**OVERVIEW**

‘Supporting Civil Society Movement towards Right to Free Public Health and Education’ is being implemented under Oxfam India’s (OIN) thematic priority area of Essential Services. This is one of the four thematic components proposed by Oxfam India for 2010-15. It contributes to OIN’s aim of creating a more equal, just, and sustainable world. The over arching vision of Oxfam India is ‘right to life with dignity for all’. The Change Goal for this priority area (Essential Services) is – to create a society where people living in poverty, especially women and girls, will realize their rights to accessible and affordable health, education and social protection.

The project aimed to strengthen capacity of Civil Society Organisations (CSOs) to monitor implementation of public health and Right to Education (RTE) in 60 villages in three districts (Gumla, Hazaribagh and West Singhbhum) of Jharkhand state. The project was of three years duration starting in 2011. In the last year of the project, OIN intended to assess the process and results through independent evaluation.

The purpose of the evaluation was to conduct a review of achievements made over the project period of three years (2011–2014) in order to understand the extent to which partner Civil Society Organizations (CSOs) have implemented the project and have been able to make sustainable impact based on the proposed objectives and outcomes, and the lessons therein.

The three partner CSOs are- Child in Need Institute (CINI) in Gumla, Society for Participatory Action and Reflection (SPAR) in West Singhbhum, and Nav Bharat Jagriti Kendra (NBJK) in Hazaribagh.

**METHODOLOGY**

The evaluation of the project progressed in a three pronged way: strategize, evaluate and charting the key outcome indicator (refer figure below).

Evaluation design evolved in 2 stages – pre field visits and post field visits. The process was initiated by undertaking Outcome Mapping exercise. This included identification of boundary partners (direct stakeholders who have a role in achieving project results) and their progression markers. Based on the feedback from pilot testing, the stages of progression for each of the boundary partners were identified as per their potential degree of participation/potential role they could play in the project. The stages of progression thus identified were used as guiding criteria during data collection.
Boundary Partners

**Community Based Organisations (CBOs)**

1. Attending initial meetings
2. Aware about the issue
3. Regular in attending meetings
4. Informed about their rights and responsibilities - along with the provisions
5. They identify the issue and suggest solution
6. Take action
7. Get more information as they face difficulties with solutions
8. Positive change

**Front Line Workers (FLWs)**

1. How they are doing their duty? Is there any change after getting associated with the project?
2. Capacity Building and by whom?
   a. How did this help them?
   b. How much did they share with community?
   c. Help from the community.
   d. What positive change do they think has taken place?
   e. Difficulties faced
   f. What more support is needed?
3. Networks

**Seven Building Blocks**

1. Sensitization
2. Collectivization
3. Collective analysis
4. Prioritization
5. Planning
6. Implementation
7. Monitoring

The Key Outcome Indicators were further disaggregated as:

1. **Gauging extent of positive changes for managing health**
   - **Qualitative Indicators**
     1. Functioning of Village Health Sanitation and Nutrition Committee (VHSNCs)
     2. Planning and implementation of village health plans, and influencing at block and district levels
     3. Planning, organization and participation in Village Health and Nutrition Day (VHND)
     4. Utilization of untied funds disbursed under National Rural Health Mission to communities
   - **Quantitative Indicators**
     1. Immunization of children (till age of 12 months)
     2. Support to Pregnant women and Mothers

2. **Gauging extent of positive changes for managing education**
   - **Qualitative Indicators**
     1. Functioning of School Management Committees (SMCs)
     2. Planning and implementation of School Development Plans (SDPs)
     3. Cross checking of District Information System for Education (DISE) data and getting it corrected
     4. Functioning of Bal Sansads
   - **Quantitative Indicators**
     1. Enrolment and retention of children (age 6-14 years) in schools
     2. Comparative analysis of DISE data sets for October 2010 and October 2013

The evaluation was based on visits to villages, and discussions with Frontline Workers, primarily Jal Sahiyas, and Anganwadi members. Overall, total of 11 villages (18 per cent of total project villages) were visited across the 3 partner CSOs, Field Level Workers (FLWs) from 7 villages; and a few district and block level government functionaries could be met with.

After the field visit, the evaluation team undertook critical analysis of the project progress, applying 2 of the 6 thinking hats based on Dr. Edward de Bono’s thinking hat technique, and organised the findings into the following lines:

**The Yellow Hat:** The thinking focuses on values and benefits. Why something may work.
**The Black Hat:** The thinking focuses on difficulties, potential problems. Why something may not work.

### KEY FINDINGS

**PROGRESS AT THE LEVEL OF IMPLEMENTATION**

Most of the members of Village Health Sanitation and Nutrition Committee (VHSNCs) and School Management Committees (SMC), in CINI and NBJK’s project villages regularly respond to the meetings called by the project and are well informed of their rights and responsibilities, i.e. have reached stage 3 of progression. Relatively, fewer have started identifying issues and their solutions [stage 4 of progression]. Some CBOs have reached to stage 5 and 6 i.e. have starting taking action on issues of their concern. The committees are able to garner support from panchayat members and mahila mandals (women’s groups). Mahila mandals were particularly strong in NBJK’s area. They displayed a fair understanding of citizens’ rights and are acting as change agents in their community. This can be attributed to NBJK’s long association with communities, better education status of women in the areas, and a supportive family environment for women members.

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1 This technique facilitates systematic thinking and analysis of all aspects of a policy, program, project, situation or idea. The 6 Thinking Hats were developed to be applied together as a set and not as partially applied in the context of this evaluation.
The project has resulted in an improved demand with communities understanding their rights and responsibilities, and accessing the government facilities and services. Village level service providers feel supported and hence are able to perform better in terms of service delivery.

Positive results were also noted on the supply side. The project interventions have led to some tangible improvements in terms of functional schools and health centres, regular visits by health workers, greater support from block level officials in addressing issues raised by the local communities, and inclusion of village plans in block level plans.

Key gaps that impact services are shortfalls in full-time teachers (many schools in the project area have only para-teachers), mid-day meal (MDM) not regularly available, no special teaching and learning material for children with special needs and malnourishment treatment centres (MTC) not being able to accommodate all cases referred.

**EFFECTIVENESS OF PROJECT**

Positive changes, as intended by the project, were evident at varying degrees across the intervention areas. The project has resulted in improved demand with communities understanding their rights and responsibilities, and accessing the government facilities and services. Service delivery has improved in terms of consistency and regularity. Increased community participation has resulted in qualitative improvements in the provision of government facilities and services.

These improvements are, however, notable in intervention sites only. At a broader level, comparison with DISE data shows no change in supply side provisions for access to quality education. In fact, in some cases the situation has worsened, especially where the demand has continued to increase thus putting more pressure on already inadequate resources. This indicates that while community awareness and ownership has increased by civil society interventions, larger programmatic response by the government is not geared to meet the expectations of communities.

**RECOMMENDATIONS AND WAY FORWARD**

- From the point of view of ensuring sustainability, the project villages are too few and too scattered to ensure lasting changes. The project will need to scale up to achieve the critical mass. Also, its geographical coverage will need to be strategic, i.e., should overlap with administrative units of NRHM and SSA.
- While the project continues to work at community level, initiatives need to be planned to get into a formal advisory role to the government to support them in facilitating community participation in attaining improved educational and health status.
- As Village Education Committee (VEC), a group of elected representatives for overseeing education issues in its entirety has been dissolved and part of its functions, including fund transfers are directly done
though SMCs, issues of pre-school education and life-skills education are neglected. The project should work towards advocating for filling these systemic gaps through advocacy and expanding community engagement in these areas. Similarly, advocacy on issues of quality education, including pre-service training of teachers need to be taken up in the future, in order to truly realise the spirit of right to education which currently seems to be limited to student-enrolment and functionality of schools.

- Health needs to be understood in the wider context of family and community health management. This would mean incorporating more components of preventive aspects in village level discussions and interventions. In addition to the inputs mobilized under ICDS, NRHM and MDM, other initiatives such as behavioural changes to address preventable diseases, wastewater and garbage disposal, use of toilets, smokeless stoves, de-addiction and kitchen gardens/balance nutrition need to be promoted. Continued low age at marriage in the region is an area of concern that can have a negative impact on overall health of women and even children.

- The project needs to adopt a much stronger child rights based approach. An example of a potential area is to influence the understanding on Bal Sansads by adopting the understanding on children’s participation as envisaged in UNChild Rights Convention (UNCRC). The current practice of engaging children (Bal Sansad members) in school cleaning, fetching water etc., in the name of child participation needs to be critically reviewed in view of child rights as well as the real motive of forming bal sansad. Safety protocols in schools where construction is ongoing should also be taken up seriously under the purview of child protection.

- Greater sharing of the project experience is required through existing networks. Ways in which the experiences can be translated into concrete strategies also need to be worked out to maximize the impact of advocacy. This is already being done but needs to step up manifold.

- The community level readiness needs to be met with appropriate policy reforms at national and state levels, backed with budgetary allocations.

- The change envisaged needs to be at structural level rather than depending on sympathetic or sensitive officials. Transfer of such officials tends to have a regressive affect on the project pace and results.