the RA2 period where 40.53% consumed less than 100 IFA while 43.16% consumed 100 IFA. Figure 7 shows the distribution of the respondents by number of IFA tablets consumed during their last pregnancy.

Figure 7: Distribution of respondents by number of IFA tables consumed during their last pregnancy (BASE: those who mentioned to receive IFA)

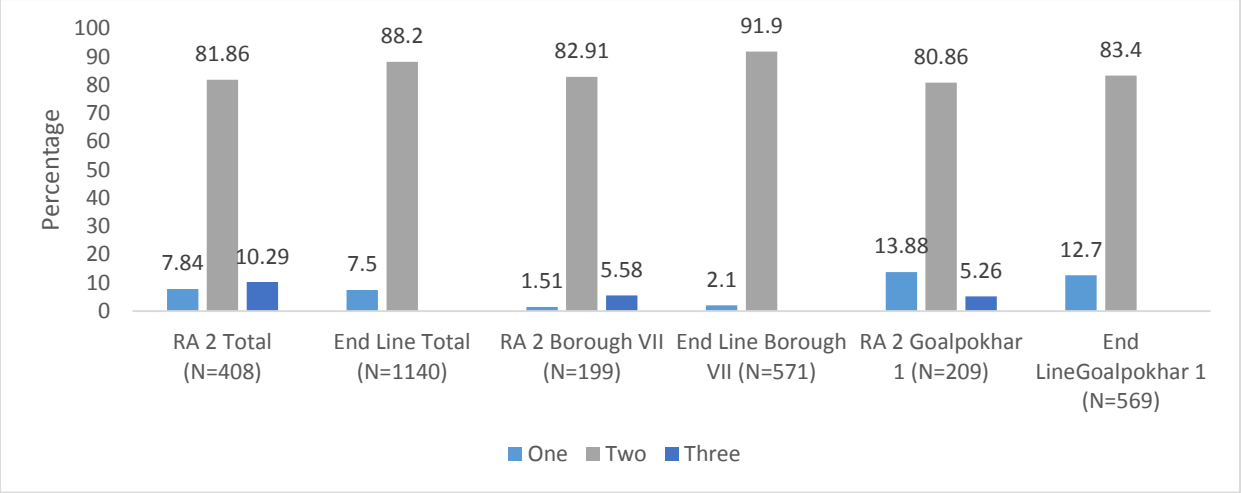


Among the respondents that did not consume IFA tablets, majority in Borough VII (44%) and Goalpokhar 1 (52.7%) mentioned vomiting as a common reason. During RA2 15.38% of the overall respondents stated family instruction as another reason. This has significantly reduced to 2.1% during the end line, indicating improved awareness about the importance of consuming IFA tablets during pregnancy amongst the respondents as well as their family members. 11.6% of the respondents in Goalpokhar 1 however stated that they did not need IFA tablets. Increase in outreach with the help of ASHA workers and Change Agents may help improve their knowledge.

TT injection

Majority of the respondents, when asked about the number of TT injections taken, mentioned taking 2 injections showing significant awareness about taking two TT shots during their pregnancy. Further, the statistics for receiving TT injections has improved from RA2 period to the end line, more significantly in Borough VII (from 82.91% to 91.9%) while in Goalpokhar 1 the findings show a change of 2.5% (from 80.86% to 83.4%). Figure 8 shows distribution of respondents by number of TT injections taken during last pregnancy.

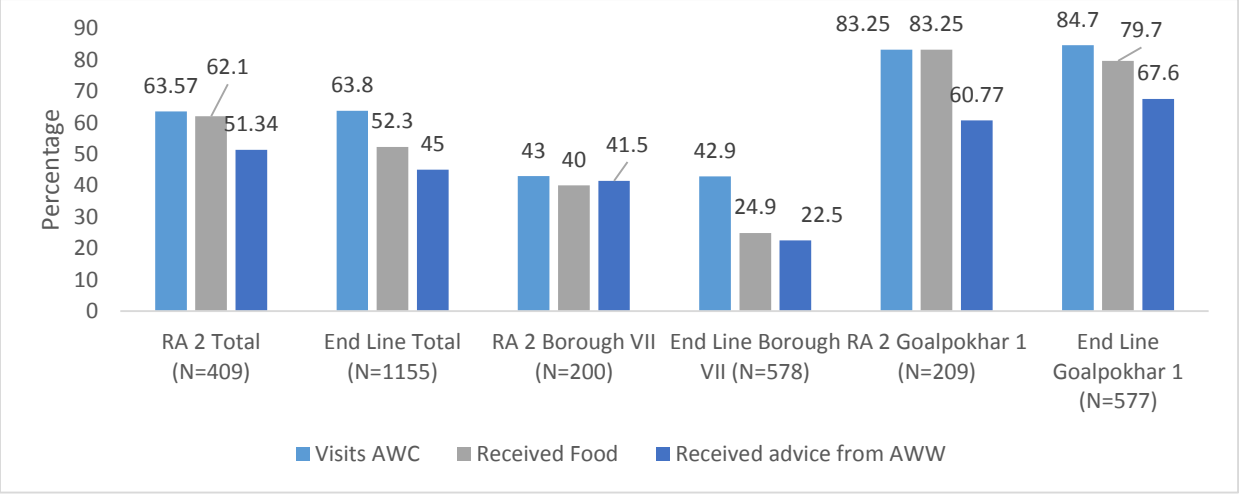
Figure 8: Distribution of respondents by number of TT taken during last pregnancy (BASE: those who mentioned to have taken TT)



Visit to Anganwadi Centers during Pregnancy

The proportion of respondents visiting Anganwadi Centers (AWC) is comparable to the baseline with 42.9% in Borough VII and 84.7% in Goalpokhar 1, however reflecting a significant difference in urban and rural settings. With respect to receiving food from AWCs, there has been a fall in proportion more significantly in Borough VII (from 40% to 24.9%) than in Goalpokhar 1 (from 83.25% to 79.7%). On receiving advice from AWW, the proportion in Borough VII (22.5%) has fallen as compared to the RA2 period (41.5%) while proportion in Goalpokhar 1 (67.6%) has increased from 60.77%. Figure 9 presents the distribution of respondents by if they visit AWC, have received food from AWC and have been advised by AWW.

Figure 9: Distribution of respondents by if they visit AWC, received food and advice during last pregnancy (BASE: all)



Among the respondents who did not visit the AWC, majority of them in Borough VII mentioned lack of AWW being there (33.9%) as a reason followed by husband and family not allowing them to visit the AWC (33.9%). In Goalpokhar 1, 36.4% have not provided specific reasons for not visiting but 33% mentioned that the AWC was too far and 12.5% mentioned not finding it necessary.

Majority of respondents that did not eat the food received from the AWC mentioned poor quality of the food as the reason (64.9%). Table 10 represents findings on aspects of service delivery at AWC.

Table 10: Distribution of respondents by different aspects of service delivery at AWC

Eaten food provided from AWC(Base: Those who reported to receive food from AWC)	**Rapid Assessment 2 (%)**			**End Line**		
	Total (N=254)	**Borough VII (N=80)**	**Goalpokhar 1 (N=174)**	**Total (N=600)**	**Borough VII (N=144)**	**Goalpokhar 1 (N=460)**
	98.03	97.50	98.28	93.9	94.4	93.7
Reasons for not eating food provided from AWC(Base: Those who reported not to eat food from AWC)	**Total (N=5)**	**Borough VII (N=2)**	**Goalpokhar 1 (N=3)**	**Total (N=36)**	**Borough VII (N=1)**	**Goalpokhar 1 (N=29)**
Not good quality	20.00	50.00	-	64.9	100	55.2
Distributed amongst family members	-	-	-	22.2	-	27.6
Don't Know/Can't Say	80.00	50.00	100.00	8.3	-	10.3

3.3. Child Birth and Janani Suraksha Yojana

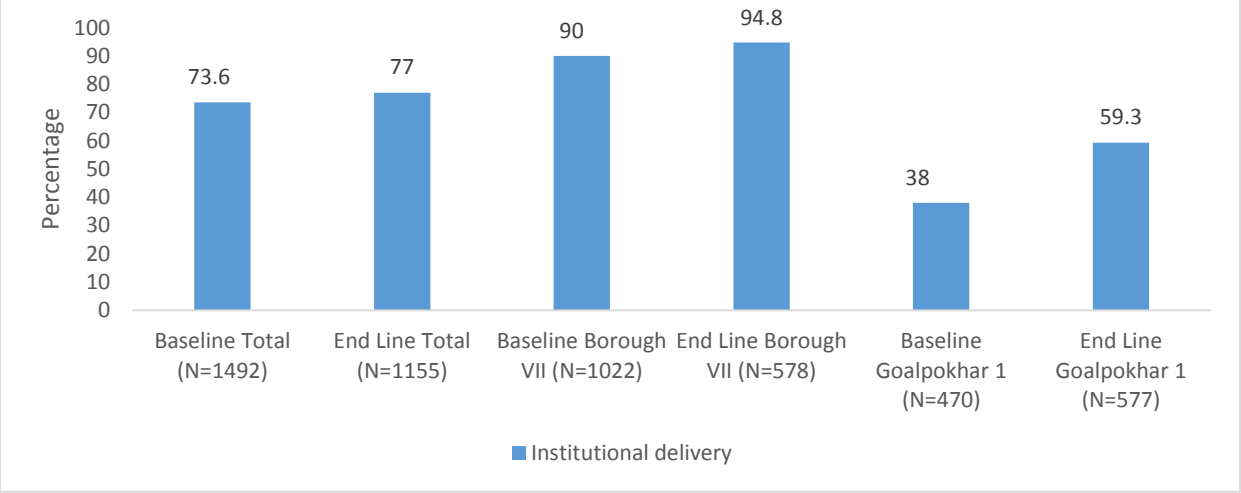
This section presents indicators on child birth, quality of care during delivery and practices on newborn care. Additional it provides details on knowledge about Janani Suraksha Yojana (JSY) and eligibility for it, among the respondents.

Institutional Delivery

Traditionally most women within the rural setting give birth at home with the help of family members, Dai, or others who don't have professional healthcare training, while the practice of institutional delivery is higher in urban settings. The same can be seen amongst our respondents where the percentage of institutional delivery in Borough VII (94.8%) is relatively more as compared to the practice in Goalpokhar 1 (90%). However, it has been observed that there has been a significant pick up of the practice (by 21%) in Goalpokhar 1 as compared to the RA2 period (38%). The baseline showed that 47.80% of Rural-Muslim and 51.30% Rural-Hindu opted for institutional deliveries while 86.20% Urban-Muslim and 92.70% Urban-Hindu opted for institutional deliveries.

Overall proportion of births within the state for the last child are high across Borough VII (95.2%) and Goalpokhar 1 (90.6%). Figure 10 presents the distribution of respondents based on institutional delivery.

Figure 10: Distribution of respondents by institutional delivery and birth within state for last child (BASE: ALL)



Among the respondents who gave birth at home instead of opting for institutional deliveries, while majority of them did not give a specific reason, the other most common reason stated in Borough VII (14.66) and Goalpokhar 1 (44.6 %) was that they did think it was necessary to go to an institution. The findings believe that this belief is more prevalent in rural settings, and therefore more behavior change communication needs to be focused to promote institutional delivery in rural areas. Table 11 gives the distribution of respondents by reasons of non-institutional delivery.

Table 11: Distribution of respondents by reasons of non-institutional delivery (BASE: those who opted for non-institutional delivery during last child)

Reasons for non-institutional delivery	Rapid Assessment 2 (%)			End Line		
	Total (N=136)	Borough VII (N=11)	Goalpokhar 1 (N=125)	Total (N=704)	Borough VII (N=191)	Goalpokhar 1 (N=513)

Costs too much	4.41	9.09	4.00	2.4	2.09	2.5
Facility not open	-	-	-	0.4	1.05	0.2
Too far/no transport	31.62	27.27	32.00	3.6	0.52	4.7
Don't trust facility/poor quality service	3.68	-	4.00	0.3	0.52	0.2
No female provider in facility	-	-	-	-	-	-
Husband/family relative didn't allow	1.47	-	1.60	0.9	1.05	1.0
Not necessary	48.53	-	52.8	36.5	14.66	44.6
No registration card	-	-	-	0.1	-	0.2
Not customary	5.88	-	6.40	-	-	-
Returned from hospital	0.74	9.09	-	0.4	-	0.6
Others	18.38	54.55	15.20	9.2	2.09	11.9
Don't know/ Can't say	-	-	-	53.0	79.58	43.1

Of the respondents who opted for institutional delivery, majority of the urban respondents (32.5%) stayed at the hospital/ nursing home for 7 days followed by 23.2% staying for a duration of 3 days. In Goalpokhar 1 (rural respondents), majority (29.9%) stayed only for 24 hours followed by 29.5% staying for 48 hours. Table 12 below presents distribution of respondents based on duration of staying at hospitals/ nursing homes.

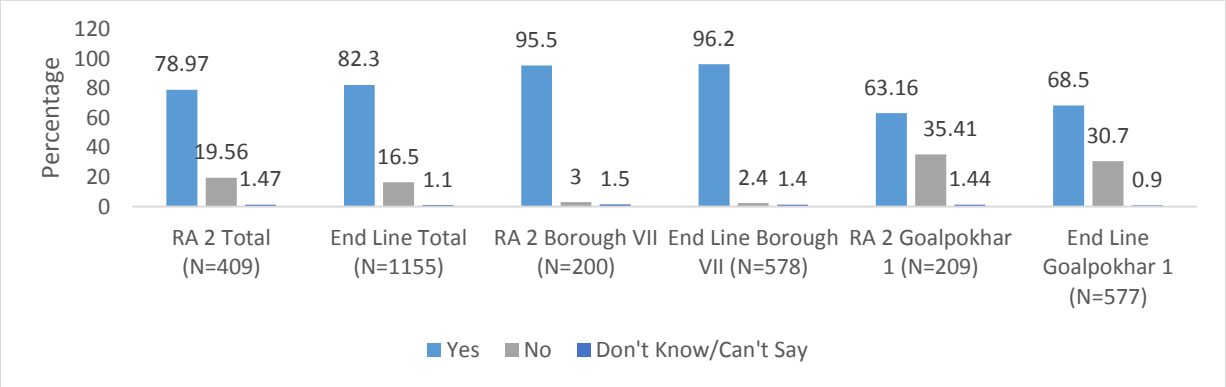
Table 12: Distribution of respondents by duration of staying at hospital/nursing home (BASE: those who opted for institutional delivery during last child)

Duration of staying at hospital/ nursing home	Rapid Assessment 2 (%)			End Line		
	Total (N=270)	Borough VII (N=187)	Goalpokhar 1 (N=83)	Total (N=835)	Borough VII (N=547)	Goalpokhar 1 (N=288)
24hours	14.81	12.30	20.48	17.7	11.3	29.9
48hours	20.74	15.51	32.53	20.2	15.4	29.5
3days	19.63	18.72	21.69	20.8	23.2	16.3
7days	28.15	34.22	14.46	26.2	32.5	14.2
Other	16.30	18.72	10.84	10.9	12.1	8.7
Don't Know/Can't Say	0.37	0.53	-	4.1	5.5	1.4

Weight measurement of the Child at birth

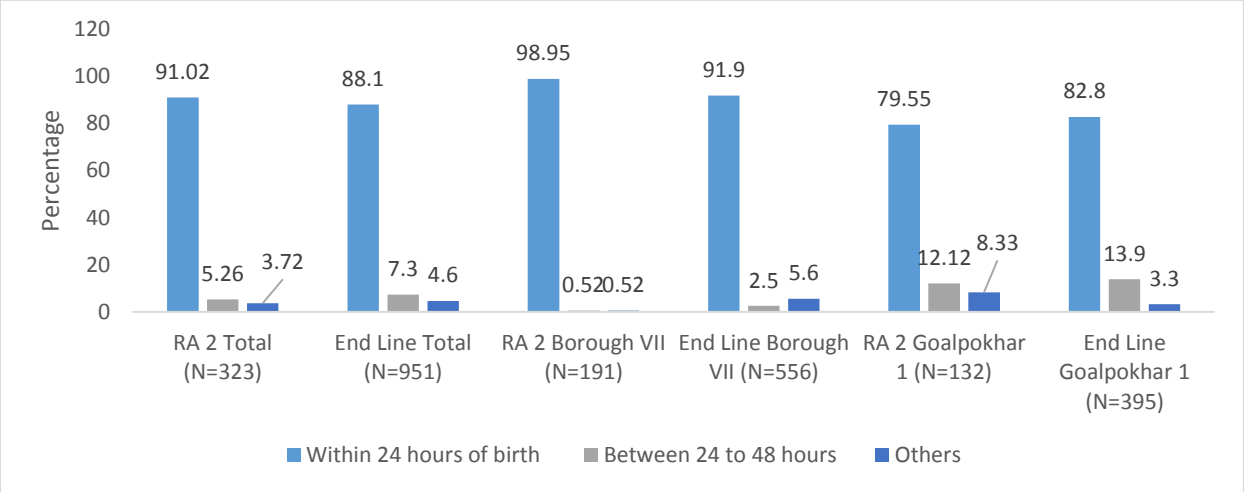
With r*espect to the child being weighed* after he/ she is born, the proportion of respondents stating that weight was taken is high in Borough VII (96.2%), however is still only 68.5% in Goalpokhar 1. While the findings show an improvement in Goalpokhar 1 from the RA2 period, 30% of the women stated that the weight was not measured. Figure 11 highlights the distribution of respondents by whether the weight of the child was measured after he/she was born.

Figure 11: Distribution of respondents by whether the child was weighed after he/she was born (BASE: ALL)



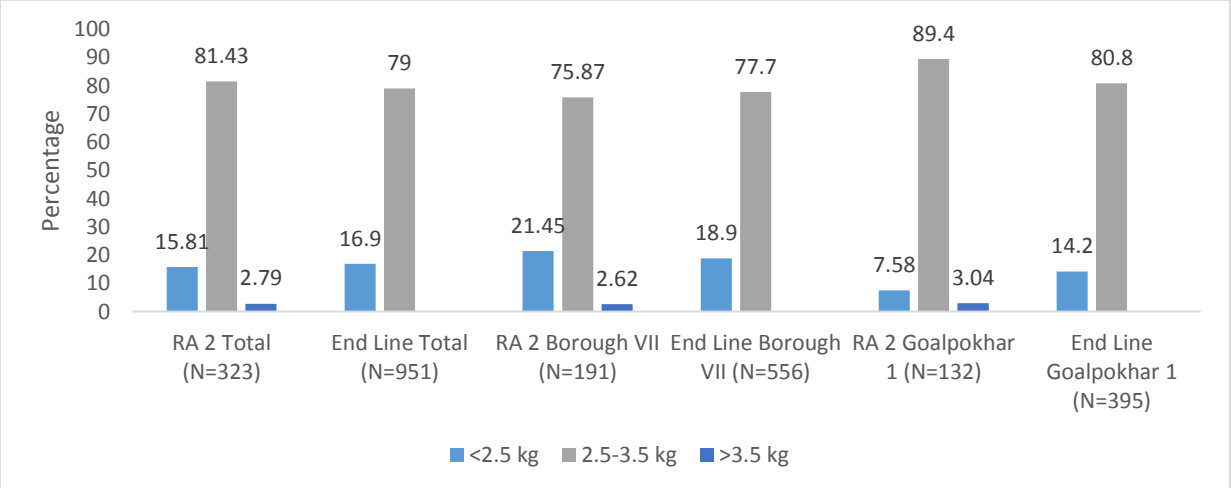
Of the respondents whose babies were weighed at birth, 91.9% in Borough VII stated that the weight was measured within 24 hours, followed by 2.5% stating weight was taken between 24 hours to 48 hours. In Goalpokhar 1, 82.8% stated that the child's weight was measured within 24 hours while 13.9% stated that weight was measured between 24 hours to 48 hours. Figure 12, represents the data below.

Figure 12: Distribution of respondents by when the child was weighed after birth (BASE: those who are weighed)



The desirable birth weight of newborn children is 2.5kgs. Majority of the respondents in Borough VII (77.7%) and Goalpokhar 1 (80.8%) stated that their last child's weight was over 2.5kgs. The distribution of respondents by birth weight of their last child is given in Figure 13.

Figure 13: Distribution of respondents by birth weight of their last children (BASE: those who are weighed)

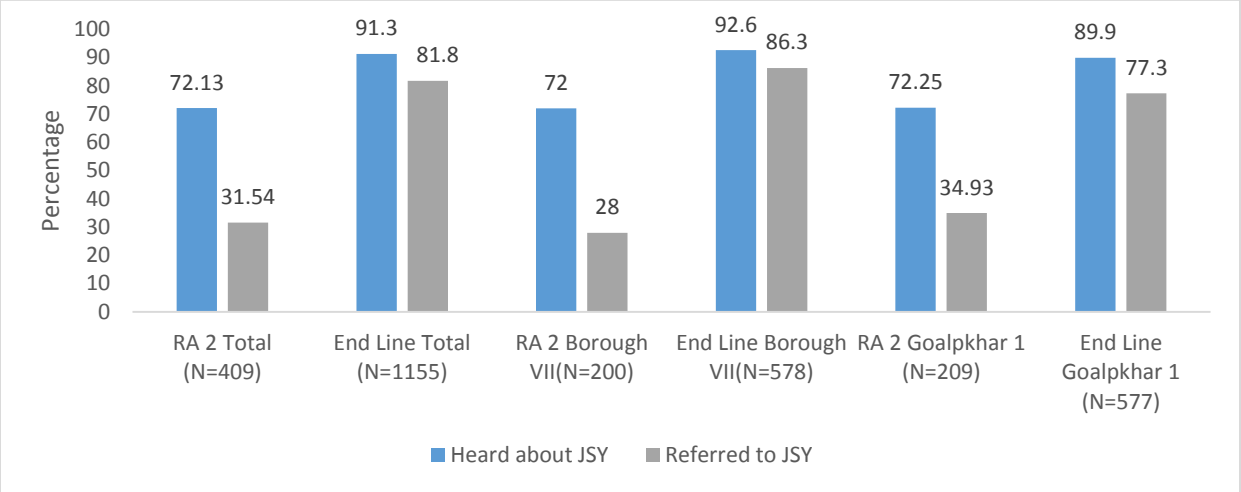


Janani Surkasha Yojana

On beings asked about their awareness about JSY during the end line study, 91.3% respondents stated that they had heard about JSY. This has been a significant improvement since the RA2, where comparatively only 72.13% of the respondents had heard of JSY. It can be inferred that knowledge regarding JSY has been disseminated since the initiation of the program, especially since the baseline figures also indicate that 73.12% in rural areas and 64.60% in urban areas were aware of JSY. These figures have improved with 89.9% and 92.6% respondents having heard of JSY in rural and urban settings respectively. Further, the number of respondents being referred to JSY has also increased visibly when

compared to RA2 findings. During RA2 only 28% mothers were referred to JSY while 86.3% were referred during the end line in Borough VII. Goalpokhar 1 also shows a significant increase from 34.93% being referred to 77.3% during the end line. Figure 14 indicates the distribution of the respondents based on their awareness about JSY and if they were referred.

Figure 14: Distribution of respondents by whether they heard about JSY and referred during last child birth (BASE: ALL)



When asked about their knowledge about JSY in terms of eligibility criteria, 22.6% of the respondents in Borough VII and 35.3% in Goalpokhar 1 stated BPL and above 18 years as the criteria for JSY. This was followed by 20% in Borough VII stating all women of all ages as the next most common criteria. In Goalpokhar 1, BPL and all ages was chosen as the next most common response at 27.2%. This shows that the respondents across rural and urban regions are not very aware of the JSY program's eligibility criteria. When asked about the number of times JSY can be availed, 45% in Borough VII stated that JSY can be availed for first two live births, while 40.7% in Goalpokhar 1 mentioned that it can be availed for all born children. Amongst the benefits one should get under the JSY, majority of the respondents across both Borough VII (89.4%) and Goalpokhar 1 (91.7%) mentioned cash after delivery as the major benefit received. Table 13 presents distribution of respondents by their knowledge about JSY.

Table 13: Distribution of respondents by their knowledge about JSY (BASE: those who heard about JSY)

Eligibility Criteria for JSY	Rapid Assessment 2 (%)			End Line		
	Total (N=295)	Borough VII (N=144)	Goalpokhar 1 (N=151)	Total (N=1054)	Borough VII (N=535)	Goalpokhar 1 (N=519)
BPL & Age above 18years	24.41	18.06	30.46	28.8	22.6	35.3
BPL & all ages	9.15	4.86	13.25	20.2	13.5	27.2
All women of 18years and above	3.39	3.47	3.31	9.3	14.6	3.9
All women of all ages	5.42	5.56	5.30	19.0	20.0	17.9
Completed 4ANC & had institutional delivery	19.32	20.14	18.54	2.5	4.1	0.8
Completed 4ANC & home delivery	1.02	0.69	1.32	1.6	3.0	0.2
Mother's ID	20.68	24.31	17.22	-	-	-
Bank Account	27.80	38.19	17.88	-	-	-
Others	3.73	6.25	1.32	6.3	9.9	2.5
Don't know/Can't Say	22.03	18.75	25.17	12.3	12.3	12.3
Number of times one can avail JSY	**Total (N=295)**	**Borough VII (N=144)**	**Goalpokhar 1 (N=151)**	**Total (N=1054)**	**Borough VII (N=535)**	**Goalpokhar 1 (N=519)**
For first two live births	21.69	25.00	18.54	41.4	45.0	37.6
For all born children	25.76	20.83	30.46	33.1	25.8	40.7
Others	6.44	6.25	6.62	3.2	3.2	3.3
Don't know/Can't Say	46.10	47.92	44.37	22.3	26.0	18.5

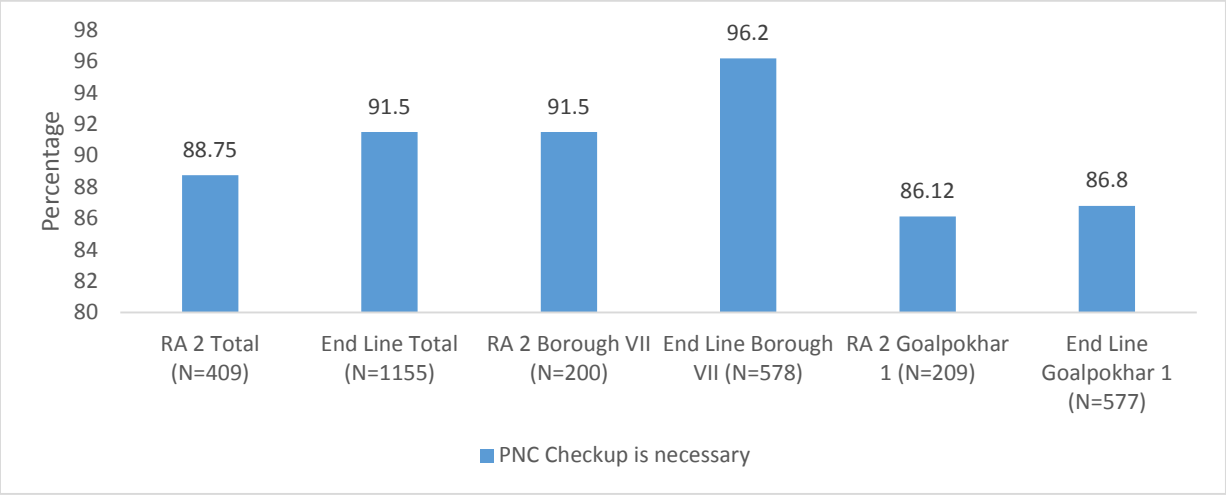
Benefits one should get under JSY	Total (N=295)	Borough VII (N=144)	Goalpokhar 1 (N=151)	Total (N=1054)	Borough VII (N=535)	Goalpokhar 1 (N=519)
Registration card	18.31	20.14	16.56	2.2	1.5	2.9
ANC	4.07	4.17	3.97	0.4	0.2	0.6
Cash after delivery	50.17	50.00	50.33	89.2	89.4	91.7
Money given for going to hospital	17.97	20.14	15.89	10.7	12.7	9.1
Free delivery	18.98	20.83	17.22	12.0	11.9	12.9
Other	1.36	1.39	1.32	0.4	111.9	0.4
Don't Know/Can't Say	26.78	27.78	25.83	4.2	5.0	3.9

3.4. Post Natal Care

Perception about Postnatal care

Of the respondents surveyed during the end line about the necessity of PNC check-ups, 96.2% in Borough VII and 86.8% in Goalpokhar 1 mentioned PNC check-ups as necessary. 94.5% in Borough VII and 86.5 % in Goalpokhar 1 mentioned having received PNC checkups. Figure 15 presents the distribution of the respondents who think PNC checkups are necessary.

Figure 15: Distribution of respondents who thinks PNC check-up is necessary (BASE: ALL)



On reasons why PNC check-ups are essential, majority of the respondents in Borough VII (94.2%) and Goalpokhar 1 (88.8%) stated 'knowing the mother's health' as the major reason. This was followed by 54% respondents in Borough VII and 33.3% respondents in Goalpokhar 1 mentioning 'knowing about child's health' as the reason. Distribution of respondents by reasons why PNC check-ups are necessary is given in Table 14.

Table 14: Distribution of respondents by the reasons of thinking PNC is necessary (BASE: those who think PNC is necessary)

Reasons	Rapid Assessment 2 (%)			End Line		
	Total (N=363)	Borough VII (N=183)	Goalpokhar 1 (N=180)	Total (N=1132)	Borough VII (N=556)	Goalpokhar 1 (N=576)
To know the health of the mother	97.52	98.91	96.11	91.7	94.2	88.8
It is customary	4.41	4.92	3.89	9.2	12.1	6.0
To know about your child's health				42.9	54.0	33.3
Don't Know/Can't Say	0.83	-	1.67	1.5	0.4	2.8
Other	0.28	0.55	-	-	-	-

Among the respondents that mentioned PNC check-ups as important, majority of them stated that one should get PNC check-ups done 4 times. In Borough VII 53.1% mentioned 4 times as the number of times PNC check-ups should be done followed by 19.1% mentioning 3 times, while in Goalpokhar 1 38.7% mentioned 4 times followed by 11% stating 3 times as the ideal number. In both areas, 16.5% (Borough VII) and 30.7% (Goalpokhar 1) stated that they did not know/couldn't say. However, compared to findings during the RA2 period (shown in Table 15), there has been a fall in the number of women not knowing.

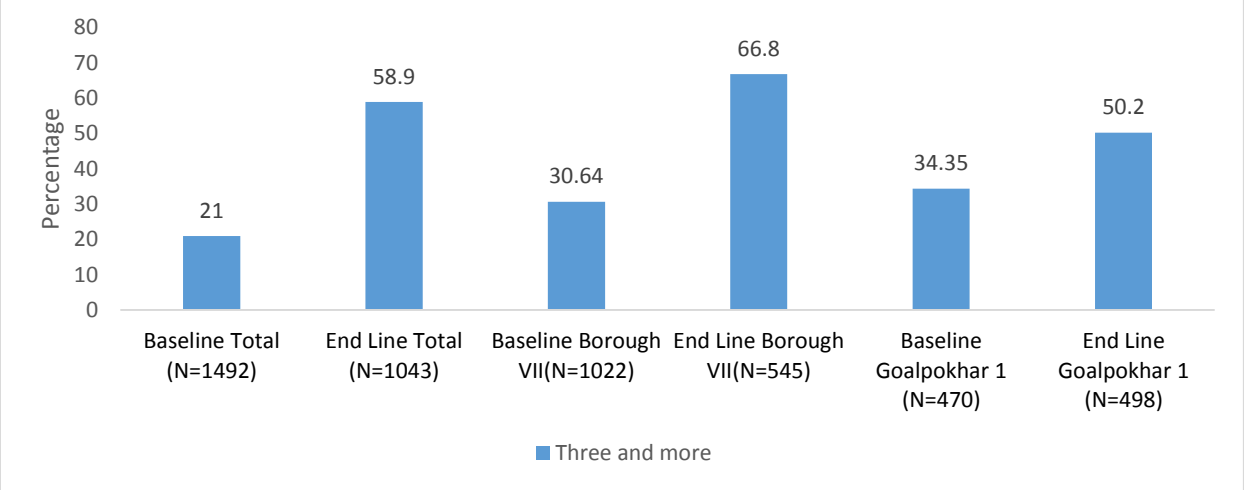
Table 15: Distribution of respondents by their knowledge about number of times one should get PNC checkups (BASE: ALL)

Number of times	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1057)	Borough VII (N=556)	Goalpokhar 1 (N=501)
1times	10.27	16.00	4.78	5.9	1.8	10.4
2times	12.96	12.00	13.88	8.1	7.7	8.6
3times	10.02	11.00	9.09	15.2	19.1	11.0
4times	13.94	13.00	14.83	46.3	53.1	38.7
6times	0.24	0.50	-	0.4	0.7	-
Don't Know/Can't Say	52.57	47.50	57.42	23.3	16.5	30.7

Women who received post natal care

Of the respondents who received PNC check-ups 66.8% in Borough VII received three or more check-ups. This shows a significant improvement from the baseline period, where only 21% received three or more PNC check-ups (the ideal number of PNC check-ups necessary). In Goalpokhar 1, the number of women receiving three or more check-ups has increased from 34.35% to 50.2%. Figure 16 below presents the distribution of respondents by number of PNC check-ups received.

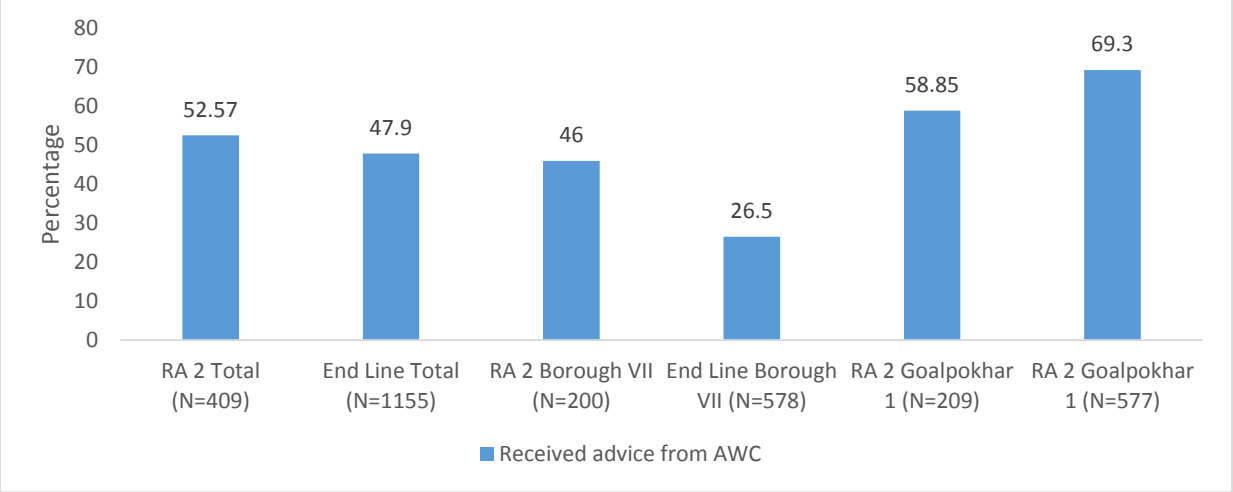
Figure 16: Distribution of respondents by number of PNC checkups received (BASE: those who received PNC)



Visit to AWC after delivery

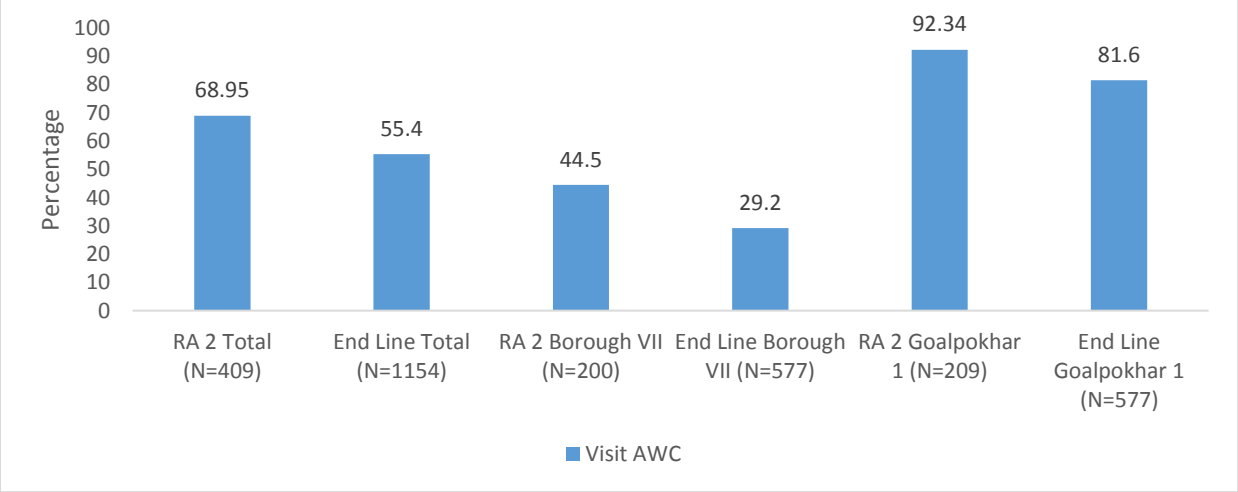
Amongst the respondents who mentioned that they received advice from AWC only 26.5% respondents in Borough VII mentioned receiving advice from AWC while 69.3% respondents in Goalpokhar 1 mentioned receiving advice from AWC. While there has been improvement in Goalpokhar 1 as compared to the RA2 period, there has been an approximate fall of 20% in Borough VII. The distribution of respondents by those who received advice from AWC is given in Figure 17 below.

Figure 17: Distribution of respondents who received advice from AWC



Only 29.2% respondents visits an AWC after their last delivery in Borough VII while 81. 6% visited an AWC in Goalpokhar 1. There has been a fall in proportion of women visiting AWC across the urban as well as rural areas as compared to the RA2 period (given in Figure 18 below).

Figure 18: Distribution of respondents who visited AWC after last delivery (BASE: ALL)



The reasons for not visiting as given in Table 16. Majority of the study group in Borough VII (36.5%) mentioned not finding it necessary as the reason for not visiting followed by 27% who mentioned the lack of an AWW being present at the AWC as the reason. In Goalpokhar 1, as well majority of women (26.7%) mentioned not being necessary as the reason followed by 21.9% women who thought that the AWC was too far. A point to note is that, overall there has been an increase in the family/husbands being unwilling/not allowing the women to visit an AWC. This proportion has increased in Borough VII from 1.8% to 5.7%.

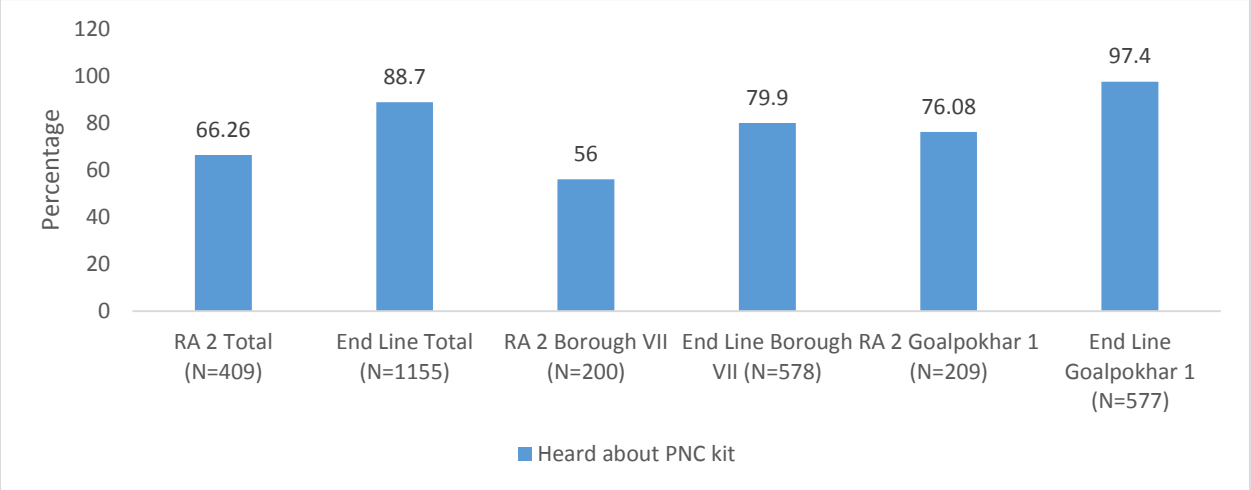
Table 16: Distribution of respondents by reasons of not visiting AWC (BASE: those who do not visit AWC)

Reasons	Rapid Assessment 2 (%)			End Line		
	Total (N=127)	Borough VII (N=111)	Goalpokhar 1 (N=16)	Total (N=527)	Borough VII (N=419)	Goalpokhar 1 (N=108)
AWW not there	3.15	3.6	0	24.4	27	14.3
Facilities not available	7.87	9.01	0	2.5	2.5	2.9
Too far	9.45	3.6	50	7.8	4.2	21.9
I didn't have enough time	15.75	16.22	12.5	3.5	3.9	1.9
Husband/family did not allow	1.57	1.8	0	5.7	7.1	-
Not necessary	7.87	9.01	0	36.5	39	26.7
Don't know where is ICDS centre	3.94	4.5	0	0.6	-	-
Don't go outside the home	0.79	0.9	0	-	-	-
one visit from AWC after child birth	0.79	0.9	0	-	-	-
No one tell to go there	1.57	1.8	0	-	-	-
AWC reject to register	0.79	0.9	0	-	-	-
Don't give khichuri	0.79	0	6.25	-	-	-
Don't Know/Can't Say	48.82	52.25	25	20.5	17.9	30.5

Postnatal care kit

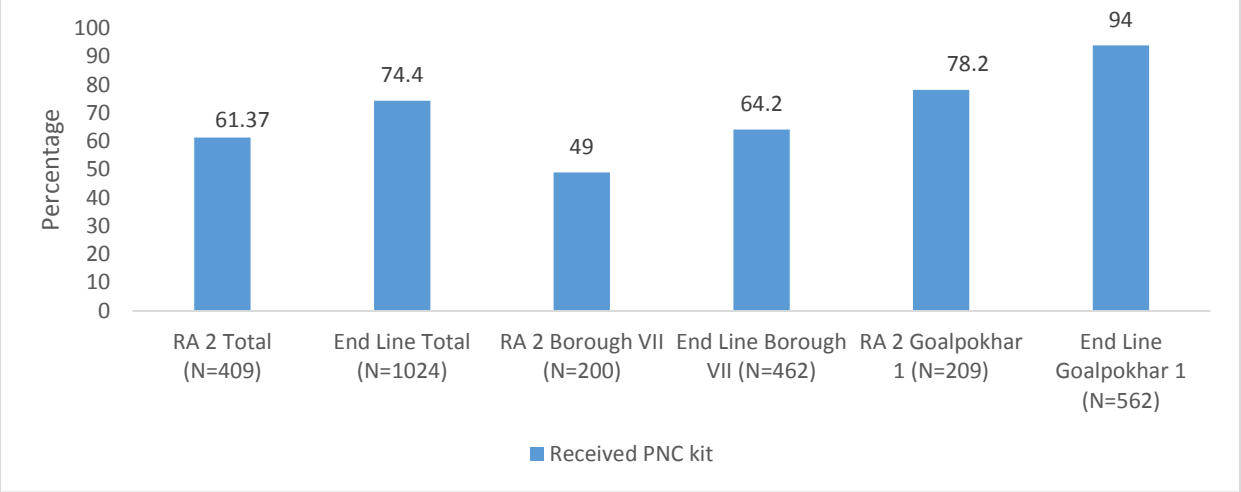
When the respondents were asked if they had heard of a PNC kit, overall 88.7% women mentioned knowing about a PNC kit as compared to 66.26% in the RA2 period. Borough VII and Goalpokhar 1, have both shown an improvement in the awareness amongst women regarding PNC kits. Figure 19 presents distribution of respondents by those who have heard of PNC kits.

Figure 19: Distribution of respondents who heard about PNC kit (BASE: ALL)



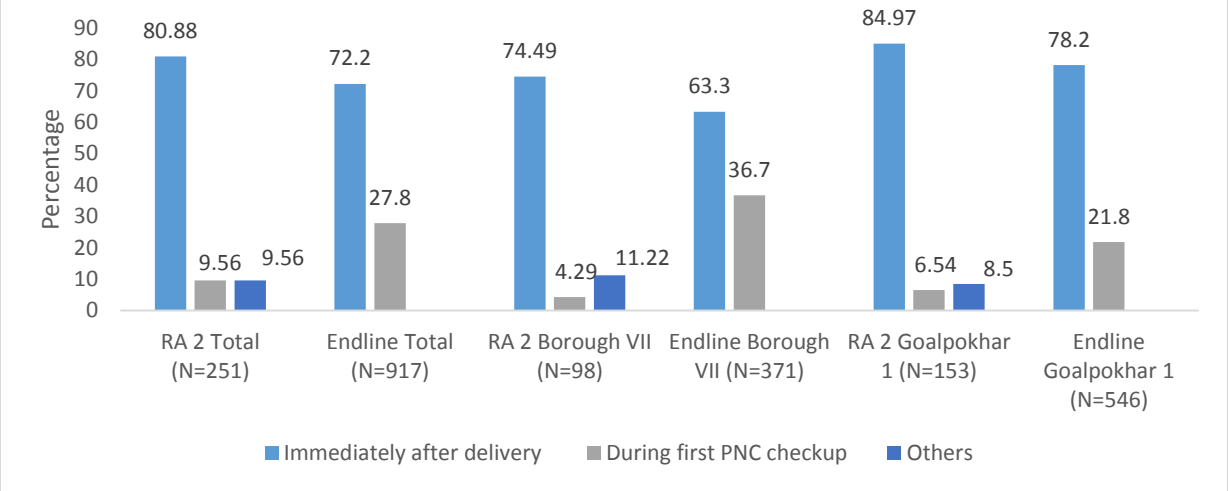
Across Borough VII and Goalpokhar 1, the number of respondents who received PNC kits has increased by 15% and 16% respectively. Figure 20 below presents the distribution of respondents by those who received PNC kits after their last pregnancy. 64.2% in Borough VII and 94% respondents in Goalpokhar 1 reported to receive PNC kits during the end line survey.

Figure 20: Distribution of respondents who received PNC kit after last delivery (BASE: ALL)



Of the respondents who received PNC kits, 63.3% of the respondents in Borough VII reported to receive the PNC kit immediately after delivery while 36.7% reported to receive the kit during the first PNC checkup. In Goalpokhar 1, a significantly higher proportion of respondents reported to receive the PNC kit immediately after delivery i.e. 78.2% while 21.8% reported to receive it during their first PNC checkup. The findings have been presented in Figure 21.

Figure 21: Distribution of respondents by when they received PNC kit (BASE: those who received PNC kits)



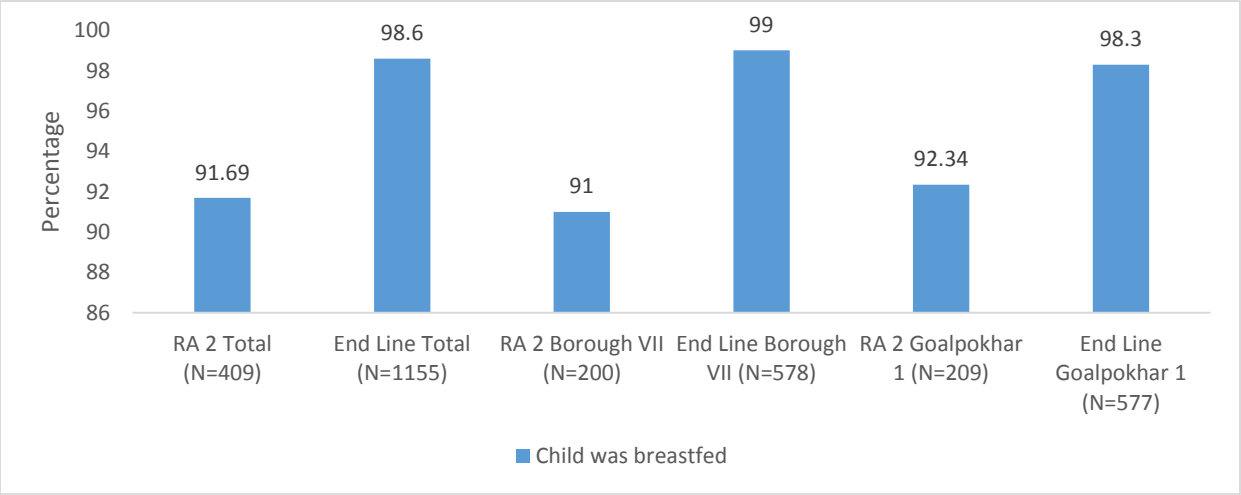
3.5. Breast Feeding and Child Care

This section focuses on findings regarding new born child care and breast feeding practices that are essential indicators for infant health and malnutrition such as early initiation to breastfeeding, feeding of colostrum, exclusive breastfeeding for the first six months with special emphasis on no water for six months, appropriate complementary feeding, respondent's hygiene practices, care for children with diarrhoea etc.

Breastfeeding of their last child

Majority of the respondents (99% in Borough VII and 98.3% in Goalpokhar 1) breastfed their last child. The practice of initiating breastfeeding has improved across the urban and rural environment from the time of the RA2. These findings suggest that the project was able to successfully share information on newborn care. Figure 22 below represents distribution of respondents by whether they fed their last child. Additionally, the reporting highlighted that colostrum feeding has improved from 87% to 95.3% in Borough VII and from 89.95% to 94.7% in Goalpokhar 1. These findings indicate that women are aware of the importance of colostrum feeding, and the awareness is similar to the awareness on importance of breast feeding.

Figure 22: Distribution of respondents by whether their last child was breastfed (BASE: ALL)



Among the respondents that did not breast feed, the majority of the respondents cited milk not being available as the reason (66.7% in Borough VII and 40% in Goalpokhar 1). Other reasons included the mother being unwell. These findings indicate that in other circumstances these respondents would have practiced breast feeding, and only didn't do so under unpreventable circumstances. Table 17 below presents the distribution of respondents by reasons for not breastfeeding.

Table 17: Distribution of respondents by the reasons for not breast feeding (BASE: those who did not breastfed)

Reasons for not breast feeding	Rapid Assessment 2 (%)			End Line		
	Total (N=34)	Borough VII (N=18)	Goalpokhar 1 (N=16)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Milk not available	94.12	88.89	100.00	50.0	66.7	40
Mother was ill	5.88	11.11	-	31.3	16.7	20
Was not suggested by doctor/nurse/ANM/AWW	2.94	5.56	-		-	-
Don't know/Can't say	-	-	-	6.3	16.7	-

Initiation of breast feeding

The end line survey with the respondents highlight that the practice of initiating breastfeeding within 1 hour of birth has increased in comparison with the RA2 period, with a 30% increase in Borough VII and a 33% increase in Goalpokhar 1. However the overall proportion of women following the practice is not very high (63.7%). Goalpokhar 1 in comparison has performed better than Borough VII with 78.5% women initiating breastfeeding within 1 hour of birth while only 49% did so in Borough VII. Table 18 presents the distribution of the respondents by the time of initiation of breast feeding.

Table 18: Distribution of respondents by the time of initiation of breast feeding (BASE: those who breastfed)

Time of first breast feeding	Rapid Assessment 2 (%)			End Line		
	Total (N=375)	Borough VII (N=182)	Goalpokhar 1 (N=193)	Total (N=1147)	Borough VII (N=574)	Goalpokhar 1 (N=573)
Within 1hour of birth	32.00	18.68	44.56	63.7	49	78.5
Between 1-2hours of birth	15.47	18.68	12.44	14.5	19.1	9.9
Between 2-24hours	13.87	24.18	4.15	11.2	17.2	5.3
After the first day	5.60	5.49	5.70	9.8	13.3	6.3
Don't Know/Can't Say	0.53	1.10	-	1.0	1.6	-

Exclusive breastfeeding

Overall 91% of the respondents feed only breast milk to their new born (i.e. exclusive breastfeeding). In Borough VII 89.6% feed only breast milk while 7.8% feed baby food and breast milk and on the other hand, 92.4% of the respondents feed only breast milk followed by 6.6% feeding other milk and breast milk. While the percentages of only breast milk feeding practice is high and has also improved in comparison to the RA2 timeline, it can be observed that women are unaware of the need to exclusively breastfeed up to 6 months. Table 19 below presents findings on respondents based on feeding practice up till 6 months.

Table 19: Distribution of respondents by feeding practice from birth till 6 months (BASE: ALL)

Kind of food provided	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1152)	Borough VII (N=576)	Goalpokhar 1 (N=576)
Only breast milk	79.71	74.00	85.17	91.0%	89.6%	92.4%
Water & breast milk	7.09	10.50	3.83	2.5%	4.7%	0.3%
Other milk & breast milk	3.91	4.00	3.83	4.2%	1.7%	6.6%
Honey & breast milk	3.42	1.50	5.26	.7%	0.5%	0.9%
Baby food & breast milk	9.05	13.00	5.26	5.5%	7.8%	3.3%
Other liquid & breast milk	0.49	1.00	-	.2%	0.2%	0.2%
Other	2.93	4.00	1.91	.1%	-	-

Majority of the respondents understand the meaning of exclusive breastfeeding. This is indicative in the end line findings where 98.3% in Borough VII and 98.8% in Goalpokhar 1 defined exclusive breastfeeding as feeding only breast milk to the child. When asked about the practice of exclusive breastfeeding 77.5% in Borough VII and 89.4% in Goalpokhar 1 exclusively fed their last child for 6 to 12 months and 9.7% and 7.5% respectively, exclusively fed their last child for less than 6 months. Tables 20 and 21 present the distribution of respondents by their knowledge about the meaning of exclusive breastfeeding and the distribution of respondents by months till the last child was exclusively breast fed.

Table 20: Distribution of respondents by their knowledge about the meaning of exclusive breast feeding (BASE: ALL)

Meaning of exclusive breast feeding	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1152)	Borough VII (N=576)	Goalpokhar 1 (N=576)
Only breast milk	95.60	94.50	96.65	98.5	98.3	98.8
Water & breast milk	2.69	4.00	1.44	0.5	0.7	0.3
Babyfood & breast milk	0.49	1.00	-	0.1	0.2	-
Other liquid & breast milk	0.49	1.00	-	0.3	0.3	0.2
Other	0.49	1.00	-	-	-	-
Don't Know/Can't Say	0.98	-	1.91	0.6	0.7	0.5

Table 21: Distribution of respondents by months till last child was exclusively breast fed (BASE: ALL)

Age in months	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Below 6	17.36	21.00	13.88	8.6	9.7	7.5
6-12	33.74	34.50	33.01	83.5	77.5	89.4
13-15	0.49	1.00	-	1.4	2.4	0.3
16-24				2.1	4.0	0.2
25-36	0.24	-	0.48	-	-	0.0
Currently Feeding	47.68	43.00	52.51	3.5	5.4	1.6
Don't Know/Can't Say	0.49	0.50	0.48	8.6	1.0	1.0

Complementary feeding

When asked about feeding practices, with respect age of the child at which semi-solid foods were given, 79.1% in Borough VII and 75.6% in Goalpokhar 1 mentioned that they fed semi-solid food to their last child at the age of 7 months, indicating that the respondents are aware of the importance of exclusive feeding upto 6 months and the age at which complementary foods can be started. Table 22 gives the distribution of respondents by age at which semi solid food were started for the child.

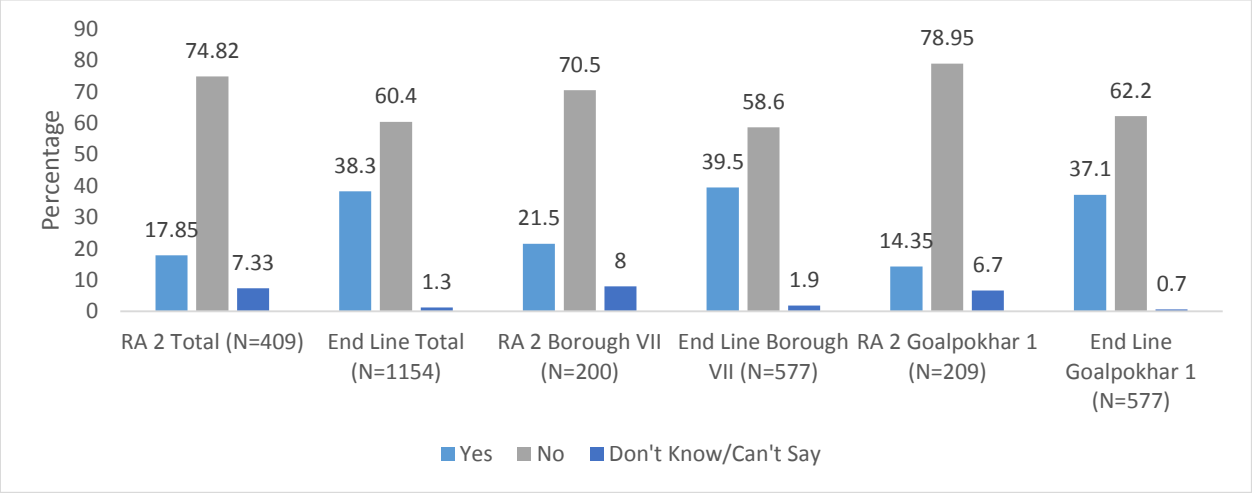
Table 22: Distribution of respondents by months after which started semi-solid foods (BASE: ALL)

Age in months	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Below 6	3.67	4.00	3.35	8.2	8.0	8.5
6	10.27	11.00	9.57	3.3	4.3	2.3
7	45.72	50.00	41.63	77.3	79.2	75.6
8	1.96	2.00	1.91	4.2	2.8	5.7
9	1.71	1.00	2.39	0.9	0.5	1.2
10	0.24	0.50	-	0.2	0.0	0.3
11	0.24	0.50	-	0.1	0.0	0.2
12	1.22	0.50	1.91	0.2	0.2	0.2
Above 12months	0.24	0.50	-	1.3	1.0	1.2
Still exclusively Breast Feeding	25.18	17.5	32.54	3.7	2.8	4.7
Don't know/ Can't say	9.54	12.5	6.70	0.7	1.2	0.2

The findings regarding respondents' child receiving de-worming tablets indicated that majority of the respondents' children did not receive de-worming tablets. However, compared to the RA2 period, in Borough VII the number of children receiving deworming has improved from 21.5% to 39.5% and the same

is the case for Goalpokhar 1 where the proportion has improved from 14.35% to 37.1%. Figure 23 gives the distribution of respondents by whether their last child received de-worming.

Figure 23: Distribution of respondents by whether their last child received de-worming tablets (BASE: ALL)



Frequency of weighing at the Anganwadi Centre

63.7% of the respondents in Borough VII mentioned that their child's weight has never been measured at the AWC while 19.6% mentioned that the frequency of weighing their child in AWC is monthly. In Goalpokhar 1 45.1% mentioned that their child is weighed once every 2 to 3 months while 34.5% mentioned the frequency to be monthly. The difference between Borough VII and Goalpokhar 1 may arise from the fact that respondents from urban communities may not go to AWCs as frequently. Table 23 below presents distribution of respondents by frequency of weighing their last child at AWC.

Table 23: Distribution of respondents by frequency of weighing their last child in AWC (BASE: ALL)

Frequency	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Every month	30.81	32.50	29.19	27.0	19.6	34.5
Once in every 2-3months	24.21	15.50	32.54	29.0	13.0	45.1
Never	40.10	43.50	36.84	42.0	63.7	20.3
Don't Know	4.89	8.50	1.44	2.0	3.8	0.2

Growth chart status of the child

Amongst the respondents whose last child was weighed at the AWC in the last three months, it was found that majority of the respondents did not know the growth chart status of their child (64.1% in Borough VII and 58% in Goalpokhar 1). About 32.6% in Borough VII and 37.8% in Goalpokhar 1 mentioned green as the growth chart status as informed by AWW. Table 24 below provides the end line findings.

Table 24: Distribution of respondents by growth chart status informed by AWW (BASE: those who weighed last 3calendar months)

Growth chart status	Rapid Assessment 2 (%)			End Line		
	Total (N=282)	Borough VII (N=136)	Goalpokhar 1 (N=146)	Total (N=1148)	Borough VII (N=574)	Goalpokhar 1 (N=574)
Orange	1.77	2.94	0.68	0.9	1.0	0.7
Yellow	0.71	0.74	0.68	2.9	2.3	3.5
Green	19.15	21.32	17.12	35.2	32.6	37.8
Don't Know/Can't Say	70.57	74.26	67.12	61.1	64.1	58.0
No colour mentioned in the chart	7.80	0.74	14.38	-	-	-

In the few cases where the children's growth chart status was orange or yellow, most respondents (Borough VII- 91.9% & Goalpokhar 1- 84.9%) stated that they were not aware about the action taken by the AWC in such cases. This was followed by 6.3% in Borough VII and 10.9% in Goalpokhar 1 mentioning that they were advised more food intake for the child. The findings revealed that this has only increased as compared to the RA2 period. Table 25 below gives the distribution of the respondents by kind of action taken by AWC in the case that the child falls in the orange or yellow growth chart status.

Table 25: Distribution of respondents by kind of action taken by AWC if their children are in orange or yellow zone of growth chart (BASE: those who weighed last 3 calendar months)

Action taken by AWW	Rapid Assessment 2 (%)			End Line		
	Total (N=282)	Borough VII (N=136)	Goalpokhar 1 (N=146)	Total (N=1140)	Borough VII (N=569)	Goalpokhar 1 (N=571)
Refer to the PHC	1.42	1.47	1.37	1.8	1.1	2.6
Advise for more food intake by the child	19.86	20.59	19.18	8.6	6.3	10.9
Gives double ration from the AWW	3.19	2.21	4.11	1.1	.7	1.6
Don't Know/Can't Say	78.01	77.21	78.77	88.4	91.9	84.9

Food/ration from Anganwadi centre

When asked about the frequency of receiving food/ ration from the AWC, majority of the respondents in Borough VII (51.9%) stated that they have never received ration from the AWC followed by 19.9% mentioning that they receive ration for 21 days in a month. In Goalpokhar 1, on the other hand, majority of the respondents mentioned receiving ration for 21 days in a month followed by 16.1% saying never. Table 26 gives the distribution of the frequency of receiving ration from AWC below.

Table 26: Distribution of respondents by frequency of receiving ration from AWC (BASE: ALL)

Frequency	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
About 21/26days in a month	34.23	32.50	35.89	39.2	19.9	58.6
About 15days in a month	8.07	2.50	13.40	6.8	3.1	10.6
Irregularly	11.00	3.50	18.18	9.4	5.7	13.2
Never	33.25	41.00	25.84	34.0	51.9	16.1
None of these	7.09	9.50	4.78	4.2	7.6	0.9
Don't Know/Can't Say	6.36	11.00	1.91	6.2	11.8	0.7

Majority of the respondents in Borough VII (59.9) who receive ration from the AWC mentioned that their children never consume the ration with only 17% mentioning that their children always consume the ration. In Goalpokhar 1 (43.3%) of respondents mentioned that their children always consume the ration received. Table 27 indicates the findings below.

Table 27: Distribution of respondents by whether their children consume rations received from AWC (BASE: ALL)

Frequency	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Yes always	23.47	19.00	27.75	30.1	17.0	43.3
Yes sometimes	17.36	12.00	22.49	22.9	11.2	34.5
Never	40.59	41.00	40.19	41.0	59.9	22.0
Other	13.94	27.50	0.96	0.7	1.4	-
Don't Know/Can't Say	4.65	0.50	8.61	5.4	10.6	0.2

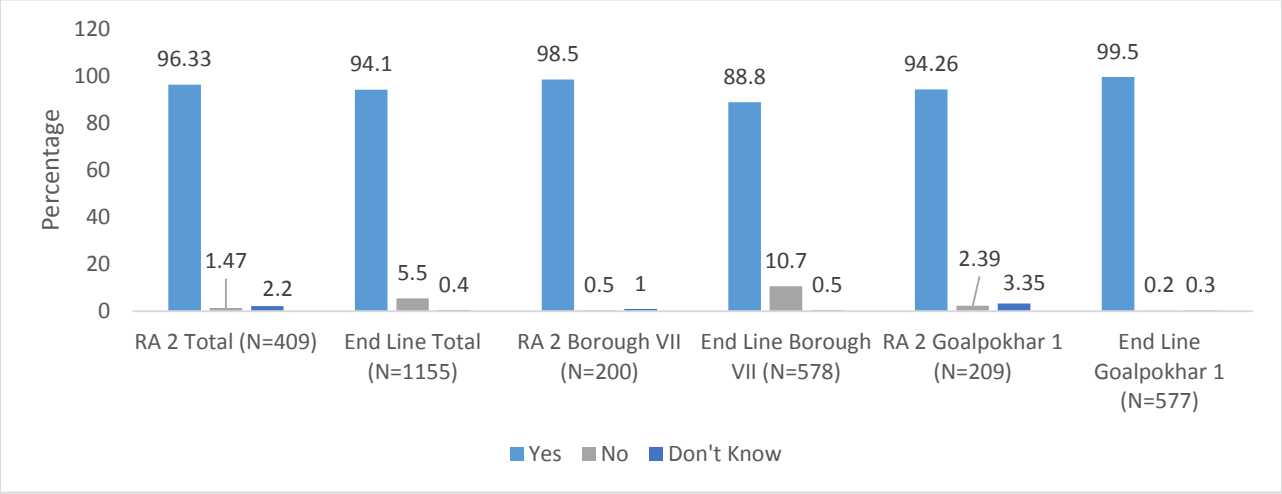
On being asked what the respondents give their children during diarrhoea, majority of the respondents in Borough VII (86.7%) mentioned ORS as compared to the majority in Goalpokhar 1 (69.4%) that mentioned medicines. Table 28 indicates the findings below.

Table 28: Distribution of respondents by what was given during diarrhoea (BASE: those who suffered with diarrhoea)

Items given during diarrhoea	Rapid Assessment 2 (%)			End Line		
	Total (N=18)	Borough VII (N=6)	Goalpokhar 1 (N=12)	Total (N=169)	Borough VII (N=45)	Goalpokhar 1 (N=124)
ORS	55.56	66.67	50.00	43.2	86.7	27.4
Plain water	16.67	33.33	8.33	5.3	6.7	4.8
Syrup	11.11	16.67	8.33	21.9	42.2	14.5
Homemade salt water solution	16.67	-	25.00	10.1	20.0	6.5
Medicines	33.33	33.33	33.33	62.1	42.2	69.4
Other	27.78	16.67	33.33	14.2	4.4	17.7

The respondents' awareness on whether washing hands affects child's health is very encouraging. 94.26% respondents in Borough VII and 99.5% in Uttar Dinajpur mentioned that they think hand washing does affect the child's health (as given in Figure 24)

Figure 24: Distribution of respondents by their knowledge about whether hand washing affects child's health (BASE: ALL)



When asked about their knowledge about when one should wash hands, majority of the respondents in Borough VII (54.5%) mentioned that all times as given in Table 29 are times when one should wash hands, while in Goalpokhar 1, 73.3% stated that one should wash hands before a meal and only 21.3% mentioned that all the above were times one should wash hands.

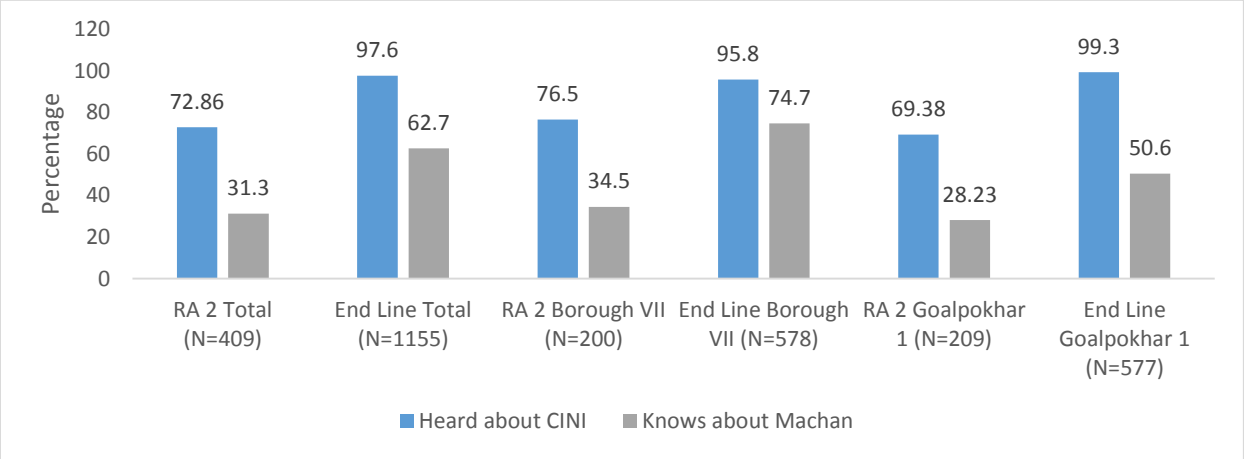
Table 29: Distribution of respondents by their knowledge about when one should wash hands (BASE: ALL)

Time to wash hands	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Before meal	69.93	77.50	62.68	58.6	43.9	73.3
After meal	49.14	49.50	48.80	31.4	26.3	36.6
After coming from the toilet	68.22	72.50	64.11	24.1	26.1	22.0
All of the above	23.47	20	26.79	37.9	54.5	21.3
Don't Know	0.24	0.5	-	1.2	1.4	1.0

3.6. Knowledge about Project Implementation and Participation

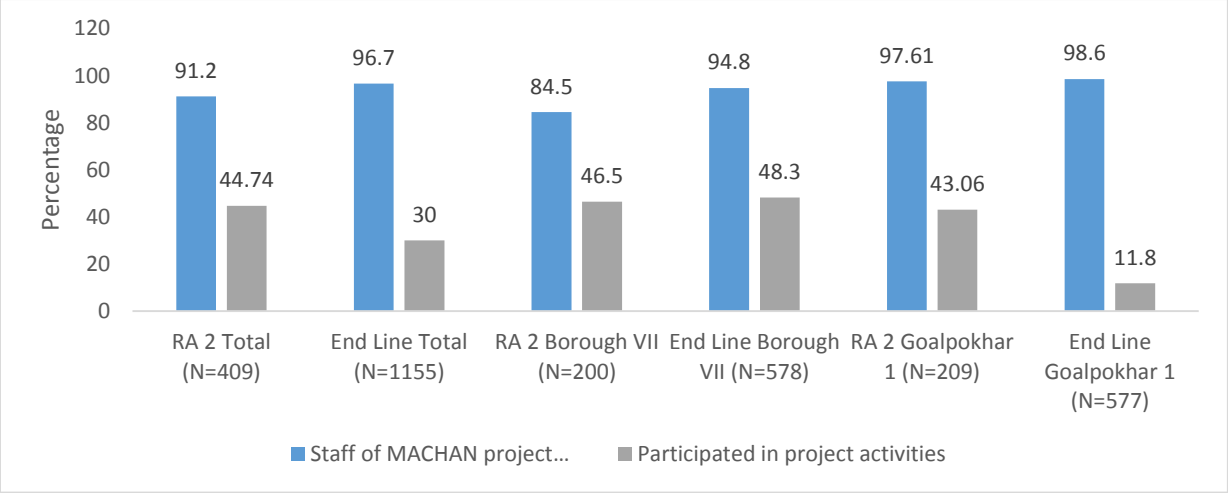
When the respondents were asked if they have heard about CINI or the MACHAN project (as given in Figure 25), it was observed that majority of the respondents had heard about CINI. 95.8% in Borough VII and 99.3% in Goalpokhar 1 were aware about CINI, however not the same proportion of the respondents were aware of MACHAN. However, over the three years of the project, based on comparison with RA2 findings there has been a significant increase in the awareness level of the respondents with respect to both CINI as well as its intervention.

Figure 25: Distribution of respondents by whether they heard about CINI and if they know about MACHAN (BASE: ALL)



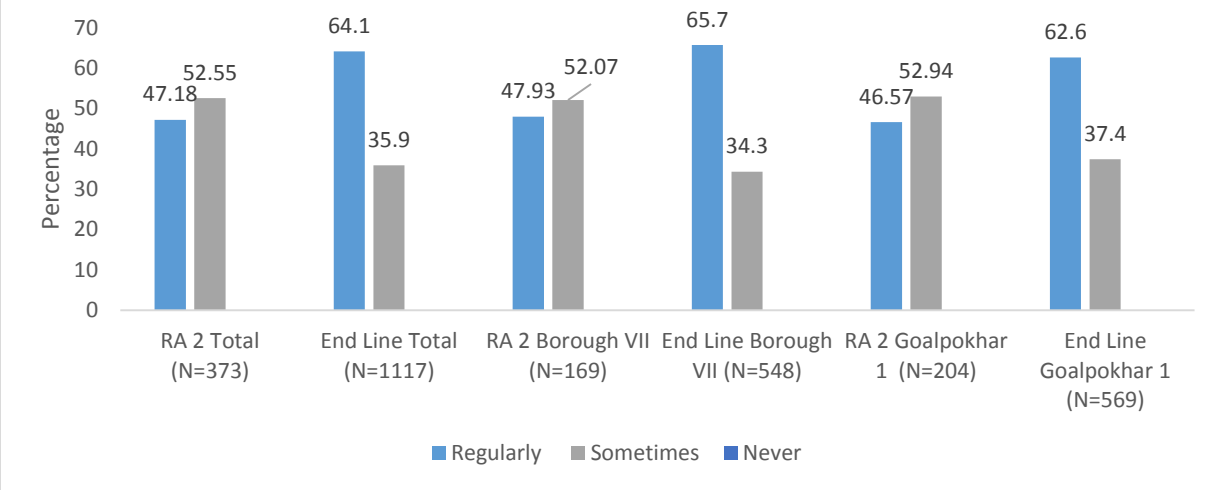
The majority of the respondents also stated that they were visited by MACHAN staff members (shown in Figure 26). In Borough VII 94.8% and in Goalpokhar 1, 98.6% of the study groups were visited by MACHAN staff. However, while in Borough VII the proportion of respondents who participated in project activities has improved (48.3%), there has been a drastic decrease of 32% with respect to participation of respondents in Goalpokhar 1.

Figure 26: Distribution of respondents by whether staffs of MACHAN visited them and if they participate in project activities (BASE: ALL)



The majority of the respondents (64.1% overall) stated that they were visited regularly by the MACHAN staff with the remaining mentioning that they were visited only sometimes. The findings have been given in Figure 27.

Figure 27: Distribution of respondents by frequency of visit by the staff of MACHAN (BASE: those who mentioned MACHAN staffs visit them)



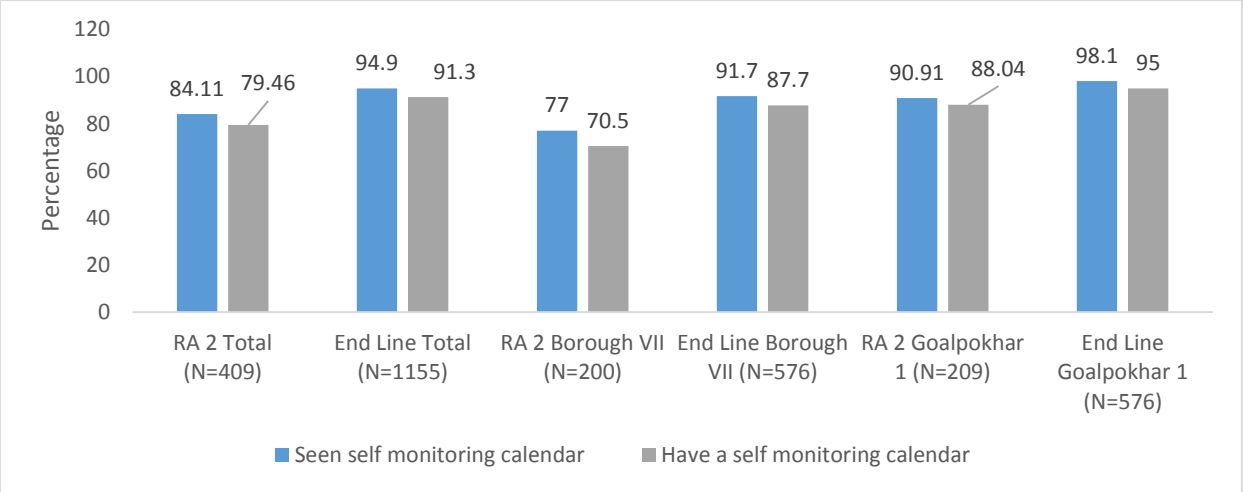
Of the project activities being conducted by the MACHAN staff, majority of the respondents in Borough VII mentioned that the most common activity conducted by the staff during the visits is checking up on the child's health (88.9%) followed by asking about the respondent's health (80.3%) and counseling on health and nutrition (77.9%). In Goalpokhar 1, 78.2% respondents mentioned asking about child's health, the respondent's health and filling up of the calendar as the activities being performed. Table 30 gives the distribution of the respondents by activities performed by MACHAN staff.

Table 30: Distribution of respondents by activities performed by MACHAN staffs during visits (BASE: those who mentioned MACHAN staffs visits them)

Activities performed	Rapid Assessment 2 (%)			End Line		
	Total (N=373)	Borough VII (N=169)	Goalpokhar 1 (N=204)	Total (N=1117)	Borough VII (N=548)	Goalpokhar 1 (N=569)
Asks about my health	71.31	75.15	68.14	79.2	80.3	78.2
Asks about my child's health	77.48	81.66	74.02	83.4	88.9	78.2
Provide information on Government health services	26.27	28.99	24.02	18.4	29.4	7.7
Counselling on health and nutrition	53.08	60.36	47.06	57.5	77.9	37.8
Counsels on referral	2.14	2.96	1.47	2.3	4.7	.4
Follow up after discharge from hospital(after birth /illness)	1.07	1.18	0.98	3.0	5.7	10.2
Fills up calendar	9.38	10.65	8.33	19.2	28.5	78.2

Figure 28, gives the distribution of respondents on whether they have seen a self-monitoring calendar and if they have one. Majority of the respondents reported to have seen a self-monitoring calendar (94.9%) and 91.3% have reported to have a self-monitoring calendar.

Figure 28: Distribution of respondents by whether they have seen self-monitoring calendar and if they have one (BASE: ALL)



On an overall basis, majority of the respondents' self-monitoring calendar's 1st page and 2nd page were completely marked (86.4%) and 75.4% respectively. In both cases, there has been a significant improvement from the RA2 period, and no respondent's 1st or 2nd page was totally blank. With respect to the 3rd page however, majority of the respondents' self-monitoring calendars were incompletely marked (84.2%). Tables 31, 32 and 33 present the distribution of the respondents by status of the 1st page, 2nd page and 3rd page respectively.

Table 31: Distribution of respondents by status of1stpage (pregnancy care) of self-monitoring calendar (BASE: those who have self-monitoring calendar)

Status of 1stpage	Rapid Assessment 2 (%)			End Line		
	Total (N=325)	Borough VII (N=141)	Goalpokhar 1 (N=184)	Total (N=1038)	Borough VII (N=494)	Goalpokhar 1 (N=544)
Completely Marked	57.23	42.55	68.48	86.4	82	90.4
Incompletely Marked	22.46	29.08	17.39	13.6	18	9.6
Totally blank	19.69	27.66	13.59	-	-	-
Lost the page	0.62	0.71	0.54	-	-	-

Table 32: Distribution of respondents by status of 2nd page (pregnancy care) of self-monitoring calendar (BASE: those who have self-monitoring calendar)

Status of 2nd page	Rapid Assessment 2 (%)			End Line		
	Total (N=325)	Borough VII (N=141)	Goalpokhar 1 (N=184)	Total (N=1039)	Borough VII (N=495)	Goalpokhar 1 (N=544)
Completely Marked	35.08	35.46	34.78	75.4	83.2	68.2
Incompletely Marked	42.46	39.01	45.11	24.6	16.8	31.8
Totally blank	22.46	25.53	20.11	-	-	-

Table 33: Distribution of respondents by status of 3rd page (pregnancy care) of self-monitoring calendar (BASE: those who have self-monitoring calendar)

Status of 3rd page	Rapid Assessment 2 (%)			End Line		
	Total (N=325)	Borough VII (N=141)	Goalpokhar 1 (N=184)	Total (N=1038)	Borough VII (N=494)	Goalpokhar 1 (N=544)
Completely Marked	9.23	13.48	5.98	15.8	24.1	8.3
Incompletely Marked	18.46	17.02	19.57	84.2	75.9	91.7
Totally blank	72.31	69.5	74.46	-	-	-

3.7. Anthropometry

Anthropometric measurements were taken for the surveyed children. Mid Upper Arm Circumference (MUAC) measurement was taken for them and they were accordingly categorized as red, yellow or green i.e. SAM, MAM and normal respectively. Table 34 indicates that majority of the children surveyed were normal (93.94% in Borough VII and 90.29% in Goalpokhar 1.

Table 34: Mid Upper Arm Circumference Measurement (MUAC)

Nutritional Status-MUAC	Rapid Assessment 2 (%)			End Line (%)		
	Total (N=325)	Borough VII (N=141)	Goalpokhar 1 (N=184)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
SAM (<11.5)(red)	2.44	1.37	3.55	0.87	0.69	1.04
MAM (11.5 to 12.5)(yellow)	4.18	3.42	4.96	7.09	5.36	8.84
NORMAL (>12.5)(green)	93.38	95.21	91.49	92.04	93.94	90.29

The children were also weighed and their Weight for Age scores were derived to understand their nutritional status, using WHO growth standards. Based on the findings it was noted that overall 66.3% of the children in Goalpokhar 1 and 80.2% in Borough VII were in the normal range. Compared to the RA2 findings, there has been an increase in the proportion of children falling in the moderate underweight

range. Further as in the case during RA2, more boys than girls are severe underweight with 10.8% boys in Goalpokhar 1 and 5 in Borough VII.

Table 35: Weight Age Measurements

Nutritional Status-Weight for Age	Rapid Assessment 2 (%)						End Line (%)					
	Goalpokhar 1			Borough VII			Goalpokhar 1			Borough VII		
	N= All=150	N= Boys=93	N= Girls=57	N= All=152	N= Boys=91	N= Girls=61	N= All=566	N= Boys=314	N= Girls=252	N= All=570	N= Boys=322	N= Girls=248
Severe underweight (<-3 sd) Red	10.0	11.8	7.0	7.2	8.8	4.9	8.3	10.8	5.2	3.5	5	1.6
Moderate underweight(<-2sd and >=-3sd) Yellow	14.0	14.0	14.0	10.5	11.0	9.8	25.4	32,2	17.1	16.3	21.4	9.7
Normal >-2sd (green)	76.0	74.2	78.9	82.2	80.2	85.2	66.3	57.0	77.7	80.2	73.6	88.7

3.8. Impact on Change Agents

Change Agents are women from the community, who will act towards transformation of the community from within. The Change Agents are trained by the CINI staff on maternal and health related issues and they work closely with field level health functionaries of the Government.

The knowledge of Change Agents with respect to pregnancy registration and ANC check-ups have improved over the project period. Most of the Change Agents seem to be well aware about the place of pregnancy registration, reasons for ANC, complications of pregnancy and necessary pre-pregnancy medicine requirement.

Some significant improvements are about 75.6 percent reporting registration as Government hospitals as compared to 50 percent during the Rapid Assessment. However, numbers is Goalpokhar 1 are not as high for Government hospitals. This can be attributed to the proximity of the Government Hospital in Goalpokhar 1 as compared to Borough VII. The number of Government hospitals is also relatively more in Borough VII as compared to Goalpokhar 1.

All the Change Agents in Goalpokhar 1 reported going to sub-centre for pregnancy registration. Thus, in both the districts all the Change Agents are aware of at least one place of pregnancy registration. The knowledge related to reasons for ANC is also good for all the Change Agents. All the Change Agents reported that ANC is needed for knowing the health of the mothers.

All the Change Agents also reported that they are aware of the complications of pregnancy. About 80.5 percent mentioned that 4 ANCs are needed during pregnancy and 73.2 percent reported that 100 IFA tablets are needed at the time of pregnancy.

With respect to knowledge on complications of pregnancy, there is a significant improvement in the knowledge of Change Agents and it clearly shows the effectiveness of various trainings/meetings conducted by CINI in last one year.

During the end line survey, about 97.6 percent mentioned vaginal bleeding as compared to 79.3 percent Change Agents during the Rapid Assessment 2. Similarly, 92.7 percent Change Agents reported to be aware of prolonged labour as compared to only 10.34 percent during the Rapid Assessment 2. For convulsions and oedema, number of Change Agents reporting have improved from 25.86 percent and 46.55 percent to 95.2 percent and 76.2 percent respectively. The figures show that Change Agents in Goalpokhar 1 are more aware about pregnancy complications as compared to Borough VII.

The knowledge of Change Agents have improved as compared to Rapid Assessment 2. During the end line more Change Agents reported the correct benefits of JSY as compared to the Rapid Assessment 2. Some significant improvements are 75.6 percent Change Agents reporting registration card as compared to 8.33 percent during the Rapid Assessment 2. Similarly, Change Agents reporting ANC, transportation cost and free delivery have improved from 11.67 percent, 16.67 percent and 18.33 percent to 70.7 percent, 34.1 percent and 56.1 percent respectively.

Table 36: Knowledge indicators of Change Agents

Knowledge indicators	Rapid Assessment 2 (%)			End Line (%)		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
At least 3 ANC check-ups	100.0	100.0	100.0	100.0	100.0	100.0
100 IFA during pregnancy	93.3	96.7	90.0	97.6	95.2	100.0
Two TTs during pregnancy	95.0	93.3	96.7	100.0	100.0	100.0
Correct benefits of JSY	83.3	76.7	90.0	90.2	81.0	100.0
PNC 4th check-up 42 days after delivery	100.0	100.0	100.0	100.0	100.0	100.0

3.9. Unintended Consequences

The program has lot of unintended consequences as well. Few of the key unintended consequences are as mentioned below:

- It is also important that men are also aware of maternal and child health issues. One of the key unintended consequences of the program was the empowerment of the clubs and increased awareness about maternal and child health issues amongst men. The program as a part of its community mobilization activities worked with various clubs formed by the local people in the villages. Most of the club members are men. Thus, the program could also reach the male members of the community with the key program messages though it is not one of the mentioned outcomes in the log frame.

- CINI has managed to create a workforce of health workers who understand the government systems and processes. The Change Agents have successfully worked with the government workers and officials under this program. Discussions are going on with the government for engaging few of these workers as urban ASHAs in Kolkata after the completion of this program.

4. Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn.

Our analysis of the program sustainability is based on the following three questions:

1. To what extent did the benefits of project continue after donor funding ceased?
2. What were the major factors which influenced the achievement or non-achievement of sustainability of the project?
3. What is the funding requirement after the project completion? How can this funding be achieved?

Change Agents are an important component of the program. Change Agents will continue good maternal and child care practices at the family and community level through peer group education. In addition to this, the other stakeholders like the CBOs, clubs and SHG groups have been empowered to demand their rights through various awareness meetings.

All the CINI agents reported that they plan to continue with the program activities after the closure of the project as well. During the discussion they mentioned that though it will be slightly difficult to keep the women motivated but the learnings from the program have been immense and they will continue to perform the role of Change Agents in the community. Many women in the locality look up to them for information and they are keen on continuing with this role.

In terms of the systems and processes created under the program like NREP, beneficiary feedback mechanism and self-monitoring calendar, about 90 percent of the Change Agents mentioned that the Government will continue to use them in their day to day learning and about 87.8 percent of the Change Agents mentioned that the community is likely to use it after the project closure. In terms of the learnings and awareness created through the program, about 83 percent of the Change Agents mentioned that the community will take ownership and work towards overall improvement in maternal and child health. It was observed that Change Agents in Goalpokhar 1 are more optimistic about the project sustainability than the Change Agents in Borough VII. This can be attributed to the difference in social networks in rural areas as compared to the urban areas. The Change Agents in Borough VII cater to a large population which is also very mobile. Further, many of these Change Agents are also engaged in other work whereas in Goalpokhar 1, it is a closer community and the Change Agents get more opportunities to interact with the other community members. Table 36 shows the perception of the Change Agents with respect to the key questions on sustainability.

Table 37: Change Agent's opinion on Sustainability

Statements	End line (%)		
	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Whether planning to continue the activities under the program after it ends	100	100	100
Whether the program created systems and processes for Government functionaries which will continue stay after it ends	90.2	81	100
Whether program has created systems and processes for Community which will continue after it ends	87.8	76.2	100
Whether the community will take ownership of continuing Program learnings	82.9	71.4	95

A total of seven Change Agents, out of the sample of 41 mentioned that the community will not take ownership of the project learnings. Out of which, 6 reported that the community lacks the motivation to change their practice and this could only be sustained through a sustained effort to change the behavior of the community. Out of these 7 Change Agents, 5 Change Agents are from Borough VII.

Table 37 depicts the distribution of the Change Agents by the reasons for which they feel that the community will not take ownership.

Table 38: Reasons for community not taking ownership as highlighted by the Change Agents

Statements	End line (%)
	Total (N=7)
Community is less motivated	6
External factors like lack of Government support	3
The results need continuous funding	2
Community leaders were not involved in the program	1

One of the key takeaways for sustainability will be to institutionalize the community feedback system into the Village Health Sanitation Nutrition Committee (VHSNC). **VHSNC** has been formed in the village under National Health Mission (NHM). The committee comprises of local elected members of Panchayat, ASHA, AWW, ANM and SHG group from each village. They assess the village needs related to health, nutrition, and sanitation and make a joint plan of action towards improvement of village.

Some of the other initiatives which can improve sustainability is the involvement of the SHGs in income generating activities and communicating in these groups. The GPAF project procured sanitary napkins for PNC kits from SHG groups and they were involved in packaging and distribution of PNC kits. Income generation was done by the groups through this work.

The NREP sessions are also a very innovative approach of addressing malnutrition. CINI should work with the Government to ensure that these sessions become part of the Government's priorities after the project closure.

The beneficiaries of the program are also acting as Change Agents of the program. This is providing the program with a multiplier effect. About 61 percent of the women mentioned they are willing to work as Change Agents themselves. About 89 percent of the women have reported to counsel other women in their neighborhood on the importance of ante natal care and post natal care. About 84 percent of the women also reported to counsel other women on the importance of immunization. However, it was found that only 26.7 percent of the women have given feedback to government stakeholders. It will be highly productive if the community as a whole is empowered to provide feedback. This can be done through more advocacy with the Government officials and community platforms like clubs, CBOs and SHGs.

Table 39: Beneficiaries opinion on Sustainability

Statements	End line (%)		
	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Whether counselled other women in the neighbourhood about importance of ANC	89.2	88.2	90.1
Whether counselled other women in the village about importance of PNC	89.2	88.8	89.6
Whether counselled other women in the village about importance of immunization	84.3	86.5	82.1
Whether given feedback to government stakeholders	26.7	13.8	39.5
Whether observed any changes after giving feedback to government system (Base: 283, K:80, ND: 228)	91.9	83.8	94.7
Willing to be Change Agents	61.0	57.3	64.6

To make the results of the program sustainable, it is imperative that the whole community start believing in the knowledge disseminated through the program. In other to understand, whether the community considers the key interventions of the program important, the women were asked to rate few attitudinal statement on a scale of three. About 82 percent of the respondents mentioned that primary health care is very important for the health of mother and child. However, it was observed that only 53 percent of the respondents mention that immunization is very important but overall 98.5 percent said, it is important or very important. Thus, the respondents believe that the key messages from the program are significant.

Table 40: Sustainability of key program learnings

Statements	End line (%)								
	Total (N=1155)			Borough VII (N=578)			Goalpokhar 1 (N=577)		
	Very Important	Important	Not Important	Very Important	Important	Not Important	Very Important	Important	Not Important
Perception about primary health care	82.3	17.1	0.6	91.7	7.3	1.0	73.0	26.9	0.2
Perception about child immunization	53.2	45.3	1.2	55.4	43.9	0.2	51.0	46.6	2.3

5. Key Learnings from

The program has implemented various innovative tools to empower community in taking ownership of their own health. Some of the innovative tools that were used in this program are:

Self-monitoring calendar: The self- monitoring calendar is another very innovative tool. It is a calendar consisting of all the major milestones related to maternal and child health like immunization, ANC and PNC. This helps in motivating the beneficiaries to access health services on a regular basis as they can keep track of their own and child's health. This also provides the health workers with more authentic information which facilitates validation of data collected by the field level health workers.

Nutrition Rehabilitation Education Programme (NREP): With the initiative of GPAF, 12 days NREP sessions were conducted jointly with ICDS workers for the mothers/caregivers of malnourished children on feeding demonstration, care and personal hygiene. These children were followed up for a period of 18 days through home contacts to track behavioural practice at home. Children who were not gaining weight within 2-3 months were referred to NRC for institutional care. CINI introduced a 12 day pictorial chart to track the attendance of visit to these sessions and it was a cartoon which is a baby and every visit will lead to drawing of one part of the baby. If someone is absent one day, that part will be not drawn (for e.g. hands) and it will be shown that the baby will not be normal. This helps in creating peer pressure and motivating the mothers to come for these sessions.

Leveraging Community platforms: The program has tested and implemented various different community engagement models. One of the key learnings of the program was the use of community based organizations, clubs and self-help groups. These groups supplemented the work done by the Change Agents and the government workers. They have also collected their own money, set up their own infrastructure and worked towards improving mother and child health. During our interactions with clubs, CBOs and the SHGs, they mentioned that they also convey the messages of the program to the community and provide monetary support during delivery. They are also keen on continuing with these activities after the closure of the project. However, they mentioned that the program has been able to create a momentum in influencing the community to seek healthcare and the key project activities should be there for at least 2 more years to make the results more sustainable.

Beneficiary feedback mechanism (BFM): The beneficiary feedback mechanism is a very innovative approach of providing feedback on Government initiatives. Earlier the community did not have any platform to voice their concerns. The opportunity of giving feedback has empowered them to raise the key concerns. This has also helped in micro level planning of the intervention and providing localized solutions. As per the annual report, there have been some changes due to this mechanism like improving sanitation conditions, services at health post and community events for improving infant and young child feeding practices. The MOICs and health workers like ANM and AWW interacted during the study reported that earlier the health seeking behavior of the community was very poor and this has improved relatively in the last three years due to initiatives like this. BFM was rolled out with technical assistance from World Vision UK. Feedback is taken from beneficiaries on a regular basis during home visits by Change Agents and this gets recorded in the project MIS by the Change Agents. In addition to this, feedback is taken

through group meetings and through feedback boxes. This gets documented in pre-defined formats. The program also introduced pictorial feedback formats. This was very impactful as the literacy levels in both the project areas is very low. This can be a best practice for any development program and can be easily replicated.

Equity and gender equality: The program has empowered village women to take decisions related to their and child's health. The increase in knowledge due to the programme has improved the health seeking behavior of these women. Community women during the focus group discussions mentioned that they participate more in decisions related to health and education of children. They are now more comfortable in discussing issues like family planning with their husbands. These women are now more aware of the good practices to be followed during and after pregnancy. More women have become empowered to discard traditional health practices, harmful to their and child's health, e.g. a large number of women do not throw the colostrum.

It was also observed that the financial incentives given to Change Agents have contributed to an increase in household income, especially in Goalpokhar-I. Many women in the community aspire to be Change Agents due to the prospects of improvement in the financial conditions and the respect associated with the role. These Change Agents, who are all women, actively participate in the community level decision making.

The program has also been successful in terms of working with one of the most marginalized population of West Bengal. Both the locations have sizeable poor population. North Dinajpur is one of the poorest districts in West Bengal. Borough VII is one of the biggest slums in Kolkata with a large number of migrant population. A vast majority of the target population is from the minority community. Machan has supplemented the government programmes in providing health services to this underserved population.

Capacity building: Capacity building was one of the key components of the program. CINI organized multiple capacity building workshops for government officials, field level health workers of the government, CINI staff, Change Agents and the community. CINI has vast training experience in the field of maternal and child health. The various trainings provided as a part of this programme are:

- Three days TOT on child health and nutrition issue training project staff
- Sensitization meeting and other events for community awareness on JSY schemes
- Training on basic Reproductive and Child Health
- Sensitization meetings to raise community awareness on PNC with men and women
- One Day workshop to orient adolescents and user groups on social marketing of sanitary napkins and NUTRIMIX
- Sensitization of CBOs and clubs on Post Natal Care and Janani Suraksha Yojana.(one month interval)
- Orienting Anganwadi Workers, Medical Officers, Integrated Child Development Scheme (ICDS) supervisors, Auxillary Nurse Midwife, Accredited Social Health Activists(ASHA), Child Development Project Officer(CDPO) on Nutrition Rehabilitation and Education Programme (NREP)
- Linking Change Agent to existing educational opportunities and provide need based medical support

The training provided by CINI is of high standard. During our interactions, all the government officials mentioned that they want more trainings to be organized by CINI on MCH issues. The other stakeholders like club members mentioned that they have learned a lot from these trainings. One of the groups suggested that the training can also include other aspects like livelihood. As health seeking behavior is also related to the economic condition of a household, focusing on issues like this will empower them to seek their own rights. It was also mentioned that most of the trainings conducted are participatory in nature and it uses different training methods like demonstrative methods, exposure visits and group discussions. CINI is very innovative in terms of developing training modules and the modules developed for this project are of high quality.

6. Value for Money

The value for money of the project is measured on three key parameters: economy, efficiency and effectiveness.

The questions which will be answered under each of the 3Es are as follows:

- Economy: Are the inputs been bought at the right price? *(Inputs here will consist of- staff, consultants, raw materials and other capital goods)*
- Efficiency: What is the cost of each output? Whether the cost is competitive w.r.t. other comparable benchmarks? *(Comparison of cost efficiency with other national or global benchmark. If this data is not available we can compare the unit cost with cost from other comparable project of CINI or GPAF)*
- Effectiveness: How well are the outputs from an intervention achieving the desired outcome? The unit cost per outcome will be calculated. Qualitative indicators will also be analyzed for measuring

6.1. Economy

CINI has followed adequate measures to economize all the project related costs. All the procurements are done through a standard tendering process where a minimum of three bidders are invited and the lowest bidder gets the final contract.
All the project staff are highly experience people and have been working in the sector for considerable amount of time. It was also found that most of the employees have been with the organization for a long time.

The organizations is using community infrastructure effectively. During our qualitative interviews, the club members and the Government stakeholders informed that they are providing infrastructure for some of the CINI activities. This has been possible due to the good rapport shared by CINI with all the stakeholders.

During the interview with the Program staff, it was also reported that the organization is very prudent about out of pocket expenditures. Most of the program staff uses public transport and uses standard accommodation for any project related travel.

The organization has been working in these areas since a very long time and thus it did not have to incur large cost in setting up the project. Many of the program staff have been working with the organization on other staff before.

One significant achievement of the program was to achieve match funding for this project. In the current context, when donor funding in India is reducing and CSR funds are not available for districts like Goalpokhar 1, the organization managed to raise money through various community platforms and leverage other Government funding. It managed to establish a symbiotic relationship with the state government, where they supported the government by bridging the manpower gap and the Government helped in achieve program objectives by aligning their activities to some of the program activities. As

per the annual report, match funding is secured for at least 25 percent of the project cost. The program has also been successful in motivating the community to contribute. During the discussions with club members and Self Help Groups, it was reported that the community is also contributing small amounts at individual level for improving overall maternal and child health status of the region.
The program staff and Child Health mentioned that, at the time of developing the budget and finalizing agreements around this partnership, they did not anticipate that the majority of UK Aid, particularly of the kind that is the most relevant to CINI and ChildHope UK, would be withdrawn from India. But the organization through its flexible and innovative approach has been able to achieve the program objectives through a community led approach.

6.2. Efficiency

We planned to analyze the efficiency of the program by comparing the unit cost of the programme outputs with comparable national and global benchmarks or unit costs of other similar programme implemented by CINI. However, data on per unit cost for these outputs is not available for the above mentioned categories. Our analysis thus focuses on the understanding whether there has been an improvement in cost efficiency over time.

During the interaction with the Program Director he mentioned that the organization took various steps to improve the efficiency of the project in terms of cost. The managers of other projects visited the project locations during their project monitoring visits and provided technical support which reduced costs of outsourcing consultants. CINI and the Government provided space for holding meetings and workshop related to the project. IT personnel from CINI provided free/low cost services for management of the database. Project management staffs, as well as field level workers were encouraged to attend other projects training programmes on relevant issues for the development of their skills. This reduced the amount of funds the project spent on training.

Under each of the outputs, we have identified few budget heads and representative program indicator for calculating the cost per output. This is as per the details below:

Output1: Women acquire the knowledge and skill to act as Change Agent

Indicator: Number of CA's trained

Budget heads:

- Sharing meeting with stakeholders at community level by Change Agent
- Linking Change Agent to existing educational opportunities and provide need based medical support
- Strengthening 4th Saturday meeting (at GP/Ward level)

Output2: Enhanced capacity of key stakeholders and service providers (CINI staff, govt Integrated Child Development Services ICDS and National Rural Health Mission supervisors) enables quality service delivery.

Indicator: Number of government health professionals trained in DFID-funded project interventions. (ICDS/ JSY social welfare schemes, proper nutrition/ feeding practices, SRH & MCH services & family planning)

Budget heads:

- Three days TOT on child health and nutrition issue training project staff
- Training on basic Reproductive and Child Health
- Developing community report cards
- Developing of training module and manual
- Project planning and sharing meet at district level
- Staff meeting at state level
- CH Project learning and disemination workshop with stakeholders at the State and National Level to share learning in year 3
- CH Training on Community based Child Protection
- CH Training on Young People's Participation and Gender in M&E

Output3: Increased access to essential Ante and Post Natal Care (ANC & PNC) services for mothers and child nutrition services for 0-2 year olds

Indicator: Percentage and estimated number of women receiving PNC kits

Budget heads:

- One Day workshop to orient adolescents and user groups on social marketing of sanitary napkins and NUTRIMIX
- Tracking and referral of mothers during their post natal care to hospitals and sub centres
- Tracking of mothers and ensuring they receive PNC package and complete PNC checkups
- Tracking and screening of malnourished cases
- Need base referral of SAM cases to the nearest NRC and their follow up.(cost of incentive @50 per case)
- Institution Based Rehabilitation of SAM (with complication)
- Conduct Nutrition Rehabilitation and Educational Programme for Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) without complications.
- Developing and procurement of Behaviour Change Communication (BCC) materials

Output 4: Increased knowledge of and referral to the government-funded Janani Suraksha Yojana (JSY) scheme for pregnant women in the target communities.

Indicator: Percentage and estimated number of eligible women referred to JSY

Budget heads:

- Sensitization meeting and other events for community awareness on JSY schemes

Output 5: Increased awareness, involvement and coordination of stakeholders in Janani Suraksha Yojana (JSY), Ante and Post Natal Care (ANC & PNC) services and Integrated Child Development Services (ICDS)

Indicator: Number of Community-Based Organisations (CBOs) showing greater awareness on MCH services and related health/ social welfare schemes

Budget heads:

- Sensitization meetings to raise community awareness on PNC with men and women
- Sensitization of CBOs and clubs on Post Natal Care and Janani Suraksha Yojana.(one month interval)

- Conducting advocacy meetings at block and ward level
- Conducting advocacy meetings at district and state level.(one at state and two at district level)
- Orienting Anganwadi Workers, Medical Officers, Integrated Child Development Scheme (ICDS) supervisors, Auxillary Nurse Midwife, Accredited Social Health Activists(ASHA), Child Development Project Officer(CDPO) on Nutrition Rehabilitation and Education Programme (NREP)
- Strengthening VHND (Convergence Health and ICDS) / RI sessions in urban
- Special events addressing key issues of mother and child health

It can be noticed that overall cost efficiency has improved for all the key outputs over the project period but in the second year there has been an increase in per unit cost for all the outputs except capacity building of key stakeholders and service providers.

Table 41: Yearly cost per program output

S.No	Output	Indicator	GBP per unit output		
			2013-14	2014-15	2015-16
1	Women acquire the knowledge and skill to act as Change Agent	Number of CA's trained	35.2	69.4	44.5
2	Enhanced capacity of key stakeholders and service providers (CINI staff, govt Integrated Child Development Services ICDS and National Rural Health Mission supervisors) enables quality service delivery.	Number of government health professionals trained in DFID-funded project interventions. (ICDS/ JSY social welfare schemes, proper nutrition/ feeding practices, SRH & MCH services & family planning)	8.4	1.0	.9
3	Increased access to essential Ante and Post Natal Care (ANC & PNC) services for mothers and child nutrition services for 0-2 year olds	Percentage and estimated number of women receiving PNC kits	728.7	1020.3	428.0
4	Increased knowledge of and referral to the government funded Janani Suraksha Yojana (JSY) scheme for pregnant women in the target communities.	Percentage and estimated number of eligible women referred to JSY	158.2	205.5	21.0
5	Increased awareness, involvement and coordination of stakeholders in Janani Suraksha Yojana (JSY), Ante and Post Natal Care (ANC & PNC) services and Integrated Child Development Services (ICDS)	Number of Community-Based Organisations (CBOs) showing greater awareness on MCH services and related health/ social welfare schemes	41.8	137.2	7.4

6.3. Effectiveness

The program has significantly improved the maternal and child health outcomes of the two target geographies. These improvements have been already highlighted in the previous sections. While assessing the effectiveness of the programme, we have estimated the cost per outcome as per the agreed log frame.

The outcomes which we have considered for this analysis are:

- Number of births attended by skilled health personnel
- Number of women attending at least 3 antenatal care (ANC) checkups during pregnancy
- Number of women having completed at least 3 post-natal care (PNC) checkups within 42 days after delivery
- Number of children having exclusive breast feeding up to 6 months of age

Data from the two Rapid Assessment surveys and the current end line survey was used to calculate the outcome of the project. As the study did not follow an experimental design from year 1, it is difficult to assess the attributable impact of the program and clearly identify the impact of the program in the absence of other interventions. But as per our discussions with Government stakeholders, there haven't been major changes in the Government policies in the last three years and CINI has played a crucial role in these two districts, we assume that these changes are due to the program for comparability purpose overtime.

The cost data contains the total yearly expenditure on the program and includes all administrative costs as well.

In the absence of comparable national and international benchmarks for similar intervention, we have shown the year wise changes in the cost effectiveness. The analysis clearly shows that the programme has managed to improve its effectiveness gradually. Though, for some key outcome indicators effectiveness was slightly lesser in year 2 than year 1, overall for all the indicators the cost per unit has fallen by year 3. Table 41 represents the unit cost of the key programme outcomes:

Table 42: Yearly cost per program outcome

S.No	Outcome	GBP per unit output		
		2013-14	2014-15	2015-16
1	Percentage and number of births attended by skilled health personnel	2033.2	2994.2	1112.4
2	Percentage and number of women attending at least 3 antenatal care (ANC) check-ups during pregnancy	2025.1	2262.7	1045.8
3	Percentage and number of women having completed at least 3 post-natal care (PNC) check-ups within 42 days after delivery	4813.9	4916.4	1954.5
4	Percentage of children having exclusive breast feeding up to 6 months of age	3912.9	2504.6	1168.5

7. Challenges and En

The major challenges faced by the program are as mentioned below:

- One of the biggest challenge of the program was acquiring the match fund as highlighted by the program staff of CINI and ChildHope. This was mainly after DFID decided to pull out their funding from India in 2012-13 which had huge influence on other UK donors e.g. JOAC, GOAC as well. However, the program team worked effectively with Government officials and community to bridge the gap in funding. The Government and community provided infrastructure for program activities. The program was also successful in leveraging other maternal and child health schemes of the Government by working closely with them

- Drop out of staff members was another challenge for the program. As Goalpokhar 1 is one of the most backward districts of the state, finding people to work in those areas was difficult

- Literacy level of some of the Change Agents was low especially in rural areas but the program mitigated that risk by providing adequate training on key issues and the success of these trainings is well reflected through the improvement in knowledge indicators of these Change Agents

- In some areas, there was lack of support from the elected representatives of the people, regular meetings were held with them to keep them informed about the progress of the project.

- Election and Government formation in the months of May/June 2014 reduced the pace of the program but this risk was mitigated by carrying out activities to the next months and the final year through a 4 month no-cost extension

- The project location has a sizeable Muslim population and initially it was difficult to convey the program messages due to conservative nature of the community. However, the program managed to effectively work towards behviour change of the community through well designed IEC materials and regular community interactions. The Change Agents also played a key role as they are also part of the community and they acted as an effective medium of communication.

8. Project Risk Matrix

The project risks are identified based on the annual reporting and interaction with the project staff. The table below represents the identified risks and the mitigation steps taken by CINI:

Risk	Mitigation Measure
Drop out of Change Agents from the program	CINI decided in consultation with ChildHope not to recruit any CA in vacant positions, create lead CA out of existing cadre to support the field operations in vacant areas
Low morale of CA due to less incentive form the project compared to ASHA worker of NRHM programme	The incentive of Change Agents have been increased from Rs 500 to Rs 600. Advocacy done with KMC for considering CA as urban ASHA workers. Thjs will also help in retaining the trained workforce in these areas.
Involvement of urban local bodies, elected political members during convergence platform	Regularly meeting them and appraise them about project progress and decisions taken on issues raised by community
JSY, PNC services not reaching the community	Discussions in forums like ward sabha, dissemination meeting and also advocacy done with government officials Change Agents visit houses to identify mothers with complications and refer them to health services Overall, the JSY and PNC coverage has increased as can be seen by the end line figures.
ICDS was not cooperating with project staff to organise NREP sessions	This has been highlighted as one of the risks in the last annual report. As a mitigation measure, regular meetings were held with CDPO and ICDS supervisor, circular issued from district headquarters to organise NREP sessions at the AWW centres where the malnutrition problem is serious. During our field visit and interaction with 3 CDPOs, it was observed that they are keen on working on the project. All of them recommended the continuation of the project.

9. Recommendations

Following are our key recommendations for the project:

1. **Extension of the program activities:** Majority of the stakeholders (Government officials, elected representatives and CBOs) categorically mentioned that for any nutritional intervention to have a significant impact, it should have a duration of at least 5 years. It is therefore recommended that the CINI program should be extended for at least 2 more years.

2. **Leveraging Government Programs:** Alternate models of implementing few crucial components of the programme (like other funding sources) should also be explored. CINI can work on leveraging existing government schemes. There is a huge shortage of manpower in the Government as highlighted by the interviewed Government respondents. The Change Agents recruited under this programme have been able to support the Government field level health functionaries and bridge the gap created by the manpower shortage. It is recommended that a funding mechanism for continuing the program for another two years should be identified and some key elements of the programme like Change Agents, Self-monitoring calendar and beneficiary feedback mechanism be retained.

3. **Greater Advocacy at state level:** The CINI programme has some innovative best practices like Self-monitoring calendar, Beneficiary Feedback Mechanism, NREP which have proved to be very useful. These innovations could be taken up at a larger level through advocacy at the state level. This will help in scaling up and sustainability.

4. **Holistic Approach to attract CSR fund:** Funding from CSR needs to be explored to a larger extent and brand CINI needs to be marketed for enhancing fund flow and implementing similar projects in future. However, it has been our experience that Corporates and PSUs are inclined towards investing in programs where there are tangible benefits which are visible and preferably in an around operating locations. Interventions that improve maternal and child health can be implemented along with other interventions on areas such as livelihood, skill development, enterprise development where there is already some amount of community mobilization.

5. **Linkage with ANMs, AWWs and ASHAs:** The sustainability of the program results is highly dependent on linkages with grass root level health workers. It is important that they take ownership of the program learnings. CINI should ensure there is a proper knowledge transfer to these stakeholders before exiting.

6. **Motivating the CBOs to take ownership:** One major success of the programme was the investment by the Community based organization like local clubs, and SHGs etc in few of the program activities like meetings and infrastructure support. The community should be further motivated to take up ownership of few critical activities. The CBOs/ULBs/PRIs can also play a crucial role in ensuring accountability of duty bearers in providing quality services.

7. **Incentivizing post natal care:** Though there has been an improvement in PNC indicator, the overall PNC coverage is low. Greater communication efforts for PNC should be put in future programs. Incentivizing PNC should be explored.

10. Annexures

10.1. Background Information

Table 43: Distribution of respondents by religion (BASE: ALL)

Religion	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Hindu	41.32	59.50	23.92	37.1	48.1	26.2
Muslims	57.95	40.50	74.64	61.7	49.7	73.8
Other (Pagans etc)	0.73	-	1.44	1.2	2.1	-

Table 44: Distribution of respondents by social category (BASE: ALL)

Social category	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
General	52.57	53.00	52.15	68.2	73.4	63.1
Scheduled Caste	15.16	20.00	10.53	17.1	14.2	20.1
Scheduled Tribe	4.89	0.50	9.09	3.2	3.8	2.6
OBC	21.52	18.00	24.88	7.5	1.0	14.0
Other	0.73	1.00	0.48	-	-	-
Don't Know/ Can't Say	5.13	7.50	2.87	3.9	7.6	.2

Table 45: Distribution of respondents by number of family members (BASE: ALL)

No. of family members	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
1-4	34.96	40.00	30.14	33.8	38.7	29.0
5-10	60.64	55.50	65.55	60.4	57.1	63.7
More than 10	4.38	4.50	4.31	5.7	4.2	7.3
Average	5.80	5.55	6.05	5.94	5.6	6.3

Table 46: Distribution of respondents by literacy levels (BASE: ALL)

No. of family members	End Line		
	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Illiterate	22.8	13.7	31.9
Can read and write	21.4	11.9	30.8
Primary	21.2	25.3	17.2
Secondary	27.6	39.8	15.4
Higher Secondary	4.4	5.7	3.1

Graduate and above	2.6	3.6	1.6

Figure 29: Distribution of respondents by migration status and possession of identity proof

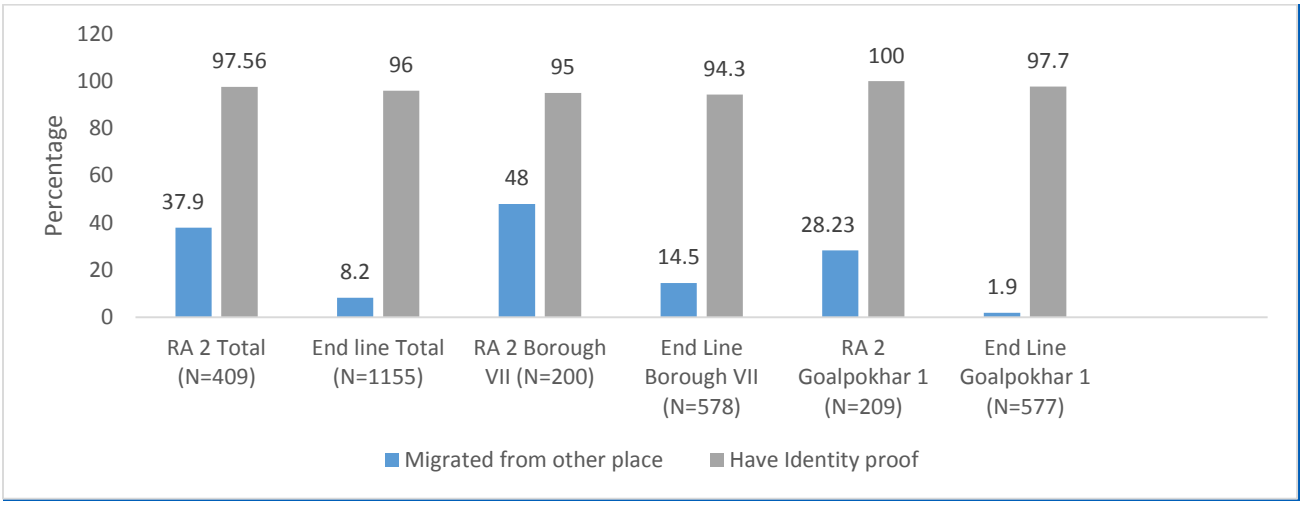


Table 47: Distribution of respondents by birth order of last pregnancy (BASE: ALL)

Birth order	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
1	61.12	70.50	52.15	37.7	45.7	29.6
2	17.11	18.50	15.79	33.0	37.7	28.2
3	9.78	8.00	11.48	13.0	10.6	15.4
4	6.11	2.50	9.57	8.9	4.0	13.9
5	3.91	0.50	7.18	3.7	1.2	6.2
6	0.73	-	1.44	2.5	0.7	4.3
7	0.98	-	1.91	0.5	0.2	0.9
8	0.24	-	0.48	0.5	-	1
Average ±SD	1.82±1.31	1.44±0.79	2.18±1.59	2.21 ± 1.4	1.8 ±0.97	2.63 ± 1.6

Table 48: Distribution of respondents by age of youngest child (BASE: ALL)

Age in months	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
0to 6	33.74	33.00	34.45	-	-	-
7to 12	28.86	26.50	31.10	34.9	32.4	37.4
13to 18	22.97	24.50	21.53	38.1	37.2	39
19to 24	14.43	16.00	12.92	27.0	30.4	23.6
Average ±SD	10.45 ±6.51	11.08 ±6.67	9.85 ±6.32	15.31 ± 4.91	15.66 ± 4.99	14.96 ± 4.81

Figure 30: Distribution of respondents by whether their last child alive or having children that are differently abled (BASE: ALL)

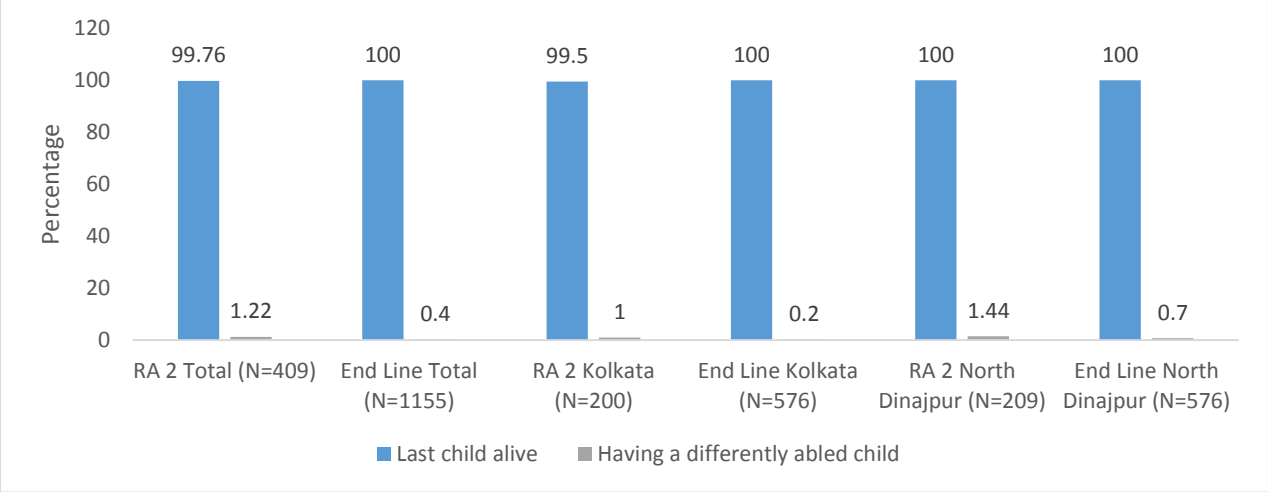


Table 49: Distribution of respondents by family occupation (BASE: ALL)

Type of occupation	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Unskilled worker	16.38	19.00	13.88	14.4	10.9	17.9
Skilled worker	27.38	34.00	21.05	24.8	31.7	18.0
Daily Labour	18.58	15.50	21.53	22.3	22.0	22.5
Petty trader	5.13	5.00	5.26	8.7	10.6	6.8
Works at other field/shop	2.44	2.00	2.87	3.0	4.0	2.1
Agriculture	12.71	-	24.88	10.7	0.3	21.1
Service	8.80	14.00	3.83	7.8	13.3	2.3
Self Employed/Business	7.33	8.50	6.22	8.3	7.3	9.4
Others	1.22	2.00	0.48	-	-	-

Table 50: Distribution of respondents by kind of toilet facilities used (BASE: ALL)

Toilets	End Line		
	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Open defecation	32.7	1.0	64.5
Own toilet	34.5	36.3	32.8
Community toilet	32.6	62.5	2.6
Pay and use toilets	0.2	0.2	0.2

Figure 31: Distribution of respondents by improved and non-improved sources of drinking water (BASE: ALL)

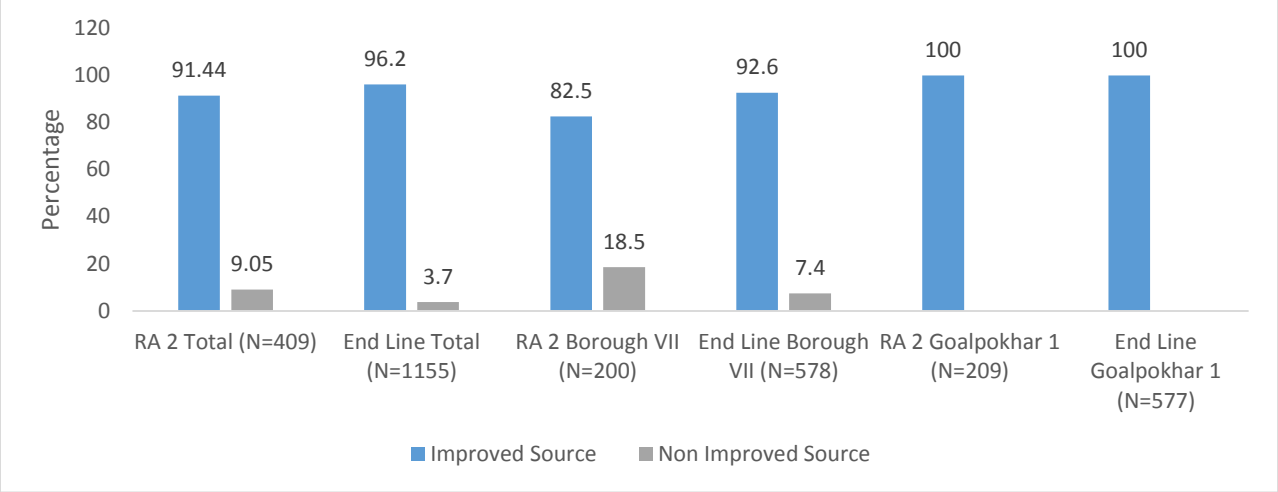


Table 51: Distribution of respondents by kind of cooking fuels used (BASE: ALL)

Cooking fuels	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Wood	18.34	4.00	32.06	17.1	4.7	29.5
Crop residues	26.89	0.50	52.15	32.8	1.0	64.6
Cow dung cakes	0.73	-	1.44	1.0	0.7	1.4
Coal/coke/lignite	1.22	2.50	-	2.3	4.7	-
Charcoal/ Kerosene	27.87	46.00	10.53	29.1	58	0.2
Electricity	1.47	3.00	-	1.9	3.8	-
Liquid petroleum gas	19.80	37.00	3.35	15.8	27.2	4.3
Bio-Gas	2.93	5.50	0.48	-	-	-
Other	0.73	1.50	-	-	-	-

10.2. Antenatal Care

Table 52: Distribution of respondents by month of registration of last pregnancy (BASE: ALL)

Month of registration	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
1st	1.71	2.00	1.44	2.2	3.5	0.9
2nd	14.67	18.50	11.00	12.9	9.9	15.9
3rd	57.70	46.50	68.42	55.2	40.8	69.7
4th	12.71	15.00	10.53	11.7	15.6	7.8
5th	10.76	16.00	5.74	14.0	25.3	2.8
6th	1.71	1.50	1.91	1.3	1.4	1.2
7th	0.49	0.50	0.48	0.4	0.7	0.2
8th	0.24	-	0.48	0.3	0.3	0.3

Table 53: Distribution of respondents by place of registration of last pregnancy (BASE: ALL)

Place of registration	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Sub-centre	44.25	2.50	84.21	42.15	0.9	83.4
AWC	4.40	2.00	6.70	9.51	1.2	17.8

PHC	1.47	0.50	2.39	1.48	0.9	2.1
Private Hospital/Clinic	7.33	11.50	3.35	4.01	7.5	0.5
Government Hospital	42.30	83.00	3.35	45.46	90.4	0.5
Don't Know/Can't Say	0.24	0.50	-	0.87	1.4	0.3
Others	0.24	-	0.48	-	-	-

Figure 32: Distribution of respondents by whether any advice received during last pregnancy and know about complications of pregnancy (BASE: ALL)

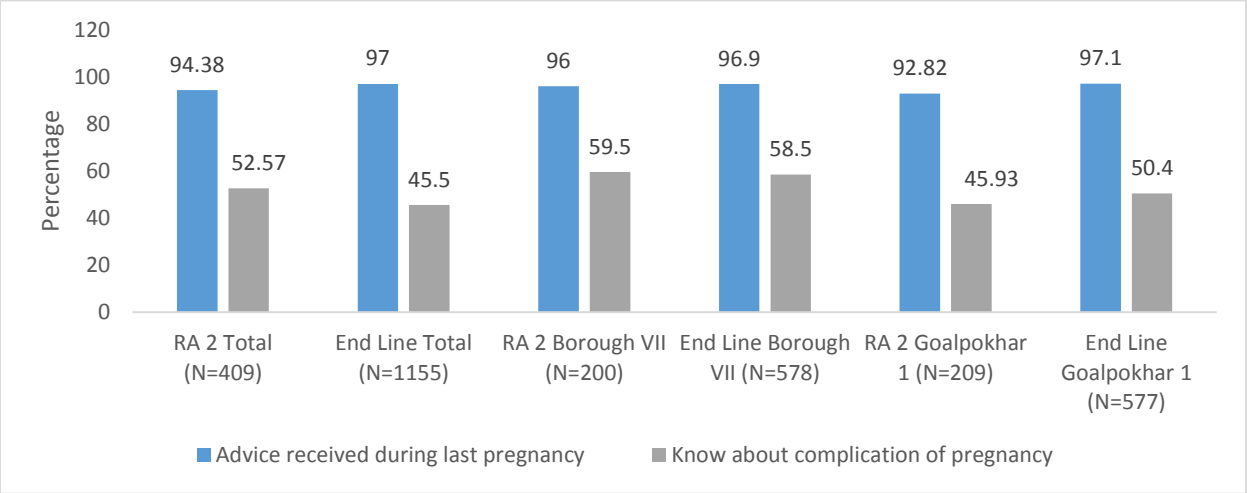


Table 54: Distribution of respondents by the kind of services they received during their last pregnancy (BASE: Those who mentioned to receive services during last pregnancy)

Services received	Rapid Assessment 2 (%)			End Line		
	Total (N=400)	Borough VII (N=193)	Goalpokhar 1 (N=207)	Total (N=1143)	Borough VII (N=569)	Goalpokhar 1 (N=574)
Weight Measurement	89.50	83.94	94.69	79.5	76.3	82.8
Immunization	83.00	77.72	87.92	82.2	69.9	94.3
Supplementary food rations	10.25	12.95	7.73	18.2	21.4	15.0
Counselling	17.75	19.17	16.43	11.5	21.1	2.1
Hb estimates	51.25	52.33	50.24	49.4	68.5	30.5
Urine test	69.25	81.35	57.97	47.5	63.1	32.1
Abdominal check-up	51.00	62.18	40.58	47.2	73.5	21.3
Given IFA tablets/syrup	60.50	54.92	65.70	97.0	96.3	97.6
Referral services	5.00	6.74	3.38	0.7	1.4	0.9
Other blood test	44.00	58.55	30.43	-	-	-
Ultrasonography	34.50	56.48	14.01	-	-	-
Others	8.75	7.77	9.66	5.6	10.5	0.7

Table 55: Distribution of respondents by their source of knowledge regarding complication of pregnancy (BASE: Those who mentioned to know about complications of pregnancy)

Source of advice	Rapid Assessment 2 (%)			End Line		
	Total (N=215)	Borough VII (N=119)	Goalpokhar 1 (N=96)	Total (N=629)	Borough VII (N=338)	Goalpokhar 1 (N=291)
Doctor	51.63	68.91	30.21	32.4	45.0	17.9
ANM	9.30	2.52	17.71	12.4	2.7	23.7
AWW	17.67	15.97	19.79	14.6	8.9	21.3
ASHA	16.74	-	37.5	21.1	0.6	45.0
HHW	0.47	0.84	-	1.7	1.5	2.4
Change Agents	29.30	30.25	28.13	71.7	73.1	70.1
CINI Supervisors	3.72	5.88	1.04	1.1	2.1	0.3

Family members	36.28	37.82	34.38	31.6	49.4	11.0
Don't know/ Can't Say	0.47	0.84	-	1.0	1.2	1.0
Others	3.26	2.52	4.17	2.2	0.9	3.4

Figure 33: Distribution of respondents whether they have received IFA and TT during their last pregnancy (BASE: ALL)

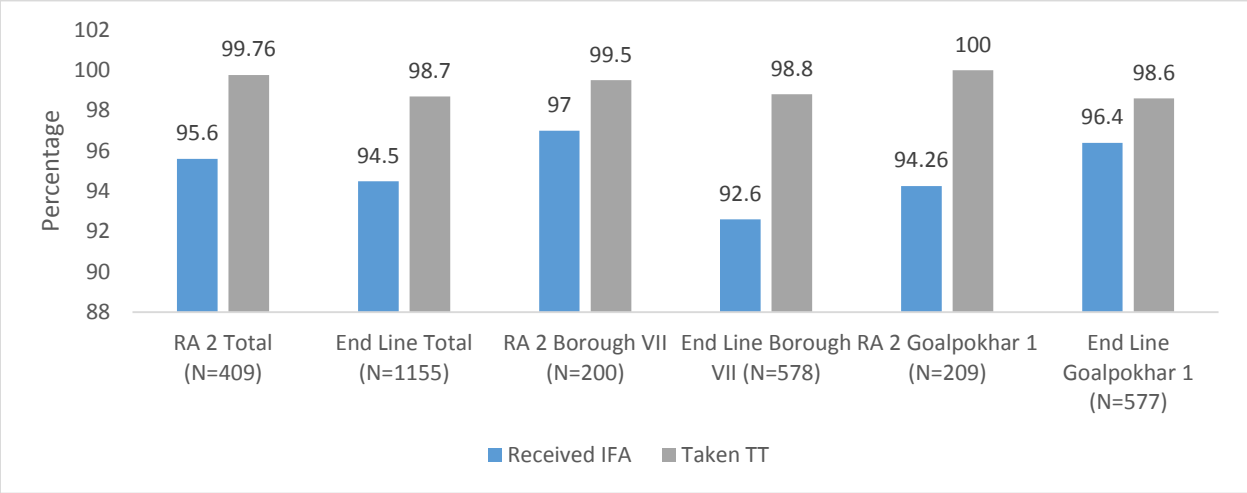


Table 56: Distribution of respondents by reasons of not consuming IFA (BASE: Those who mentioned not to consume IFA)

Reasons for not consuming IFA	Rapid Assessment 2 (%)			End Line		
	Total (N=13)	Borough VII (N=6)	Goalpokhar 1 (N=7)	Total (N=187)	Borough VII (N=75)	Goalpokhar 1 (N=112)
Creates constipation	-	-	-	4.3	5.3	3.6
Vomiting	53.85	50.00	57.14	49.2	44	52.7
Family member's instruction	15.38	-	28.57	2.1	-	3.6
No need of IFA	-	-	-	8	2.7	11.6
Other	30.77	50.00	14.29	57.8	66.7	51.8
Don't know/ Can't say	-	-	-	11.8	17.3	8.0

Table 57: Distribution of respondents by reasons of not visiting AWC (BASE: Those who reported not visit AWC)

Reasons for not visiting AWC	Rapid Assessment 2 (%)			End Line		
	Total (N=149)	Borough VII (N=114)	Goalpokhar 1 (N=35)	Total (N=418)	Borough VII (N=330)	Goalpokhar 1 (N=88)
AWW not there	10.07	9.65	11.43	29.2	33.9	11.4
Facilities not available	8.72	11.40	-	6.9	8.5	1.1
Too far	10.07	3.51	31.43	10.8	4.8	33.0
I didn't have enough time	18.12	21.05	8.57	9.1	11.2	1.1
Poor quality service	6.04	2.63	17.14	1.9	1.5	2.3
I am from a lower caste	-	-	-	-	-	-
AWW is from lower caste	-	-	-	-	-	-
Husband/family did not allow	0.67	0.88	-	14.4	33.9	2.3
Not necessary	8.05	10.53	-	11.0	8.5	12.5
Don't Know	3.36	3.51	2.86	21.1	4.8	36.4
Other	41.61	43.86	34.29	-	-	-

Table 58: Distribution of respondents by different aspects of service delivery at AWC

	Rapid Assessment 2 (%)	End Line

Frequency of food provided from AWC (Base: Those who reported to receive food from AWC)	Total (N=254)	Borough VII (N=80)	Goalpokhar 1 (N=174)	Total (N=604)	Borough VII (N=144)	Goalpokhar 1 (N=460)
About 21/26days in a month throughout the pregnancy	62.99	90.00	50.57	72.4	74.3	71.1
About 15days in a month throughout the pregnancy	13.39	5.00	17.24	11.9	5.6	13.9
Irregularly throughout the pregnancy	18.90	3.75	25.86	13.2	16	13.3
Others	4.72	1.25	6.32	-	-	-
Don't know/ can't say	-	-	-	1.2	2.8	0.7
Kind of advices received from AWW (Base: Those who reported to receive advice from AWW)	**Total (N=210)**	**Borough VII (N=83)**	**Goalpokhar 1 (N=107)**	**Total (N=520)**	**Borough VII (N=130)**	**Goalpokhar 1 (N=390)**
Extra food	83.33	84.34	82.68	71.0	65.4	83.0
Counselled about Janani Suraksha Yojana (JSY)	1.43	2.41	0.79	22.9	31.5	22.8
Godbharai	3.33	3.61	3.15	-	-	-
Cleanliness	44.29	54.22	37.80	56.5	61.5	62.6
Birth preparedness	13.81	10.84	15.75	8.1	9.2	8.8
Institutional delivery	5.24	9.64	2.36	12.3	12.3	14.0
Family Planning	22.86	16.87	26.77	16.9	29.2	14.6
To take rest	64.76	67.47	62.99	58.7	71.5	62.3
To go for postnatal check-up	24.76	28.92	22.05	6.2	10.0	5.6
Early initiation of breast milk	23.33	14.46	29.13	1.5	1.5	1.8
Exclusive breast feeding	16.67	16.87	16.54	4.4	6.9	4.1
Other	1.90	3.61	0.79	3.8	4.6	4.1

10.3. Child birth and Janani Suraksha Yojana

Table 59: Distribution of respondents by who assisted during their last delivery (BASE: ALL)

Assisted during last child birth	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Doctor	65.77	93.00	39.71	91.00	93.94	88.04
ANM	0.73	1.00	0.48	3.64	5.19	2.08
Nurse	9.29	13.50	5.26	40.87	49.83	31.89
ASHA/HHW	0.98	0.50	1.44	0.87	0.17	1.56
Dai	20.29	3.00	36.84	16.02	2.94	29.12
Friend/relative	6.85	1.00	12.44	1.39	0.52	2.25
None	0.49	-	0.96	0.35	0.35	0.35
Others	4.89	2.00	7.66	7.27	0.87	13.69

Figure 34: Distribution of respondents by type of delivery during last child (BASE: ALL)

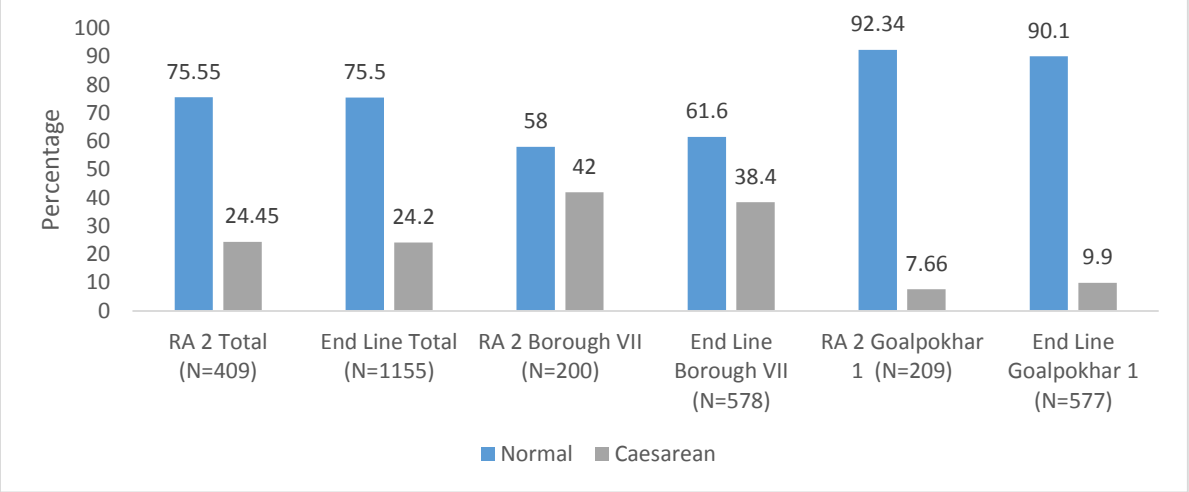


Figure 35: Distribution of respondents by whether dried and wrapped in clean/dry clothes immediately after he/she was born (BASE: those who reported home delivery)

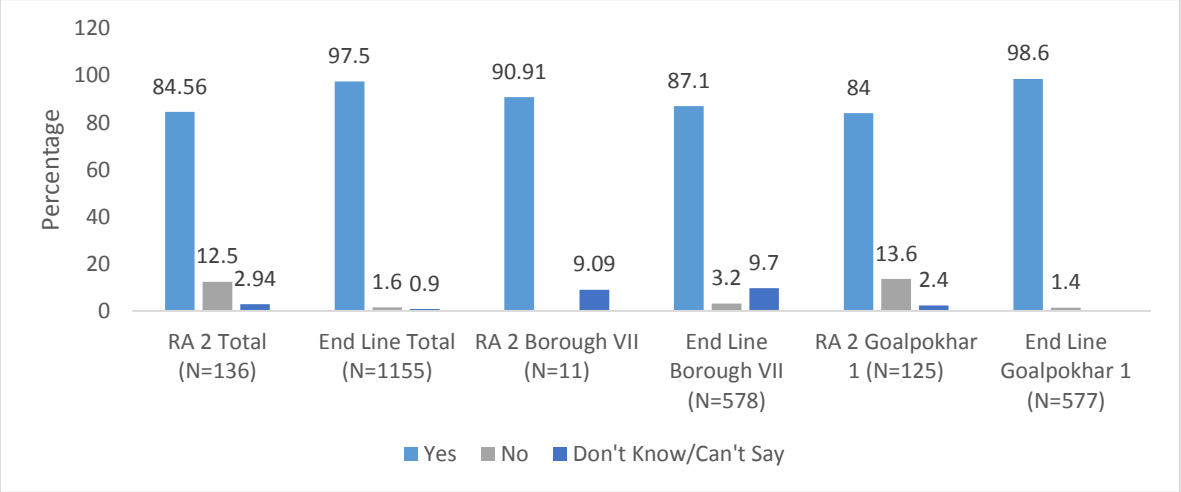


Table 60: Distribution of respondents by who referred for JSY, amount of money received and reasons for not receiving money (BASE: those who were referred forJSY)

Person who referred them to JSY	Rapid Assessment 2 (%)			End Line		
	Total (N=129)	Borough VII (N=56)	Goalpokhar 1 (N=73)	Total (N=945)	Borough VII (N=499)	Goalpokhar 1 (N=446)
Doctor	23.26	37.50	12.33	13.3	17.4	8.7
ANM	10.85	1.79	17.81	16.0	9.8	22.9
AWW	10.85	12.50	9.59	12.8	8.2	17.9
ASHA/HHW	26.36	-	46.58	30.8	1.2	63.9
Change Agents	37.21	37.50	36.99	78.3	85.4	70.4
CINI Supervisors	10.08	21.43	1.37	1.4	1.4	1.3
Family members	-	-	-	8.0	10.0	5.8
KMC	-	-	-	-	-	-
Others	2.33	5.36	-	4.9	8.4	0.9
Don't Know/Can't Say	0.78	1.79	-	0.4	0.4	0.4

Amount of money received from JSY	Total (N=129)	Borough VII (N=56)	Goalpokhar 1 (N=73)	Total (N=945)	Borough VII (N=499)	Goalpokhar 1 (N=446)
Rupees 500	13.18	0	23.29	11.3	-	24
Rupees 900	24.03	51.79	2.74	10.3	18.4	1
Rupees 1000	-	-	-	6.9	2.6	12
No money received	-	-	-	67.2	72.1	62
Other	4.65	1.79	6.85	1.8	2.0	2
Don't Know/Can't Say	1.55	3.57	0	2.5	4.8	-
Reasons for not receiving money (Those who did not receive money)	**Total (N=61)**	**Borough VII (N=24)**	**Goalpokhar 1 (N=37)**	**Total (N=635)**	**Borough VII (N=360)**	**Goalpokhar 1 (N=275)**
No registration card	9.84	20.83	2.7	1.7	1.4	2.2
Hospital did not give	-	-	-	1.6	1.9	1.5
Delivery in private hospital	-	-	-	7.4	8.3	6.2
No paper/lost documents	4.92	4.17	5.41	4.3	6.7	1.1
Did not submit documents on time	14.75	29.17	5.41	18.7	11.9	27.6
No bank account	37.7	66.67	18.92	40.8	60.0	15.6
No ID proof	-	-	-	12.6	17.8	7.6
Don't Know/Can't Say	11.48	4.17	16.22	1.9	1.4	2.5
Other	42.62	8.33	64.86	47.6	15.6	89.5

10.4. Postnatal Care

Figure 36: Distribution of respondents who actually received PNC checkups(BASE: ALL)

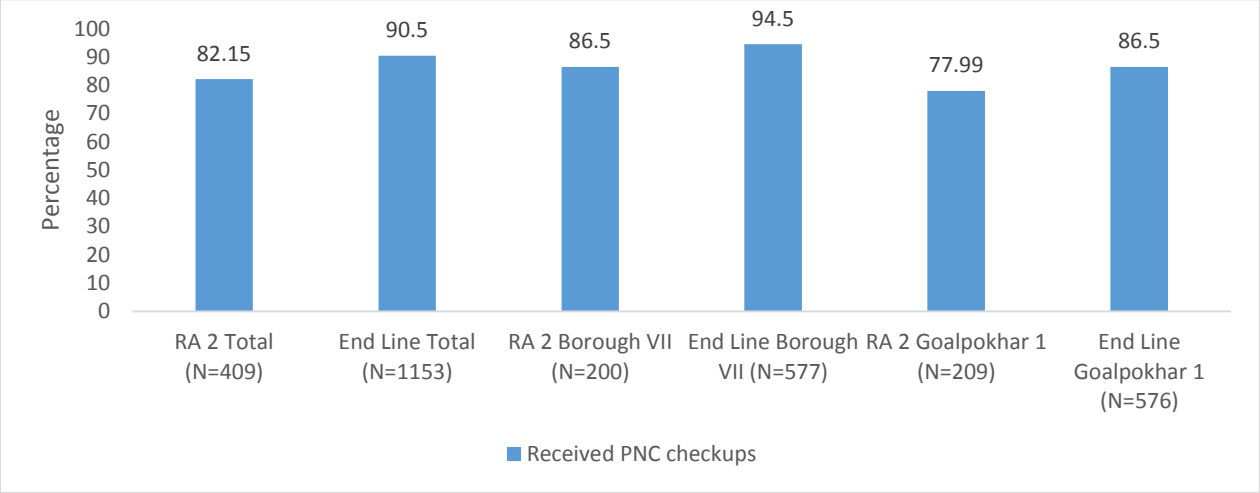


Table 61: Distribution of respondents by their knowledge about the number of day after delivery one should receive first PNC (BASE: those who mentioned to know the number of checkups required)

Day	Rapid Assessment 2 (%)			End Line		
	Total (N=194)	Borough VII (N=105)	Goalpokhar 1 (N=89)	Total (N=1057)	Borough VII (N=576)	Goalpokhar 1 (N=576)
1st	42.78	28.57	59.55	65.5	68.2	62.5
2nd	6.19	8.57	3.37	2.5	3.1	1.8
3rd	11.34	4.76	19.1	1.8	2.7	0.8
7th	13.92	20.95	5.62	4.0	6.3	1.4
Others	25.8	37.12	12.34	26.2	19.7	33.5

Table 62: Distribution of respondents by the place where they received first PNC check-ups (BASE: those who received PNC)

Place	Rapid Assessment 2 (%)			End Line		
	Total (N=336)	Borough VII (N=176)	Goalpokhar 1 (N=163)	Total (N=1051)	Borough VII (N=550)	Goalpokhar 1 (N=501)
Home	21.12	1.88	40.12	21.7	2.7	42.5
Government Hospital	62.42	84.38	40.74	66.7	86.9	44.5
Private Hospital/Nursing Home	9.63	13.13	6.17	10.6	8.9	12.4
Govt. Health Centre	5.59	-	11.11	5.1	1.8	8.8
Other	1.24	0.63	1.85	0.8	0.4	1.2

Table 63: Distribution of respondents by the person who did first PNC check-ups (BASE: those who received PNC)

Person	Rapid Assessment 2 (%)			End Line		
	Total (N=336)	Borough VII (N=176)	Goalpokhar 1 (N=163)	Total (N=1122)	Borough VII (N=573)	Goalpokhar 1 (N=549)
Doctor	83.23	96.25	70.37	14.4	6.8	22.4
Nurse	8.39	11.25	5.56	86.1	96.5	75.2
ANM	2.48	-	4.94	3.0	0.3	5.8
ASHA/HHW	6.21	-	12.35	6.1	1.9	12.0
Dai	1.55	-	3.09	1.5	0.9	2.7
Other	4.04	0.63	7.41	-	-	-

Figure 37: Distribution of respondents received advice and food from AWC after last delivery (BASE: ALL)

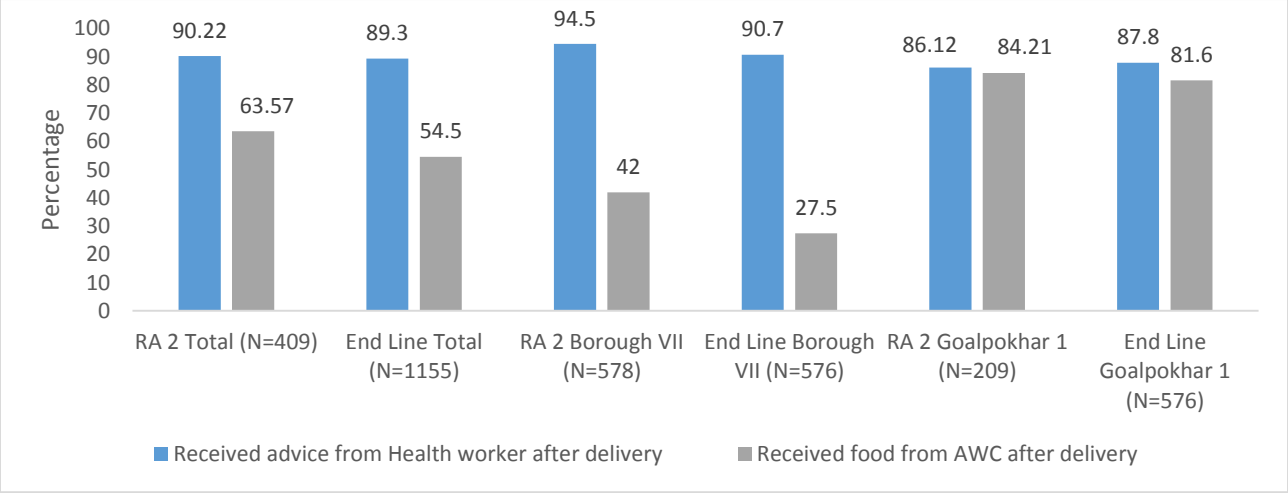


Table 64: Distribution of respondents by the person who provided advice after child birth (BASE: those who received advice)

Source of advice	Rapid Assessment 2 (%)			End Line		
	Total (N=369)	Borough VII (N=189)	Goalpokhar 1 (N=180)	Total (N=1030)	Borough VII (N=524)	Goalpokhar 1 (N=506)
Doctor	49.32	73.54	23.89	43.2	51.3	34.8
ANM	16.26	2.65	30.56	14.1	11.6	16.6
AWW	34.42	30.69	38.33	11.2	9.0	13.4
ASHA/ HHW	34.96	0.53	71.11	29.1	0.8	58.5
CINI Change Agent	76.42	70.90	82.22	68.3	74.4	62.1
Supervisor	8.94	6.35	11.67	-	-	-
Others	5.96	7.94	3.89	5.1	6.5	3.8
Don't know/ Can't say	-	-	-	1.8	1.9	1.8

Table 65: Distribution of respondents by kind of advice provided afterchild birth (BASE: those who received advice)

Kind of advice	Rapid Assessment 2 (%)	End Line

	Total (N=369)	Borough VII (N=189)	Goalpokhar 1 (N=180)	Total (N=1030)	Borough VII (N=524)	Goalpokhar 1 (N=576)
Monitoring of weight	62.06	59.26	65.00	65.0	63.5	66.6
Immunization	77.78	74.60	81.11	76.6	63.4	90.3
Supplementary food rations	11.11	13.23	8.89	16.2	22.3	10.1
Counselling	23.58	26.98	20.00	8.5	15.3	1.6
Cleanliness	58.27	64.55	51.67	61.1	76.3	45.3
Infant and Young child feeding advice	23.04	26.46	19.44	21.7	29.8	13.4
Breastfeeding	78.05	78.31	77.78	83.0	91.0	74.7
Referral services	4.34	4.76	3.89	1.4	2.5	0.2
PNC check	16.53	14.81	18.33	8.7	12.6	4.7
Family Planning	10.03	10.58	9.44	14.8	21.9	7.3
Others	0.54	0.53	0.56	0.4	0.8	-
Don't know/ Can't say	-	-	-	1.3	1.5	1.0

Table 66: Distribution of respondents by duration of food provided from AWC after child birth (BASE: those who received food from AWC)

Time duration	Rapid Assessment 2 (%)			End Line		
	Total (N=260)	Borough VII (N=84)	Goalpokhar 1 (N=176)	Total (N=630)	Borough VII (N=159)	Goalpokhar 1 (N=471)
About 1-2months	2.69	7.14	0.57	6.3	10.1	5.1
3-4months	3.46	3.57	3.41	10.5	8.2	11.3
6months	30.77	29.76	31.25	77.6	67.9	80.9
Continuing till date	61.92	57.14	64.20	0.2	0.6	-
Other	1.15	2.38	0.57	5.1	13.2	2.3

Table 67: Distribution of respondents by frequency of food provided from AWC after childbirth (BASE: those who received food from AWC)

Frequency of food provided	Rapid Assessment 2 (%)			End Line		
	Total (N=260)	Borough VII (N=84)	Goalpokhar 1 (N=176)	Total (N=630)	Borough VII (N=159)	Goalpokhar 1 (N=471)
About 21/26days in a month	62.69	88.10	50.57	74.6	83.6	71.5
About 15days in a month	16.54	5.95	21.59	9.4	3.8	11.3
Irregularly	18.46	2.38	26.14	15.4	10.7	17.0
Never	0.77	1.19	0.57	.2	.6	-
None of these	1.15	1.19	1.14	.5	1.3	.2
Don't Know/Can't Say	0.38	1.19	-	-	-	-

Table 68: Distribution of respondents by kind of advice provided from AWC after child birth (BASE: those who received advice from AWC)

Advice received from AWC	Rapid Assessment 2 (%)			End Line		
	Total (N=215)	Borough VII (N=92)	Goalpokhar 1 (N=123)	Total (N=1286)	Borough VII (N=403)	Goalpokhar 1 (N=883)
Extra/Additional food	72.56	67.39	76.42	47.8	47.7	21.6
Advice on breastfeeding	66.05	61.96	69.11	76.4	82.4	33.5
To keep the baby warm	26.98	29.35	25.20	10.3	13.1	4.2
Cleanliness	46.98	56.52	39.84	48.9	53.6	21.3
Family Planning	19.53	14.13	23.58	13.8	23.5	4.5
To take rest	43.26	43.48	43.09	33.5	41.8	13.7
To go for PNC check-up	6.98	6.52	7.32	2.2	1.3	1.1
Other	4.19	9.78	-	-	-	-

Table 69: Distribution of respondents by their knowledge about contents of PNC kit (BASE: ALL)

Contents of PNC kit	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=200)	Total (N=1155)	Borough VII (N=576)	Goalpokhar 1 (N=576)
Sanitary napkin	57.70	50.00	65.07	80.8	72.8%	88.7%
Condom	7.09	12.00	2.39	25.3	50.5%	
IFA tablets	13.45	22.50	4.78	28.1	53.8%	2.4%

Nutrimix packet	54.28	42.00	66.03	82.9	70.8%	95.1%
Others	0.73	1.00	0.48	0.5	0.7%	.3%
Don't Know/Can't Say	37.41	48.50	26.79	13.9	24.6%	3.3%

Table 70: Distribution of respondents by number of PNC kit they received (BASE: those who received PNC kits)

Number of PNC kits	Rapid Assessment 2 (%)			End Line		
	Total (N=251)	Borough VII (N=98)	Goalpokhar 1 (N=153)	Total (N=917)	Borough VII (N=371)	Goalpokhar 1 (N=546)
One	42.63	33.67	48.37	22.6	30.2	17.4
Two	28.29	23.47	31.37	49.1	56.1	44.3
More than two	26.69	41.84	16.99	26.5	12.1	36.3
Others	1.59	-	2.61	1.0	-	1.6
Don't Know/Can't Say	0.80	1.02	0.65	0.9	1.6	0.4

10.5. Breast Feeding and Child Care

Figure 38: Distribution of respondents by whether their last child was colostrum fed after birth (BASE: ALL)

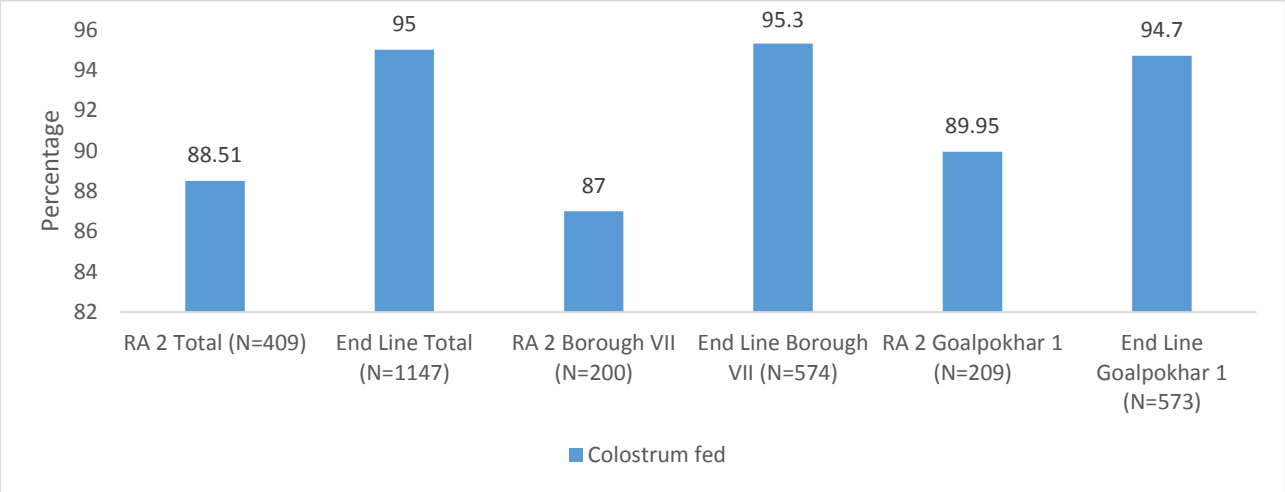


Table 71: Distribution of respondents' knowledge by importance of feeding colostrum (BASE: those who fed colostrum)

Reasons for not feeding colostrum	Rapid Assessment 2 (%)			End Line		
	Total (N=362)	Borough VII (N=174)	Goalpokhar 1 (N=188)	Total (N=1152)	Borough VII (N=576)	Goalpokhar 1 (N=576)
Increases child's immunity	45.58	50.57	40.96	57.4	78.3	36.1
It is good for child's health	59.12	55.75	62.23	73.0	73.8	72.3
Don't Know/Can't Say	11.33	6.90	15.43	5.6	4	11.5
Other	1.93	1.72	2.13	0.1	0.2	-

Figure 39: Distribution of respondents by the items provided before starting breast feeding (BASE: those who given anything other than breast milk after birth)

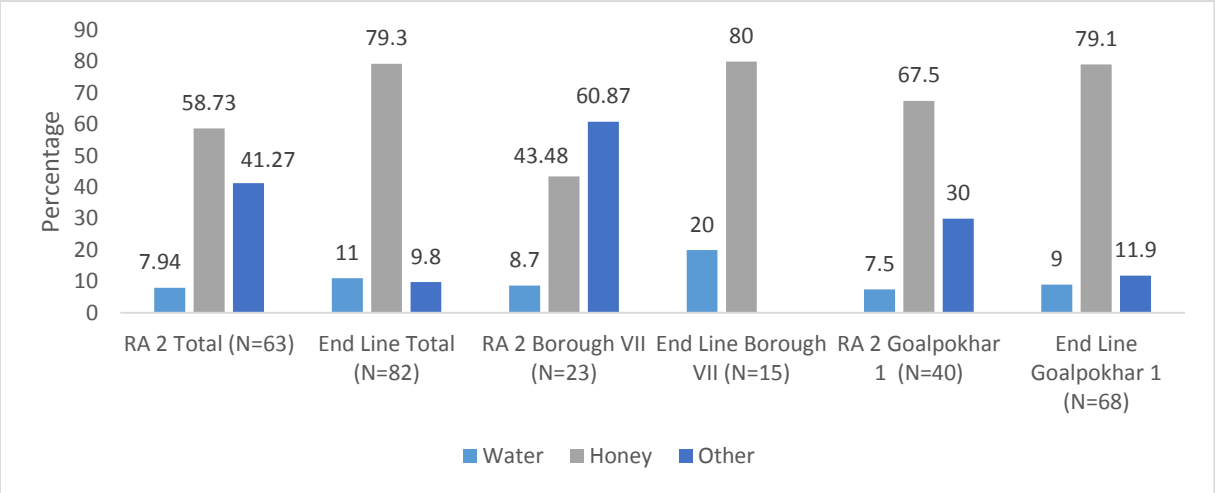


Figure 40: Distribution of respondents by changes in feeding practice during mother's as well as child's illness (BASE: ALL)

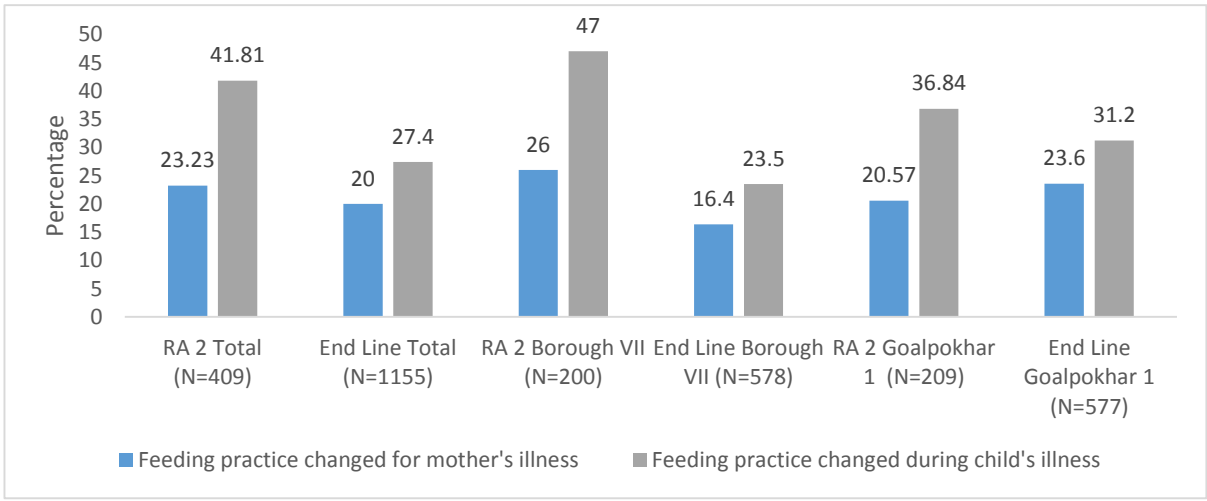


Table 72: Distribution of respondents by kind of changes in feeding practice during mother's illness (BASE: ALL)

Changes	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=231)	Borough VII (N=95)	Goalpokhar 1 (N=136)
Increased the number of breastfeeds	5.26	5.77	4.65	10.0	2.1	15.4
Decreased the number of breastfeeds	48.42	38.46	60.47	72.3	69.5	74.3
Not given breast milk	15.79	25.00	4.65	11.7	22.1	4.4
Increased other food	14.74	19.23	9.30	5.6	6.3	5.1
Decreased other food	26.32	13.46	41.86	.4	-	.7
As usual	24.21	21.15	27.91	-	-	-
Others	3.16	5.77	-	-	-	-

Table 73: Distribution of respondents by kind of changes in feeding practice during child's illness (BASE: ALL)

Changes	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=316)	Borough VII (N=136)	Goalpokhar 1 (N=180)
Increased the number of breastfeeds	21.14	22.92	18.99	33.2	23.5	40.6
Decreased the number of breastfeeds	53.71	46.88	62.03	55.7	61.8	51.1
Not given breast milk	7.43	10.42	3.80	3.8	8.1	.6
Increased other food	4.57	5.21	3.80	3.5	2.9	3.9
Decreased other food	53.14	52.08	54.43	3.8	3.7	3.9
As usual	4.00	2.08	6.33	-	-	-
Others	2.29	4.17	-	-	-	-

Figure 41: Distribution of respondents by whether they received any advice on breast feeding and if they are currently breast feeding (BASE: ALL)

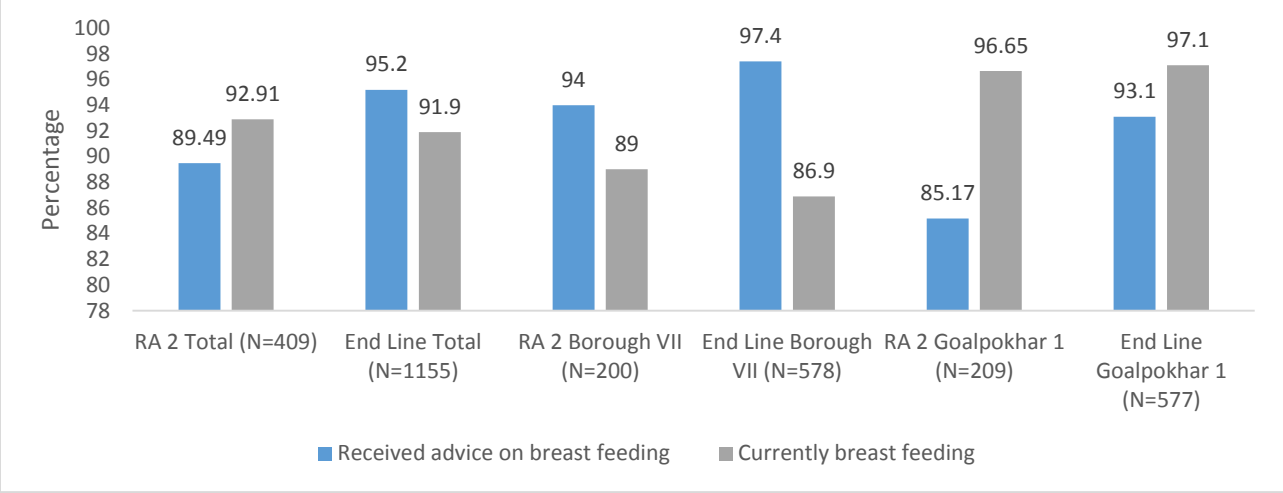


Table 74: Distribution of respondents by source of advice on breast feeding (BASE: those who received advice on breast feeding)

Source of advice	Rapid Assessment 2 (%)			End Line		
	Total (N=366)	Borough VII (N=188)	Goalpokhar 1 (N=178)	Total (N=1100)	Borough VII (N=563)	Goalpokhar 1 (N=537)
ANM	17.76	5.32	30.90	11.1	3.0	19.6
Change Agent	81.15	75.53	87.08	83.5	89.7	77.1
ASHA/ HWW	30.05	1.06	60.67	26.6	1.4	53.1
Anganwadi Worker	36.61	35.11	38.20	14.5	9.2	19.9
Mother	21.58	28.72	14.04	30.1	43.9	15.6
Other	7.38	13.30	1.12	2.6	3.0	2.2

Table 75: Distribution of respondents by their knowledge about one should continue breast feeding (BASE: ALL)

Duration	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
As long as possible	47.68	43.00	52.15	36.8	33.0	40.6
Till four months of age	0.24	-	0.48	-	-	-
Till six months of age	25.18	32.00	18.66	12.7	16.6	8.8
Till 24 months of age	-	-	-	38.0	33.2	42.8
Till the child grows its first tooth	1.47	-	2.87	0.6	0.3	0.9
Others	24.94	24.50	25.36	8.8	11.6	6.1
Don't Know/Can't Say	0.49	0.50	0.48	1.8	2.9	0.7

Table 76: Distribution of respondents by how long they did continue exclusive breast feeding for their last child (BASE: ALL)

Age in years	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Below 6months	2.20	-	4.31	1.3	0.9	1.7
6months	84.35	93.00	76.08	83.7	79.1	88.4
7-12months	5.38	2.50	8.13	4.2	4.2	4.3
16-24months	4.16	3.00	5.26	8.0	12.3	3.6
25-36months	0.49	0.50	0.48	0.5	0.7	0.3
Don't Know/Can't Say	3.42	1.00	5.74	2.3	2.9	1.6

Table 77: Distribution of respondents by the type of food provided to their last child during last 24 hours prior to survey (BASE: ALL)

Type of food	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Rice	57.70	62.00	53.59	85.02	87.0	83.0
Milk/Curd	32.03	38.50	25.84	67.53	78.0	57.0
Eggs	18.09	19.50	16.75	35.32	43.9	26.7
Meat/Chicken	1.96	1.50	2.39	11.95	14.7	9.2
Nuts	0.49	0.50	0.48	4.07	7.6	0.5
Pulses	42.05	44.50	39.71	33.94	46.0	21.8
Vegetables	38.39	43.00	33.97	56.62	61.6	51.6
Fruits	12.47	19.00	6.22	28.40	42.4	14.4
Processed Food (biscuits, breads)	40.10	40.50	39.71	83.64	86.7	80.6
Not Applicable (child is breastfed)	26.65	21.00	32.06	4.68	6.9	2.4
Others	21.27	23.50	19.14	13.33	8.1	18.5

Table 78: Distribution of respondents by the number of times food provided to their last child during last 24 hours prior to survey (BASE: ALL)

Number of times food was provided	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
1times	10.27	11.00	9.57	2.9	2.9	2.9
2times	17.85	18.00	17.70	19.7	18.2	21.1
3times	13.45	13.50	13.40	25.7	22.5	28.9
4times and more	9.78	15.50	4.31	37.2	8.7	24.3
Not yet started	48.66	42.00	55.02	14.5	6.2	22.7

Table 79: Distribution of respondents by number of times breast feed to their youngest child during day time (BASE: those who breast feed their child)

Number of times	Rapid Assessment 2 (%)			End Line		
	Total (N=380)	Borough VII (N=178)	Goalpokhar 1 (N=202)	Total (N=1062)	Borough VII (N=502)	Goalpokhar 1 (N=576)
1	2.37	4.49	0.50	1.8	3.0	.7
2	4.21	5.62	2.97	11.1	14.5	8.0
3	2.63	4.49	0.99	11.9	15.3	8.8
4	4.74	7.30	2.48	18.3	20.7	16.1
5	4.21	3.37	4.95	18.6	13.9	22.9
6	5.00	7.87	2.48	18.0	14.1	21.4
7	2.63	3.93	1.49	10.6	6.6	14.3
8	3.42	5.06	1.98	8.1	10.6	5.9
9	2.63	2.81	2.48	1.6	1.2	2.0
10	4.74	5.62	3.96	-	-	-
10+	2.89	3.37	2.48	-	-	-
Average	**2.63 ±5.17**	**3.58 ±7.38**	**1.80 ±3.45**			

Table 80: Distribution of respondents by number of times breast feed to their youngest child during night (BASE: those who breast their child)

Number of times	Rapid Assessment 2 (%)			End Line		
	Total (N=380)	Borough VII (N=178)	Goalpokhar 1 (N=202)	Total (N=1062)	Borough VII (N=576)	Goalpokhar 1 (N=576)
1	3.68	5.06	2.48	6.5	12.9	.7
2	5.00	6.74	3.47	17.6	22.5	13.2
3	8.95	11.80	6.44	28.2	24.9	31.1
4	7.11	9.55	4.95	21.3	19.5	22.9
5	7.37	10.67	4.46	12.0	10.2	13.6
6	2.37	2.25	2.48	9.0	8.0	10.0
7	1.32	2.25	0.50	5.2	1.4	8.6
8	1.32	1.12	1.49	.1	.2	-
9	0.53	0.56	0.50	-	-	-
10	0.79	1.69	-	-	-	-
10+	0.52	1.12	-	-	-	-
Average ±SD	**1.59 ±2.45**	**2.21 ±2.75**	**1.05 ±2.01**			

Table 81: Distribution of respondents by vaccination details of their last child (BASE: ALL)

Vaccination	Rapid Assessment 2 (%)			End Line		
	Total (N=406)	Borough VII (N=197)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
BCG	93.89	98.50	89.47	93.5	95.8	91.2
DPT 1	85.57	94.50	77.03	92.8	95.8	89.8
Polio 1	84.11	91.00	77.51	92.1	95	89.3
DPT 2	81.42	92.00	71.29	90.5	95.2	85.8
Polio 2	77.26	84.50	70.33	90.6	94.6	86.5
DPT 3	69.68	85.00	55.02	87.5	94.1	80.9
Polio 3	66.75	78.00	55.98	86.3	92.6	80.1
Measles	47.43	58.50	36.84	75.7	83.2	68.1
Hepatitis B-1	76.77	87.00	66.99	80.3	89.8	70.9
Hepatitis B-2	71.64	84.00	59.81	79.2	89.1	69.3
Hepatitis B-3	64.55	80.00	49.76	75.1	85.8	64.3
Vitamin A oil	39.85	47.50	32.54	76	78.5	73.5

Table 82: Distribution of respondents by number of times their last child weighed in AWC (BASE: ALL)

Number of times	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1154)	Borough VII (N=577)	Goalpokhar 1 (N=577)
None	27.63	26.00	29.19	22.3	20.5	24.1
Once	35.70	29.00	42.11	22.5	21.7	23.4
2-3times	33.25	39.00	27.75	54.2	56.5	51.8
Don't Know/Can't Say	3.42	6.00	0.96	1.0	1.4	.7

Figure 42: Distribution of respondents by whether their last weighed in last calendar months and if their mothers were informed about it (BASE: those who weighed last 3 calendar months)

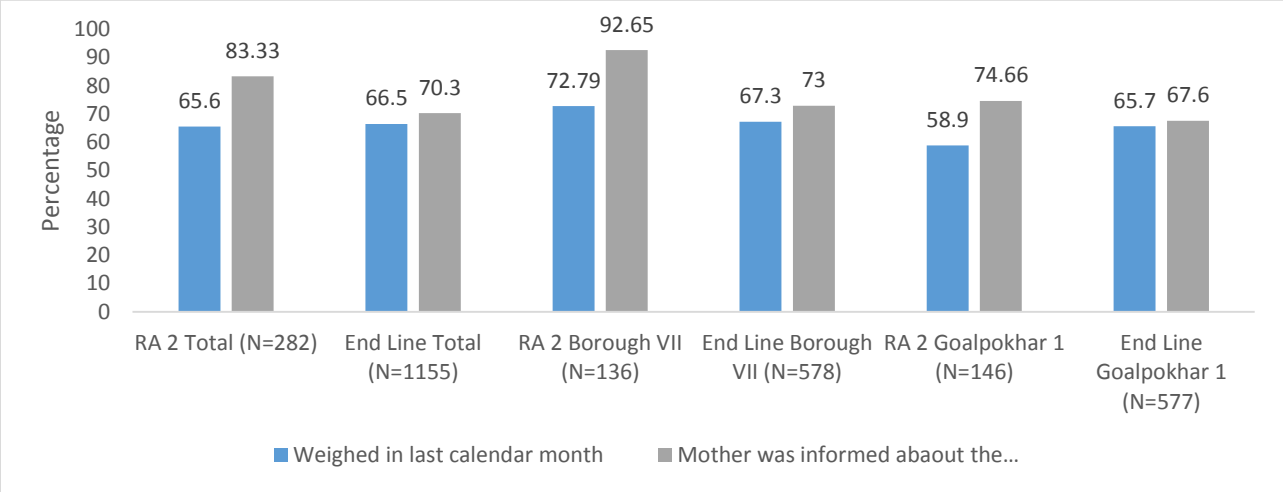


Table 83: Distribution of respondents by their knowledge about with what one should wash hands (BASE: ALL)

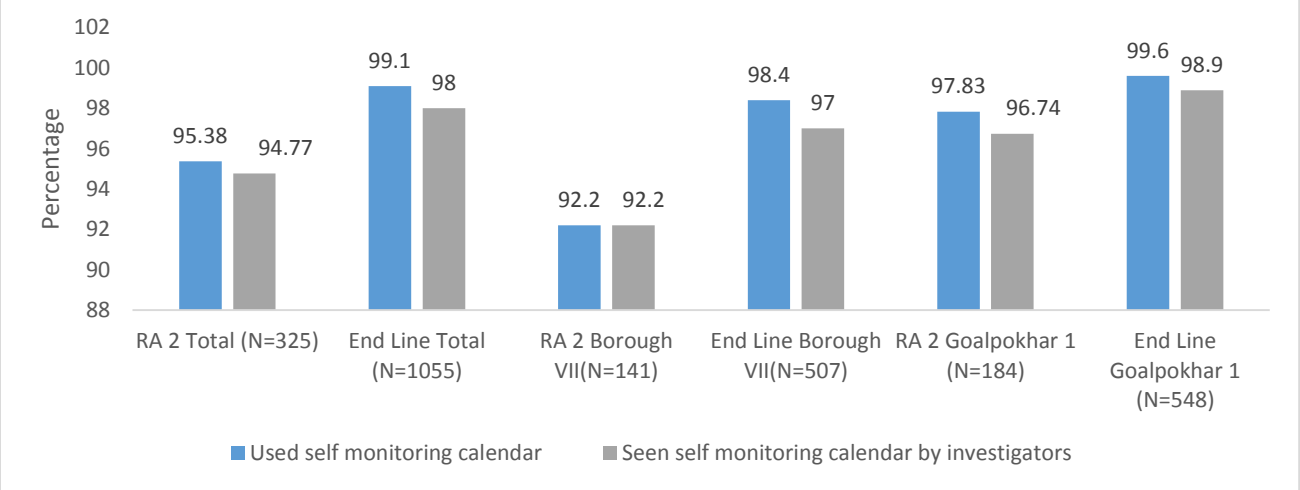
Items to be used to wash hands	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
Soap and water	95.11	97.50	92.82	95.4	97.8	93.1
Mud and water	1.71	-	3.35	0.8	0.2	1.4
Ash and water	0.24	-	0.48	0.2	-	.3
Only water	9.05	6.50	11.48	3.5	1.7	5.2
Others	0.73	1.00	0.48	0.2	0.1	-

10.6. Knowledge about Project Implementation

Table 84: Distribution of respondents by activities of the project attended by them (BASE: ALL)

Activities attended	Rapid Assessment 2 (%)			End Line		
	Total (N=409)	Borough VII (N=200)	Goalpokhar 1 (N=209)	Total (N=1155)	Borough VII (N=578)	Goalpokhar 1 (N=577)
MUAC measurement/MUAC	16.94	22.58	11.11	17.3	19.4	8.8
PNC kit distribution	21.31	21.51	21.11	10.1	7.5	20.6
Distribution of Self Monitoring Calendar	36.07	37.63	34.44	9.8	7.9	17.6
Food and Nutrition Counselling	38.25	35.48	41.11	35.4	40.1	16.2
Meeting with mothers	75.41	70.97	80.00	74.6	76.0	69.1
Attending 12day session for malnourished children	2.19	3.23	1.11	1.115.5	6.1	2.9

Figure 43: Distribution of respondents by whether they use self-monitoring calendar and if the same was seen by the investigators (BASE: those who have seen monitoring calendars)



10.7. Impact on Change Agents

Profile of respondents

Table 85: Age wise distribution of the respondents

Groups (In years)	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
15 to 18	15.00	23.33	6.67	14.6	19.0	5.0
19 to 24	38.33	16.67	60.00	36.6	9.5	65.0
25 to 34	23.33	16.67	30.00	41.5	52.4	30.0
35 to 44	18.33	33.33	3.33	9.8	19.0	-
45 to 54	5.00	10.00	-	-	-	-
Average	**26.75**	**29.83**	**23.67**	**25.04**	**27.85**	**22.1**

Table 86: Distribution of the respondents by social category

Groups (In years)	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
General	66.67	86.67	46.67	70.7	81.0	60.0
Scheduled Caste	13.33	10.00	16.67	19.5	9.5	30.0
Schedule Tribe	1.67	-	3.33	2.4	4.8	-
OBC	16.67	3.33	30.00	7.3	4.8	10.0
Don't Know/Can't Say	1.67	-	3.33	-	-	-

Table 87: Distribution of respondents by their highest qualification

Highest education	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Class 1-12	83.33	80	86.66	41.5	42.9	40.0
Graduation	15.00	16.67	13.33	41.5	47.6	35.0
Post-Graduation	1.67	3.33	-	17.1	9.5	25.0

Orientation and trainings

Figure 44: Distribution of respondents by whether they received orientation and training

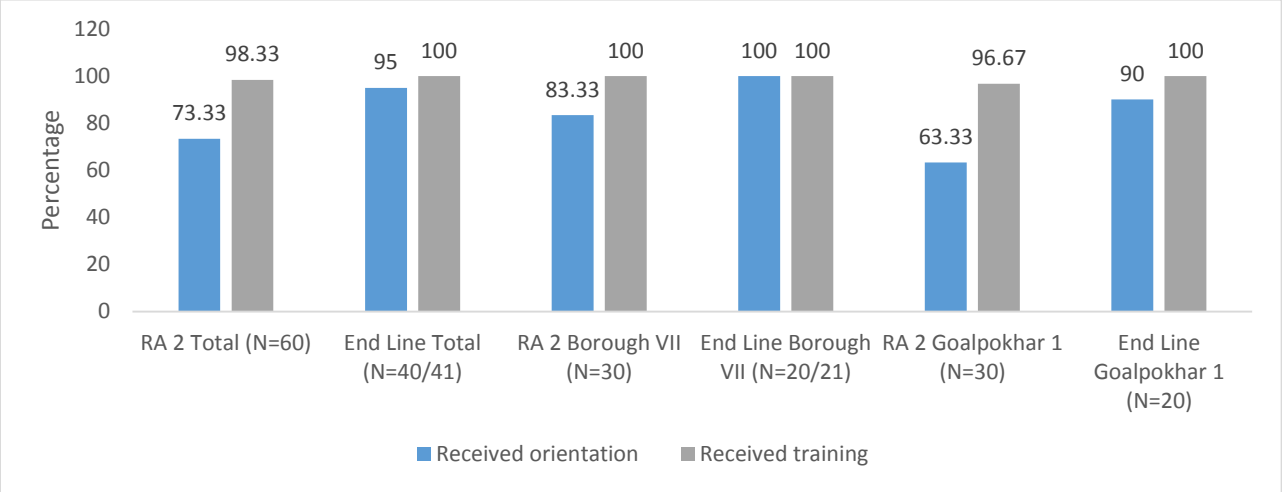


Table 88: Topics covered in trainings

Topics covered	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Maternal health(ANC,PNC,JSY)	100.00	100.00	100.00	100.0	100.0	100.0
Child health (Immunization, Growth Monitoring)	69.49	60.00	79.31	95.1	95.2	95.0
Nutrition	59.32	60.00	58.62	92.7	100.0	85.0
Exclusive Breastfeeding	62.71	60.00	65.52	95.1	100.0	90.0
Complementary Feeding	35.59	33.33	37.93	97.6	95.2	100.0
Nutrimix	52.54	63.33	41.38	100.0	100.0	100.0
PNC kit	33.90	46.67	20.69	100.0	100.0	100.0
1000 days care	45.76	43.33	48.28	100.0	100.0	100.0
Hand washing practice	23.73	13.33	34.48	97.6	100.0	95.0
Monthly Reporting	13.56	23.33	3.45	95.1	95.2	95.0

Knowledge about project and participation

Table 89: Knowledge about project activities

Project activities	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
MUAC measurement/MUAC	66.67	73.33	60.00	100.0	100.0	100.0
PNC kit distribution	51.67	60.00	43.33	100.0	100.0	100.0
Distribution of 1000 days calendar	50.00	50.00	50.00	100.0	100.0	100.0
Health and nutrition counselling	81.67	90.00	73.33	100.0	100.0	100.0
Meeting with mothers	60.00	73.33	46.67	100.0	100.0	100.0

NREP	-	-	-	48.8	95.2	95.0
Special events	-	-	-	85.4	95.2	90.0
VHND/RI	-	-	-	87.8	81.0	85.0
Ward/gram sabha	-	-	-	87.8	90.5	85.0
Feedback collection	-	-	-	87.8	90.5	85.0

Table 90: Project activities performed by Change Agents

Project activities performed	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
MUAC measurement	83.33	93.33	73.33	95.0	95.2	94.7
PNC kit distribution	71.67	73.33	70.00	97.5	100.0	94.7
Distribution of 1000 days calendar	65.00	73.33	56.67	97.5	100.0	94.7
Checking of calendar	45.00	60.00	30.00	95.0	100.0	89.5
Health and nutrition counseling	68.33	76.67	60.00	97.5	100.0	94.7
Group Meeting with mothers	61.67	70.00	53.33	100.0	100.0	100.0
Home visits	73.33	80.00	66.67	100.0	100.0	100.0
MIS/MPR	18.33	36.67	-	90.0	85.7	94.7
Organizing NREP session	21.67	40.00	3.33	90.0	90.5	89.5
Follow up of children who attended NREP session	20.00	33.33	6.67	87.5	90.5	84.2
Maintaining of Tracking Register	30.00	46.67	13.33	95.0	100.0	89.5
Planning with ASHA/AWW	21.67	23.33	20.00	52.5	52.4	52.6
Participation in government programmes	10	20	-	65.0	61.9	68.4
Special events	-	-	-	92.5	90.5	94.7
Ward/gram sabha	-	-	-	82.5	71.4	94.7
Feedback collection	-	-	-	72.5	76.2	68.4

Table 91: Knowledge of Change Agents about the contents of PNC kit

Contents	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=40)	Borough VII (N=20)	Goalpokhar 1 (N=20)
Sanitary napkin	93.33	96.67	90.00	100.0	100.0	100.0
Condom	61.67	66.67	56.67	51.2	100.0	-
IFA tablets	58.33	76.67	40.00	53.7	100.0	5.0
Nutrimix	91.67	96.67	86.67	100.0	100.0	100.0
Don't Know/Can't Say	3.33	-	6.67	-	-	-

Table 92: Knowledge of Change Agents about eligibility for getting PNC kit

	Rapid Assessment 2 (%)	End Line

	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Pregnant women	21.67	16.67	26.67	2.4	4.8	-
Mothers who come for PNC	30.00	36.67	23.33	100.0	100.0	100.0
Anyone who comes for check-up	20.00	23.33	16.67	9.8	19.0	-
Mothers who come for first PNC	48.33	40.00	56.67	-	-	-
Don't Know/Can't Say	1.67	-	3.33	-	-	-

Table 93: Knowledge of Change Agents about time of delivering PNC kit

Time of delivering PNC Kit	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=40)	Borough VII (N=20)	Goalpokhar 1 (N=20)
During every PNC visit	30.00	46.67	13.33	65.9	71.4	60.0
Whenever they meet a lactating mother	36.67	23.33	50.00	48.8	33.3	65.0
Whenever they want	11.67	6.67	16.67	2.4	-	-
During first PNC	36.67	36.67	36.67	-	-	-
Don't Know/Can't Say	1.67		3.33	-	-	-

Support from project staff and stakeholders

Table 94: Activities done by the supervisors during their visits

Activities	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=40)	Goalpokhar 1 (N=20)
Checks Tracking registers	73.33	76.67	70.00	100.0	100.0	100.0
Checks MIS sheets	40.00	60.00	20.00	87.8	90.5	85.0
Gives feedback	26.67	43.33	10.00	97.6	95.2	100.0
Does home visits along with Change Agent	13.33	23.33	3.33	100.0	100.0	100.0
Solves problems of Change Agents	58.33	63.33	53.33	100.0	100.0	100.0
Orients Change Agents	40.00	43.33	36.67	92.7	90.5	95.0
Supports in organizing NREP session	26.67	40.00	13.33	92.7	95.2	90.0

Table 95: Reasons for considering particular individual as their greatest support

Reasons	Rapid Assessment 2 (%)			End Line		
	Total (N=57)	Borough VII (N=27)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Solves problem	77.19	70.37	83.33	100.0	100.0	100.0
Extends support	28.07	48.15	10.00	90.2	81.0	100.0
Available when needed	38.60	55.56	23.33	87.8	76.2	100.0
Have good contacts	7.02	11.11	3.33	87.8	81.0	95.0

Table 96: Activities supported by AWW

Support in	Rapid Assessment 2 (%)			End Line		
	Total (N=53)	Borough VII (N=26)	Goalpokhar 1 (N=27)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Community Level awareness camps	64.15	69.23	59.26	87.1	66.7	100.0
NREP session	37.74	42.31	33.33	77.4	58.3	89.5
Joint counselling	41.51	50.00	33.33	71.0	41.7	89.5
Providing logistic support	28.30	50.00	7.41	64.5	25.0	89.5

Table 97: Activities supported by Club Members

Reasons	Rapid Assessment 2 (%)			End Line		
	Total (N=38)	Borough VII (N=27)	Goalpokhar 1 (N=11)	Total (N=40)	Borough VII (N=20)	Goalpokhar 1 (N=20)
Community Level awareness camps	68.42	62.96	81.82	84.2	68.4	100.0
NREP session	28.95	33.33	18.18	50.0	15.8	84.2
Joint counselling	42.11	51.85	18.18	57.9	31.6	84.2
Providing logistic support	47.37	55.56	27.27	71.1	57.9	84.2

Knowledge of Change Agents on issues covered in the project

Table 98: Knowledge of Change Agents on ANC

ANC attributes	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Place of pregnancy registration						
Sub-Centre	30	-	60	53.7	9.5	100.0
AWC	30.00	16.67	43.33	61.0	38.1	85.0
PHC	5.00	10.00	-	36.6	23.8	50.0
Private Hospital/Clinic	10.00	20.00	-	53.7	47.6	60.0
Government Hospital	50.00	100.00	-	75.6	100.0	50.0
Reason of ANC check-ups						
To know the health of the mother	95.00	96.67	93.33	100.0	100.0	100.0
To know the health of the child	80.00	86.67	73.33	82.9	85.7	80.0
It is customary	1.67	-	3.33	39.0	42.9	35.0
Number of ANC check-ups needed						
One ANC	-	-	-	12.2	-	25.0
Three ANC	6.67	13.33	-	2.4	4.8	-
Four ANC	86.67	73.33	100.00	80.5	90.5	100.0
More than Four ANC	6.67	13.33	-	4.9	100.0	-
Number of IFA should be consumed during pregnancy						
Less than 100	-	-	-	2.4	4.8	-
Equal to 100	93.33	96.67	90.00	73.2	95.2	50.0
More than 100	6.67	3.33	10.00	24.4	-	50.0

Number of TT should be taken during pregnancy	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=30)	Total (N=40)	Borough VII (N=21)	Goalpokhar 1 (N=19)
One	1.67	3.33	-	-	-	-
Two	95.00	93.33	96.67	100	100	100
Don't Know/Can't Say	3.33	3.33	3.33	-	-	-
Knows about complications of pregnancy	**Total (N=60)**	**Borough VII (N=30)**	**Goalpokhar 1 (N=30)**	**Total (N=41)**	**Borough VII (N=21)**	**Goalpokhar 1 (N=20)**
Yes	96.67	100.00	93.33	100	100	100
No	3.33	-	6.67	-	-	-

Table 99: Knowledge of Change Agents on complications of pregnancy

Complication of pregnancy	Rapid Assessment 2 (%)			End Line		
	Total (N=58)	Borough VII (N=30)	Goalpokhar 1 (N=28)	Total (N=41)	Borough VII (N=20)	Goalpokhar 1 (N=20)
Vaginal bleeding	79.31	70.00	89.29	97.6	95.2	100.0
Prolonged labour	10.34	16.67	3.57	92.7	85.7	100.0
Convulsions	25.86	46.67	3.57	97.6	95.2	100.0
Oedema	46.55	46.67	46.43	87.8	76.2	100.0

Table 100: Knowledge of Change Agents on kind of services one should receive during pregnancy

Services	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=60)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Weight Measurement	91.67	90.00	93.33	100.0	100.0	100.0
Immunization	83.33	83.33	83.33	100.0	100.0	100.0
Supplementary food rations	33.33	53.33	13.33	80.5	61.9	100.0
Counselling	16.67	23.33	10.00	85.4	85.7	85.0
Hb estimates	40.00	23.33	56.67	92.7	90.5	95.0
Urine test	51.67	56.67	46.67	100.0	100.0	100.0
Abdominal check-up	55.00	53.33	56.67	90.2	85.7	95.0
Given IFA tablets/syrup	55.00	73.33	36.67	97.6	95.2	100.0
Referral services	11.67	23.33	-	73.2	61.9	85.0

Table 101: Knowledge of Change Agents on JSY

JSY attributes	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=60)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Eligibility to avail JSY						
BPL	88.33	76.67	100.00	80.5	61.9	100.0
SC/ST	28.33	33.33	23.33	70.7	42.9	100.0
Women above 19 years	8.33	13.33	3.33	70.7	42.9	100.0
More than 2 children	5.00	6.67	3.33	58.5	19.0	100.0
Women from all age group	8.33	16.67	-	26.8	38.1	15.0
All children irrespective of parity	1.67	3.33	-	31.7	33.3	30.0
What benefits one can get under JSY						

Registration card	8.33	16.67	-	75.6	52.4	100.0
ANC	11.67	20.00	3.33	70.7	42.9	100.0
Cash after delivery	83.33	76.67	90.00	90.2	81.0	100.0
Money given for going to hospital	16.67	23.33	10.00	34.1	23.8	45.0
Free delivery	18.33	30.00	6.67	56.1	42.9	70.0

Table 102: Knowledge of Change Agents on PNC

PNC attributes	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=60)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Reasons why one should go for PNC check ups						
To know the health of the mother	76.67	90.00	63.33	100.0	100.0	100.0
It is customary	3.33	3.33	3.33	17.1	23.8	10.0
Don't Know/Can't Say	1.67	3.33	-	-	-	-

Table 103: Knowledge of Change Agents on child health and hand washing

Child health and hand washing knowledge	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=60)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Name of the measurements to know nutritional status						
MUAC	96.67	96.67	96.67	97.6	95.2	100.0
Weight	95.00	93.33	96.67	100.0	100.0	100.0
Height	13.33	13.33	13.33	-	-	-
What does growth chart show						
Progress of weight	41.67	56.67	26.67	97.6	100.0	95.0
The nutritional status of a child	90.00	86.67	93.33	92.7	95.2	90.0
When should a person wash hands						
Before meal	90.00	90.00	90.00	87.8	76.2	100.0
After meal	71.67	80.00	63.33	73.2	52.4	95.0
After coming from the toilet	51.67	60.00	43.33	85.4	76.2	95.0
All of the above	20.00	26.67	13.33	78.0	61.9	95.0
With what one should wash hands						
Soap and water	98.33	96.67	100.00	100.0	100.0	100.0
Mud and water	1.67	3.33	-	14.6	4.8	25.0
Ash and water	3.33	6.67	-	17.1	4.8	35.0
Only water	1.67	3.33	-	17.1	-	30.0

Table 104: Knowledge of Change Agents on NREP and NRC

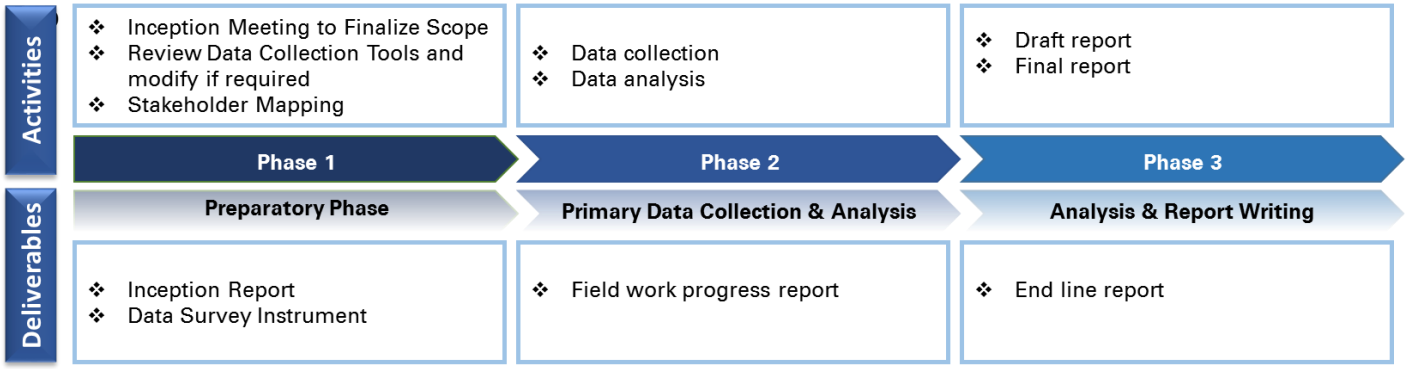
NREP and NRC attributes	Rapid Assessment 2 (%)			End Line		
	Total (N=60)	Borough VII (N=30)	Goalpokhar 1 (N=60)	Total (N=41)	Borough VII (N=21)	Goalpokhar 1 (N=20)
Which children should brought to NREP session						

Children with MUAC red	51.67	56.67	46.67	51.2	47.6	55.0
Children with MUAC yellow	15.00	23.33	6.67	65.9	85.7	45.0
Growth chart (red)	51.67	50.00	53.33	80.5	71.4	90.0
Growth Chart (yellow)	11.67	16.67	6.67	78.0	71.4	85.0
For how many days NREP session conducted						
12 days	78.33	76.67	80.00	100.0	100.0	100.0
Other	15.00	13.33	16.67	-	-	-
Don't Know	6.67	10.00	3.33	-	-	-
Under which condition children should be referred to NRC						
Severely malnourished	80.00	73.33	86.67	68.3	90.5	45.0
Severely malnourished with oedema	11.67	16.67	6.67	53.7	38.1	70.0
Severely malnourished with medical complications	16.67	30.00	3.33	26.8	38.1	15.0

10.8. Implementation of the Study

The end-line evaluation was conducted by KPMG in three phases. The figure below summarises the planned implementation process undertaken for this study.

Figure 45: End-line evaluation implementation process



10.8.1. Preparatory Stage

The contract between KPMG and CINI was signed on 23rd December 2015, following which CINI and KPMG project members organized an inception meeting to discuss the MACHAN project, its implementation and the scope of the evaluation.

Following the finalization of the scope of the study, the qualitative and quantitative research tools were reviewed and the necessary changes were incorporated, as well as the field work plan was finalized. These were shared with CINI in the form of an Inception Report on 1st February 2016.

The final data survey instruments, as approved by CINI, were then translated into the local language Bengali.

10.8.2. Training

A 3-day training programme was conducted for all field personnel involved in the study. This training familiarized them with the questionnaire and its flow, the techniques of interviewing, the target respondents, and other relevant elements of the survey.

CINI staff members also participated in the training programme. A pilot survey was also conducted after the training and before the main fieldwork began. Revisions to the questionnaire, were made after the pilots and training in consultation with the CINI team.

10.8.3. Field Work

The field work was executed by Research teams from KPMG and investigators selected from the pool of interviewers who have been working regularly with KPMG's partner organization Marketxcel in Borough VII and who have previous experience with similar studies.

To ensure quality, the research team conducted all the qualitative interviews and at least 50 percent of the quantitative interview.

10.8.4. Data Entry and Table Generation

The survey was conducted via Paper and Pencil Interviewing (PAPI), and the responses were then recorded and analysed in Microsoft excel and SPSS. The Evaluation team finalized the analysis plan for each round of survey after the finalization of the questionnaire in consultation with the client. The qualitative data was analyzed at every round to assess the relevance, effectiveness and efficiency of the programme. The data was provided to CINI in SPSS and excel format.

10.8.5. Evaluation Framework

We have used the internationally accepted evaluation criteria of the Organisation for Economic Co-Operation and Development–Development Assistance Committee (OECD-DAC) as the framework for addressing the evaluation questions and assessing whether the intervention is relevant, efficient, and effective, and whether it has a positive, sustainable impact.

- Relevance can be defined as "the extent to which the aid activity is suited to the priorities and policies of the target group, recipient, and donor";
- Efficiency as "the measurement of the outputs relative to the inputs";
- Effectiveness as "the extent to which an aid activity attains its objectives";
- Impact as "the positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended"; and
- Sustainability as "a measure concerning "whether the benefits of an activity are likely to continue after donor funding has been withdrawn" (OECD-DAC, 2002).

In addition to this, the study also assesses how much additional fund has been secured or contributed by CINI. Following the quantitative and qualitative data analysis, we can then also assess the cost-effectiveness and sustainability of the program.

The study will also answer specific questions on lessons learnt with respect to the objectives mentioned above, and will also identify triggers and barriers to the program and provide recommendations for future programming.

However, since the baseline was unable to cover all indicators necessary to assess the project's impact, the end line findings will be compared to the findings of the second Rapid Assessment (RA2) conducted.

10.8.6. Techniques used for Data Validation and Absence of Bias

The following measures were taken to ensure quality control:

- All of the interviewers would be accompanied by a supervisor for the first few interviews to appraise their performance in the field. All minute issues such as the manner in which questions are administered and the flow of the discussion would be checked and corrected if necessary.

- All completed questionnaires would undergo 100% scrutiny. This would not only help in identifying the errors or mistakes interviewers could make but also ensure the completeness and comprehensiveness of the information recorded into the questionnaires.

- 25% of the sample would be back checked to ensure the correct respondent has been met, if relevant questions were administered, and to check reliability of the data collected.

10.8.7. Ethical Consideration

Informed consent was taken prior to all the quantitative and qualitative interviews. As a part of the process for obtaining informed consent, the interviewers explained the objectives of the study to

respondents. Interviewers also communicated that participation was voluntary and that respondents would be able to request to stop the interview at any time or refuse to answer a question if they felt uncomfortable doing so.