2019

End Term Evaluation

of CBPHC MCH, Mohulpari, Dumka, JH IN

Evaluation Team
MONIJINJIR BYAPARI,
ABRAHAM DENNYSON,
MATHEW SANTHOSH THOMAS
12/12/2019

CONTENTS

ACKNOWLEDGEMENT

The end term evaluation has been a rich learning experience. Interacting with community members, church leaders, staff team, and each other of evaluation team has enriched us. Everyone was warm, open,and honest with their opinion, even when faced with challengingquestions.

We would like to thank Dr Pradip Soren Medical Superintendent of MCH for providing us the opportunity to be part of this evaluation exercise. We would especially like to acknowledge the assistance received from:

- The hospital leadership, staff and project team at Mohulpahari
- The Moderator, Secretary and officers of NELC Synod
- The Bishop and leadership of the Diocese of Dumka

The CBPHCP team had been extremely helpful and forthcoming. We thank them for providing us with all the information and also went out of their way to make our visit comfortable and fruitful as possible. A special thanks to Mr Cecil and Mr Nathanial Hembrom who patiently accompanied the evolution teams throughout the visit and providing excellent coordination.

Last but not the least we thank Dr Shailendra Awale, Advisor of the CBPHC for his advice, guidance and for the wisdom shared from his long association with MCH on its context, NELC Church, its structure, diversity and many other areas.

MONIJINJIR BYAPARI,
ABRAHAM DENNYSON,
MATHEW SANTHOSH THOMAS

EXECUTIVE SUMMARY

Though the evaluation focussed on Congregational Based Primary Health Care project's final phase of the program from 2017 – 19, the team was mandated to reflect on organizational learning for Mohulpahari Christian Hospital and NELC at large. The evaluation team facilitated exploring new perspectives for the Church in managing its healing ministry, with the changing context of the nation and community at large. The summary tries to capture all these three components.

The project had a dream of facilitating active, functional and sustainable community-based organizations and empowering communities these groups represent, to claim and access existing governmental and primary health care and social security services. This was part of a larger dream of enabling the CBOs to be a critical mass in the democratic decision-making process where they will be able to manage and sustain their social capital, and thus ensuring a life of dignity.

Overall the project has made much headway in community empowerment with a quite a few active SHGs and Peoples organizations that are actively engaged in advocating for their community-based needs. This is facilitated by a few women leaders who are dynamic and proactively involved. Many women leaders have come up through this project, as evidenced by their active participation in gram sabhas and partaking in political processes. But they were unable to move into a border framework of engagement at policy level due dearth of leadership from other community groups like men and youth. The limited time frame of less than three years for this last phase of community mobilization for policy level engagement was another limiting factor.

In the health component the contribution of CBPHC on Maternal Child Health of this region is difficult to assess, since government primary health services have improved over the last few years. But the project has reduced the gap between the state systems and right holders in accessing and availing government schemes. This is not only for maternal and child health but for other health and social security schemes also. The emerging and visible needs of Mental health, addictions and alcoholism, challenges affecting family structures, youth, education and economic empowerment etc., did not get any focus, in the current phase of project.

Congregational engagement in the project was hardly visible, though the larger leadership of NELC was engaged in owning and providing governance support to the project at large.

The broader management learning and impact is mostly limited to the community and project level and has not been able to impact MCH and or NELC, at large. Though the initial phases of the project had contributed to sustainability of the hospital, this was not visible in this phase.

There is an urgent need to revisit and reposition the hospital with the larger changes happening around, in health care and emerging community needs and expectations.

Looking ahead, there is the need for ongoing community engagement to address the emerging issues of Mental health and Alcoholism, Child rights and Education, Livelihood support, focusing on Entrepreneurs training and skill development, and developing Leadership from the younger generation. At the same time the CBOs will need ongoing support to move to a people movement mode. Gender related issues is one another area which must be explored.

Any upcoming program should explore newer and innovative methods of engagement with the active participation of the church alt large, than the structures and systems followed in the last decade. At the same time, based on the learnings, it is urgent and critical to address the various governance, structural and management challenges of MCH and NELC. This will help in repositioning the healing ministry of the church at large, to make it relevant to the context and community, sustainable and facilitate community transformation.

CHAPTER 1: INTRODUCTION

The Project and Programme

The Congregational Based Primary Health Care project of Mohulpahari Christian Hospital of Northern Evangelical Lutheran Church (NELC) is a continuation of the Hospital Development Project started in 1999. Presently supported by Normisjon and Digni, the legal project holder is NELC[1], a registered as Non-govt company and is registered at Registrar of Companies, Jharkhand. Mohulpahari Christian Hospital (MCH)is not independently registered.

The NELC was founded in 1868 by two missionaries a Danish and a Norwegian in Santhal Parganas. The membership comprises primarily Santhal, Bodo and Bengali people, and it is spread across 5 dioceses in 3 states of Eastern and North Eastern India. Its headquarters is in Dumka Jharkhand. The Church is headed by a Synod with a Moderator; each of the Dioceses is headed by a Bishop, and each Diocese is divided into Circles. NELC as several primary schools and one University of Seramporeaffiliated Theological college at the B Th level which is going to become a BD level college.

MCHis the largest NELC Hospital with 130 beds and a Nursing School that runs ANM and GNM courses. MCH went through a Hospital Development Project 1999 to 2004, and then the Congregation Based Primary Health Care Project (CBPHC) was started and went through 4 phases: 2004- 2009 (Phase II), 2011-2015 (Phase III) and 2017-2019 (Phase IV- ongoing).

The project is funded by Normisjon, which is an association of three missionary organisations in Norway. NELC has been supported by Normisjon in building the capacity of the church to administer and manage many institutions and projects.

DEVELOPMENT AND PROJECT GOAL WITH BROAD OUTPUT

Development Goal

To improve health conditions of the socially excluded (Adivasi and Malpaharia) communities and to strengthen on-going movements, enabling them to be a critical mass in the democratic decision-making process where they will be able to manage and sustain their social capital, ensuring a life of dignity.

1Northern Evangelical Lutheran Church (NELC) is a multi-lingual Lutheran Christian church that is centred mainly in four states of North India - Jharkhand, Assam, Arunachal Pradesh, and Bengal. The reach of the Church extends into Nepal and Bhutan

Project goal

Active, functional and sustainable community-based organizations, (POs, CBOs, and SHGs) representing the socially excluded population in Shikaripara, Dumka and Ranishwar blocks, empower communities to claim and access existing governmental and primary health care and social security services.

Project output

1. CBOs and POs are claiming rights and hold duty bearers accountable and social security entitlements are availed by socially excluded community.
2. Mother and Child related health care service system is strengthened at community level
3. Good Governance and management practices are developed at CBPHCP and MCH.

Project Strategies

The project strategies as mentioned in the PD are

1. To develop community-based organizations at the village level
2. To building Peoples Organization with multi stakeholder partnerships and inclusive leadership.
3. Collaboration with ASHA in creating awareness regarding mother and child health.
4. Community-based organizations will be linked with village health nutrition and sanitation committee in the planning and monitoring of the service delivery.
5. It was expected that these POs will engage in policy analysis and formulation process.

CHAPTER 2 EVALUATION DESIGN

The objectives of the evaluation

The Key objectives of the evaluation are as follows

1. To investigate changes that has happened and to what extent it has due to the project intervention.
2. To what extent has the project contributed to the development goal (this includes to verify changes in the goals: improvements in the health conditions of the socially excluded communities, strengthening of the movements (PO, CBO, SHG), enabling them to be a critical mass, able to manage and sustain social capital and ensure life of dignity
3. To assess to what extent this is due to other factors as well as the project. Project output should also be verified.

The evaluation will also integrate to study the outcomes and impacts made by the project in, to facilitate organizational learning for Mohulpahari Christian Hospital and Northern Evangelical Lutheran Church and back donors. As this project was an extension of the Hospital Development Project launched in 1998, it would also try to find the impact of the project in terms its contribution in the long-term sustainability of the hospital, developing the perspectives of the Church in managing its healing ministry and building community assets.

The purpose of the evaluation

The purpose of this evaluation will be to focus on the community's satisfaction with the program, and the extent to which the project has made progress in achieving the expected results, since its 2017 to 2019

Scope of the Evaluation

1) Evaluation of the CBPHCs proposal from the period, 2017-2019
    a. Determine the extent to which the strategic objectives have been met as stated above
    b. Assess the relevance of the proposal to the priority focus groups and in the context of changes (national and international)
2) Evaluation the programmes carried out in the states of Jharkhand, 3 blocks Dumka against the criteria of effectiveness, efficiency, impact, sustainability, and empowerment.
3) Assessment of the organization structure, internal governance, human resources, external relations and partnerships and PMER (Planning, Monitoring, Evaluation, Reporting, and Learning) in context of proposal
4) Identify best practices that can be taken over for replication and implementation

Intervention logic and findings

The evaluation report briefly describes and assesses the intervention logic and distinguishes between findings at the different levels: inputs, activities, outcomes and impacts.

The evaluation criteria provided in the terms of reference are in line with OECD Development Assistance Committee-DAC-Criteria proposed for evaluation namely relevance, effectiveness,

efficiency, impact and sustainability. The evaluation also explores empowerment using the Empowerment Assessment tool (EAT) of Digni by assessing empowerment from the parameter of resources, agency and achievements

Key Evaluation questions

- What is the nature of alignment or disjunction between the needs of CBPHC and target group, stakeholders demand and organization's own intent and vision?
- Are the strategic approaches effective in delivering intended results?
- Whether the existing management structure and mechanism as well as leadership patterns are effective during the implementation of the programmes
- Have there been any other changes at community, government or institutional levels, policy level and health service (expected/ unexpected) because of CHPHCP advocacy
  Has sustainability component been included in the project design?

Approach

The evaluation adopted a participatory approach. The evaluationteam brought expertise in a range of relevant evaluation approaches and developed a specific evaluation design relevant to this consultancy. The detailed evaluation plan was developed based on discussion with and input from CBPHCP and relevant stakeholders from the hospital management in a transparent and participatory manner. The evaluation team paid attention to the guidance for ethical practice, addressing issues associated with consent, confidentiality, respect, humility and cross-cultural understanding.

Methods and Tools of Data Collection

Analysis and synthesis of existing reports: Program reports were reviewed against the evaluation questions to draw out the most relevant information and identify critical elements. This process guided the development of questionnaires for subsequent evaluation elements, including FGDs and semi-structured interviews.

Scanning of other documents: The evaluation team examined in detail all the documents cited earlier with the help of a check list developed in agreement with the evaluation questions.

Semi–structured interviews: Right holders, their family members, women's groups, program staff and others identified from community (e.g. CBO, SHGs and community leaders, local panchayat members) and government stakeholders like MOIC, BPO, Health workers etc. were interviewed with pre-designed interview schedule. The interview schedule was developed in cooperation with CBPHCP, to maximize feasibility. Questions were based on TOR and information gleaned from reports.

Focus Group Discussions (FGDs): FGDs were held for Community Organisers (CO) and field staff, nurses and hospital staff, PC committee, community members and small groups of women. The

FGDs were supported with discussion guide containing points related to the effects of their participation in the program and the nature and level of changes that have occurred in their lives.

Sources used

A. Secondary Sources

- Annual Reports of the project
- Report of relevant evaluation studies done in the past
- Baseline report
- Learning appraisal report
- Byelaws of NELC
- Data collection formats
- Appointment letters
- Organogram,

B. Primary sources

Sl.No.	Respondent Group	Sample Size
1	Staff	7
2	Community Officers	19
3	CBO members	34
4	SHG members	30
5	PO members	11
6	ANM	6
7	Sahya	3
8	Doctors	4
9	Hospital Staff	9
10	Panchayat leaders	2
11	PC committee	8
12	Nursing Staff from School	3
13	MOIC (Shikaripara CSC)	1
14	Block Program Officer (BPO)	1
14	Pradhan NGO	2

15	Lok Prerona NGO	1
16	Old Staff	2
17	District Program Officer (DPM)	1
18	Jharkhand State Livelihood Promotion Society (JSLPS)	2

Data Analysis

Throughout the data collection process, the aim was to check with respondents about the interpretation and meaning assigned to information. This was particularly important during FGDs to ensure that the views were fairly and accurately represented. Once data collection was completed and collated, quantitative information wasanalyzed using quantitative measures. Simple quantitative measures like CATs and monitoring tool measurements of EAT was used.

Qualitative information was assessed for key themes and ideas against the evaluation purposes and questions. Those themes were reviewed across all sources of data and general views and conclusions were developed based on that data.

Triangulation of all major findings and themes were ensured with at least two sources of information to verify their relevance and consistency. Existing quantitative data and analysis from program reports were reviewed and taken into consideration. In addition to validation of data and quotes from evaluation, review of related literature was used to establish the contextual framework for discussions and to confirm the findings and recommendations.

Evaluation schedule

Sl No	Activities	Days
1	Introductory meeting of the Evaluation team by Zoom	1
2	Briefing workshop	1
3	Data collection for evaluation	5
4	Data Analysis	3
5	Workshop on New Vision and Recommendations	1
6	Report writing	1
7	Debriefing	1
8	Raising the draft report for feedback and comments	1
9	Revising the draft report to final one	1/2
10	Submitting the final report	1/2

Reporting Plan

The report followed in general the outline given was as per the ToR. The Consultant made a few changes in the outline not making much deviations. The team leader was responsible for compiling the reports based on input from the other team members and program.

Limitation of the study

The study was very specific and contextual. Hence, the scope for generalization is limited, but valid to the population studied. The only limitation was sometimes the Santhali language and not visiting the Malpaharia community.

CHAPTER 3:OBSERVATION AND FINDINGS

Context of the State:Jharkhand

The State of Jharkhandhas an approximate population of 33 million according to the Census of India, 2011 which saw a 22.42 per cent increase from the population of 26.9 million in 2001. Of this, the number of children up to six years of age were 5.39 million. The current sex ratio of the state is 948 females per thousand males which has witnessed an increase from 941 in 2001. Of the total population of Jharkhand 75.95 per cent live in the rural areas while only 24.05 per cent live in urban areas. The Human Development Index [2]of Jharkhand is 0.376 compared to National HDI being 0,624.There has been a growth of 32.36 per cent in the population of urban areas in the past decade owing to migration for work to towns and cities. The state has witnessed an increase of about 12.85 per cent in the literacy rate and stands at 66.41 per cent with male literacy rates still being significantly higher than females in both rural and urban settings. In Jharkhand, the IMR is 36 which is lower than the national average, but the MMR stands at 211 being significantly higher than the national average of 167[3].

The state of Jharkhand is affected by different kinds of disasters. Drought, Mining Accidents, Chemical and Industrial Hazards, Lightning, Avian Flu, Flood, Earthquake, Fire/Forest Fires, Elephant Attacks, Landmine Blasts etc. are the major disasters in the state. The last decade has shown the increasing severity of drought situation in Jharkhand. Severe heat wave conditions are noticed in the years 2004, 2005 and 2010. Forest fires constitute a major threat because the forests of the State are mostly dry deciduous.

Context of the District:Dumka

The district of Dumka (replacing the old name Santhal Pargana) was created on 1st of June, 1983[4] with the remaining jurisdiction of the then Santhal Pargana district after creation of districts like Godda, Sahebganj (on 17th May, 1983) and Deoghar (on 1st June, 1983). Dumka town has the distinction of being headquarters of old Santhal Pargana district in past and presently that of Dumka district and Santhal Pargana division. The district Dumka of Jharkhand has an area of 3716.02 Sq. KM. It has an average elevation of 137 meters (449 feet). The Santhal Parganas is in the north-eastern extension of the Deccan plateau. The region is bounded on the west and south by a few districts of Jharkhand and to the east by some districts of West Bengal.

---

2 http://www.in.undp.org/content/dam/india/docs/jharkhand_factsheet.pdf

3http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2011_12/Jharkhand_Factsheet_2011-12.pdf

4 District census handbook 2011 Jhakhand Series 21 Part III A

Total population of Dumka is 32,988,134[5] of which male is 16,930,315 and female is 16,057,819. Sex ratio in Dumka is 948 per 1000 of male. As per 2011 census, 93.18 per cent of population of Dumka district live in rural areas. Average literacy rate of Dumka in 2011 was 66.41 per cent, male literacy being 76.84 per cent and female literacy being 55.42 per cent.

The Institutional context -MCH

The current MCH and its facilities has more than 50 years of history though NELC has more than 150 years of existence and had health care focus prior to the establishment of the current hospital. The hospital was supported by Normisjon from late 1990 's initially for hospital development andlater forcommunity outreach, working on health issues and for empowering the communities to organise and access health schemes.

MCH.a few decades back had reached its prime stage. The hospital was the sought-after prime health care service provider for the whole region, provided leadership for other health care services, and maintained continuous growthfor a period andwas financially sustainable with own revenue generation.The hospital continues to be a 130 bedded secondary service provider but is not doing well in terms of utilization of its services by the community and is no more the leader in the region. Many factors are affecting the institutions sustainability and relevance.

The previous evaluation and efforts taken up till now

CBPHC which started as project to provide health servicesto communities, later adopted a model of micro entrepreneurship by SHGs to support communities for accessing health services. Subsequently a Right based approach was taken up, adopting Advocacy as a tool whereby communities can seek and demand social security schemes.

In the current phase, the project focus ison developing community resources in terms of people's organisations /movements, networking among health care workers and to ensure policy development, engagement and its implementation.

The last evaluation for CBPHCP was in 2013, the recommendations from the evaluation highlighted the following issues.

- A gap was visible between what is needed for overall development of the communities and what exists at the project level.There was a need for all players in the field to join hand to make the difference. MCH was needs to continue the efforts to bridge the gaps.
- There was a need to reorganize the program to focus on the strengths for consolidation, and work on weak areas. The strengthening of women's groups and few men's groups should be the focus for the project.
- All groups need training and diversification in various activities. They have the potential to be the largest advocacy group in the district if they are empowered with necessary knowledge and skills.

[5]Religious division (in which Hindu-1044726, Muslim-106865, Christan-86404, Sikh-234, Buddhist-267, Jain-162, Other religion-78622 and religion not stated-4162 are consisted.)

- Networking with other similar groups and NGOs was needed for these groups and issue-based collaborations should be explored.
- Congregations and Church are integral part of the project and CBPHCP and MCH should work with the NELC leadership to develop a strategy to make this partnership stronger and mutually beneficial.
- Project should utilize the opportunity to build on its strengths and develop and empower community-based organizations.

In the light of recommendations, some significant measures taken are as follows:

- Redesigning of the project with rights-based approach with advocacy as core strategy, aligned with appropriate objectives, outcomes and indicators in 2014.
- Introduced Tally based finance management system with appropriate accounting practices adopted as per DIGNI standard.
- Capacity building of the staffs incorporated as regular componentin the project, in the areas of community organizing, facilitation, finance, and program management through workshop, trainings and exposure.
- In the annual activity plan of the year 2016 emphasis has been given in strengthening the monitoring system with appropriate base line development
- Inclusion of the external expert in the project management committee and engaging for periodic review of the progress.

In general, the project seems to have made quite a bit of headway in community engagement primarily but has not able to scale to policy engagement or an issue-based people's movement. Similarly, the management learning and impact is quite limited to the project level but has not able to touch governance and perspective of MCH and NELC, which is very critical in terms of sustainability and impact of the gains of the project. MCH itself facing issues related relevance and work output. The morale of an institute that's facing its own viability has an impact on the project governance and its organizational systems. NELC has gone through leadership changes and the new team, is trying to address the demanding task of taking forward the transformational agenda and running of its institutions. Present political, social and economic challenges those are inimical to the church and larger civil society have made the context complex and is threatening the larger issues of community's identity itself.

CHAPTER 4: ANALYSIS: PROJECT RESULTS AGAINST EVALUATION CRITERIA

Relevance

The issue of relevance relates to '*are we doing the right thing*'. In terms of the ToR[6] for the evaluation, key questions have been elaborated on in this aspect. The issues relating to relevance are triangulated herein and analysed to understand if CBPHCP is '*doing the right thing*'.

[6] Reference may be made to Annex I – Terms of Reference (ToR) for the CBPHCP Evaluation

Relevance of the of target group

There are 32 tribes (2011) in Jharkhand of which Santhals are the largest and represent 33percent of the aggregate tribal population. The other major groups are Oraon, Munda and Ho contributing to over 10 per cent to the aggregate tribal population.(source Census 2011) Eight out of the thirty odd tribes of Jharkhand fall under Primitive Tribal Group (PTG). They are Asur, Birhor, Birajia, Korwa, Savar, Pahariya (Baiga), Mal Pahariya and SouriyaPahariya. CBPHCP is working with biggest tribal representation i.e. the Santhhal and also two PTG i.e.the Birhor and Mal Malpahariya.

The project is working in the district of Dumka in three Community Development Block (i.e. Sikaripara, Dumaka and Ranishwar) covering 90 of revenue villages and 14 congregations. The selection of the villages is as per congregation and not as per revenue structure. The project was initiated as part of the healing ministry of the church and as an outreach from the Hospital.The project desired to improve the health of the community through a community mobilisation approach. There was expectation that the service provisions of the hospital would be enhanced through this community engagement.

As per the need's assessment done in the month of March 2016,it was found that despite various government welfare programs and pro tribal constitutional provisions and improvement in socio-economic outcome, the government has failed to address the issues of exclusion. Some of the reasons are enumerated below.

- Due to lack of political will and inadequate awareness.
- Lack of women participation in decision-making and governance.
- High Prevalence of alcoholism creating issues of mental health and abuses.
- Lack of organized assertive voice, confidence and capacity in claiming rights and entitlement and negotiating with duty bearers.
- Poor functioning of Gram Sabha as Institutions of Local Self Governance on the matters of approving plans, programs for socioeconomic development and identifying beneficiaries under poverty alleviation programs
- Limited functioning and influence of participatory governance structures

It is very interesting to note that the context where the project is places and the issues identified as per the need assessment is very relevant. Initially the project planned to work on alcoholism but it due to fund reduction the project didn't continue to work on it

But in the current phase of the project and at implementation level, the focus of CBPHCP was limitedto helping the community access maternal and child health care services and other social security schemes. The community and the staff expressed that CBPHC could have worked on others relevant issues like exclusion, alcoholism, gender discrimination etc.

Relevance of the goal:

From the Project document CBPHCP 2017-19 we find the overall developmental goal of the project as'improving the health conditions of the socially excluded (Adivasi and Malpaharia)

people group and to strengthen on-going movements, enabling them to be a critical mass in the democratic decision making process where they will be able to manage and sustain their social capital, ensuring a life of dignity.'

Thespecific project goal envisages 'active, functional and sustainable community-based organizations, (POs, CBOs, and SHGs) representing the socially excluded in Shikaripara, Dumka and Ranishwar blocks, empower communities to claim and access existing government primary health care and social security services.'

While assessing the understanding of the project staff regarding these goals, the linkage to healing ministry of NELC and its implications,it was evident that all the staff are committed and are passionate to work for the Santhali community. But most of them lackthe overallorganisations perspective and projects linkage with healing ministry.The new field supervisors consider CBPHCP as a project working for the community. Only two senior staff out of the seven could clearly articulatethe right perspective of CBPHCP, it goals and its link with the healing ministry of NELC. They shared that CBPHCP is a process driven organisation affirming life of individual, community, and one which tries to establish identity and dignity.The broader understanding of working with perspectives, process and values linked to the churches mandate and healing ministrywas only understood wellby the project coordinator and programme coordinator.

This lack of perspective has had some impact on the overall goal,as evidenced by CBOs and PO organising for accessing entitlements but not taking forward thePeoples movement or forming a critical mass that can influence policy.

Relevance of the Project Strategy:

The attempt to develop strong institutions and have rights-based approach is very relevant to the context. In line with the CBPHCP strategy[7], the CBOS and POs have been successful in accessing several social security schemes, women are proactively involved and vocalise their issues with the community leaders, participate in local self-governance, utilize banking services and interact with various departments of the government. Some of them have submitted applications under right to Information Act. Some instances of addressing issues related to property disputes, domestic violence or addressing corruption for food distribution at local PDS were also reported.

CBOs' involvement is limited toaccessing social security schemes from the government. They are not engaging with the larger and critical village problems. Like alcoholism, land acquisition etc.

[7]To shift from the local community-based problem solving work to issue/ theme based interventions. The project will facilitate community-based organizations to view day-to-day problems in a larger framework relating to a larger issue of exclusion. It will also focus on building Peoples Organization with multi stakeholder partnerships and inclusive leadership. The Community organizers will work in collaboration with ASHA in creating awareness regarding mother and child health. Along with this, existing community-based organizations will be linked with village health nutrition and sanitation committee in the planning and monitoring of the service delivery. It was expected that these POs will engage in policy analysis and formulation process.

Neither CBOsnor POs have members from multi generation or varied background and not so inclusive leadership, which might be critical, if larger issues are to be addressed. Majority of stakeholders are women between the age group of 30 to 60 years. There was no evidence ofactive participation of youth or men (farmers) in the CBO.The community organisers role appeared to be limited to logistic arrangements, data collection, counselling and accompanying the government deputedASHA and Sahyas than focussing on the above issues.

Themes addressed by the project and its relevance:

CBPHCP is working with two broad themes i.e.strengthening civil society and health issues. It is important to note that for DIGNI two themes that are mandatory are - strengthening civil society and gender. CBPHCP is working with only one mandatory theme as a primary focus.

Strengthening civil societyis to strengthen the community as'civil society actors', working towards transformation of communities. In CBPHCP context we see community-based organizationsemerging in the form of collectives and accessing and availing the rights and entitlements. There wasalso a possibility of Church emerging as civil society organization where the 'Reign of God' can lead to an integral transformation of humanity and the recreation of the world as we know it, This could help in the liberation of men and women from all forms of bondage and oppression, personal and social.

Even through the project was designed initially as a Congregation based Primary Health Care project whereby congregations would play a crucial role, with the shift in perspective and changes in implementation, this aspect of the project was not taken up proactively. The project intervention areas were selected based on the presence of the 14 congregationsto focus on a congregational approach. The evaluation team could not appreciate nor find evidence of active engagement of the congregations for strengthening the civil society.

Health. CBPHCP had a larger objective of strengthening the hospital referral system and mother and child health care systems at the community level. The CBPHCP focusedprimarily on strengthening the mother and child health care services at community level. The project is working to ensure institutional delivery(JSY), and access toimmunization.Project tracks data related to these regularly.

There are other issues of health that the community is challenged with, of which a critical issue is that of mental health and alcohol abuse. This is leading to loss of life, disintegration of family values and resources. The project has not been able to focus on this critical issue.

Dumka town is emerging as a district headquarters with free and fast improving government medical facilities, and good roll out of Ayushman Bharat[8]in institutions. These changes have affected MCH hospital utilization. The outreach medical camps done by the MCH as part of CBPHCP has not led to hospital services being better utilized.

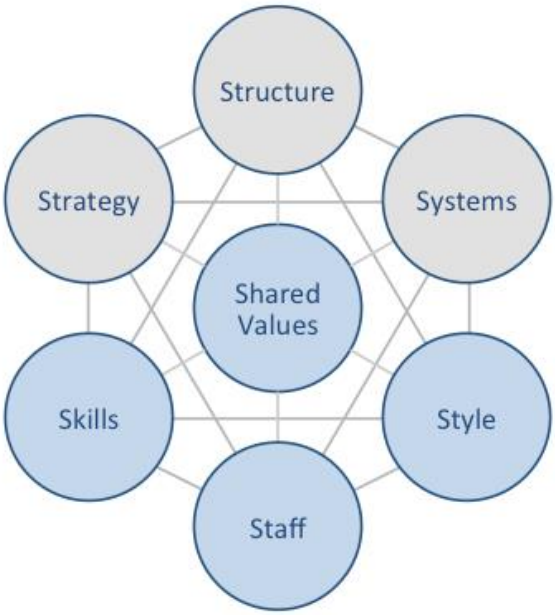
The Community Organisers are working in close collaboration with the ASHA and Anganwadi workers and havecreated a good network of relationships. Most of the health data is tracked from what the ASHA provides. In manyplaces there is duplicity of work between ASHA and the

8Ayushman Bharat Yojana or Pradhan Mantri Jan Arogya Yojana (PMJAY) or National Health Protection Scheme a centrally sponsored scheme launched in 2018, under the Ayushman Bharat Mission of MoHFW in India. The scheme aims at making interventions in primary, secondary and tertiary care systems, covering both preventive and promotive health, to address healthcare holistically. It is an umbrella of two major health initiatives namely, Health and Wellness centres and National Health Protection Scheme (NHPS)

Community Organisers. The data received from the ASHA is not further utilized for management decision making process of MCH or CBPHCH.

Gender issues:Power structures and hierarchy that negatively influences gender and gender-based violence as prevalent issues in the community. Gender as per the DIGNI framework is a mandatory theme. CBPHCP does not have a specific strategy or output on gender inclusion.

But in the SHGs and CBOs formation we find effective participation of the women members. All the activities are undertaken for their strengthening,leadership and availing of schemes especially related to health is directly benefiting the women. Women who were volunteers of CBPHC have contested political elections and is now a part of the political decision-making process. But there is hardly evidence of women active in decision making process on issues related to property rights and or succession. Project does not influence the social organisations of the Santhals where the Majhi harem, The Godet , the Naeke and the Kudum Naeke (i.e. the Headman, the messenger, the priest and the assistant head man respectively) are allpredominately men. In such a social organisation the role of a women or the opportunity for women to inherit asset is very minimal.



At the project implementation especially at community intervention we find out of 19 community organisers 17 are female and 2 are male. These female community organizers are contributing towards the empowerment of the women at community level but leaving behind the male stakeholders. At the CBPHCP office and leadership level, all the field supervisors and programme officer and project coordinators are male.Therefore, gender inclusion and addressing gender related issues is an area that the project did not give adequate focus.

Effectiveness

McKinsey's 7-S framework[9] (figure below) has been used in order to analyse the main characteristics of the organisation

9McKinsey's 7-S framework The model is based on the theory that, for an organization to perform well, these seven elements need to be aligned and mutually reinforcing. So, the model can be used to help identify what needs to be realigned to improve performance, or to maintain alignment (and performance) during other types of change. Whatever the type of change – restructuring, new processes, organizational merger, new systems, change of leadership, and so on – the model can be used to understand how the organizational elements are interrelated, and so ensure that the wider impact of changes made in one area is taken into consideration

The three "hard" elements in grey are strategy, structures (such as organization charts and reporting lines), and systems (such as formal processes and PMER systems.) These are relatively easy to identify, and management can influence them directly.

The four "soft" elements viz shared values, skills, style of leadership and staff on the other hand, is harder to describe, less tangible, and more influenced by organisational culture. But they're just as important as the hard elements if the organization is going to be successful.

Shared value:

As the CBPHCPproject is the part of the hospital outreach programme it shares the vision ofMCH" *to show the world the love and glory of God through the healing ministry as shown by Jesus Christ*."It also shares the mission of serving the people of Santhal Pargana and surrounding areas especially poor and needy by providing best possible medical care under rural setting, community health service, training for nurses and other healthcare workers, spiritual ministry, to witness Christ and proclaim the gospel so as to glorify God.

The shared values are respected by all the staff but with the change in socioeconomic and politicalcontext and improvement of the government healthcare system,it will be increasingly difficult to keep it together the social development and the spiritual aspect together.

Strategy

Formation of community-based organisation at the village level is visible but this is not functional in all 90 villages. There are 3 Peoples organisation in 3 clusters. Peoples movement is the strategy of developing CBO and PO with multi stakeholders, but this is yet to take place. The main reason for this is the structure of people's institutions the community level. There is no evidence of any strategies of involving the men and farmers or the youth as a part of community collectives. There is some representation ofmen,but it is not uniform.

From the data collected on health we find activecollaboration with ASHA workers and ANMs, in addition to developing village health plans, counselling lactating and pregnant women. We do not find dynamic health data tracking on immunization and vaccination of children. The awareness of women in more onanti-natal care but not much on post-natal care.

The strategy of community-based organisation be linked with village health nutrition and sanitation committee is visible only in in the villages where thevillage health plan is developed.

The component of WaSH is only to the extent of accessing toilets and tube wells, but behavioural change aspect of safe drinking water and sanitation was not seen. Due to the Swaach Bharat almost all the villages have toilets but open defecation is not reduced uniformly and toilets are still used in many locations for storing cattle feeds.

The last strategy of people's organisation being used for policy change and policy formulation remains yet to be initiated.

Structure

As per the structure the legal project holder is NELC, the project contact person is the medical Superintendent.The governance of the project is handled by the Project committee which comprises of seven members from NELC, Dumka diocese and from MCH including the moderator and the secretary of NELC. The chairman of the PC is the Medical Superintendent and the Project coordinator is an ex –officio member. The financial control of the project is by the hospital management and the hospital medical superintendent is the main signatory with another doctor as the co signatory. The current decision making and management process follows the rules and regulations of the hospital. There have some instances of delay fund flow since the fund comes first to the FC account of NELC, then gets transferred to the FC link account of the MCH.

The PC members attend all the meetings but most of them are health care professionals, administrators or principals of schools. There are no development experts in the PC anda thus a potential dearth of expertise on the various development interventions. The PC members reported that they receive the reports and the plan and take full ownership of the project.There is no written down document covering the functions, roles and operating procedures of the Project committee.

In the current structure there does not seem to be an effective governance and management separation. For anefficientstructure governancecan be separated from the management team so that there is more directional accountability and better governance.

For project operation at the community levelfollowing structure is followed. Project Coordinator,ProgrammeOfficer, Accountant,and four Field Supervisors whooversee 19 Community Organisers, each supervising 3-8 villages each.

At the project level, operation is through four clusters. In Benagari cluster there are 11 villages and only two female community organisers, in Tilabani cluster there are 31 villages and nine community officers of which seven are females and two males. Molpaharia cluster has 29 villages and four community officers of which three are female and one male and Kalapani cluster has 19 villages and four female community officers. The numbers of villagesper community officers is not uniform and this sometimes hampers the work and interventions. The lack of adequate combination of male and female community workers might have contributed to the lack of involvement of the male stakeholders at the community level

System: Organisational systems are divided into programme, finance, and communication systems

Programme monitoring system

Planning Monitoring and Reporting process: Good formats has been designed by the project for the monitoring the project interventions. Some of the formats like leadership matrix, CBO matrix are very effective for tracking the progress of the intervention. But utilization of the information from these formats for decision making in project implementation has not been effectively done.

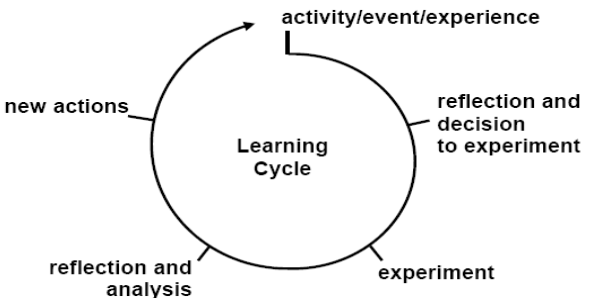
CBPHCP has systems of collating data from village level, cluster level and community level meetings for continuous information gathering every month. Meetings are being conducted as per the plan but generation of issue specific data for community mobilization is lacking.Despite having data at village and cluster lever the staffwere unable to formulate the issues based on data.The data which should be a part of the management information systems is not used for decision-making process nether at the management or as the community level. There is no mechanism designed to feed back the information generated out of data base for community mobilization.

The table below reflect the type of reports and the end use by each staff

Staff	Type of Data and reports done	End use
Community Officers	1.Monthly Report 2. Monthly Plan 3. Health Tracking sheet, 4. CBO Strengthen, 5. Case Study 6 Quarterly Monitoring Survey.	Capturing achievement, Challenges,
Field Staff	1. Monthly Report 2. Activity Report, 3. Tracking Sheet (Grievance, CBO Strengthen, Stake holder meeting, Advocacy meeting, Discrimination Report, Recommendation report.) 4. Case Study 5. Monthly Quantity Report. 6. Quarterly Monitoring Compilation data.	Analysis on Progress, Achievement,
Programme Officers	1.Monthly Compile Progressive Report, 2. Quarterly ,3. Activity Tracking Report, 4. Health Data 5. Social Security Schemes Data 6. Compile Case Study. 7. Quarterly Compile Monitoring data	Analysis on Progress, Achievement, Challenges&Monthly Strategic Plan
Project coordinators	1.Half yearly & Annual Donor Report,2. Half Yearly & Annual Finance Report	Analysis, Strategic Plan, Donor Compliance Budget Tracking&revision

For any learning organisations, there is a growing realisation that organisational effectiveness is positively correlated with the ability to learn from experience. This insight is of relevance for the development sector, as entities dedicated to social economic and transformative change, they predominantly function as the natural open systems, where performance is very dependent on and sensitive to instability and rapid change in the external environment.

The project as a practise of going through learning appraisals which is an annual event.



But the learning and the reflections of the same is not incorporated or practises.

CBPHCP while evolving its own PMR and learning systems could study various learning models and adapt the most suitable. The diagram shown is one such learning cycle diagram which may be suitable (not a prescriptive) for CBPHCP

Finance system

The project management approach and tools have made a difference to the management of MCH. One such example is the use of Tally to computerise the accounts which was done first in the CBHCP project and is now being introduced in MCH

The use of a separate auditor and also changing of auditors every three years for CBHCP accounts, is also a good practice followed. The finance department lacks documented policies and operational guidelines for financial controls, checks and balances, etc. There is a need to have policies related to procurement, anti -fraud and anti -corruption which is part of the due diligence of the DIGNI/Normisjon and critical for a robust finance system. Few samples policies have been prepared and presented by the coordinator to the PC but these polices needs to further strengthened with SOPs for routine implementation.

Coordination system

Following tables reflects the coordination system that is followed by the project

Sl. No.	Meeting	Frequency	Participants	Functions
1	Donor meeting	Yearly	Moderator, Secretary, Medical Superintendent, Coordinator	Due diligence, Donor Compliance
2	Project Committee	Quarterly	Moderator, Secretary, Medical Superintendent, Principal Nursing School, Mr. Christopher Soren(Central Coordinator),Coordinator	Quarterly Progress, Annual Progress Review & Quarterly Financial Review, Staff recruitment, Review on Polices
3	Staff meeting	Monthly	Coordinator, Program Officer, Accountant, Field Supervisor	Review on achievement, Planning & budgeting for next month, Review & Analysis.
4	Review Meeting	Monthly	Program Officer, Field Supervisor & Community Organizer	Report collection, Monthly review at cluster level, Monthly progress, Target setting.

But while doing an exercise of how they visualize the communication system the envisioning exercise by the staff reflected communication as

- Selective
- Partial information
- Many barriers and challenges which reduces the space of communication
- Single leader and gaps with team and leadership.

The communication gap related issues were also shared by the project coordinator and that is has sometimes led to mistrust and discontent.Having a proper communication process and documented and transparent HR policies with proper line and reporting functionscould reduce some of these.

Style and Culture of leadership

There are three leadership teams involved with the project. First, the NELC Synod leadership comprising of the Moderator and the secretary, second, the Hospital team under the leadership of the Medical Superintendent and third the project leadership comprising of the project coordinator. At all levels the leaders are new. This gives theman opportunity to develop a new culture of dialogues, discussion, and a space for coming together.The CBHCP, especially under the present coordinator, has been able to develop a good rapport with the Church and the hospital leadership.

Leadership of the hospital is left to medical people primarily and there does not seem to be a multidepartmental leadership team. If the health care work must be repositioned, and comprehensive community engagement is to be continued, there will need to be a leadership team that comprises of Medical, Nursing, Administrative and Community department leaders, who will work and plan together for the change management process. A revisiting of the leadership structure will be required.

Staff and Skill

Human Resource at the project level

- The **Project Coordinator** is a theologically trained and has immense Programme implementation experience at various capacities. He is heading the project since 2015 immediately after the change of organizational perspectives.
- The **program officer** has years of experience in the field of movement building and associated with the project since 2014 during the process of shifting of perspectives.
- The **Accountant** has both programmatic and financial experiences with different project. Shifted from the RD project in 2015.
- There are **four field officers** with the project out of them twowere engaged with the other project of CBPHCP called RD. Therefore they have good knowledge of field and the problem. However, the right based perspectives are quite new for them and all four staff has no degree on social development. The motivation level of the staff is very high and there is a sense of calling to work for mission and to work for the Santali community.
- The 19 **community organizers**are thebiggest strength of the project. They all have years of experience of community organization. The strength is that they are from the community and working for their own community. They have adapted the new approach very well and understand the inherent value of movement building and the importance

The provisions for staff capacity building have been used well and have had an enormous impact on the hospital and its sustainability. It is rare to find, in a mission hospital like MCH, such a good exposure of a range of staff (medical, nursing, and to some extent administration) to external inputs – conferences, workshops, short and longer training programmes. The investment on the knowledge, competencies, and perspectives of these staff is significant, but this is not much reflected in their work.

There is also a high level of staff turnover among the middle level especially among the field supervisors. This level is presently the weakest structure, the role of the FS is mostly in delivering information and resources to the COs and in turn bringing back data from the field. The role of the FS could further be diversified, they would be based in field rather than in office. Their linkages with the govt office bearers and with other dept or other NGOs are also very weak.

Efficiency

Efficiency in terms of organization's leverage on mobilizing capital and resources including skill and capacities of human resources over the last 3 years

Skill and capacity: During the project intervention period effort was given on enhancing the staff and the management capacities for better operations and efficiency some of the training the staff went through in the last three years (2017-2019)

Sl No	Name Staff and Management	Designation	Training received
1	Mr. I. Murmu	NELC Secretary	1. Course on NPO Governance Program 2019
2	Mr. Marselius Hansdak	NELC Treasurer	1. NGO Finance Management EFFICOR 2018
3	Dr. P.E. Soren	Medical Superintendent	1.Diploma in Finance Management 2016 FMSF 2. NGO Financial Management training &Accountability -2017 3.Organizational Leadership for twenty first Century -2015
4	Dr. (Mrs.) M.Tudu	Medical Officer	1.Diploma in Finance Management 2016 FMSF 2. Leadership& Change management-2015
5	Mr. Cecil Hembrom	Project Coordinator	1. Healing Ministry CMAI -2016 2. ProjectManagement 2017 EFFICOR, 3. Diploma in financial management

			training. 2019 FMSF
6	Mr. Nathaniel Hembrom	Program Officer	1. Monitoring & Evaluation 2016 2. Effective documentation & report writing EFFICOR 2017 3. Healing Ministry CMAI 2018
7	Mr. Jolen Soren	Accountant	1.NGO Finance Management 2018 EFFICOR, 2. Healing Ministry CMAI 2018
8	Mr. Bikram Baskey	Field Supervisor	1. Social Worker Training EFFICOR 2018
9	Mr. Niculash Hembrom	Field Supervisor	1. Social Worker Training EFFICOR 2019
10	Mr. Priyaranjan Murmu	Program Officer(Stone Quarry)	1. Monitoring & Evaluation 2016 EFFICOR

It was revealed that many staff who was given capacity building from the project have even got better jobs mostly in government sector. Linkage with these staff is not much visible with the project, this linkage would have been very important for the visibility and widerliaisoningof the project.

The management team trained also felt that they could not handle the audit and other statutory compliances related to FCRA efficiently since requirements are fast changing.

Organization's efficiency in networking, engaging with other, reaching its voices out to overall health ecosystem?

Presently the project has only Normisjon /DIGN as the main Foreign funding sources. Apart from that the project has not initiated any other sources. At the intervention area there are various agencies like PRADAN, CATHOLIC AGENCIES, LWSIT working on livelihood and various other issues. LWSIT is working in stone quarry affected community and one of the partners for the project is MCH. But we do not see much collaborative action between CBPHCP and the MCH LWSIT programme. There were no campaignsas joint ventureswith other partners, observed within the project time frame.

Strengthening mother and child related health care system

CBPHCP tried to develop working relationship with the ANM, ASHA but the relationship is limited to collecting information from the ANM and ASHA and involving them in few training programmes.

Name of the Organization	Year of Engagement	Purpose of Engagement	Issues Address
District Health department Govt. of Jharkhand	2017	To improve health condition of mother & child health Community get more health services Empowerment on health care facilities	Improve ANC/PNC Recognized Institution Delivery Minimize mortality rate Govt. facilities
Lok Prerna Non Govt. Organization	2013	Empower community on MGNREGA scheme for job opportunity.	Minimize unemployment Create assets

The Hospital on the other hand have linkages with CMAI and EHA which has helped the hospital and the project on capacity building, information related to compliances andin hospital management.

The hospital had previously had affiliation with CMC Vellore, but this connection has not been revived in recent years. As per information provided, the hospital management is taking efforts to revive this relationship.

Impact

The impact of the project will be seen from the context of the project outcomes of the LFA See Annexure 3

Outcome

- Out of the target of 40 CBOs and 3 POs CBPHCP have two fullyfunctional POs and 20 CBOs at their intervention area
- The target for three years for the right holders to avail government schemes was 6508 out of the target 1083 could avail government schemes leading to a 16.62 per cent
- 1389 Target community are receiving quality mother and child health care services which is 88 per cent of the target achieved

The number target for CBOs was not fulfilled and there is a deviation, most of the CBOS requires more handholding, they are still interdependent on CBPHCP volunteers

The target achieved in health is much appreciable than the target achieved in availing government schemes

Output level One: CBOs and POs are claiming rights

- Out of three POs the CBPHCH as two POs with proper structure, issue identification and agenda of action/Charter of demand
- 30 leaders are meeting the duty bearers regularly for advocacy, they are giving deputation, filing RTI and even submitting memorandum
- 25 female and 15 male leaders are trained on gender rights, tribal right to land and identity and strengthened to be able to articulate issues of social exclusion
- 322 members participating in gram sabha proceedings which is 300 per cent higher than projected at baseline
- One Resource support team formed Acting as expert and resource to the available CBOS and Pos to sustain the efforts of CBOS by providing relevant information and keep them organized towards movement building.

Output level two:Mother and child related health care service system is strengthened at community level.

1. 1912birth conducted in a Health facility
2. 849 women and 633 children (Lactating) are able to state at least three danger signs during pregnancy and delivery
3. 1606 mothers are visiting the ANC services which is 95 per cent of the target
4. Out of the 50 village health nutrition and sanitation committee only 19 were formed which arePlanning and Monitoring of their own community health plan and effective utilization of untied fund provided by government in that process.
5. Janani Suraksha Yojna (maternity benefit schemes) are facilitated by ASHA and 679 pregnant women have availed it
6. 170 women with children (Lactating) are aware in area of ARI prevention and seeking treatment from recognized service providers.
7. 88 women and children of the target of 485 are aware in area of diarrhea prevention and seeking treatment from recognized service providers

Output level three: Good governance and management practices are developed at CBPHCP and MCH

- PME and Roles and responsibility of Staffs developed, Baseline created
- Policies like gender, conflict of interest, procurement and anti-fraud is submitted to project advisory committee
- A good practice of learning appraisal and staff appraisal was conducted each year, this helped in timely submission of programme and financial report to the donor
- The staff of CBPHCP as well as the management have gone through several trainings under good governance which helped them towards better management practises
- There has been few instances of cross learning between MCH and CBPHCP especially the nursing units. The MCH staff also participated well during the vision building and planning process of CBPHCP

OverallAnalysis and Trends

Collectivization process: At the community level CBPHCP has 215 SHG group and 82 CBOs. Each village has an average of 6 to 10 SHGs comprising of women from the Santhal or socially excluded communities. Two representatives from SHG goes to the CBO. We do not find any functional farmers groups nor youth groups at the village level. Representation of male in CBO is subjective and selection is done without any criterion. From SHG groups it is usually the secretary and the president of the group who represents at the CBO. There is no representation of youth in the CBO.

Clarity in perspective and process is visible: The CBO and SHG groups can articulate well the functional difference between SHG s, CBO and PO. Many CBOs shared clearly the process of how they identify problem and gather information on the problem and then do advocacy on it . They are able to internalize the perspective of movement building through the rights-based approach and move towards the transformation of the community. All the people met could articulate about identification of issues, organising for the issues asserting and availing for their rights.

Overlapping of approaches and Work of other NGOS and Churches:it is important torecognize that other NGOS and almost six churches like FMBP, Full Gospel, RC, Presbyterian and Pentecostal are working in these areas. Most of them have their own development programs in the same communities. Thedifference inapproaches, churches/NGOsworkingon service provision approach and CBPHCP is working on RBA, have created lack of participation and loss of interest in engaging with CBPHCP.

Leadership Development: The continuous stress on choosing correct leadership and leadership development has led to the emergence of very few dynamic and active leaders who are slowly guiding the CBOs and POs towards a stronger collective. We could see that few women leaders have been encouraged to contest in the current elections and some of them are part of the political decision-making process. While interacting with one such leader one could see the potential of the person to bring change for the community, but the utilization of such leaders is limited to logistic arrangements like calling for meetings or requesting her for a meeting hall. The leaser is not taken as an agent of advocacy for influencing duty bearers.

Table on leadership

Year	Average		Strong		Very Strong			
	Male	Female	Male	Female	Male	Female	Total	Total
2017	6	0	4	0	3	0	13	0
2018	2	6	2	4	0	0	4	10
2019	6	8	0	0	0	1	6	9
	14	14	6	4	3	1	23	19

19 female leaders and 23 male leaders were developed by the project out of which in the all the categories of average, strong or very strong, men have either equal or outnumbered women in leadership. This also indicates that even through participation of women is more, but leadership is still with men , this itself indicate a requirement of gender inequality and patriarchy . Even in number the women are more in CBOs and POs the leadership is still more amongst the male counterpart.

Understanding the power of a collective: One of the major impacts is that the community is recognizing the strength of a collective and that is they are united they can achieve much more. There has been a marked increase in the collective consciousness of the people especially the groups which have matured. They have become confident, vocal and fearless. While there are still a few CBOs who are behind than the other CBOs they are soon catching up and learning from the experiences for others. The exposures given to the CBOS to other State has also helped them to learn from the peer groups

Coverage and selection: The CBOs are covering 82revenue villages out of the 91 villages that CBPHCP isworking . Few CBOs have no representations of men.The selections of the village is as per congregations and not on basis of constituency, so constituency development for larger advocacy would be difficult as in some case a particular panchayat may only have one village.

Lack of follow up of SHG: The CBPHCP has no updated information about the status of SHGs nor it is a part of the regular data collecting process. No information is available about the amount of money that the SHG has nor about the loan it received or the type of group level entrepreneurship the SHG is involved with. The SHGs meets two times a month for the meeting which is usually for saving, lending and some discussion on issues that they have identified at their own level. The CBOs usually sits for meeting once a month further discussion on the issues identified and how to collectively solve it.The SHG groups that were initiated by CBPHCP have been taken up by NGOs like PRADHAN / JSLPS. The community organisers continue to engage in their meetings.

PO to PM: There are three Peoples organisation i.e. at the Benagaria, Kalhapani and Molpaharia Clusters. Peoples organisation meetings are not regular. Out of the two-area visited one area meets monthly and the other area once in three months. There is not much support provided at the PO level by CBPHC. This might have contributed to the inability of to move towards a PM. Most initiatives of PO or CBOS are for submission under RTI Acts. The data from RTI is not utilized for addressing the politics underlying the issue or for collectivizing people on that issue.

Focusing on maternal health:Over last few years, the government havedeveloped strong structures on maternal healthcare with ASHA (SHAYA), AWW and ANM who are regularly available at the village level. The community officers do the same work as that of SAHYA. There are many pertinent issues like alcoholism, adolescent health, HIV transmission related factors, WaSH and factors contributing toanaemia. These are not addressed by the CO. Even though mental health, WaSH are major indicators of the project, there has not much focus. Many villagers suffer from health access and disease related sigma's andaccess the quacks as their primary health care provider.

The impact on the overall context of Dumka

The projects has an outcome of strengthening civil society and right to maternal health. This hasin some ways impacted the context of Dumka. But the contribution of CBPHC as the prime mover in this impact on Maternal Child Health of this regionis difficult to assess. The government

has stepped up the deliverysystems during this period. But the project has reduced the gap between the duty bearers and right holders in accessing and availing government schemes. The direct interventions of the project has reduced extortion from the middle man. The women are accessing facilities from the government in relation to maternal health care schemes. The women's participation in gram sabha has also increased and few women have also contested in elections.

Sustainability

The project goal emphasised on strengthen on-going movements, enabling to develop a critical mass and managing andsustaining social capital, for ensuring life with dignity. Somehow as mentioned earlier, this dream of movement building has not been achieved.

For a project to sustain there is a need explore a few ways ahead.

Donor diversification and resource generation: MCH need to be outward looking in order to tap resources from other funders and partner with other organizations who are working in Jharkhand. MCH will need to build its capacity to diversify donors andneed to develop a donor database.

It is very much essential for the organisation to identify and partner with the government services available for trafficked victims and create linkage with those agencies that are involved in such initiatives.

PO sustainability: the CBO and PO is the natural heir of the project. Much potential is visible in CBO and POs, butthese groups need ongoing support to be more formalized with proper standard operating procedures. CBO assessment and leadership assessments are done by CBPHCP based on the definitions and grading of what is good,average, or poor. But there is a lack of clarity on some of these definitions. There are no proper plans visible to move the CBOS from poor category to a good category. These plans are essential for sustaining a CBO.

Hospital sustainability is a major issue for the project as it has direct impact on the community engagement and the project and the overall healing ministry of NELC. The hospital statics is slowly going down, utilization is dropping due to much improved facilities in the public health care sector and inability to access government programs. There also seems to be work ethics related issues that are affecting hospital utilization. Though it was communicated that financially the hospital is breaking even, with the current numbers and statistics, this may not continue long. Changes in the public facilities and community expectation will continue to challenge the viability of the hospital. In view of this, there is an urgent need to revisit Hospital directions and reposition based on a renewed understanding of the directions.

CHAPTER 5: EMPOWERMENT ASSESSMENT TOOL

Indicators

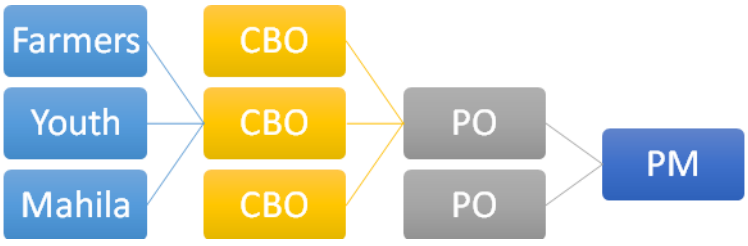
- There is a high degree of organization in the target groups
- Local communities are able to identify and solve their challenges together
- Communities provide equal opportunities for women and men
- Rights-holders are holding duty-bearers accountable
- Local partners have strong capacity
- Churches are mobilizing core assets in development

EAT is a framework for assessing the degree of empowerment achievement in Digni-funded projects. The purpose of the tool is assessing the degree to which target groups are empowered to live life of dignity. The tool may be used to assess both degree of empowerment and level of change, according to set scale. An empowerment assessment of this project answers the following questions:

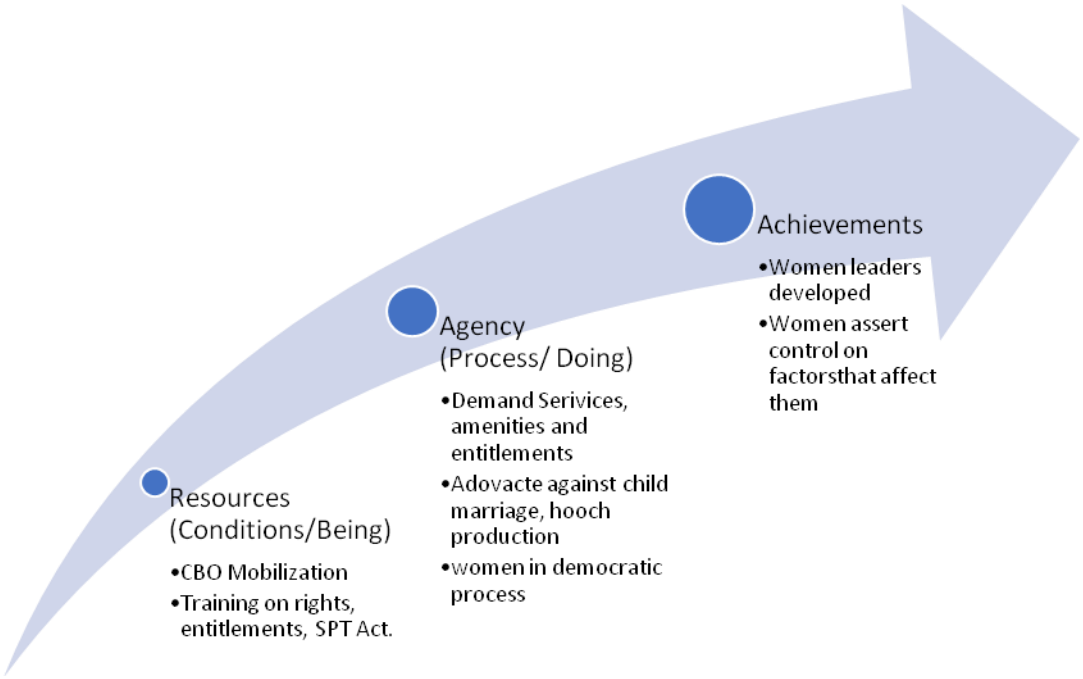
- To what degree is the change in empowerment– at output, outcome, or impact level?
- At what levels is the empowerment taking place: Individual, Community or Society?
- Are there differences in empowerment with regard to "themes/areas of work" in the project?

Strengthening Civil Society

Following is the structure visualised for community mobilization towards people's movement in the project planning.



The composition of the CBOs has been largely members of women SHGs. The participation of youth and male members are negligible due to various reasons including migration for studies and labour. Historically MCH was involved in forming and promoting SHGs which was later taken over by PRADHAN (NGO) which was running the JSLPS project from 2014-2018 as part of government mandate. Now JSLPS is directly promoting SHGs.

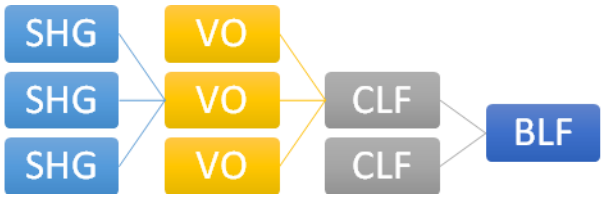


CBO members are trained in rights and entitlements of various social security schemes and Santhal Pargana Tenancy (SPT) Act. Following which

- CBO have demanded services like Road, Culvert, Toilet, construction, Issue of Jobcards (NEREGA), Water Spots – Handpump, implementation of Job guarantee scheme etc.
- There have been also reports of CBO taking efforts to curb the menace of hooch production and stopping child marriage by way of talking to the families concerned.
- Some women were already in the fray for elections in Panchayati Raj (local governance system) 2014 and become people's representative (ward member).

Tribal women standing up and talking to government officers (in some cases to non-tribal officer) and demanding services is an indication of their empowerment. Women also have reasoned out with their male counterparts, who try to restrict them for being vocal and outgoing.

JSLPS works with a vision of socio-economic empowerment for a dignified life[10], their model of functioning is as follows



[10]"Create a socio-economically developed Jharkhand through inclusive growth strategies for empowering the underprivileged members of vulnerable communities/groups, resulting in them leading a dignified life." http://jslps.org/about-us/vision-mission/

VO – Village organisation, CLF – Cluster Level Federation, BLF – Block Level Federation

With the limited participation of Men and youth in CBO the CBPHC model is ending up being similar in structure and competing for time and space of the same women members. At the village level following are the scheduled meetings

JSPLS (2014-2018 through PRADHAN)	CBPHC
Saturdays (x4)- SHG meet (collect Rs.10/month) Fortnightly VO meets, 15th &30th of every month, (Collect Rs.30/month) 5th of every month CLF meets	22nd of every month CBO meets 23rd of every month PO meets

While the additional training through JSLPS adds value to the CBOs, some community members (men including) failed to see benefits in 'capacity building' compared the economic activities promoted by JSPLS.

Church as institution and key stakeholder in the implementation of the project is lost over a period. The interaction is limited to congregation members being part of the CBO and church buildings used for meetings.

Good Health

CBPHC through community organisers (CO) have worked closely with Field Level Health Workers like ANM, ASHA, and AWW in identifying, counselling, and motivating pregnant women for ANC registration. Over the period they have also worked with community in changing perception and dispelling their fear towards immunization, ANC, and institutional delivery. Maternal and Child Health care access have dramatically improved, thanks to the government Conditional Cash Transfer (CCT) schemes.

Jharkhand state has taken remarkable strides in the health sector; Institutional deliveries, which were only 13.5 per cent in 2000, have increased to 80 per cent and complete vaccination has gone up from 9 percent to 87 per cent. In 2019 the state has ranked among top three States in terms of annual incremental performance in health outcomes[11]. (Kerala, Andhra Pradesh & Maharashtra ranked on top in terms of overall performance)

Indicators

- Right holders have access to adequate health services
- Target groups demonstrate knowledge about conditions affecting the health of households
- Target groups openly address stigma related to health

[11] https://pib.gov.in/newsite/PrintRelease.aspx?relid=190737

This region has a history of being endemic to TB and vector borne disease like Malaria, Filaria and Kala-azar (Leishmaniasis). The government has given a lot of emphasis on surveillance and awareness generation of Kala-azar. CBPHC has jointly engaged with NHM (MOIC) to create awareness on the same which recognized and appreciated by the stakeholder.

With regards to TB, it is associated with poverty, overcrowding, alcoholism, stress, drug addiction, and malnutrition. The disease spreads easily in overcrowded, badly ventilated places and among people who are undernourished[12]. This is the prevailing environment in this tribal community and hence the incidence. Lack of expertise in mental health, de-addiction has let to CBPHC avoiding intervention in the sector; efforts of the government also are left a great deal to be desired.

Typhoid is also prevalent as mentioned by the CBO members and MOIC – Shikaripara, which indicates contaminated water or not treated/ boiled before use. As part of the 'Swatch Bharat' most of the households are provided given toilets and declared ODF villages. As mentioned by the CBO members, toilets are not put to use as (there no piped water and) it takes lot of effort to collect water from the hand pump and store it for washing and flushing the toilets. More the members at home, more the water and hence more the effort compared to open defecation.

Evaluation Team Rating

Based on the above discussion and the empowerment scale (refer annexure1) the Evaluation Team rated the level of empowerment and degree of change as follows.

	Level 1 (Output)	Level 2 (Output)	Level 3 (Outcome)	Level 4 (Outcome)	Level 5 (Impact)
	Individual or Community			Community and/ or Society	Community/ Society/ Structural
Strengthening Civil Society					
Good Health					

Field supervisors rating

The field supervisor were asked to rank the degree of empowerment and level of change based on following indicators

[12]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3190550/#CIT115

Strengthening Civil Society

1. Organization of CBO, number of meetings in year
2. Youth representation in the CBO
3. CBO ability to identify their own problem and
4. CBO ability to overcome challenges
5. Women getting equal opportunity in the community.
6. Holding duty bearers accountable
7. Their ability to solve problem and
8. Their ability to create new assets

Good Health

1. Level of access to health services
2. Health awareness and behavior change
3. Ability to address health related stigma

The average ratings of the field supervisors are represented in the table below.

	Level 1 (Output)	Level 2 (Output)	Level 3 (Outcome)	Level 4 (Outcome)	Level 5 (Impact)
	Individual or Community			Community and/ or Society	Community/ Society/ Structural
Strengthening Civil Society					
Good Health					

Project coordinator and officer's rating

The project coordinator and officers were asked to rate based on the empowerment scale (see Annexure 1). According to their assessment the level of empowerment is at 'impact' level and degree of change is at community, society, and structural. Their average ratings represented are as follows:

	Level 1 (Output)	Level 2 (Output)	Level 3 (Outcome)	Level 4 (Outcome)	Level 5 (Impact)
	Individual or Community			Community and/ or Society	Community/ Society/ Structural
Strengthening Civil Society					
Good Health					

Since the perceptions of the evaluation team are developed over short period, they decided to capture the perception of the project staff team as well. While the field supervisors rating and evolution teams are not so different the rating of the Project coordinator and officer was significantly higher.

RECOMMENDATIONS

The end term evaluation recommendations are suggested keeping in mind that when NELC starts a new community engagement the findings and the learning of the last phase can be incorporated.

The interaction with multiple stakeholders clearly indicated that as a church NELC need to continue its community base engagement, though how it might evolve and what should be done, is unclear at this point of time. Given below are few thoughts as potential issues to consider as and when NELC explores the way ahead.

A. NELC at large, governance and leadership related issues

NELC should go for an overall organisational development process, which will help the NELC to redefine and reposition its future of healing ministry and community engagement.

To improve Governance, planning and accountability, NELC needs to develop technical capacity for health and development, and other interventions and governing its institutions. It may be appropriate to revisit governance and management structures so that there is adequate separation between management and governance,

Establishing technical boards, for healing ministry, education and or other themes**,** that can support the management to plan, and reposition and hold them accountable could be a way forward. This board could be set up with technical experts being part of the board.The board should report to the NELC synod and provide directional advice to the synod for its technical areas of community engagement and running of institutions like hospital and Nursing school.

For community-based programs, NELC being the legal project holder, it could appoint a point person with adequate power to monitor fund management and project implementation. At the same time Project committee (PC) should be empowered to scrutinize, monitor and guide the project through field visits and technical people being part of PC.

Policies are required for NELC in terms of handling programme and finance along with standard operating procedures for operations. The members of the synod need to be educated with these policies and procedures to govern effectively.

There should be systems of leadership rotation and building of future leaders.Leadership teams should be set up than individual leadership alone. There should be ways of assessing the leadership team's capacity to lead, reposition, and realign institutions and programs.

A proactive identification of youth for building of next generation of leaders is important for the future of NELCs community engagement, healing ministry and running of institutions. Youth should be counselled and challenged to take up health care thematic areas as career options.

They should be sent for training in various areas of health care themes like Physiotherapy,counselling, Laboratory, pharmacy and various newer areas of training. Intentional leadership development of these young people should be a clear focus and direction. CMC Vellore links should be re-established and strengthened for this purpose.

B. MCH related issues

In addition to the governance related issues, there seems to be an urgent need to reposition the institution.

What seemed to emerge is that the hospital statics is slowly going down; utilization is dropping due to much improved facilities in the public health care sector and inability to access government programs. There also seems to be work ethics related issues that are affecting hospital functions. Changes in the public facilities and community expectation will continue to challenge the viability of the hospital. In view of this, there is an urgent need to revisit Hospital directions and reposition based on a renewed understanding of the directions.

A repositioning exercise, based on studying community needs and expectations, other stake holder analysis, need to be done as soon as possible. Dependence on the current services and way of functioning to bring in more patients or make hospital sustainable does not seem to be feasible.

C. Taking forward the current program and themes

The project has done well in empowering CBOs and facilitating women's leadership in many communities. But It has not been able to support the CBOs to reach a point of becoming a People's movement. There needs to be thinkingon how to maintain the momentum set in and support the Pos, CBOs and empowered leaders to move ahead with the dream of becoming a people's movement and policy level engagement.

The project seems to have made quite a bit of headway inareas of awareness generation on various rights and entitlements, The CBPHCP have mostly organized women and formed community-based organisations, and these CBO are accessing and availing schemes and entitlement related to livelihood and health. But most of the CBOS are not addressing critical issues related to their identity be it of food, livelihood, land. The CBOS are also not inclusive in nature. It is recommended that the CBOS become more inclusive involving youth and farmers. Their capacity should be built to address issues related to identity as a larger community.

CBPHC had laid foundation for well-functioning SHG at the community level where women had easy access to microcredit. Representatives from these SHGs are part of the CBOS, but project has stopped handholding these SHG groups. It is recommended that any new initiative keeps up relationship with the SHGs and support the women to take loans to start their own business and increase their economic status.

Some women who were community officers have contested for panchayat elections,many staff who left are employed with NRHM and JLM, but the project has not actively kept relationship

with them. It is important to keep the relationship with these and other such community leaders who in turn can help in community-based health development initiatives.

The project missed to focus on gender issues, and this is a concern which need to be considered. Many issues like gender-based violence, discrimination and inequality is not in the purview of the current project. Future interventions will need to have a clear positioning on gender and related issues.

D. Looking at emerging issues

The focus on marginalised groups, Tribal, Adivasi and Malpaharia community should continue. At the same time, there should be focus on Youth and men in addition to the traditional women's focus. For exploring a new community engagement, a envisioning exercise, based on studying community needs and expectations, other stake holder analysis, need to be done as soon as possible.

The emerging and felt needs expressed by the community include, Mental health and Alcoholism, Child rights and EducationLivelihood focusing on Entrepreneurs training, Skill development, and developing New Leadership from the younger generation.

E. Approach wise changes that might be required

The program though it was planned as a congregation-based engagement, it turned out to be a standalone project run by the hospital.

There is a need to revisit and explore newer and innovative methods of engagement with the active participation of the church alt large, than the structures and systems followed in the last decade

There should be a focus on congregation-based planning and development and implementation of the project. Inclusion of the church leadership in developing theological understanding of the community's challenges and community-based engagement and biblical teaching based on these might help in ownership by the leadership of the congregations.

Any new interventions should be planned with intentional and proactive partnership with local NGOS and otherlocal churches. There should be alsoa convergence approach for many programmes especially for entrepreneurship development.

There should be operational links with block and district officers specially the departments related to health, education and livelihood. The NELC staff should participate in NGO forum and district health department review meetings held at the block and district level. This will help in relationship building and getting a grip of ground realities and states directions for the issues community is facing.

F. Management systems that need to be investigated

For programme and financial management, there is a need to have operational guidelines. These should include financial checks and balance, conflict of interest and procurement etc. Appropriate HR policies and statuary compliances (PF & ESI) should be explored and set up.

The data from the project need to be analysed and used for future program development. NELC should develop an MIS for the NELC, community interventions and its institutions.

There is a need to have a clear conceptual position statements and operating procedures for all themes of engagement. For e.g. the position papers on health, livelihood, civil society, gender and other themes. Terminologies like campaigns, people's movement, strengthening civil society are commonly used by the staff, but each person has different understanding of the same. There need to be a proper glossary and shared common understanding for all the terminologies used by the project and project staff.

G. Concluding section

The Santhal communities are in a critical season, whereby their many identity-based issues are being challenged. The church at large, is struggling with lack of younger generational leaders, and issues related their identity as a faith community and Kingdom character.

Three critical issues that can transform the church and communities are that of building a community of faith through intentional discipleship with Kingdom values, leadership development from the younger generation and congregational capacity building for addressing specific issues affecting the community. NELC with its presence in the district can make great impact if these issues are proactively addressed.

ANNEXURE 1: EMPOWERMENT SCALE

Empowerment scale

Below we have provided definitions or characteristics of each level in the assessment table:

LEVEL 1 (Output):

Resources:	have increased, been provided by project to individuals and/or community and/or other target groups
Agency:	No demonstration of target groups having changed their behavior or *using* resources to act.
Achievement/Results:	There are no documented changes in target groups situatio

LEVEL 2 (Output):

Resources:	have increased by project to individuals and/or community some local resource mobilization.
Agency:	Target groups tell that they have gained "power within", increased their self-esteem, and/or have changed perspectives. Still little change in behavior and signs of agency.
Achievement/Results:	There are few documented changes in the target groups' situation.

LEVEL 3 (Outcome):

Resources:	have increased by project to individuals and/or community and/or other target groups. There might be some local contribution of resources to the project.
Agency:	Target groups show that they have gained not only individual power, but also some collective agency, the "power with". There are some documented actions.
Achievement/Results:	There are documented changes in target groups' situation.

LEVEL 4 (Outcome):

Resources:	have increased, been provided by project to individuals and/or community, and/or local resources are contributed.
Agency:	Target groups show that they have gained not only individual power, but also collective agency, the "power to" act. There are documented community/target group action.
Achievement/Results:	There are documented changes in the situation for direct and immediate indirect target groups. There are indications of results at "structural level" for instance stakeholders such as local government and/or others power elites are providing some resources or changed their behavior/practice to some degree.

LEVEL 5 (Impact):

Resources:	have increased, been provided by project, and/or local resources are contributed, and/or provided by stakeholders.
Agency:	Target groups show that they have gained collective agency, the "power to" act, but also some "power over". There are documented community/target group action.
Achievement/Results:	There are substantial documented changes that most often goes beyond improvement of the situation for the direct target groups. The changes are often perceived to be sustainable and results are often at a "structural level". There might be multiplication effects and adoption of project methodology by others. Examples may be change in norms and harmful traditions, policies and laws; Stakeholders such as local government and/or others power elites are providing increased resources or changed their behavior and institutional practice.

ANNEXURE 2 NELC WORKSHOP SUMMARY

Along with the evaluation, the evaluation team and Dr Shailendra Awale, spent a day with the NELC leadership team.

There were two broad objectives for that day. The first objective was to reflect together on the future of healing ministry of the church. The second objective was to reflect and learn from the evaluation findings and explore how this will impact their ongoing engagement in health and healing ministry.

The participants included the NELC church leaders, (The Moderator, One Bishop, Secretary , Treasurer, Central coordinator and few other staff), the Hospital representatives (3 doctors, nursing principal, faculty and staff representatives,) Staff of CBPHCP, Dr Shailendra Awale and the External evaluators.

A. Introductions and objective setting

After prayer by the Moderator and welcome from Dr Pradip Soren, Dr Shailendra Awale shared the history and background of the project, and various timelines over last 20 years. He gave an overview of the original project, where hospital strengthening was one of the objectives along with reduction in maternal mortality and MCH becoming a hub of partnership for broader engagement in health and healing ministry. The three approaches included leadership, systems development and infrastructure development.

The current PHC project, its evolution and the various phases and some of the key learnings were also shared. He concluded the session with challenging all to reflect on the future of our engagement with the communities and the larger picture of healing ministry over the days various sessions.

B. Reflection session based on Biblical foundations

Dr Santhosh Mathew using John 8 and 9 as the basis, reflected on Jesus model of health and healing and community engagement. The Bible study brought up 4 issues as foundations and raised 4 questions for the group to reflect on. The foundational issues being

1. The question of Identity - who are we, does our life and character communicate our identity as Kingdom citizens (Tribal vs Christian or Kingdom citizens?)
2. The Mission – being true to our mission of noticing the un-noticed and the poor
3. Asking the right questions to understand the emerging needs and context around us
4. Doing things differently - Courageous, innovative, and tradition breaking engagement like Jesus

The four questions raised for reflection were

- How do we build and strengthen the lifestyle and character of each of us and our communities as citizens of God's kingdom?
- Will we hold true to our Mission amid the challenges around us?

- What does it mean to us - Recognize the context, ask the right questions and discern Gods purpose and plan for such a context?
- How can we do things differently to facilitate transformation, reveal Gods heart and facilitate reflective communities?

As a continuation of the reflection, Dr Shailendra asked the group to consider and reflect on the context 20 years ago and correlate it to the context faced by their children today.

The reflections are summarized below

- We were well rooted in theology and connected to each other by the Bible, but today this has been lost
- There were less opportunities for children and less demands from them, now there are more opportunities and much more demands
- In earlier days we would submit to parents, but today communication between parents and children are lost and there is blame passed on between parents and children
- There was a shared understanding on various issues as a church and Christian community. This has eroded and there is hardly any shared understanding.
- There is much more peer pressure, pressures from the context around and hardly much internal strength to hold on for parents and children alike.

Subsequently the group reflected on the four questions rose during the bible study and came up with thoughts on NELC at large. The same is summarized below.

1. The question of Identity - who are we, does our life and character communicate our identity as Kingdom citizens (Tribal vs Christian or Kingdom citizens?)
   - We are a faith community
   - We have become very selfish; we are thinking of ourselves and weneed to change based on what the bible teaches us
   - Change being selfish to consider the issues facing the larger community and people groups
   - We invested so much on ourselves and forgotten the bigger mandate
   - We have isolated ourselves from others
   - We need to get back to the biblical principle of "seek first the Kingdom of God and all these things shall be added to you" and believe this and live by it
   - There is the lack of discipleship in our life and we need to rebuild a community of faith
   - We need to make Jesus as our model

2. Will we hold true to our Mission amid the challenges around us?
   - We need to be committed to our goal
   - We need to communicate our goal and mission with others
   - We should network and cooperate with others who have similar goals
   - Demonstrate our mission through our dedicated services
   - We should develop good teamwork
   - We should revisit what we are doing, we should consider if we are doing the right things and have a system of regular analysis and follow up on issues,
   - Our administrative systems should be strong and good.

3. What does it mean to us - Recognize the context, ask the right questions and discern Gods purpose and plan for such a context?
    - Our overarching purpose should be - John 10:10, to work for "life in abundance"
    - All around us, Life is being abused but our mandate is to affirm in fullness.
    - We are created in God's image, we are the true citizens of Jharkhand, but we are abused, and our space is claimed by others and this situation is very disturbing.
    - We should hold on to the sovereignty of Lord
    - We need to build and grow ourselves as a Community of Faith

4. How can we do things differently to facilitate transformation, reveal Gods heart and facilitate reflective communities?
    - We need to assess the ministries of the church, hospital community, to understand who is being benefited
    - Reflect and reveal in our daily life the kingdom values and we should be witnesses
    - We should Make Jesus as the role model
    - Our work needs to demonstrate the Kingdom character
    - We need to share about salvation and communicate the gospel
    - We need to be merciful
    - We need to change our attitudes
    - We need to build good fellowship
    - Our lives should be a living sacrifice
    - We may need to do things differently from what we are doing now

It was also emphasized that as we consider change the following core issues cannot be compromised.

- Our identity and character as a Community of faith/Kingdom people
- Focus on marginalized and vulnerable
- Holding on to our vision
- We cannot continue to do as we have done - We will need to change the methodology by which we do things

C. Organizational and personal life cycle assessment

Dr Shailendra shared a presentation on Organizational life cycle and asked the participants to reflect on where they are individually, and their organization on the organizational life cycle graph. He helped the participants to reflect where they are in relation to the organization in the life cycle map, and then how each of them can be a change agent.

He challenged those who are ahead in the cycle that theycan change the course of organization. He challenged those who are lagging behind the organization to reflect on their own journey and improve themselves. He also challenged the groups that even if you and your organization are mature, you need to reinvent both.

The participants also were asked to reflect if they are holding on to the larger Kingdom Vision or narrow institutional vision or a self-focused personal vision.

D. Understanding the larger context

Through a short presentation Dr Shailendra shared the larger context challenges that are affecting the nation and community at large.

The presentation covered global changes, national changes, Jharkhand and local and tribal community level changes, from socio-political, economic, religious and ethnic perspectives. He also shared about the challenges and changes in NGO sector, the expectation from the government and changing regulations. Similarly, the fast-changing health care scenario, access related issues both national and local were highlighted, reflecting the challenges our health and healing work would face with these changes.

He shared 2 stories of repositioning exercises at 2 locations and challenged the participants to learn from these.

E. Project evaluation key findings

The evaluators summarized the key findings of the evaluation through a presentation and shared pertinent issues emerging from the presentation, are given below.

1. Wide and broad-based vision of the program plan while at the field level the vision is limited to completing the activities.
2. Lack of multi-generational and inclusive (men and women) leadership. Leadership in the CBOs which is now mostly limited to women, who may not have the potential of creating larger impact on policies.
3. Context and culture-based issues seem to be impacting the overall outcome of the program.
4. Governance level challenges of ownership and vision, Challenges from institutional structures impacting the project, Structure and the challenges and its impact on the larger community.
5. Fund flow and other management related issues that affected project activities and cycle.

F. Concluding reflective planning session

The participants spent time, reflecting on 4 questions regarding the future of NELCs community-based engagement. The questions and the responses are summarized below.

1. Should NELC continue to engage with community at large?
   - All the participants were clear that NELC should continue its community-based engagement.
2. If NELC should continue to engage with community, which community?
   - Youth and young generation
   - Tribal communities, excluded communities, Adivasi, and women
3. On what issues they should focus
   - Spiritual Growth of communities
   - Alcoholism
   - Education
   - Employment generation and livelihood
   - Leadership development – from the younger generation
4. What new ways of engagement can you consider for addressing above issues
   - Lay persons engagement in decision making process
   - Develop a Lay persons-based resource pool
   - Counselling for the parents
   - Vocational bible study
   - Partnership with similar stakeholders
   - Pool of resources with shared values
   - Conscientization process for addictions and other issues faced by the community
   - De addiction centers
5. Other issues that were identified are given below
   - There should be a system for Policy analysis

- Review of the present organizational structure
- Need to focus on Entrepreneurs training
- There are pockets where we need to create health care awareness
- We should create a platform where different groups with different abilities should come together

In summary, it was felt that the key issues are that of discipleship, leadership development from the younger generation and capacity building for addressing specific issues affecting the community. At the same time issues as Alcoholism and building up families have to be addressed. It was also felt that NELC at large has strength within its members to address many of these issues.

G. Personal reflections

The day ended with sharing of personal reflections from the day's proceedings, which is summarized below.

- It was a good time of understanding the real output of what changes happened in the project,
- Was reminded of the values of cultural practices
- Kingdom values were reinforced, and refocused
- The need of working together for overall church development in a spirit of cooperation
- We are not uniform, but we should work towards the unity and respect our diversities
- Why are we here and what is my calling, why am I called and for what? We need to reflect on the purpose again and again
- My potential or our potential can be used, and we can take this church to the right position. this recognition of potential and this affirmation can change the church
- We need to create a forum to take these things forward
- What is next and who will carry this forward is a question
- Who will own all these discussions?
- We need a revival in the church and community
- We need to think of meeting again and we need to continue this discussion
- Behold God is doing something new with a new energy
- We lack Due diligence and Policies, and this must be addressed

The day ended with prayer and benediction and vote of thanks form the NELC team and the Evaluators.

ANNEXURE 3 COMPILED LFA DATA

Expected Results (Outcomes & Outputs)	Indicators (with Baseline and Indicative Targets) & other Key Areas to Monitor	Base value as per Baseline	Target 2017-2019	Value Year 2017	Value 2018	value 2019	Total	percent
Outcome: Active, functional and sustainable community-based organizations, (POs, CBOs, and SHGs) representing the socially excluded in Shikaripara, Dumka and Ranishwar blocks, empower communities to claim and access existing governmental and primary health care and social security services.	1. 40 CBOs and 3 POs are raising issues and demanding for their rights	6 CBO& 1 PO	40 CBO 3 PO	10	8 CBO & 2PO	2CBO & 2 PO	20 CBO/ 2 PO	
	2. Govt. Programmes and schemes benefitting 90% of the target community	4965	6508	311	410	361	1082	17%
	3. 80% of the target community are receiving quality mother and child health care services at a health facility	789	1578	342	567	480	1389	88%
OUTPUT 1: CBOs and POs are claiming rights and hold duty bearers accountable and social security entitlements are availed by socially excluded community.	1. 3 POs exist with a proper structure, issue identification and agenda of action/Charter of demand	1	3	0	2	2	2	67%
	2. 40 CBOs and 3 POs are meeting with the duty bearers with their agenda	6 CBOand 1 PO	40 CBO 3 PO	10	10	10	30	
	3. 70 CBO leaders out of which at least 50% are women are trained and strengthened to be able to articulate issues of social exclusion	12	70	13	7	20	40	57%
	4. 100 CBO members participating in gram sabha proceedings	12	100	28	245	49	322	322%
	5. 90% beneficiaries Availing Govt. Schemes	4965		311	410	361	1082	347.91
	6. Resource support team formed	0	1	0	1	0	1	100%

OUTPUT 2: Mother and child related health care service system is strengthened at community level.	1. 86% of birth conducted in a Health facilities	1065	6161	806	626	480	1912	31%
	2. 75% of women having children (Lactating) are able to state at least three danger signs during pregnancy and delivery	691	1480	314/165	292/208	243/ 260	849/633	
	3. 85% increase in 4 ANC conducted by health providers	888	1677	621	567	418	1606	96%
	4. Janani Suraksha Yojna (maternity benefit schemes) are facilitated by ASHAs for 53% of eligible women	552	1045	342	197	140	679	65%
	5. 50 Village health nutrition and sanitation committee will develop Village Health Plan	0	50	0	9	10	19	38%
	6. 70% women with children (Lactating) are aware in area of ARI prevention and seeking treatment from recognized service providers.	430	547	113	23	34	170	31%
	7. 62% women with children(Lactating) are aware in area of diarrhoea prevention and seeking treatment from recognized service providers providers	196	485	39	29	20	88	18%
OUTPUT 3: Good governance and management practices are developed at CBPHCP and MCH	1. PME system and roles and responsibilities for staff & Gender policy available	1	4	> 2017 -2(PME Developed & Roles and responsibility of Staffs developed) > 2018 - 1 (Conflict of Interest Policy submitted for review) > 2019 - 2(Procurement and Anti Fraud Policy submitted for review)			5	
	2. 1. Indicator based programme report and 1. Financial compliance report prepared and submitted on time	0	0	>2017 - Annual and finance Report for the year 2017 submitted on time. >2018 - Half yearly finance report submitted on time, >2018 - half yearly program report was submitted late >2018 - Annual report for the year was submitted on time. > 2019 - Reports we submitted in time				

	3. Increase in activities that ensure participation of MCH staff in CBPHCP (qualitative increase)	0	0	>2017 - All categories of MCH staffs participated in this process and significant inputs were provided in the study. > 2018 - Nil > 2019 - Significant Participation of MCH staffs in the process of Evaluation		
	4. 3 staff have acquired expertise in their selected subject	0	3	>2017 - 2 (Project Coordinator on Project Management and Program Officer on Effective report Writing) >2018 - 2 (Field Supervisor on Course on Social work and Accountant on Financial management of NGO) >2019 - 1 (Field Supervisor for the course on 15 days Intensive Social Work training.)	5	