give

Impact Assessment Report

Wipro Cares

Rural Literacy and Health Program

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1 Executive Summary

In India, maternal, child, and adolescent health remain critical public health concerns, especially in rural areas. Despite significant improvements in healthcare infrastructure and access to medical facilities, the country continues to struggle with high rates of maternal and child mortality, malnutrition, and communicable diseases. The lack of access to quality healthcare services and limited awareness of health issues amongst the rural population exacerbate the problem. Therefore, interventions around mother, child, and adolescent health are crucial to improve health outcomes and reduce morbidity and mortality in rural India. To tackle these issues, Wipro Cares partnered with Rural Literacy and Health Program (RLHP) to deploy a long-standing program on routine maternal neonatal child and adolescent health (RMNCH+A) program in the villages of Mysore, Karnataka. This program is in alignment with Wipro's key thematic area of healthcare as it is centered around holistic mother, child and adolescent health improvement. A total grant of INR 1.28 Cr was disbursed over three years (2019-2021) of the project agreement. The intervention addresses SDG 3 of the UN SDGs, Agenda 2030. Nationally, it targets activity (i) of Schedule VII of the Companies Act, 2013.

Key features of RMNCH+A strategy by the National Health Mission include[1]:

- Health systems strengthening (HSS) focusing on infrastructure, human resources, supply chain management, and referral transport measures.
- Prioritization of high-impact interventions for various lifecycle stages.
- Increasing effectiveness of investments by prioritizing geographical areas based on evidence.
- Integrated monitoring and accountability through good governance, use of available data sets, community involvement, and steps to address grievance.
- Broad-based collaboration and partnerships with ministries, departments, development partners, civil society, and other stakeholders.

The government of Karnataka (GoK) as part of their maternal health schemes have introduced 'Madilu Kit' to[2] 1) promote institutional deliveries in the state, 2) reduce out of pocket expenditure during delivery and post-natal period.

The RMNCH+A intervention of Wipro in Mysuru, KA has been a decade long program that has the following objectives:

#	Program Objectives	Progress
1	Registration of pregnant women for ANC and institutional delivery	100% identified pregnant women registered for ANC and institutional delivery
2	Awareness creating about importance of feeding colostrum milk immediately after delivery and good nutrition during lactation phase	100% lactating women fed colostrum milk to their baby right after birth and were educated about importance of good nutrition
3	Immunization of children	100% identified children have been immunized via home visits and at anganwadi centers/ NGO health camps
4	Reduction in malnutrition amongst children aged 0-10	All mothers reported seeing an improvement in their child's health after incorporating nutrition supplements (provided by the NGO) in their diet
5	Educating adolescents about sexual and reproductive health	Reproductive health education sessions have been conducted in most of the village schools

[1] https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168

[2] https://karunadu.karnataka.gov.in/hfw/nhm/pages/mh_schemes_madilu.aspx

6	Improvement in infrastructure and awareness about personal hygiene and community sanitation	Most village households have a personal toilet and have attended waste management sessions
7	Prevention of child marriage and child labour	Child marriage has stopped in most villages and 99% children complete schooling (as reported by community volunteer)

The secondary data suggest that Mysuru taluk has the highest utilisation of MCH services in the state of Karnataka, our assessment suggest otherwise. The nearest primary health centre (PHC) is atleast 6-8 km away from the villages. The objective of state sponsored 'Madilu Kit' thereby proves futile considering out of pocket expenditures incurred in visiting to the nearest PHC. This establishes the need for RMNCH+A services by Wipro Foundation in the villages it is currently having an intervention rolled out.

The impact assessment sets a logical framework analysis against the expected theory of change, to understand the parameters, indicators, output, outcome, and overall impact. A mixed method approach was deployed to collect and analyze qualitative and quantitative data. The total sample size for the impact study was 340 out of which a total of 270 respondents were the primary beneficiaries of the project i.e., pregnant and lactating women, mothers of children, adolescents and general community members. The Give team conducted in-depth KIIs with the other stakeholders, vital in determining the impact of the project's interventions.

The assessment indicates behavioural change amongst the village communities with regards to timely health checkups, immunization and importance of good nutrition and sanitation have happened. A positive change was observed in ante-natal checkup (ANC) seeking trend amongst pregnant women. All women have now started opting for ANC checkups. In addition, all respondents were found to have sought ANC partially compared to no ANC prior to the intervention. Institutional delivery was found to be highly prevalent. However, challenges like lack of awareness about the importance of adopting family planning methods persist. The respondents were hesitant to discuss the specific challenges faced by them when it comes to family planning. Give feels that superstitions, negative personal beliefs and resistance from men might be probable causes for low adoption of family planning methods. The NGO should work on identifying the causes and then then conduct education sessions centered around the dispelling them.

In regard to nutrition, the villagers were found to have incorporated protein rich items such as milk, eggs and locally available seasonal vegetables in their diet like. The mothers received nutrition supplements provided by the NGO every month. This helped their children to overcome malnourishment. All the children present during the interaction appeared to be healthy. Considering their socioeconomic condition, the sustainability of these practices is debatable. It will be worthwhile to have livelihood centric interventions like empowering women to generate income through small businesses. This will ensure each household has multiple income streams thus increasing financial stability required to afford good nutrition in the long term.

With respect to sanitation, most village households and schools were found to have toilets and access to clean drinking water. Minor challenges related to space restriction persist for which some households haven't been able to construct toilets. Toilet usage rate was also found to very high in all villages except one which further corroborates that physical infrastructure of the toilet is being used. A few public toilets can be built in villages to solve the issue of lack of household toilets due to space restriction.

Most of the activities had taken place telephonically during peak COVID-19 periods in FY 2020-21. The NGO had also conducted sessions on COVID-19 safety precautions. An underutilization of ~28% was observed due to programmatic changes that happened during the COVID-19 pandemic.

Overall, the Give team found that the NGO has done a commendable job in ensuring sustainability of the interventions by adopting a behavioural change centric model and empowering the communities to seek reforms through the local

village authorities. However, that the implementing partner can further strengthen the sustenance of the program by improving the public health ecosystem in villages through activities like capacity building of community health workers, collaborating with local government bodies to ensure presence of ASHA and ANM workers in all villages and ensuring that the anganwadi centres are functional in every village.

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2 Introduction

*Figure SEQ Figure * ARABIC 1: Project Timeline*

Mother, child, and adolescent health are critical components of the overall well-being of any society. In India, significant progress has been made in recent years in improving the health outcomes for these groups, but challenges persist. Maternal and infant mortality rates in India remain high, with an estimated 42,000 maternal deaths occurring in India in 2020, and an infant mortality rate of 28 deaths per 1,000 live births. Adolescent health is also an area of concern, with limited access to reproductive and sexual health education leading to unintended pregnancies, unsafe abortions, and an increased risk of sexually transmitted infections.

The Government of India through one of several initiatives has introduced National Health Mission which aims to improve access to quality healthcare for all. The government has also implemented targeted programs to reduce maternal and infant mortality rates, such as the Janani Suraksha Yojana, which provides financial assistance to pregnant women for institutional deliveries. These policies have helped to improve health outcomes for mothers and children, but challenges remain in accessing these policies, particularly in rural areas.

Rural communities in India face several challenges in accessing healthcare services, including inadequate infrastructure, limited availability of skilled healthcare workers, and financial barriers. These challenges have a disproportionate impact on the health outcomes of vulnerable groups such as women and children, who often have limited access to healthcare services.

Sanitation, including access to toilets, is also crucial for the overall health and wellbeing of mothers and children. Lack of access to toilets can lead to poor sanitation and hygiene, which can cause infections and diseases. Additionally, there is a lack of awareness about the importance of timely immunization of children and growth tracking in rural areas, leading to malnutrition and other health issues.

The spatio-temporal analysis of the maternal and child health (MCH) services reveals that Mysore taluk has level of MCH services utilisation compared to other taluks in the state from 2015-16 to 2017-18. The assessment suggests that the nearest PHC is at 6-8 km whereas DH is at 10-12

km from the village. Wipro Foundation as a result rolled out the intervention to bridge this gap.

The RMNCH+A program by RLHP seeks to improve the health status of women, children and adolescents through improved awareness about good health and nutrition practices and routine medical screening of pregnant and lactating women, children aged 0-10 and adolescents. Community engagement remained a crucial aspect of implementation whereby community volunteers were identified and trained on various health topics for conducting health awareness sessions for the larger community. The program involved activities under the following four main verticals:

- **Improvement of Women's Reproductive Health**: Involved screening of pregnant women for high-risk pregnancies at health camps and health melas, ANC registration in government clinics, health awareness sessions on importance of breastfeeding, family planning and timely immunization. The NGO also helped the women in registering for relevant maternal and child health related government schemes.
- **Malnourishment Improvement Initiative**: Involved routine malnutrition screening, distribution of protein mixture powder, eggs and spirulina chikki and conduction of nutritional recipes demonstration camps.
- **Training of Adolescents**: Involved education sessions on sexual and reproductive health and identification and training of green team leaders in schools. The green team trainings consisted of awareness generation regarding waste management, environmental protection and home and community sanitation.
- **Community Health and Sanitation Initiative**: Involved setting up of health camps in villages, health awareness sessions on menstrual hygiene, sanitation etc., teleconsultation service during the pandemic, empowerment of community members to lobby for and seek necessary reforms from the village panchayat, promotion of personal and community sanitation through environment friendly practices.

As part of the assessment, the Give team conducted a physical visit to 10+ villages of Mysore and interacted with the following stakeholder groups: Children's parents, Pregnant and lactating women, Community volunteers, Adolescents, Village community members, Community health workers, Village panchayat leaders and the NGO program team. The Wipro Cares CSR team was interviewed virtually.

This impact assessment report will examine the current status of mother, child, and adolescent health in the intervention region, including the progress made, the challenges that remain, and the impact created. The report will also explore the barriers to accessing healthcare services faced by rural communities and provide recommendations for improving access to quality healthcare for mothers, children, and adolescents.

3 Objectives and Scope of Study

The study aims to understand the implementation pathway of the project and its impact on maternal, child and adolescent health in the villages of Mysore. The impact assessment study tries to map the program implementation against the proposed plan and draws focus on how the intervention has helped the pregnant and lactating women, children and adolescents inculcate good health, nutrition and sanitation practices and overcome high-risk pregnancies, child malnutrition and improve personal and community sanitation.

3.1 Objectives of the Study

The major objectives of the study are as follows:

- **Assess** the relevance and efficiency of the intervention: To ensure that beneficiaries challenges are addressed by the project and to review the implementation pathways - assessing process and activities
- **Understand** the effectiveness of the intervention: How each activity has led to creating the desired outcomes
- **Understand** the major success factors and challenges in the intervention
- **Find the areas of improvement** across all the factors from program design to implementation
- **Provide an assessment framework** to be able to capture impacts in a manner that is effective recommendation

3.2 Limitations of the Study

- The beneficiary interactions were conducted in groups. There is a possibility that lack of anonymity (in a group setting) might have influenced individual answers.
- The NGO team members were present during the group interactions. Although they did not partake in the interactions, their presence might have influenced the feedback given by the beneficiaries about the NGO's initiatives.
- The Give team observed that stigma about menstruation and sex education is still prevalent in the villages. The adolescent and the pregnant/lactating women beneficiaries were hesitant of openly discussing about the sessions on reproductive health and hygiene and family planning methods delivered by the NGO team.

4 Assessment Framework

To create an overall framework for the impact assessment, following activities were undertaken. We began by establishing the scope of the assessment in terms of type of stakeholders to be engaged and topics to be discussed with them. Based on this and the understanding of the project activities, we developed stakeholder-wise detailed questionnaires to ascertain factors including rationale for supporting the program, the implementation process, roadblocks in operations and beneficiary (community members) feedback about the efficacy of the program. The findings and recommendations arising out of this process are mentioned in the subsequent sections of the report.

4.1 Theory of Change

The THEORY OF CHANGE FRAMEWORK (ToC) for the given program is illustrated below:

Theory of Change (ToC)				
Need	**Input**	**Output**	**Outcome**	**Impact**
Improvement of RMNCH+A status in the villages of Mysuru taluk, KA through activities targeted at behavioral change of community members towards health, nutrition and sanitation	**Improvement of women's reproductive health** • High risk pregnancy screening through health camps • Nutritional status assessment of pregnant and lactating mothers • Government health facility referral for ANC registration • Awareness sessions on importance of breast feeding • Promoting adoption of family planning methods	• No. of high-risk pregnancy identified and treated • No. of women registering and receiving ANC • No. of women incorporating high protein diet during pregnancy/lactation • No. of women feeding colostrum milk to infant • No. of women practicing exclusive breastfeeding for 6 months	• % reduction in maternal and infant mortality • Birth of healthy babies because of high-quality ANC • Reduction in malnutrition amongst children of ages 0-10 • Healthy growth and development of children • Preemption of STIs and reproductive issues in adolescents	• Overall improvement in maternal, child and adolescent health • Stronger foundation for good health of the children because of routine immunization.

	Malnutrition Improvement Initiative • Malnutrition screening of children up to the age of 10 • Protein powder supplement for malnourished children • Sensitization of parents about the importance of good nutrition and sessions on growth tracking of their children • Nutritional recipes training for primary caretakers • Timely immunization through immunization camps and follow-up with parents	• No. of children treated for malnutrition • No. of community members adopting healthy nutrition and routine immunization practices for their children		
	Training of Adolescents • Sensitization of adolescents on various aspects of sexual and reproductive health. • Identification of green team leaders • Training sessions on waste management, environmental protection and personal and community sanitation for green team leaders	• No of adolescents sensitized • No. of green team leaders sensitized • No. of adolescents having access to clean toilets at home and school • No. of adolescents having access to sanitary napkins		
	Community Health and Sanitation Initiative • Conducting health camps and health melas for health checkups • Conducting health, nutrition and sanitation awareness sessions	• No of patients screened at health camps and melas • No. of patients referred to PHCs/ government hospitals • No. of community members having toilet at home • No. of community members using toilet regularly		

4.2 Logical Framework Model

A LOGICAL FRAMEWORK MODEL is created against the identified ToC to reflect the identifiable indicators, means of verification, and assumptions, as given below:

Log Frame Analysis (LFA)				
	Project Summary	**Indicators**	**Means of Verification**	**Assumptions**
Impact ↓	• Overall improvement in maternal, child and adolescent health • Stronger foundation for good health of the children because of routine immunization.	• Prevalence of routine immunization and timely ANC post program implementation • Prevalence of good health and nutrition practices post program completion • Community engagement strategies adopted to ensure sustainability of the initiatives	• Beneficiary survey • KIIs with NGO program team and community volunteers • FGDs with community health workers and VHSNC members • Program reports	N/A
Outcomes ↓	• % reduction in maternal and infant mortality • Birth of healthy babies as a result of high-quality ANC • Reduction in malnutrition amongst children of ages 0-10 • Healthy growth and development of children • Preemption of STIs and reproductive issues in adolescents	• % Change in maternal and infant mortality in the intervention area • % Increase in the number of institutional deliveries • % Change in number of children having a normal BMI • Change in dietary habits of the community members • Change in attitude of people towards seeking medical help	• Beneficiary surveys • Baseline Study report • KIIs with NGO program team and community volunteers • FGDs with community health workers	• Community members continue to practice good health and nutrition practices post NGO exit

Output	• No. of high-risk pregnancy identified and treated • No. of women registering and receiving ANC • No. of women incorporating high protein diet during pregnancy/lactation • No. of women feeding colostrum milk to infant • No. of women practicing exclusive breastfeeding for 6 months • No. of children treated for malnutrition • No. of community members adopting healthy nutrition and routine immunization practices for their children • No of adolescents sensitized • No. of green team leaders sensitized • No. of adolescents having access to clean toilets at home and school • No. of adolescents having access to sanitary napkins • No of patients screened at health camps and melas • No. of patients referred to PHCs/ government hospitals • No. of community members having toilet at home • No. of community members using toilet regularly	• Same as project summary	• Beneficiary surveys • KIIs with NGO program team and community volunteers • FGDs with community health workers • Project progress reports	• Community members have sufficient resources to follow the advices given during sensitization and health awareness sessions •
Input	• High risk pregnancy screening through health camps • Nutritional status assessment of	• No. of women, children and adolescents screened • No. of women enrolled for ANC • No. of sensitizations	• Beneficiary surveys • KIIs with NGO program team and community volunteers •	• Community people can grasp the topics covered during sensitization and health awareness sessions

	pregnant and lactating mothers • Government health facility referral for ANC registration • Awareness sessions on importance of breast feeding • Promoting adoption of family planning methods • Malnutrition screening of children up to the age of 10 • Protein powder supplement for malnourished children • Sensitization of parents about the importance of good nutrition and sessions on growth tracking of their children • Nutritional recipes training for primary caretakers • Timely immunization through immunization camps and follow-up with parents • Sensitization of adolescents on various aspects of sexual and reproductive health. • Identification of green team leaders • Training sessions on waste management, environmental protection and personal and community sanitation for green team leaders • Conducting health camps and health melas for health checkups • Conducting health, nutrition and sanitation awareness sessions	sessions conducted • Topics covered during sensitization sessions and nutritional recipes training Patient footfall in health camps		

4.3 Three Point Assessment Framework

Based on the TOC and the LFA created, we examined the relevance of services, the preparedness for program activities, qualitative and quantitative assessments, efficiency, and effectiveness of delivery of services as well as any innovations that may have been implemented on the ground.

The impact assessment findings are further anchored around **Give's Three-point Assessment Framework** as illustrated here.

Program Design

We studied program design through program strategies, inputs and resources, assumptions, outreach mechanisms, and much more. We also consider if the program design attends to specific needs of the stakeholders, program locations, social categories, site, and situation, among other development needs. Give's Impact Assessment approach for program design is based on Assessment criteria like Relevance and Preparedness using methodologies such as assessment of baseline survey.

Program Delivery

Give assesses the Program Delivery to understand the success of the program delivery mechanism in attaining the overall objectives such as cost effectiveness, resource efficiency, equity in service delivery, best practices and challenges, perception about the services among the relevant stakeholders, among other actors.

Impact

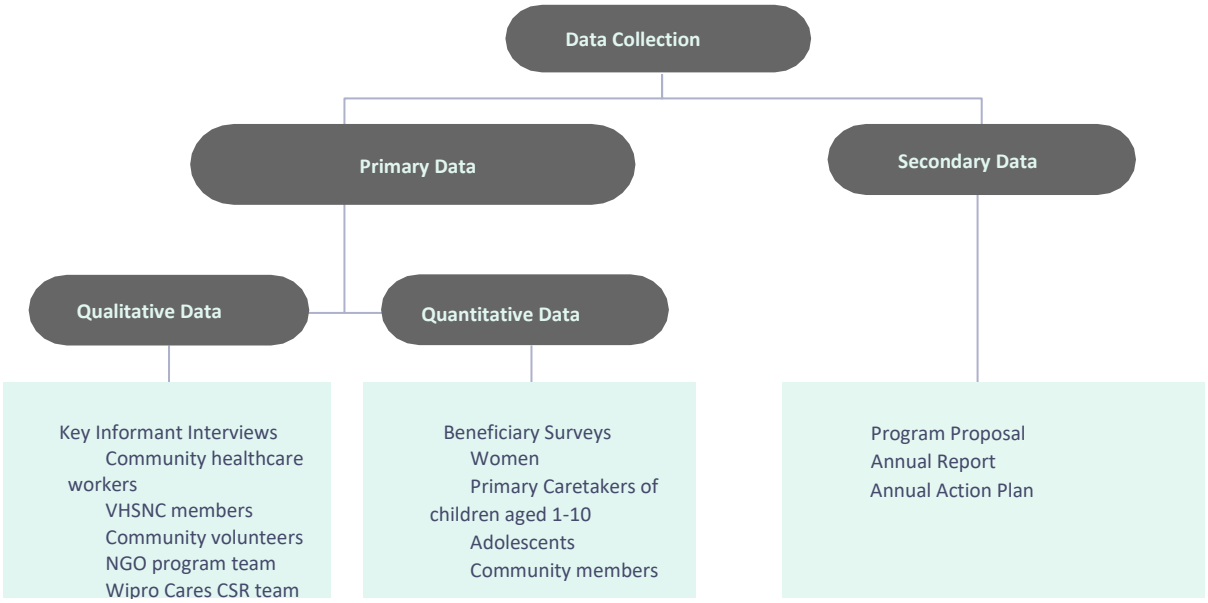
The program's impact potential was assessed to ascertain whether a change or the desired outcome can be attributed to the program intervention. Give uses criteria such as scale of Impact and impact sustainability to understand the impact potential of the projects.

5 Methodology Adopted

We initiated the impact assessment study by identifying the key stakeholders for the project. These stakeholders were ratified in consensus with the implementing partner. The study takes a 'mixed method' approach which includes both qualitative as well as quantitative data capture and analysis.

The quantitative tools provide values to key indicators related to awareness, adoption, quality. It also maps the outputs against the targets and outcomes perceived by the beneficiaries. On the other hand, the qualitative method and approaches provide a better understanding and help to build a storyline for the achievements and gaps in the program from the lens of immediate stakeholders involved in the program implementation, other than the beneficiaries. A qualitative study gives substantiated evidence for a better understanding of the processes involved in the program implementation. Thus, the 'mixed method' approach also helps in developing a framework for gap identification and course correction.

5.1 Data Collection



Primary Data: Primary data is the key to collecting first-hand information as evidence from the beneficiaries and stakeholders on the interventions. It allows us to understand the benefits delivered, its effectiveness and key challenges to assess the impact created by the program and arrive at recommendations that enhance it.

Secondary Data: For secondary data collection, the program proposal, MoU, and annual and quarterly program report were referred. These documents gave high level insights about the projects including the inception and implementation phase along with the processes followed.

5.2 Sampling Strategy

The program has impacted the village committees on a holistic level. Considering a confidence interval of 95%, and 5% allowable margin error, the study planned for data collection of 382 stakeholders.

The following formula details out the sample size calculation process with the assumptions considered.

$$\text{Sample size} = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1 + \left(\frac{z^2 \times p(1-p)}{e^2 N}\right)}$$

- N = Total stakeholder population
- z = Z Score (Z-score is the number of standard deviations a given proportion is away from the mean and 1.96 here corresponding to a 95% confidence interval)
- e = Margin of Error (Percentage in decimal form; here taken as 0.05 (+/- 5% error)
- p = sample proportion (0.5)

The sample size of ~382 was distributed amongst the beneficiaries, community volunteers, VHSNC members, community health workers and the NGO Program team. For the quantitative data collection, we created representative and stratified samples to ensure accurate results.

Sampling Plan for Beneficiary Surveys (Quantitative Data Collection): We stratified the sample by the main stakeholder groups: Pregnant/lactating women, mothers of children, adolescents, and general community members.

Following table elaborates the sample size and distribution as per the strategy.

Stakeholders	Sample size planned	Sample size achieved	Remarks	Mode of interview
Pregnant/ Lactating Women	80	46		Physical
Mothers of children aged 1-10	80	47		Physical
Adolescents (Including green team leaders)	80	77	Age groups 14-16 years: 36 Age Group 16-20 years: 41 Males: 20; Females: 57 Green team leaders: 19	Physical
Community members	100	100	Male: 17 Female: 83	Physical
Total	**340**	**270**		

The study could record survey interviews of 270 beneficiaries over a period of 5 days, from 20th February to 24th February 2023.

Key informant interviews: Questionnaires were designed for each stakeholders' interaction. All relevant questions were asked to the respondents and were captured. This was done through purposive sampling.

Stakeholder Group	No. of Interviews (Planned)	No. of Interviews (Achieved)	Mode of interview
Community volunteers	10	11	Physical
VHSNC (panchayat members, SDMC, health department)	20	4	Physical
Community health workers (ASHA)	10	9	Physical
NGO Program team	5	5	Physical

Wipro Cares CSR team	1	1	Virtual
Total	**46**	**30**	

6 Analysis & Findings

Descriptive statistic (basic features of the data including frequencies, counts, percentages), comparative analysis (before and after comparisons), and content analysis (for qualitative data to interpret and analyze unstructured textual content into manageable data) were done to analyze and interpret the data collected. The findings for the program are organized as per the three-point assessment framework described earlier.

Basic Profile of the Beneficiaries

For the scope of the impact assessment, the study was conducted in over 10 villages of Mysore district in the state of Karnataka. Since the project was centered around RMNCH+A initiatives, most of the beneficiaries interviewed were females in the age group ranging from 14-52 years. All the adolescents surveyed were found to be students and all the other community women reported to be home-makers. The women beneficiaries, including the pregnant and lactating mothers, were found to have 2-3 children each, on an average. Most of the families had a single source of income. The primary profession was found to be daily wage or construction labourers.

In addition to beneficiary surveys, in-depth KIIs and FGDs were conducted with the Village Health Sanitation and Nutrition Committee (VHSNC) members that included village panchayat leaders, school development committee members and ASHA workers, the community volunteers, the NGO program team and the Wipro Cares CSR team.

1. Program Design

Relevance of the project is analyzed based on how relevant the project activities are with respect to the needs of the community and the issues prevalent prior to the intervention. The rationale behind implementation in the select locations is also scrutinized to check if the most underserved are being benefitted through the program. The preparedness of the NGO team is assessed on the basis of the implementation methods adopted and the strategies in place for handling envisaged challenges during execution.

Relevance

The intervention villages were chosen in consultation with the gram panchayat leaders and *sanghas*. The panchayat and sangha members discussed the issues related to health, nutrition and sanitation prevalent in their villages and a call for shortlisting of villages took place based on the severity of the issues. The socio-economic background and ST category of the villagers were one of the selection crieria during finalization of villages.

The community volunteers reported that there were no toilets and drinking water taps in most of the households prior to the intervention. Parents were also unaware about the importance of education. They sent their kids to work after finishing high school. The girls, in particular, were married off within a few years of completing high school. After the NGO's intervention, the incidence of child labour and child marriage have dramatically reduced.

The women beneficiaries reported that they did not avail of ANC prior to the intervention because of low accessibility to government hospitals/ PHCs. The closest government hospital/PHC was reported to be at a distance of 5-6 Km (for 1 village, it was 12-18 km) from their villages. In some villages, the community members resorted to private hospitals in Mysore city for seeking treatment (in case of serious health issues).

Preparedness

The NGO team leveraged government collaborations (with Anganwadi centers and gram panchayat) and community engagement to maximize community outreach. They set community volunteers (animators) in each village to mobilize

the beneficiaries. The community volunteers reported that they did not have any knowledge related to mother, child and adolescent health prior to the intervention. They underwent multiple training sessions with the NGO to gain knowledge about common issues faced by these groups. In addition to mobilizing community members for health education sessions, they also conducted these sessions in schools.

The anganwadi centers present in the villages were used to conduct the health awareness and education sessions for the village women. The NGO team collaborated with the gram panchayat and the anganwadi teachers to collectively spread awareness about various government schemes that can be availed by the villagers.

All the mothers surveyed reported that their children were screened for malnutrition by the NGO team whereby all the children were found to be malnourished. However, they were not aware about the level of malnourishment (severe/moderate) of their children. Although all villages had anganwadi centers, the families did not avail of their services like growth tracking and immunization support.

A section of school students, the green team leaders, were found to be specifically trained on environmental and sanitation aspects to further these causes amongst the larger village community. They also motivated the village families to establish a kitchen garden.

The assessment sheds light on the fact that RLHP lacks proper MIS software for beneficiary database management. They relied on excel for recording and tracking beneficiary data. The community volunteers reported maintaining beneficiary data on a notebook. The Give team as well as the Wipro Cares CSR team feels that there is a scope to improve data management practices at the NGO level by subscribing to a data management software. This will enable the NGO team to draw greater insights from the data and aid them in risk assessment and mitigation planning.

Stakeholder	Parameter	Ratings (out of 5)
CSR Program Team	Response to needs of communities	4
Mothers of children aged 1-10	Adherence to COVID-19 precautions during physical meetings	4
Pregnant and lactating women	Adherence to COVID-19 precautions during physical meetings	4
Adolescents	Relevance of the educational content for your personal growth and development	4.5
Community health workers	Relevance of the healthcare initiative to the ground situation	4
NGO Program Team	Relevance of the activities to the needs of the villages	4
	Adherence to COVID-19 protocols during physical sessions	4

2. Program Delivery

Efficiency of the intervention is analyzed based on how well resources were used in terms of the activities conducted for the community members. Effectiveness is analyzed based on the extent to which the intervention has achieved its objectives as outlined in the project proposal. The lens adopted for the scope of the impact assessment is to analyze both efficiency and effectiveness through each of the project objectives.

Efficiency

The NGO team was found to be highly efficient in resource mobilization. To enhance scale of the intervention with limited NGO resources, they highly relied on community volunteers and green team leaders to carry out the planned interventions in their respective villages.

The NGO team reported that ~95% of the community members have enrolled for government schemes. Some of the schemes that the beneficiaries reported being enrolled for are:

- **Pradhan Mantri Matrutva Vandana Yojana** – provides cash incentive of INR 5000 directly to pregnant/lactating women
- **Bhagyalaxmi Yojana** – aimed at promoting birth of girl children to BPL families
- **Mathru Poorna** - aimed at providing at least one nutritious meal to pregnant/lactating women

The community volunteers stated challenges in mobilizing beneficiary during the initial phases of the project due to resistance from male family members. Differences in caste was cited to be the primary cause fueling the resistance. However, they leveraged the positive experience of beneficiaries who got impacted through this project to mobilize the others. There were also challenges in ensuring timely immunization during the pandemic as the community members did not want to interact with any outsider. The community volunteers reported taking help of the panchayat leaders and the NGO to conduct home visits and vaccinate the children.

Effectiveness

The program was found to have been effective in improving the RMNCH+A status in the intervention geography and meeting its pre-determined objectives.

#	Program Objectives	Achievement status
1	Registration of pregnant women for ANC and institutional delivery	100% identified pregnant women registered for ANC and institutional delivery
2	Awareness creating about importance of feeding colostrum milk immediately after delivery and good nutrition during lactation phase	100% lactating women fed colostrum milk to their baby right after birth and were educated about importance of good nutrition
3	Immunization of children	100% identified children have been immunized via home visits and at anganwadi centers
4	Reduction in malnutrition amongst children aged 0-10	All mothers reported seeing an improvement in their child's health after incorporating nutrition supplements (provided by the NGO) in their diet
5	Improvement in infrastructure and awareness about personal hygiene and community sanitation	Most village households have a personal toilet and have attended waste management sessions
6	Prevention of child marriage and child labour	Child marriage has stopped in most villages and 99% children complete schooling (as reported by community volunteer)

The NGO team was found to be highly effective at getting pregnant women enrolled for ANC. All the women beneficiaries surveyed reported registering for ANC and availing partial ANC (< 4 checkups) because of the intervention. All the women beneficiaries reported getting institutional delivery done after being made aware of the complications that can arise from home delivery of their baby. This is envisaged to reduce the maternal and infant mortality rate. They also reported following the routine immunization support for their infant. The adoption of family planning methods was found to still remain a challenge with all respondents mentioning that they do not feel a need to use family planning methods.

The health camps conducted by the NGO every month was highly appreciated by the village community members (women

and men alike). The community members mentioned that the NGO team conducted home visits to screen them for blood pressure and diabetes. The villagers were found to mostly depend on the NGO team home visits and these health camps for their health checkup needs. However, since the health camps only happened monthly, many of them still had to visit private hospitals in case of serious health issues that required immediate attention.

All the mother reported seeing an improvement in the health of their children after adopting dietary changes suggested by the NGO. The NGO team and community volunteers reported conducting growth charting and monitoring of their kids. The Give team found that the anganwadi centers were not involved in growth monitoring of the children. All the mothers reported receiving nutrition supplements from the NGO on a monthly basis and making modifications in their children's diet post the information sessions like including ragi malt, milk, eggs and locally available vegetables. However, the respondents could not mention any specific recipes.

The adolescents reported that the sexual and reproductive health education sessions were successful in answering their questions and clarifying all their doubts related to the topic. The sessions were reported to be conducted by community volunteers in their respective schools. None of the adolescent girls reported facing any challenges related to following menstrual hygiene practices. With regards to village reforms, the adolescents reported that the village panchayat has started acting on some of their requests. The adolescents did not mention the specifics of their ask.

The Give team observed that over 90% of the village households had personal toilets. The community volunteers reported that toilet adoption was 100% in most villages. Only one village (Duddgiri) showed resistance in toilet use by the male members. School drop-out rates due to non-existing/non-functional toilets have been reported to reduce by 99% over the entire project duration. The sharp decrease in school drop-out rate occurred as a result of infrastructure upgradation like availability of clean functional toilets and safe drinking water in schools. The community volunteers reported that other causes like child labour and child marriage that led to drop-outs after high school were mostly eliminated from all intervention villages.

Stakeholder	Parameter	Ratings (out of 5)
CSR Program Team	Delivery of expected outcomes	4
Community members	Quality of treatment offered at the health camps	5
Mothers of children aged 1-10	Services provided by the NGO to improve your child's health	5
Pregnant and Lactating Women	Ease of understanding of health education sessions	5
	Support provided for ANC registration and immunization	4
Adolescents	Ease of understanding of the information shared during the education sessions	4.5
	Support provided by NGO for approaching gram panchayat for school and village development activities	3.5
Community healthcare workers	Effectiveness of the initiative to reduce rate of high-risk pregnancies, malnutrition and adolescent health risks	5

NGO Program Team	Effectiveness of the activities in improving the health of children, pregnant mothers and adolescents	5

3. Impact & Sustainability

The assessment indicates that the program has been successful in initiating a mindset change with regards to adopting good health and nutrition practices amongst pregnant and lactating women, children, and adolescents of the intervention villages. The program has also succeeded in improving household and community sanitation of the villages. Most village households have toilets and report high toilet usage. The village public areas were found to be very clean during the assessment. Some households mentioned challenges with their drainage system- overflowing of drainage tank and difficulty in constructing toilets due to lack of space. However, village panchayats were reported to be working on resolution of these issues.

The NGO has ensured sustainability of the program by adopting a behavioural change centric model to health, nutrition and sanitation. However, the Give team feels that true sustainability can ensue only with strengthening of the government healthcare system and financial stability of the village communities. Some of the villages lack presence of community health workers, the government health clinics are not accessible from most villages and communities currently depend on nutrition supplements provided by the NGO for fulfilling their children's nutritional needs. The project can focus on rectifying these aspects in upcoming phases to improve sustainability of the project.

Stakeholder	Parameter	Ratings (out of 5)
CSR Program Team	Scope to ensure sustainability	5
	Contribution to brand value	3.5
Community members	Impact of the health services (teleconsultation, ration distribution, access to masks etc.) on your well-being during the pandemic	5
Community health workers	Ability of the initiative to bring forth sustainable change in the attitude of the community members towards a healthy lifestyle	4
NGO Program team	Impact of the intervention in reducing malnutrition amongst children and high-risk pregnancies in the region	4

7 Financial Verification

This section analyses the financial utilization achieved for the program in comparison with the approved budget as provisioned under various expense categories. The deviations in the financial utilization are also mapped as part of this process.

The process involves verification of the amount disbursed by Wipro Cares with the audited UC. The Wipro CSR team reported that **the difference in budgeted amount as per MoU and amount disbursed each year has been taken care of by the Wipro team in subsequent years**. The Give team has verified the same.

Project Financials and Utilization				
Particulars	**Year 2019**	**Year 2020**	**Year 2021**	**Total**
Budget approved as per MOU	4,403,960	4,580,760	41,45,080	1,31,29,800
Amount disbursed by Wipro Cares	4,417,754*	4,336,047	2,703,046	1,14,56,847
Utilisation as per UC	4,173,041	3,138,726	4,070,393	1,13,82,160
Difference between amount disbursed and utilization	**2,44,713**	**1,197,321**	**(1,367,347)**	**74,687**

*Closing balance of 2018 as per the UC is also included .

Approved Budget

- The total budget approved for the agreement period was INR 1,28,58,029 as per the MoU. Unutilized balance of INR 271,771 was reported from FY 2018. Therefore, the total budget available for utilization during 2019-2021 was INR 1,31,29,800.
- The table below presents a category wise analysis of the budgeted amount vs utilized amount as category wise bifurcation of disbursed amount was not known. The detailed analysis can be found in Annexure II.
- As per the analysis, it is observed that the NGO utilized 86.69% of the total budget (as per MoU). However, as per the amount disbursed the NGO's utilization was 99.35% (very slight deviation).

Financial Utilization Analysis from 2019-2021				
Sr. No.	**Particulars**	**Budgeted amount as per MoU**	**Utilised amount as per UC**	**Utilization %**
1	Salaries	49,60,320	47,30,364	95.36%
2	Programmes	76,44,480	61,70,073	80.71%
3	Overhead cost	5,25,000	4,81,723	91.75%
	Total	**1,31,29,800**	**1,13,82,160**	**86.69%**

Deviations Observed from Budget Estimation for FY 21

- It was observed that the NGO was able to carry out all planned activities in a lesser budget than the one that was approved by Wipro Cares.

8 SWOT Analysis

A SWOT analysis is carried out to understand the program's strengths, weaknesses, opportunities, and threats. It was conducted from the responses received from the program team and other implementation-level stakeholders, at the same time considering the beneficiary feedback.

Strengths	Weakness
• The program ensures maximum reach and impact through community engagement (via community volunteers and green team leaders) during project implementation. • The program takes a holistic approach towards improving the health status of the community members by supporting the beneficiaries on all aspects of health, nutrition and sanitation. • The program ensures sustainability by following a behavioural change centric model for all the interventions. • The NGO was able to successfully implement all planned activities in a lesser budget.	• The current program model does not focus on livelihood activities. Since the beneficiaries are for an extremely underprivileged background, income enhancement is required to enable them to afford good nutrition in the long term. • Inertia of eligible couples to adopt family planning methods due to negative peer pressure and social stigma for family planning that might be prevalent in the villages.
Opportunities	**Threats**
• Introducing comprehensive de-addiction programs in villages to tackle the issue of alcoholism amongst men. • Introduction of vocational skills training for women and promotion of women entrepreneurship to raise the social status of women in the community and increase household income. • Strengthening of public health ecosystem in the villages by capacity building of community health workers and anganwadi teachers. The NGO should also collaborate with local authorities to ensure presence of community health workers in villages where there are none.	• Discontinuity of good nutrition practices due to poor financial conditions

9 Conclusion and Recommendations

Based on the data gathered during interactions, we find that program is relevant and effective in improving the sanitation and health outcomes of the communities it served. The program has been able to reach out to a significant number of beneficiaries, including adolescents, pregnant and lactating women, and members of the community.

The program's focus on building toilets in homes and schools was successful, with all respondents who did not have a toilet at home getting one constructed during the intervention. Additionally, all school-going beneficiaries who did not have toilets at school reported that their schools got toilets constructed because of the intervention, which were currently clean and functional. This is envisaged to lower drop-out rates, especially amongst female students, as they reported facing no other hindrance in continuing education.

The program's efforts to improve maternal and child health outcomes were also successful, with all pregnant women opting for institutional delivery and availing partial ANC (as compared to no ANC prior to the intervention). However, the low awareness of the importance of adopting family planning methods remains a concern that needs to be addressed.

The program's delivery was efficient and effective, with the community volunteers mobilizing the beneficiaries for various sessions. The NGO team was able to properly address the doubts and queries of the adolescent beneficiaries about reproductive health, and all females reported having access to sanitary napkins without any challenges in procurement. The NGO's proactive role in providing disaster relief efforts during the COVID-19 pandemic was also appreciated by the community members.

Overall, the program's success in achieving its objectives highlights the importance of community-driven approaches in addressing health and sanitation challenges in rural areas. The program's focus on building local capacity through community empowerment and awareness-raising initiatives was key to its success.

Recommendations

The following recommendations have stemmed from on-ground observations and interactions with the beneficiaries/stakeholders.

Challenges/ Observations	Recommendations
Very low adoption of family planning methods amongst eligible couples. The respondents stated that they did not feel the need of using family planning methods.	Negative personal beliefs and resistance by male partners can be probable causes. The NGO needs to deep dive to pin down the root cause and design and implement behavioural change centric education sessions on the same.
Lack of PHC/ government hospital in/near the villages. The communities currently rely on health camps conducted by the NGO for getting health checkups.	The NGO can consider the following to rectify the situation: o Collaborate with village or block level officials to ensure presence of ASHA/ANM workers in villages where they are currently not operating (No ASHA workers were reported to be present in Ghunthahalli village) o Conduct capacity building of ASHA, ANM and AWW workers of other villages to ensure effective health screening of pregnant/lactating women during home and anganwadi visits. o Collaborating with the nearest PHC/hospital to launch a teleconsultation service for the distant

	villages. ○ Revive VHSND days in the villages in collaboration with VHSNC so that village women can opt for ANC there instead of the PHCs
Some households are unable to get toilets constructed due to lack of space.	○ Public toilets can be constructed to tend to families who cannot afford a toilet a home due to space constraints.

10 Annexure - I

*Figure SEQ Figure * ARABIC 2: Interaction with pregnant/lactating women and mothers*

*Figure SEQ Figure * ARABIC 3: Interaction with VHSNC*

*Figure SEQ Figure * ARABIC 5: Interaction with community members*

11 Annexure - II

Year-wise Financial Analysis

Year 2019:

1st January 2019 - 31st December 2019				
Sr. No.	**Particulars**	**Budgeted amount as per MoU**	**Utilised amount as per UC**	**Difference**
1	**Salaries**			
	Programme director	1,59,720.00	1,57,410.00	2,310.00
	Programme coordinator	2,32,320.00	2,00,050.00	32,270.00
	community mobilizer	6,38,880.00	6,02,515.00	36,365.00
	Accountant	1,16,160.00	1,15,280.00	880
	Documentation Officer	1,30,680.00	1,24,353.00	6,327.00
	Office Assistant	1,12,200.00	1,10,550.00	1,650.00
	Social Security	1,20,000.00	1,20,000.00	-
	Total Salaries	**15,09,960.00**	**14,30,158.00**	**79,802.00**
				-
2	**Programmes**			
	Health and sanitation curative care-health clinics in 14 villages			-
(i)	**14 camps in a month**			-
	(a) Honorarium for doctors 5 Nos	2,01,600.00	1,97,766.00	3,834.00
	(b) 6 new village 2 camps in a month 12 camp)	1,72,800.00	1,61,400.00	11,400.00
	(c) medicines for 20 villages- 312 camps	2,49,600.00	2,32,230.00	17,370.00
	(d) Driver Honorarium Rs 13200	1,58,400.00	1,37,200.00	21,200.00
	(e) Vehicle fuel charges	2,18,400.00	1,66,655.00	51,745.00
	(f) Accessories	35,000.00	22,289.00	12,711.00
	(g) First aid kit	6,000.00	6,000.00	-
	Sub Total	**10,41,800.00**	**9,23,540.00**	1,18,260.00
				-
(ii)	**Health Training Programme**			
	(a) Awareness on health for children, adolescent woman & community)	1,28,000.00	1,44,375.00	-16,375.00
	b) Training on reproductive health for woman/ANC/PNC/Immunization/Nutrition food	1,60,000.00	1,59,982.00	18

	c) Nutritious food demonstration training programme for mother for the 6 new villages, 10 existing villages - 6 months (100 children)	1,80,000.00	1,76,956.00	3,044.00
	d) Training for adolescent girls and youth on reproductive health and hygiene	80,000.00	79,608.00	392
	e) Health mela 6 programmes in 20 villages	60,000.00	58,950.00	1,050.00
	f) Green team formation & training programme for a children Green team member for each school	60,000.00	59,549.00	451
	g) Distributing Plants (Papaya, Drumstick and other herbal medicines) to 6 villages (3 plants 500 families × Rs 150	10,000.00	10,000.00	-
	h) Events (World health day, HIV AIDS day, World Environment Day, World Farmer's Day, International Woman Day & world breast feeding day) information education communications (IEC) materials on material handbills etc	60,000.00	51,747.00	8,253.00
	i) Capacity building training for Village Health sanitation committee (VHSC) on the Govt schemes, Rights and entitlements	1,40,000.00	1,39,286.00	714
	j) Mass contact programmes (3 programme each year)	60,000.00	60,050.00	-50
	k) Heath and Sanitation Training for school development monitoring committee (SDMC) and Balavikasa members for 20 villages on covid and health schemes	40,000.00	22,445.00	17,555.00
	l) Community Development and Reproductive and Child Health (RCH) training for ASHA workers for 20 villages	10,000.00	12,080.00	-2,080.00
	m) Capacity training for projects staff on health and development	30,000.00	30,927.00	-927
	n) Capacity building training for Gram panchayat members on Health and Sanitation and Mother and Child Health (MCH)- 4 programs	30,000.00	26,208.00	3,792.00
	o) Honorarium for Health Volunteers -20 Nos	5,28,000.00	5,12,600.00	15,400.00
	Sub-Total	**15,76,000.00**	**15,44,731.00**	31,269.00
				-
(iii)	**Trainings**			
	a) Honorarium for resource persons- 4 days	8,000.00	10,000.00	-2,000.00
	b) Food expenses for 24 persons	9,600.00	6,830.00	2,770.00
	c) Travel for volunteers	9,600.00	7,650.00	1,950.00
	d) Training Material posters, wall painting, first aid kit and other health related awareness material	25,000.00	22,810.00	2,190.00
	e) Monthly review material for 20 members	24,000.00	24,280.00	-280
	f) Exposure visit			-
IV)	**Emergency fund- Curative Care**	25,000.00	27,697.00	-2,697.00
	Total Training Cost	**1,01,200.00**	**99,267.00**	**1,933.00**
	Total Program Cost	**2,719,000**	**2,567,538.00**	**1,51,462**
3	**Overhead cost**			
	a) Travel	90,000.00	90,908.00	-908
	b) Administration cost	70,000.00	69,437.00	563
	c) Auditing	15,000.00	15,000.00	-
	Total Overhead Cost	**1,75,000.00**	**1,75,345.00**	-345

	Grand Total	**44,03,960.00**	**41,73,041.00**	**2,30,919.00**

Year 2020:

1st January 2020 - 31st December 2020				
Sr. No.	**Particulars**	**Budgeted amount as per MoU**	**Utilised amount as per UC**	**Difference**
1	**Salaries**			
	Program Director		1,76,800	
	Programme Coordinator		1,66,685	
	Community Mobilizer		6,92,569	
	Accountant		1,27,920	
	Documentation Officer		1,10,182	
	Office Assistant		1,04,610	
	Social Security		1,20,000	
	Total Salaries	**16,48,920**	**14,98,766**	**1,50,154**
2	**Programmes**			
	Health and sanitation curative care-health clinics in 14 villages			
(i)	**14 camps in a month**			
	(a) Honorarium for Doctors 5 Nos		24,979.00	
	(b) 6 New village 2 camps in a month 12 camp)			
	(c) Medicines for 20 villages- 312 camps		37,453.00	
	(d) Driver Honorarium Rs 13200		1,46,200	
	(e) Vehicle fuel charges		85,039.00	
	(f) Accessories			
	(g) First aid kit		4,177.00	
	Sub Total		**2,97,848**	
(ii)	**Health Training Programme**			
	(a) Awareness on health for children, adolescent woman & community)		94,419.00	
	b) Training on reproductive health for woman/ANC/PNC/Immunization/Nutrition food		1,17,083	
	c) Nutritious food demonstration training programme for mother for the 6 new villages, 10 existing villages - 6 months (100 children)		1,58,053	

	d) Training for adolescent girls and youth on reproductive health and hygiene		70,580.00	
	e) Health mela 6 programmes in 20 villages			
	f) Green team formation & training programme for a children Green team member for each school		56,433.00	
	g) Distributing Plants (Papaya, Drumstick and other herbal medicines) to 6 villages (3 plants 500 families × Rs 150			
	h) Events (World health day, HIV AIDS day, World Environment Day, World Farmer's Day, International Woman Day & world breast feeding day) information education communications (IEC) materials on material handbills etc		4,734.00	
	i) Capacity building training for Village Health sanitation committee (VHSC) on the Govt schemes, Rights and entitlements		81,506.00	
	j) Mass contact programmes (3 programme each year)		34,200.00	
	k) Heath and Sanitation Training for school development monitoring committee (SDMC) and Balavikasa members for 20 villages on covid and health schemes		35,300.00	
	l) Community Development and Reproductive and Child Health (RCH) training for ASHA workers for 20 villages			
	m) Capacity training for projects staff on health and development		21,098.00	
	n) Capacity building training for Gram panchayat members on Health and Sanitation and Mother and Child Health (MCH)- 4 programs			
	o) Honorarium for Health Volunteers -20 Nos		4,80,523	
	Sub-Total		11,53,929	
(iii)	**Trainings**			
	a) Honorarium for resource persons- 4 days		6,000.00	
	b) Food expenses for 24 persons		1,174.00	
	c) Travel for volunteers		3,260.00	
	d) Training Material posters, wall painting, first aid kit and other health related awareness material		16,620.00	
	e) Monthly review material for 20 members		19,751.00	
	f) Exposure visit			
IV)	**Emergency fund- Curative Care**		10,000.00	
	Sub-Total		**56,805.00**	
	Total Program Cost	**27,56,840**	**15,08,582**	**12,48,258**
3	**Overhead cost**			
	a) Travel		46,500.00	

	b) Administration cost		69,878.00	
	c) Auditing		15,000.00	
	Total Overhead Cost	**1,75,000**	**1,31,378**	**43,622**
	Grand Total	**45,80,760**	**31,38,726**	**14,42,034**

Year 2021:

1st January 2021 - 31st December 2021				
Sr. No.	**Particulars**	**Budgeted amount as per MoU**	**Utilised amount as per UC**	**Difference**
1	**Salaries**			
	Program director 25% share		1,93,200.00	
	Programme coordinator		2,81,040.00	
	Community mobilizer (4 no)		7,72,800.00	
	Accountant (part time)		1,40,400.00	
	Documentation officer		1,58,160.00	
	Office assistant		1,35,850.00	
	Social security		1,20,000.00	
	Total Salaries	18,01,440.00	**18,01,440.00**	-
2	**Programmes**			
	Health and sanitation curative care-health clinics in 14 villages			
(i)	**14 camps in a month**			
	(a) Honorarium for doctors 5 Nos		1,00,800.00	
	(b) cost of camps (12 camps)		1,04,775.00	
	(c) medicines for 20 villages- 312 camps		1,58,752.00	
	(d) Driver Honorarium		1,84,020.00	
	(e) Vehicle fuel charges		1,25,626.00	
	(f) Accessories (weighing machines, B P Operator, Stethoscope)		35,000.00	
	(g) First aid kit		6,059.00	
	Sub Total		**7,15,032.00**	
(ii)	**Health Training Programme**			
	(a) Awareness on health (covid- hand hygiene, personal hygiene,sanitation,community hygiene, communicable & water borne diseases, water conservation, protection of		61,312.00	

	soil, education of plastic, kitchen garden, open defecation, mental health) for children, adolescent woman & community) - 80 programmes (each village 4 programs a year			
	b) Training on reproductive health for woman/ANC/PNC/Immunization/Nutrition food- 20 villages		61,263.00	
	c) Nutritious food demonstration training programme for mother for the 16 villages - 6 months (100 children)		2,19,083.00	
	d) Training for adolescent girls and youth (early marriage, sex education, personality development, life skills, HIV Aids, Health, Personal Hygiene, Menstrual Hygiene Management		30,397.00	
	e) Health mela 3 programmes in 6 villages		30,993.00	
	f) Green team training programme for a children (on covid hand wash precautions on viral attack, water conservation, kitchen gardening, hygiene practices, herbal plants, plastic eradications, soil and water pollutions - each school 40 programmes)		30,630.00	
	g) Events (World health day, HIV AIDS day, World Environment Day, World Farmer's Day, International Woman Day & world breast feeding day) information education communications (IEC) materials on material handbills etc		36,206.00	
	h) Capacity building training on health, schemes, covid-19, hand wash methods, Right to food, Right to health, Leadership, Monitoring & advocacy training for Village Health sanitation committee (VHSC) on the Govt schemes Rights and entitlements- 20 programs		49,861.00	
	i) Mass contact programmes		19,967.00	
	j) Heath and Sanitation Training for school development monitoring committee (SDMC) and Balavikasa members for 20 villages on covid and health schemes		20,081.00	
	k) Community Development and Reproductive and Child Health (RCH) training for ASHA workers for 20 villages		4,990.00	
	l) Capacity training for projects staff on health and development, psychosocial support on natural calamities and covid-19		17,790.00	
	m) Capacity building training for Gram panchayat members on covid 19 Health and Sanitation and Mother and Child Health (MCH)- 4 programs		29,093.00	
	n) Honorarium for Health Volunteers -20 Nos		5,16,534.00	
	Sub-Total		**11,43,213.00**	
(iii)	**Trainings**			
	a) Honorarium for resource persons- 4 days		11,250.00	
	b) Food expenses for 24 persons		9,670.00	
	c) Travel for volunteers		5,605.00	
	d) Training Material on covid-19		1,25,602	

	e) Monthly review material for 20 members		23,334.00	
	f) Exposure visit		39,879.00	
IV)	**Emergency fund- Curative Care**		20,368.00	
	Sub-Total		**2,35,708.00**	
	Total Program Cost	**21,68,640.00**	**20,93,953.00**	**74,687.00**
3	**Overhead cost**			
	a) Travel		90,000.00	
	b) Administration cost, (Telephone bills, Electricity charges and stationary expenses etc)		70,000.00	
	c) Audit Fees		15,000.00	
	Total Overhead Cost	1,75,000.00	**1,75,000.00**	-
	Grand Total	41,45,080.00	**40,70,393.00**	74,687.00

12 Annexure - III

Stakeholder Questionnaires

Stakeholder Group: Mothers of Children aged 1-10

Basic Profile

1. Name
2. Number of children:
3. Gender of child/children
4. Age of child/children
5. Total number of family members
6. Primary Occupation
7. Average family income per month:
    1. <10,000
    1. 10,000-20,000
    1. 20,000-30,000
    1. >30,000

Program Design: Relevance and Preparedness

0. Were ASHA workers present in your community prior to the intervention? (Y/N)
0. If yes, did they conduct home visits to instruct you on childcare and benefits available at Anganwadi centres? (Y/N)
0. Did you go to Anganwadi centres to get your child's growth and development monitored before the intervention? (Y/N)
0. What was the reason for not visiting Anganwadi centres?
    1. AWC not present in the village
    2. AWC not functional
    3. Unawareness about AWC
    4. Location of AWC too far
    5. AWC is not clean and do not have toilets
0. Do you go to Anganwadi centres now for growth monitoring of your child? (Y/N)
0. **How far is the nearest Anganwadi centre from your home? (in Km) [Validate the same during visit]**
0. What did your child's diet primarily include before the intervention?
0. Have you adapted their diet post the intervention? (Y/N)
0. If yes, what kind of diet do you follow now?
0. Did you have a toilet at home prior to the intervention? (Y/N)
0. Do you have a toilet now? (Y/N) **[To be verified by enumerator]**
0. Do you and your family members use the toilet regularly?
    1. Everyone uses it
    2. Only women and children use it
    3. Others, _____
0. If not, what is the reason for the same?
    1. Lack of water supply
    2. Superstitions
    3. Lack of awareness about importance of toilet usage

Program Delivery- Effectiveness and Efficiency

0. Was your child screened for malnutrition by the NGO team? (Y/N)
0. If yes, what was the malnutrition status of your child?
    1. Was found to be malnourished
    2. Was found to be healthy
0. If malnourished, did you receive protein powder, eggs and chikki from the NGO for your child? (Y/N)
0. For how many days were these supplements provided by the NGO?
0. Did your child consume all the supplements provided? (Y/N)
0. If not, why?
    1. Quality of products were below the mark
    2. Was used for feeding other family members as well
    3. Others, _____
0. Did you attend the health awareness sessions on importance of good nutrition and locally available nutritious food? (Y/N)
    1. If not, why? _____
0. If yes, What recipes were taught to you by the RLHP team? (name the recipes)
0. On a scale of 1-5, how would you rate the ease of understanding of the health awareness sessions. (1- very difficult, 2- Difficult, 3- Moderate, 4- easy, 5-very easy)
0. Do you face any challenges in procuring nutritious food for your child at present?
    1. Cannot afford nutritious food/supplement
    2. Nutritious food items not available easily
    3. Nutritious recipes taught are difficult and time consuming to cook
    4. Others, _____
0. Do you follow routine immunization of your children? (Y/N)
0. If not, what challenges do you face for the same?
    1. Lack of information about vaccination
    2. Anganwadi centre/ Clinic is located too far
    3. Others, _____
0. Do you have a kitchen garden/ grow your own vegetables at home?
0. How do you manage household waste?

Impact and Sustainability

0. What type of improvement did you find in the malnutrition status of your child?
    1. Child is healthy now
    2. There is a positive change
    3. No change observed
0. Do you require any further support to improve your child's health?
0. On a scale of 1-5, how would you rate the following: (1- Very Poor, 2-Poor, 3- Satisfactory, 4-Good, 5-Excellent)
    1. Adherence to COVID-19 precautions during physical meetings
    2. Services provided by the NGO to improve your child's health
0. Do you know which organisation has funded this program?
0. Testimonial

Stakeholder Group: Pregnant and Lactating Women

Basic Profile

1. Name
2. Age
3. Number of family members
4. Number of kids
5. Primary profession
6. Average monthly family income
    1. <10,000
    1. 10,000-20,000
    1. 20,000-30,000
    1. >30,000
7. Were you a pregnant or lactating mother at the time of the intervention?
    1. Yes, pregnant
    1. Yes, lactating
    1. None

Program Design: Relevance and Preparedness

0. Had you gone for routine ANC for your previous pregnancies, prior to the intervention? (Y/N)
0. If not, what was the reason?
    1. Unawareness about the importance of ANC
    2. Did not know where to go to
    3. PHC/government clinic was too far away
    4. Others, _____
0. Did you avail of routine ANC during the intervention? (Y/N)
0. If yes, how many ANC visits did you make?
    1. Full ANC (4 visits)
    2. Partial ANC (< 4 visits)
0. Where did you get your delivery done?
    1. Home
    2. Institutional Delivery
0. Had you fed the first milk to your baby right after delivery? (Y/N)
0. Do you feel it is important to feed the first milk to your baby right after delivery? (Y/N)
0. For how many months did you do exclusive breastfeeding for your baby? If answer is less than 6 months: Why did you stop exclusive breastfeeding before 6 months?
0. What kind of food did you feed your baby after stopping exclusive breastfeeding?
0. Did you use any family planning methods prior to the intervention? (Y/N)
0. Have you adopted any family planning methods now? (Y/N)
0. If not, what is the reason?
    1. Unawareness about various available methods
    2. Don’t feel the need to
    3. Low accessibility to contraceptives
    4. Others, _____
0. Have ASHA workers visited you after the delivery to educate you about proper child care practices? (Y/N)
0. Do you have a healthy and supportive environment for the baby at home? (Y/N)
0. Did you have a toilet at home prior to the intervention? (Y/N)
0. Do you have a toilet now? (Y/N) **[To be verified by enumerator]**
0. Do you and your family members use the toilet regularly?
    1. Everyone uses it
    2. Only women and children use it
    3. Others, _____
0. If not, what is the reason for the same?
    1. Lack of water supply

2. Superstitions
3. Lack of awareness about importance of toilet usage

Program Delivery- Effectiveness and Efficiency

0. Did you attend the awareness sessions conducted by the NGO? (Y/N)
0. If not, why?
0. Where did you register yourself for ANC?
    1. PHC
    2. Government hospital
    3. NGO health camp
    4. Others, _____
0. Did you register yourself for any government health schemes related to mother and child health during the intervention? (Y/N)
0. If yes, what benefits have you received from those schemes after registration?
0. If not, what is the reason for the same?
    1. Not aware of these schemes
    2. Don't know how to register
    3. Registration process is very complicated and time-consuming
    4. Others, _____
0. Have you been able to follow routine immunisation of your child since his/her birth? (Y/N)
0. If not, why not?
0. Do you face any challenges in ensuring timely immunisation of your child? (Y/N)
0. If yes, please explain the challenges.
0. Are you aware of healthy feeding practices for your baby to complement breastfeeding after 6 months? (Y/N)
0. If yes, have you been able to follow the said practices? (Y/N)
0. If not, what challenges do you face?
0. Do you have a kitchen garden/ grow your own vegetables at home?
0. What kind of diet did you follow during your lactation phase?

Impact and Sustainability

0. Do you face any challenges in accessing ANC at present? (Y/N) If yes, what challenges?
0. Do you follow good nutrition and sanitation practices at home? (Y/N) If not, what challenges do you face?
0. Did you have lesser number of pregnancy complications during the intervention as compared to your previous pregnancies? (Y/N)
0. Do you have any recommendations on what could have been done better?
0. On a scale of 1-5, rate the following: (1- Very Poor, 2-Poor, 3- Satisfactory, 4-Good, 5-Excellent)
    1. Adherence to COVID-19 precautions during physical meetings
    2. Ease of understanding of health education sessions
    3. Support provided for ANC registration and immunisation
0. Do you know which organisation has funded this program?
0. Testimonial

Stakeholder group: Adolescents

Basic Profile

1. Name

2. Gender
3. Age
4. Profession
    1. School student
    1. College student

Program Design: Relevance and Preparedness

0. Had your family members or school teachers taught you about the importance of menstrual hygiene and educated you on child marriage, sex education, STDs etc? (Y/N)
0. Are you aware about the intervention that RLHP rolled out in your village? (Y/N)
    1. If not, why?
0. Did you have a toilet at home before the intervention? (Y/N)
0. Do you have a toilet at home now? (Y/N)
0. Do you and your family members use the toilet regularly?
    1. Everyone uses it
    2. Only women and children use it
    3. Others, _____
0. If not, what is the reason for the same?
    1. Lack of water supply
    2. Superstitions
    3. Lack of awareness about importance of toilet usage
0. Did your school have a functional and clean toilet prior to the intervention? (Y/N)
0. Is there a functional and clean toilet in your school now?
0. Do you feel availability of a clean toilet at school is sufficient for you to keep attending school and complete school education? (ask about family pressure for marriage, child labour etc)
0. Are you a green team leader at your school?
0. Were sessions on waste management and kitchen garden conducted by the NGO team/ green team leaders? (Y/N)
0. What kind of topics were covered by the NGO team at the health education sessions?
0. How did you get to know about these sessions?
    1. Through community volunteers
    2. School Teachers
    3. NGO personnel
    4. Others, _____

Program Delivery- Effectiveness and Efficiency

0. Do you feel the education sessions were effective in clearing any doubts you might have had related to reproductive health? (Y/N)
0. Do you have access to sanitary napkins at present? (Y/N)
0. If not, what is the reason?
    1. Cannot afford
    2. Social stigma
    3. Others, _____
0. Have you approached the gram panchayat for any school/village development activity after the education sessions? (Y/N)
0. Has the gram panchayat acted on your requests? (Y/N/ Acted on some requests)
0. Do you face any challenges with attending school? (unsupportive family, distance of school from village, work at home etc)

Impact and Sustainability

0. Do you feel the sanitation of your school, home, and community area has improved after the intervention? (Y/N)
0. If yes, in what ways?
    1. Toilets constructed at home
    2. Clean toilets available at school
    3. Periodic cleaning of parks and other community areas (ponds/water bodies) are conducted
    4. Others, _____
0. Do you have any suggestions on what other topics can be covered at the education sessions?
0. Do you feel your family members are supportive of your school education? (Y/N)
0. If yes, in what ways?
    1. You and your siblings are equally motivated to attend school
    2. You are not required to support your parents in their jobs
    3. You have a good study environment at home
    4. Others, ____
0. Do you have any recommendations about how things could have been done in a better manner or any other support that you require from the NGO?
0. On a scale of 1-5, how would you rate the following: (1- Very Poor, 2-Poor, 3- Satisfactory, 4-Good, 5-Excellent)
    1. Relevance of the educational content for your personal growth and development
    2. Ease of understanding of the information shared during the education sessions
    3. Support provided by NGO for approaching gram panchayat for school and village development activities
0. Do you know which organisation has funded these activities?
0. Testimonial.

Stakeholder group: Community members

Basic Profile

1. Name
2. Gender
3. Age
4. Number of children
5. Number of family members
6. Primary occupation
7. Average monthly family income
    1. <10,000
    1. 10,000-20,000
    1. 20,000-30,000
    1. >30,000

Program Design: Relevance and Preparedness

0. Where did you go for medical check-ups prior to the intervention?
    1. PHC
    2. Government hospital
    3. Private clinics
    4. Others, _____
0. Did you face any challenges in getting quality medical care from these facilities?
    1. High cost of consultation

2. High cost of medicines
3. Location too far from village
4. Long waiting times
5. Others, _____

0. Did the health camps set up by the NGO solve these challenges? (Y/N)
0. If not, what challenges remained?
0. Were these health facilities accessible during the pandemic? (Y/N)
0. If not, did you avail of the teleconsultation facility provided by the NGO?
    1. Yes
    2. No
    3. Was not required
    4. Was not aware of it
0. Did you get all the required help (in terms of ration, access to masks, sanitizer etc) from the NGO and community volunteers during the pandemic? (Y/N)
0. Were you aware of government work and health schemes prior to the intervention? (Y/N)
0. Are you registered for such schemes now? (Y/N) [MNREGA, health schemes etc]
0. Do you feel your gram panchayat was proactive with village development and sanitation activities prior to the intervention? (Y/N)
0. If not, did the NGO initiatives help in connecting with the local government and resolving village-level developmental issues?

Program Delivery: Effectiveness and Efficiency

0. Where were the health and COVID-19 awareness sessions conducted?
0. Were COVID-19 protocols like social distancing followed during these meetings? (Y/N)
0. Do you feel the health camps have increased your accessibility to low-cost medical check-ups? (Y/N)
0. Do you have to pay anything for the check-up at the health camps? (Y/N)
0. If yes, how much do you have to pay?
0. Do you prefer the NGO health camps over government clinics? Why or why not?
0. Have you attended NGO education sessions on health, nutrition, importance of school education etc? (Y/N)
0. Do you feel your children, especially daughters, should continue with high school education? Why or why not?
0. By what age do you want to get your children married? (Both male and female)

Impact and Sustainability

0. Whom do you approach at present if you require support with your health needs?
    1. Community volunteers
    2. PHCs/ Anganwadis
    3. NGO staff
    4. Ohers, _____
0. How frequently do you seek medical intervention in case of need? hat development activities (toilet construction, drinking water facility, cleaning of community roads/grounds etc) have taken place in the village as a result of the intervention?
0. Is there a support you believe can help to further improve the health of the village community people? (Y/N)
0. On a scale of 1-5, how would you rate the following:
    1. Quality of treatment offered at the health camps
    2. Impact of the health services (teleconsultation, ration distribution, access to masks etc) on your well-being during the pandemic

Stakeholder group: Key Community Members (VHSNC, Community volunteers)

Basic Profile

1. Name
2. Gender
3. Age
4. Profession/ Designation
5. Since when have you been associated with RLHP?
6. Roles and responsibilities with respect to this project

Program Design: Relevance and Preparedness

0. According to you, what characteristics of this area make health, nutrition, and sanitation most preferred thematic interventions? (availability of functional PHCs, Anganwadi, awareness and accessibility to these facilities etc)
0. What were the primary challenges faced by the villagers in the area of maternal and child health prior to the intervention? (unawareness about importance of ANC, institutional delivery, immunization, good breastfeeding practices, lack of finances for affording healthy food etc)
0. What do you feel were the key developmental challenges in the village prior to the intervention? (lack of toilets in homes, schools, lack of access to clean drinking water etc)
0. How common were child marriages and child labour in the village prior to the intervention?
0. What was the average drop-out rate of boys and girls from school? Which standard had the highest drop-out rate? What do you think were the reasons for drop-out?
0. What kind of renovation/ development requirements did the schools and anganwadi centre of the village have?
0. How did the pandemic impact the lifestyle of the villagers?
0. Do you have any prior experience/ knowledge about mother, child and adolescent reproductive health issues? (For community volunteers)
0. Do you feel the activities were relevant as per the need on ground? (Y/N)
0. If not, why not?
0. What kind of preparatory activities were conducted by RLHP to orient you to the program? (For community volunteers)
0. Whom did you get in touch with if you needed any support during program implementation? (For community volunteers)
0. What kind of capacity building activities were conducted by the RLHP team? (For VHSNC)

Program Delivery: Effectiveness and Efficiency

0. Why did you opt to volunteer for the program? (For community volunteers)
0. How were you chosen to be a volunteer? (For community volunteers)
0. How many volunteers were present in your village? How many number of beneficiaries were you responsible for monitoring and follow up? (Y/N) If yes, how many households/beneficiaries did you monitor? (For community volunteers)
0. How do you keep track of follow-up calls/visits to be made? (personal register etc) (For community volunteers)
0. What percentage of families have access to toilets in the village at present? To what extent are those toilets used by the villagers? (both make and female)
0. What are the key reasons for less toilet usage?
0. Have you noticed a reduction in open defecation because of the intervention? (Y/N)
0. According to you, has the intervention been effective at reducing drop-out rate amongst the boys and girls? (Y/N) By what percentage has it reduced?
0. Has school/ anganwadi centre renovation/ upgradation happened because of the intervention?
0. Do you feel the exposure visits were effective at making you aware about the various government health and child development facilities? (Y/N) (For community volunteers)

0. What were the key challenges faced by you in conducting your duties? How did you overcome them? (For community volunteers)

Impact and Sustainability

0. Are you still involved in conducting health awareness sessions and health screenings and referrals for the community members? (Y/N) If not, why? (For community volunteers)
0. Do you feel the mindset of families have changed with respect to child marriage and child labour?
0. Do you feel the intervention has resulted in an increase in ANC registration of pregnant women and timely immunisation of children?
0. What are the key changes that you have observed because of this intervention?
0. Do you feel the intervention has resulted in a reduction in malnutrition amongst children?
0. Do you have any recommendations on what can be done to make the intervention more impactful in the future?
0. On a scale of 1-5, how would you rate the following: (1- Very Poor, 2-Poor, 3- Satisfactory, 4-Good, 5-Excellent)
    1. Relevance of the information given during training workshops to the need of the community
    2. Adherence to COVID-19 protocols during physical sessions
    3. Need and relevance of the activities with respect to the RMNCH+A situation on ground
    4. Effectiveness of the activities in improving the health of children, pregnant mothers and adolescents
    5. Impact of the intervention in reducing malnutrition amongst children and high-risk pregnancies in the region
0. Do you know which organisation has funded this program?

Stakeholder group: Healthcare Workers (community healthcare workers, PHC staff Anganwadi worker etc)

Basic Profile

1. Name
2. Designation
3. Location
4. Institute/Organization
5. Roles and responsibilities with respect to this project (involved in training/ health screening/ online consultation etc)

Project Design: Relevance and Preparedness

0. What were the key shortcomings of the existing RMNCH+A services in the community at the time of RLHP intervention?
0. What was the infant and maternal mortality rate in the village(s) prior to the intervention?
0. To what would you attribute the malnutrition and maternal mortality rate? What effect did the pandemic have in worsening/improving the condition?
0. What were the key reasons for the high malnutrition rate amongst children?
0. Would you say the nutrition supplements provided (Protein powder) by RLHP along with nutritional recipes awareness was sufficient to sustain good nutrition practices and combat malnutrition and anaemia? (Y/N)
    1. If yes, how long did they have to consume?
    2. How did you monitor the child's growth?
0. What do you feel were the primary reasons for pregnant women not registering for routine ANC check-ups?
0. To what extent do you feel those concerns have been addressed by this initiative?
0. Do you feel the RLHP team was prepared to implement the program in the backdrop of the pandemic and keeping in mind the increased risk that the pandemic posed to children and pregnant women?(Y/N)

1. If not, how did you determine?

Program Delivery: Effectiveness and Efficiency

0. Do you feel the health and education sessions conducted by RLHP were effective at making the community members aware about the importance of timely immunisation and healthy diet? (Y/N)
0. Have you observed a reduction in malnutrition, high risk pregnancy cases and anaemia amongst children, pregnant women and adolescents respectively post the intervention? (Y/N)
0. If not, what do you think is the reason for the same?
0. What do you feel are the key factors that might be hindering the community members from adopting healthy nutrition practices?
0. , approximately what percentage of the community members seek medical attention after being referred by the volunteers?
0. What do you feel are the reasons for not seeking medical advice even after being referred? (lack of time, financial burden, fear of being diagnosed with a severe disease etc)
0. What were the key problems being faced by adolescents as a result of lack of sexual and reproductive health awareness?
0. Do you feel the initiative has been effective at reducing these problems?

Impact and Sustainability

0. What changes has the initiative brought about a behaviour change amongst the community members with regards to timely medical intervention and nutritional diet practices?
0. If not, what do you feel are the key reasons for the same? What recommendations would you give to bring about a sustainable change in the attitude of people?
0. On a scale of 1-5, how would you rate the following:
    1. Relevance of the healthcare initiative to the ground situation
    2. Effectiveness of the initiative to reduce rate of high-risk pregnancies, malnutrition and anaemia
    3. Ability of the initiative to bring forth sustainable change in the attitude of the community members towards a healthy lifestyle

Stakeholder group: NGO Program Team

Basic Profile

1. Name
2. Designation
3. Roles and Responsibilities

Program Design: Relevance and Preparedness

0. On what basis did you choose this geography for the intervention?
0. Was any baseline study or gap analysis conducted to identify the needs of the community?
. Yes, What were the important insights? _____
. No
0. What kind of partnerships did you have with the gram panchayat, anganwadi centre etc? What role did they play in this program?
0. Were community health workers like ASHAs and ANMs active in the community prior to the intervention? (Y/N) If yes, what kind of value addition did RLHP created in the maternal and child health ecosystem?
0. What percentage of vulnerable population were covered in these villages?

0. How many beneficiaries were linked with government health schemes? What % of them actually availed benefits from those schemes?

0. Could you describe the process of identifying community volunteers?

0. Can you give an estimate of the frequency with which the different activities were conducted during the intervention period?

0. What kind of approach were taken for the various activities in 20-2021, keeping the pandemic situation in mind?

0. Were there any modifications in the original project plan due to the pandemic? (Y/N) If yes, what were the key changes?

Program Delivery: Effectiveness and Efficiency

0. Considering the shortcomings of the village how were the camps and outreach sessions conducted?

0. Where were they conducted?

0. Where did you source the food supplements (protein powder) from?

0. Was there any quality check procedure in place for the protein powder and other food supplements distributed? (Y/N)

0. What according to you were the major challenges of this project? How did you overcome them?

0. How many beneficiaries were planned to be impacted through the project? (Direct)

0. How many beneficiaries have actually been impacted through the project? (Direct)

0. How did you document the beneficiary data throughout the program?

Impact and Sustainability

0. Do the health screenings and referrals still take place? (Y/N)

0. If not, has there been any follow up done to check the vulnerable population enabled to seek help and follow healthy nutrition and immunisation practices by themselves?

0. Which RMNCHA areas (malnutrition/ ANC-PNC/ Breastfeeding etc) in the villages require further intervention and support?

0. On a scale of 1-5, how would you rate the following: (1- Very Poor, 2-Poor, 3- Satisfactory, 4-Good, 5-Excellent)

1. Relevance of the activities to the needs of the villages
2. Adherence to COVID-19 protocols during physical sessions
3. Effectiveness of the activities in improving the health of children, pregnant mothers and adolescents
4. Impact of the intervention in reducing malnutrition amongst children and high-risk pregnancies in the region