# Lessons from the Field

## Evaluating an Integrated Reproductive Health Program: India Case Study

This report details the methods and findings of a participatory evaluation of integrated reproductive health programs in two villages in India, with comparisons to a third village that had no reproductive health programming. The results suggest that the integrated approach used by World Neighbors-India and its partners is effective in achieving high rates of reproductive health knowledge and positive practices, improvements in women's status, and significant benefits from participation in savings and credit groups.

# Preface

World Neighbors has always been committed to learning through program experience. In the area of reproductive health, World Neighbors has had the unique opportunity to contribute to others working in the field by documenting the results of an integrated approach in which reproductive health is a central feature.

The following evaluation study concerns an established World Neighbors' program which has incorporated a reproductive health component. Previously, the program (in the Gulbarga District of the state of Karnataka in India) had been oriented to dry land sustainable agriculture. While women were included in the farmers' groups, men were the primary program partners. The reproductive health component was developed based on previous World Neighbors' experiences in Nepal.

The process of establishing the reproductive health component presented multiple challenges and opportunities for the WN India team and its partners. They continually adapted what they had learned in their previous work with communities to meet these challenges. With strong leadership and a clear process for learning, the program team and partners have constructed a meaningful integrated program that has achieved the important results which are presented here.

This evaluation originally was designed to examine the impact of the reproductive health component and make recommendations for modifications before the program was expanded elsewhere. However, the results of the evaluation were so compelling that World Neighbors decided to produce this document as a means of sharing both the program approach and the evaluation methodology, as both encompass unique aspects that may be valuable to others.

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The evaluation team would like to sincerely thank the women and men of Nellur, Yelenavadgi, and Khanapur for their participation in these evaluation activities. The BSRDS staff also worked long hours to make the evaluation a success. The on-going work in these villages is truly an inspiration for others.

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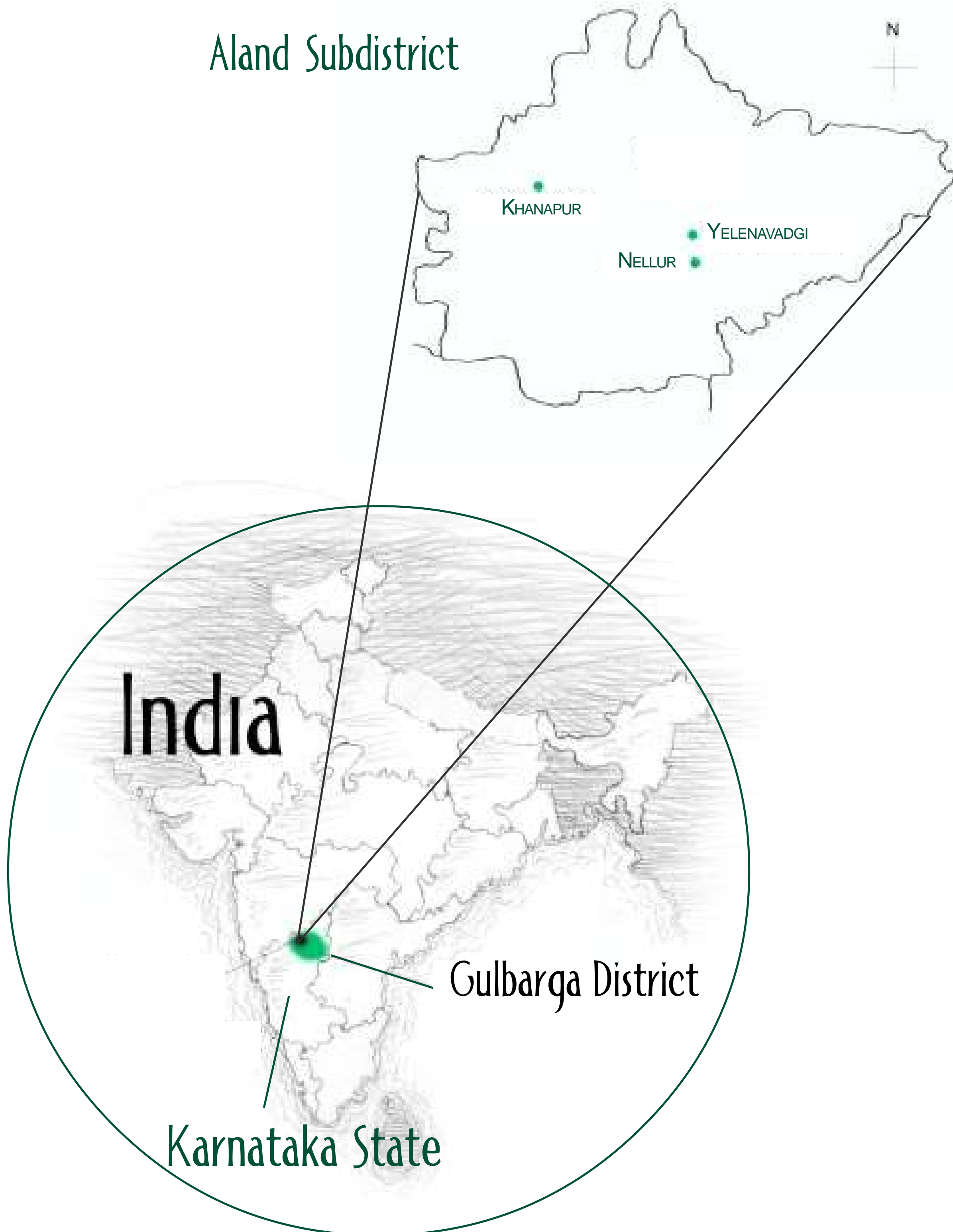
# Map of the Program Area



# Executive Summary

An evaluation of the reproductive health component of the Bayalu Seeme Rural Development Society (BSRDS) integrated program took place between April 25 and May 16, 2001 in the villages of Nellur, Yelenavadgi, and Khanapur in the Aland Subdistrict of the Gulbarga District in the southern state of Karnataka in India. The reproductive health component was initiated in 1998 by World Neighbors, in partnership with BSRDS. The objectives of the evaluation were to

1) review the reproductive health component of the BSRDS integrated program to examine impact, outcome, and process;
2) determine the lessons learned for application for BSRDS and others; and
3) develop capacity of NGO staff for self-evaluation.

The evaluation design had three key features. First, the evaluation itself was integrated; the dimensions examined included women's status, reproductive health, group capacity, organizational capacity, integration, and savings and credit. Second, the design included a comparison village; information from women's group members and non-group members in two intervention villages (Nellur and Yelenavadgi) were compared to information from the wives of agriculture group members and non-members in a non-intervention village (Khanapur). Approximately 200 women and 60 men from the three communities participated in the evaluation exercises. Third, the evaluation incorporated quantitative and qualitative methods. Both participatory methods and a short survey were used to facilitate the triangulation of data for verification and attribution.

Key findings from the evaluation:

1) Significant changes were reported in key reproductive health practices and rates for service use for intervention villages. The family planning use rates observed among group and non-group members in Nellur (78%-74%) and Yelenavadgi (88%-78%) greatly surpass the rates of Khanapur, the comparison village, (53%-48%), and for rural Karnataka as a whole (56.6%). The use of antenatal care (ANC) also demonstrated similar patterns.

The group and non-group members in the intervention villages cited the regularity of visits from the auxiliary nurse midwife (ANM), the periodic gynecology camps, and the ongoing work of selected group members as trained birth attendants (TBA) as major achievements of the groups.

2) There were reported changes in indicators of women's status for intervention villages, particularly for group members. Women noted positive changes in decision making, property ownership, girl child education, and reduction of violence against women, all largely attributed to the group's activities.

According to the women, the groups have provided them with the confidence to organize to undertake a variety of initiatives ranging from closing bars and gambling houses to using civil disobedience to improve water supplies.

3) There were indications that the loans given by the groups have had an impact on livelihood status for about a third of the group members. According to the evaluation findings, five members of the Nellur group and six members of the Yelenavadgi group increased their livelihood status. According to the women interviewed, while these changes are small, they are significant.

Women cited two other key benefits of their savings and credit activities as group solidarity or support and freedom from moneylenders. Both groups

reported that in case of emergency, they would give loans to members, even if they knew those members would not be able to pay the group back.

4) The women's groups and BSRDS staff have developed capacities to effectively implement, monitor, and evaluate their activities. These skills include technical knowledge, communication, and program management. The women's groups are confident in their ability to sustain key activities after the phase out of BSRDS.

Although BSRDS didn't have any prior experience in reproductive health, they were able to effectively implement the activities. In the Gulbarga District, BSRDS is now seen as a resource for reproductive health. BSRDS notes that the addition of the reproductive health component has significantly contributed to their integrated development approach and has strengthened their relationship with village women.

5) In the area of integration, it was clear that the linkages between the men's agriculture groups and the women's groups have been important. In particular, the role of the agriculture groups in the formation of the women's groups and their ongoing support for their activities has been invaluable. The agriculture group members assisted in the formation of the women's groups by encouraging their wives to participate and, in some cases, by convincing other men to do the same. The men's group members have also provided ongoing support in terms of assisting with the organization of the periodic gynecology (gyne) camps and the regular discussion of issues (RH, agriculture, and social issues) with the women's groups. Individually, the men have also encouraged their wives to attend the gyne camps to receive services.

At Nellur and Yelenavadgi, there was apparently good communication regarding dry land agricultural (DLA) issues between men and women because of the existence of both men's and women's groups. As a result, there appeared to be improved awareness in women's group members regarding key agricultural practices, and women report using these techniques in their agricultural work. In contrast, at Khanapur (the comparison village), there was relatively low awareness. However since the DLA men's group is new (one year) it makes comparison with Nellur and Yelenavadgi, where the groups are five years old, difficult.

6) The integrated model appeared cost-effective. The cost of the women's group activities averaged about $11 per group member. These activities included capacity building, outreach reproductive health services, savings and credit, and leadership development. The evaluation also demonstrated the effects of the program beyond the group members, particularly in the area of reproductive health. The costs calculated were inclusive of support from BSRDS and WN-India.

In summary, the integrated approach used by World Neighbors-India and BSRDS appears effective as demonstrated by the outcomes of this evaluation. In the two intervention villages, there are high rates of reproductive health knowledge and family planning use for both group and non-group members. The group members also appear to have made progress in many areas of improving the status of women, as well as benefiting from the savings and credit activities of the group. These are remarkable achievements in a relatively short period of three years.

# Background and Evaluation Rationale

World Neighbors India (WN-I) began activities in reproductive health (RH) in April 1998. These first activities were initiated with a partner organization, the Bayalu Seeme Rural Development Society (BSRDS), in two villages where agricultural activities were ongoing. Over the past three years, WN India has greatly expanded RH activities with eight partner NGOs, currently working in 44 villages with 58 women's groups. This evaluation was intended to allow WN India to carefully examine RH activities and analyze lessons learned for application to other WN India supported programs.

BSRDS was founded in 1993 to work with marginalized groups in two sub-districts (talukas) of Gulbarga District in the southern Indian state of Karnataka. BSRDS has a staff of six persons: the director, training coordinator, accountant (typist), community organizer, field assistant, and reproductive health worker.

BSRDS has six major objectives: 1) to organize target groups to undertake development activities; 2) to give formal and informal training to women, handicapped persons, and children without access to schools; 3) to create employment opportunities for the rural poor and establish training centers for self employment for youth and women; 4) to plan and implement various rural employment and development programs with the cooperation of local groups for the all round development of the people; 5) to bring about a positive social change to improve the economic condition of people; and 6) to sustain all development activities targeted to the groups.

WN-I selected BSRDS as a partner to pilot the RH activities because of confidence in the leadership of the organization and the fact that the BSRDS area is particularly remote and under-served. For its part, BSRDS was willing to pilot the activities because of the need in the area and its strong relationship with WN-I.

Table 1 shows the timeline of key events in the development of the BSRDS reproductive health component, and WN-I expansion of reproductive health services to other partners. The evolution of the RH component of BSRDS is described as follows by Dr. Subhash Gumaste, Country Director, WN India:

*"When WN India and BSRDS considered addressing women's issues with particular reference to reproductive health and social issues, it was first discussed with the Field Assistant (FA) of BSRDS who worked in close association with the men's groups of dry land farmers. Later the BSRDS Director and the FA suggested Nellur and Yelenavadgi for the program sites, because they felt the men's groups of dry land farmers were doing a fine job.*

*First, the idea of forming groups consisting entirely of women was shared with the farmer group members in the two villages, since it was the wives of farmer group members who would address RH and other issues faced by women. In the meanwhile, BSRDS identified Mahadevi Kavalagi to work as the reproductive health worker. Mahadevi was trained intensively by the WN team in technical and facilitation skills. She was also provided training by Family Planning Association of India (FPAI) and Denise Caudill, the WN RH Consultant at that time.*

**Table 1: RH Component Development Timeline**

| Date | Activity |
|---|---|
| January 1998 | Feasibility survey and selection of villages |
| February 1998 | WN-I discussions with BSRDS and agriculture group leaders in Nellur and Yelenavadgi |
| April 1998 | Funding received for RH component; Ms. Pankaja Kalmath hired as WN RH Consultant; BSRDS Women's Groups formed in Nellur and Yelenavadgi |
| November 1998 | **RH Experience Sharing Workshop I** facilitated by Dr. Denise Caudill |
| February 1999 | Cross-visit to Nepal to study RH Integration with Agriculture (WN-I team and BSRDS staff) |
| April 1999 | Cross visit of seven WN-I partners to BSRDS RH villages to study integration. |
| July 1999 | BSRDS expanded RH to two more villages. |
| September 1999 | **RH Workshop II** facilitated by Dr. Denise Caudill. All partners attended. |
| January 2000 | RH components initiated in ten villages in cooperation with five other NGO partners. |
| March 2000 | Ms. Mamatha hired as WN RH Consultant |
| April 2000 | Family Planning Association of India (FPAI) Training for RHWs and NGO Directors |
| July 2000 | FPAI Training for RHWs and NGO Directors; Laxmi Madras hired as WN RH Consultant; BSRDS expands RH to two additional villages. |

# Background and Evaluation Rationale

*The BSRDS reproductive health worker and the field assistant met with the women separately, and with their husbands, and encouraged them to form a group. Encouraged by the idea, in both villages 8-10 women came forward to form groups of women. As an entry point activity, a savings and credit group was initiated. This met some immediate needs, as for the rural poor women money is a big constraint. This activity attracted other women of the village and thus the groups grew in size to have 15-20 members. All of the members were either the wives of marginalized farmers or landless laborers.*

*As the groups were intended to be small in membership, they did not allow more members to join groups but encouraged them to have a separate group. The groups selected their leaders who were periodically trained in technical and facilitation skills by the WN India team. Initially, the reproductive health worker attended the meetings every fortnight and guided the groups in conducting meetings and discussing issues. After a few months when group members started attending the meetings regularly, the reproductive health worker assisted them in identifying and prioritizing RH and social issues faced by the women, using flash cards. The groups prepared action plans to address the prioritized issues. As the leadership developed and groups gained experience in conducting activities, the reproductive health worker attended the meetings less frequently. Thus the groups started working and learned to take ownership of the program."*

## Glossary

| | |
|---|---|
| ANC | Antenatal Care |
| ANM | Auxiliary Nurse Midwife |
| BSRDS | Bayalu Seeme Rural Development Society |
| DLA | Dry Land Agriculture |
| EDP | Entrepreneur Development Program |
| FA | Field Assistant |
| FP | Family Planning |
| Gyne | Gynecology |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| NGO | Non-governmental organization |
| MOH | Ministry of Health |
| PNC | Postnatal Care |
| RH | Reproductive Health |
| RHW | Reproductive Health Worker |
| RTI | Reproductive Tract Infection |
| SSI | Semi-structured Interview |
| STI | Sexually Transmitted Infection |
| TBA | Trained Birth Attendant |
| WN | World Neighbors |
| WN-I | World Neighbors India |

# Operational Phases of Adding the RH Component

The addition of a reproductive health component into established village activities can be described in three major operational phases. During the first two phases the support of the NGO staff, BSRDS in this case, is essential. These are the critical phases of establishing the women's groups and developing capacities and implementing activities. Program staff estimates that it takes about three to four months to establish a new group. The capacity building phase requires about three years. In the first year, there is intensive guidance and support from the NGO staff to establish a firm basis. In the next two years the support is gradually reduced as the groups strengthen their capacities. In the third phase the women's groups conduct activities independently with little support from the NGO. The major activities of each phase are outlined below.

**Phase 1: Establishing Women's Groups**

- WN staff hold initial discussions with NGO director and field assistants.
- NGO and WN staff hold discussions with agriculture groups about possibility of starting a women's group in the village.
- WN staff work with the NGO to identify and train the reproductive health worker (RHW).
- NGO and WN staff hold discussions in the village about the program.
- Women meet together to form a group of between 15 and 20 members.

**Phase 2: Capacity Building of Women's Groups with help of RH Worker**

During the intensive phase, the NGO RH Worker helps organize the women's group. The initial activities of the group include:

- Selection of leaders
- Training of leaders (The topics include group management, decision-making, record keeping, fund management, and monitoring and evaluation techniques. Leaders are also trained in technical aspects of reproductive health and income generation.)
- Selection and training of trained birth attendants
- Establishment of group rules
- Identification of important group capacities
- Initiation of savings and credit

During this period the RH worker attends all group meetings and assists the group in developing and monitoring their capacities and monitoring savings and credit activities. She also assists the group to identify and prioritize reproductive health and related social issues (see drawings at right, developed for problem identification). She works with the group to develop an action plan to address the issues. The RH worker also assists in action plan as indicated. In most cases this includes helping with letter writing to health authorities requesting regular visits from the auxiliary nurse midwife assigned to the village and the organization of the first gynecology camp.

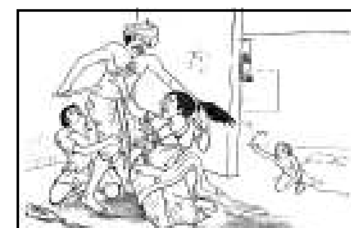
As groups develop capacities in these areas, the support of the RH worker becomes less intense. She visits less frequently, but continues supporting key training events. For example, she trains and assists the group in self-evaluation of their group capacities once every six months. She also organizes cross-visits to successful groups as and when required.

**Phase 3: Women's Groups Conduct Activities Independently**

This phase is transitional, as NGO support will eventually phase out. The RH worker visits the group every three to six months. The groups have responsibility for planning and implementing activities, monitoring capacities and progress on action plans.

*Family size*

*Miscarriage*



*Violence Against Women*

# Evaluation Framework and Methodology

The evaluation took place in several stages:

A. **Pre-planning**
B. **Evaluation Design**
C. **Development of Evaluation Tools**
D. **Data Collection Training**
E. **Field work**
F. **Data Analysis**
G. **Report writing**

## A. Pre-planning

As it had been planned for some time to evaluate the RH experience with consultant support, in November 2000, Dr. Subhash Gumaste, WN India Country Director, Dr. Catharine McKaig, WN RH Coordinator and Dr. Denise Caudill, Consultant, met to discuss the evaluation process. At that meeting two key decisions were made. First, it was determined that there was an opportunity to use a comparison village to strengthen the evaluation design. Second, it was also decided to use a combination of methodologies including a short questionnaire to help assess outcomes and allow for triangulation of evaluation results.

The WN-I team worked with BSRDS to identify the villages for the evaluation exercise (see Table 2 below). A map of the evaluation villages is on page 2.

The team tried to identify influences from other development sectors in the intervention and comparison villages. One of those influences, the Entrepreneur Development Program (EDP), was initiated in the program villages in 1998 and will continue through 2002. In this program, women from marginalized castes receive credit for economic activities. None of the women participating in EDP in Yelenavadgi and Nellur are members of women's groups. In the Women's Holistic Empowerment Program (SHE) in Khanapur, begun in June 2000, in addition to credit, stress is also placed on empowering selected women socially, economically, and educationally. It was felt that the EDP and SHE programs were not significant factors in the outcomes examined in this evaluation.

Of note is also the availability of health services prior to the program. While the government structure calls for essential health services to be provided to each village on a weekly basis by an auxiliary nurse midwife (ANM), according to the accounts of the villagers, BSRDS staff, and the ANM herself, these services were not regularly provided.

## B. Evaluation Design

During the first day of the evaluation period, the WN and BSRDS teams clarified the objectives of the evaluation and determined the key questions to be answered during the course of the evaluation. The key questions helped to identify the kind of information required and the participatory exercises to be conducted. This was an important step because not all the team members had been involved in the earlier pre-planning discussion.

Although the primary focus of the evaluation was on the reproductive health outcomes, savings & credit, agricultural, and women's status outcomes were also examined.

Those participating in this meeting were the World Neighbors team, Dr. Subhash Gumaste, Dr. Shiva Sharanappa M. Hallad, Mr. Iranagouda Goudappa Patil, Ms. Laxmi M. Madras, Ms. Kellye O'Bryan, and Dr. Cat McKaig; and the BSRDS team, Mr. Subbanna

**Table 2: Evaluation Field Sites**

| Village | Number of households[1] | WN/BSRDS Activities | Number of Group Members | Other Development Activities |
|---|---|---|---|---|
| Nellur | 231 | 3 dry land agriculture groups<br><br>3 reproductive health groups | 16/20/20<br><br>15/12/26 | Entrepreneur Development Program - 15 women from marginalized castes receive credit for economic activities |
| Yelenavadgi | 294 | 4 dry land agriculture groups<br><br>4 reproductive health groups | 15/15/11/17<br><br>15/11/20/15 | Entrepreneur Development Program - 15 women from marginalized castes receive credit for economic activities. |
| Khanapur (comparison village) | 210 | 1 dry land agriculture group | 17 | Women's Holistic Enpowerment - Savings & Credit |

*[1] BSRDS collected this information initially through social mapping in 1994. It was updated in 1998 with a house-to-house survey when the RH activities began.*

# Evaluation Framework and Methodology

Biradar (Director), Mrs. Mahadevi Kavalagi (RHW), and Mr. Mallikajun Kavalagi (Field Assistant).

The following objectives and key questions were identified:

**Objectives of the evaluation:**

1. To undertake an evaluation of the RH component in the BSRDS integrated program to examine impact, outcome, and process.

2. To determine the lessons learned for application to BSRDS and elsewhere (Action Learning).

3. To develop the capacity of NGO staff for self-evaluation.

**Table 3: Key Questions, Information Needed, and Means of Collection**

| Key Questions | Information Needed | How to Collect It? |
|---|---|---|
| Q1. How has the program affected the awareness of group and non-group members? | Changes in the knowledge and behavior among group and non-group members. | Survey and Participatory Methods |
| Q2. Did the program create a demand for government services? | Number of people using government services. | Participatory methods, survey, ANM reports/records |
| Q3. What has been the role of the male agriculture groups in addressing RH issues? | * Participation of men group members in addressing RH isues.<br>* Perception of women regarding how men have participated.<br>* Knowledge of men regarding RH issues. | Participatory methods with men's and women's groups |
| Q4. What has been the impact/outcome of the program activities on:<br>a) RH<br>b) Savings and credit<br>c) Women's status | a) Reproductive Health<br>i. Adoption of RH key practices (family planning, safe delivery, ANC & PNC)<br>ii. Perceptions of RH status in the family<br>b) Savings and credit<br>i. Amount saved and loans given<br>ii. Number of people benefitted<br>iii. Purpose of loan<br>iv. Perceived impact of the savings and credit activity<br>v. Benefits to the group as a whole from savings and credit activity.<br>c) Women's status<br>i. Key perceptions of men<br>ii. Key perceptions of women<br>iii. Information on women's empowerment | 1) RH<br>i. Survey, group records, participatory methods<br>ii. Participatory methods<br>b) Savings and credit<br>i. Participatory methods<br>ii. Group records<br>iii. Survey<br>c) Women's status<br>i. Participatory methods<br>ii. Survey |
| *Q5.[2] How does the wealth distribution of groups compare to that of the village?* | *- Criteria for wealth ranking*<br>*- Households ranked by criteria* | *Participatory methods with key informants* |
| Q6. What is the capacity of the group to sustain activities? | Information on self-evaluation of group capacities. Information on actions taken towards sustainability | Participatory methods, group records |
| Q7. What is the awareness and adoption of improved dry land agriculture (DLA) practices by women group members and non-members? | - Knowledge and participation in imporved sustainable agriculture practices.<br>- Perceptions of men and women about women's roles in sustainable agriculture. | Participatory methods with men's and women's groups, survey |

[2] *The team was unable to address question #5 due to the large size of the villages and the time constraints*

C. **Development of Evaluation Tools**

Participatory Exercises

The team met to determine the participatory exercises best suited to collect the required information. The following exercises were identified[3]:

1. **Women's Status**
2. **RH Historical Matrix**
3. **Group Capacity Evaluation**
4. **Focus Groups/Semi-structured Interviews**
5. **Livelihood Ranking**

The table below demonstrates how the exercises were designed to be used with the different groups and their relationship to key questions. The team used the verification with key questions to ensure that exercises collected the necessary information.

**Table 4: Participatory Exercises in Relation to Key Questions**

| | Women's Groups | Men's Groups | Women Non-group Members |
|---|---|---|---|
| RH Historical Matrix | Q1, Q2, Q4 | | Q1 |
| Group Capacity | Q6 | | |
| Wealth Ranking[4] | Q5, Q4 | Q5 | Q5 |
| SSi- Men in RH | Q7 | | |
| SSI - Women in Ag | | Q3 | |
| Women's Status | Q4 | Q4 | Q4 |
| RH Couple Status | Q1, Q3, Q4 | Q3 | Q1, Q3, Q4 |

These exercises were designed to be complementary to the questionnaire. The participatory exercises are described in the next section. Other data collection activities included: 1) reviews of group records (savings and credit, meeting notes, and gynecology [gyne] camp records), 2) interviews with Ministry of Health (MOH) officials, and other key persons.

Survey Instrument- Questionnaire

The WN-I team worked to develop the questionnaire instrument based on variables identified during the November meeting and adding others they judged to be valuable. It was finalized just prior to the evaluation period but not yet pre-tested. The instrument had a total of 22 questions (see Appendix A for a copy of the questionnaire). Time was spent during the training workshop to review and revise the instrument.

The questionnaire was administered to six separate groups: a purposeful sample of RH group members (approximately 40) and an equal number of non-group members in both Nellur and Yelenavadgi. In Khanapur, the questionnaire was administered to the wives of members of the agriculture group (17) and other women who were not wives of agriculture group members (23). Efforts were made to match non-group members on age and economic status.

**D. Data Collection Training**

Six female reproductive health workers (RHWs), one male RHW, and one extension agent all from other partner NGOs served as interviewers and facilitators of the participatory exercises during the evaluation period.

A training workshop intended to familiarize the RHWs in data collection and the tools took place from April 26-29, 2001. The major areas of the training included: 1) explanation of objectives and key questions, 2) survey methodology and practice with the questionnaire, and 3) participatory methods and practice. (A copy of the training agenda is included as Appendix B.)

Key tools were field tested with two BSRDS women's groups who were not conducting RH activities. The tools that were field-tested included: 1) RH Matrix, 2) Women's Status, and 3) the questionnaire. The team found the field-testing to be invaluable as it helped familiarize the team with the methods and also allowed an estimation of time required for the different exercises.

**E. Field Work**

The evaluation field work took place over an eight-day period from April 30 to May 8, 2001. The following table describes the dates, villages, participatory exercises, survey work, and additional interviews undertaken.

*[3] RH Matrix and Women's Status exercises were adapted from Denise Caudill, "We Tried to Measure Ourselves and Find We Have Progressed!", 1998, WN, BBFW and FPAN.*

*[4] Wealth ranking was not used for the entire village to answer question 5. However, the team did use wealth ranking as a tool to identify changes in livelihood for women's group members.*

**Table 5: Field Work Schedule**

| Date/Time | Village | Group/Person | Exercise/Activity |
|---|---|---|---|
| 30/04/01 | Nellur | Women's Group Members<br>Men's Agriculture Groups<br>RHW | RH Matrix, Questionnaire<br>Focus Group - SSI (RH)<br>Group Record Review |
| 01/05/01 | Nellur | Women's Group Members<br>Women Non-Group Members<br>Key Informant's Women's Group<br>PHC Center Physician | Group Capacity Evaluation<br>RH Matrix, Questionnaire<br>Livelihood Ranking<br>Interview |
| 02/05/01 | Nellur | Women's Group Members<br>Non-Group Members<br>All | Women's Status, Focus Group - SSI (Ag)<br>Women's Status<br>Debriefing/sharing session |
| 03/05/01 | Yelenavadgi | Women's Group Members<br>Men's Agriculture Group<br>RHW | RH Matrix, Questionnaire<br>Focus Group - SSI (RH)<br>Group Record Review |
| 04/05/01 | Yelenavadgi | Non-group Members<br>Key Informant's Women's Group<br>Agriculture Group Leader | Questionnaire<br>Livelihood Ranking<br>Interview |
| 05/05/01 | Yelenavadgi | Women's Group<br><br>Non-Group Members<br>All | Group Capacity Evaluation, Focus Group - SSI (Ag), Women's Status<br>RH Matrix, Women's Status<br>Debriefing/sharing |
| 06/05/01 | ----------- | ------------------ | Rest day |
| 07/05/01 | Khanapur | Agriculture Group<br>Wives of Agriculture Group | Focus Group - SSI (RH)<br>RH Matrix, Focus Group - SSI (Ag), Questionnaire |
| 07/05/01 | Yelenavadgi | ANM | Interview |
| 08/05/01 | Khanapur | Wives of Agriculture Group<br>All | Women's Status<br>RH Discussion and Debriefing/sharing |

*Pretesting the questionnaire*

*Yelenavadgi Women's Group: Women's Status Exercise*

# Evaluation Framework and Methodology

### F. Data Analysis

Preliminary analysis of the questionnaire took place during the evaluation. In order to provide timely feedback to participants, selected knowledge and practice questions were analyzed for a sub-sample of the three villages and presented during feedback sessions in the villages. All the questionnaires were analyzed for the key knowledge and practice variables and the results are presented in this report.

A two-day data analysis workshop was held in Gulbarga with the WN-I team, the BSRDS team, and two of the RHWs who had participated in the evaluation. On the first day, the group reviewed the notes for each participatory exercise, questionnaire results and interview notes for the following topics: 1) reproductive health, 2) women's status, 3) capacity – women's groups and BSRDS, 4) integration, and 5) savings and credit. The groups summarized the major findings by topic. On the second day, the key questions were reviewed and answered, and lessons learned and recommendations were identified.

*Subbanna and Mahadevi, BSRDS, prepare Data Analysis presentation*

### G. Report Writing

The final phase of the evaluation was report writing which took place on the last three days of the evaluation period. Below is a calendar of the entire evaluation period.

**Table 6: Evaluation Calendar: April 25th - May 15, 2001**

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| | | | 25<br>Arrival - Planning Meeting | 26<br>Planning<br><br>Training | 27<br>Training | 28<br>Training |
| 29<br>Field Test | 30<br>Field Work - Nellur | 1<br>Field Work - Nellur | 2<br>Field Work - Nellur | 3<br>Field Work - Yelenavadgi | 4<br>Field Work - Yelenavadgi | 5<br>Field Work - Yelenavadgi |
| 6<br>Rest Day | 7<br>Field Work- Khanapur | 8<br>Field Work - Khanapur | 9<br>RHW Evaluation<br><br>BSRDS Capacity | 10<br>Data Analysis Workshop | 11<br>Data Analysis Workshop | 12<br>Report Writing |
| 13<br>Report Writing | 14<br>Debrief<br><br>Report Writing | 15<br>Departure | | | | |

# Evaluation Findings

The findings from the evaluation are presented in summary for five thematic areas:

A. **Women's Status**
B. **Reproductive Health**
C. **Capacity-Women's Groups and BSRDS**
D. **Integration**
E. **Livelihood-Savings and Credit**

For each thematic area, the participatory exercise is introduced, and in most cases the findings are presented in table format which combines results from both the exercises and the survey work for Nellur, Yelenavadgi (RH group villages) and Khanapur (comparison village).

The quotes in each section were collected during the participatory exercises.

## Participatory Exercise 1: Women's Status*

### Objectives:

1. To identify indicators of women's status as identified by women
2. To compare women's status indicators before and after three years of group formation
3. To identify the factors to which women attribute the changes

### Steps:

- Define the objective of the exercise
- Ask the participants to list the indicators for women's status by discussing among themselves
- Ask the participants to prioritize five important indicators from the those identified by using beans
- Ask the participants to identify the changes which occurred over a period of three years in each of these indicators as improved, remain the same, or getting worse
- Ask the participants to attribute the changes: are they due to group activities, external factors, or both?
- Sum up the exercise and share the results with the participants

### Materials needed:

Cards to list indicators; markers; tape; wall or board to post and prioritize indicators; matrix to list and attribute improvements; beans or stones

| | Issue | Improvements attributed to: | | |
|---|---|---|---|---|
| | | Group | Other | Both |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

* *adapted from Denise Caudill, "We Tried to Measure Ourselves and Find We Have Progressed!", 1998, WN, BBFW and FPAN.*

# Evaluation Findings: Women's Status

**A. Women's Status**

Participatory exercises on women's status were carried out with women's group members and non-group members in Nellur and Yelenavadgi, and with the wives of the agriculture group members in Khanapur. Participants identified and discussed issues they felt were related to women's status. While several issues seemed to be context-specific, many similar issues were identified across groups. These included decision-making, property ownership, participation in politics, girl child education, family planning, reproductive health, dowry, right to divorce, violence against women, child marriage, women's mobility, and widow remarriage. The groups then prioritized their lists. Results are presented in Table 7 (pages 16-17); issues that were identified but not prioritized are also indicated. The information is complemented with the results of the survey for selected indicators.

The groups examined the eight priority issues in more detail and determined whether there was improvement, no change, or deterioration. Those issues that had improved were re-grouped to identify the reasons for the changes and whether they were attributable to group activities, other factors or both. The results from this step are presented in Table 8 (page 18).

The groups noted improvements in decision making attributable to group activities in Nellur and Yelenavadgi. This is supported by the questionnaire results that indicated group members have the most decision making abilities (84% and 91%) compared to non-group members (61% and 76%). Both group and non-group members in Nellur and Yelenavadgi have more decision making skills than women in Khanapur (where only 28% of wives of agriculture group members and 24% of wives of non-agriculture group members felt they had decision making skills).

Property ownership was another area in which improvements were cited as a result of group activities in Nellur and Yelenavadgi. This is difficult to verify with the questionnaire data. While the questionnaire data showed land ownership to be higher in the intervention villages among non-group members, land ownership by women is minimal in both intervention villages and non-existent in Khanapur. The lack of a clear baseline and the complexity of the issues of land ownership make interpretation difficult.

Women in all three villages cited participation in politics and girl child education as important issues. In Yelenavadgi and Nellur, these two were seen to be improving. However, the groups disagreed with regard to reasons for their improvement. While in Yelenavadgi, group members said the improvement was due to the work of the group, the Nellur group members said that women's participation in politics in their village was improving due to efforts of the government. For girl child education, the Nellur non-group members said that the situation was improving because of government efforts, but the Nellur group members attributed the improvement to the efforts of the group.

All of the five groups in the three villages identified family planning as an issue related to women's status. As discussed

*"This exercise on women's status helped us to know where we are and how to continue to increase our status."* Subadra, Yelenavadgi Women's Group

*"We lived a life of animals without understanding what women's status was, until we formed our group."* Indubai, Yelenavadgi Women's Group

*"I do not know exactly how much I benefited from the honorarium, but being a group leader, certainly my position is elevated in society",* Bimbai, group leader, Nellur Women's Group.

"*We had a saying here—whatever the daughter eats becomes mud and whatever the son eats becomes gold."* Yelenavadgi Women's Group Member

*"We are not educated and we were afraid to talk to you. If we don't send our daughters to school, they will also be afraid, like us."* Non-group member, Yelenavadgi

*"In past years, we would put a* bindi *on the stomach of a pregnant woman to indicate that the baby, if a girl, was already promised in marriage."* Member, Nellur Women's Group.

*Women's Group Members, Yelenavadgi*

# Evaluation Findings: Women's Status

in the next section, women's group members had higher rates of family planning use than did non-group members. Women in Khanapur had the lowest rates of family planning use. While improvements in family planning were generally attributed to group activities, the non-group members in Yelenavadgi also cited government activities as contributing to improvements.

Similarly, reproductive health was also an issue frequently identified by the groups. Improvements in reproductive health were attributed exclusively to the group, with the exception of the Nellur non-group members who also attributed improvements to government activities. In Khanapur, reproductive health was not identified as an indicator for women's status.

It is interesting to note that both groups in Yelenavadgi and those in Khanapur identified violence against women as an issue. The survey results demonstrated that group members were more likely to feel they could protest against a husband who beats his wife than non-group members or women in the comparison village. Improvements in the area of violence against women were attributed to the group activities.

In the intervention villages, "dowry" was identified as one of the most important issues by all four groups. However, none of the groups felt that there had been positive changes in the area of dowry and all four felt that the situation was getting worse.

Finally, the issue of women's mobility presents an interesting case. All groups in the three villages identified the freedom of women to travel as important and in two of the groups, it was rated among the most important issues. In Yelenavadgi, the women's group members said the situation had improved as a result of the activities of the women's group. In the comparison village, it was rated as unchanged.

While the questionnaire showed clear differences in the ability of women to travel to neighboring villages without asking permission, it is not clear how much this indicator is influenced by economic status. According to staff, for poorer women mobility is less of an issue, since they are often forced to travel to neighboring villages for work. The usefulness of this indicator is not clear in the program context and will need to be reviewed.

# Evaluation Findings: Women's Status

**Table 7: Women's Status Results:**

| | Nellur | | | |
|---|---|---|---|---|
| Issue/indicators | Rankings by importance [5] | | Questionnaire Results [6] | |
| | Group | Non-group | Group (N=43) | Non-group (N=54) |
| Decision making | 3 | 6 | 36 (84%) | 33 (61%) |
| Property ownership[7] | 4 | 1 | 5 (12%) | 11 (20%) |
| Participation in politics | 7 | * | 33 (77%) | 9 (17%) |
| Girl child education | 8 | 2 | -- | -- |
| Family planning[8] | 9 | 3 | 28 (78%) N=36 | 37 (74%) N=50 |
| Reproductive health | 1 | 4 | -- | -- |
| Dowry-awareness | 10 | 8 | -- | -- |
| Divorce | 2 | * | -- | -- |
| Violence Against Women[9] | -- | -- | 33 (77%) | 14 (26%) |
| Child marriage | 5 | 7 | -- | -- |
| Mobility | * | * | 41 (95%) | 31 (57%) |
| Family size | 6 | 5 | -- | -- |
| Public protests | -- | -- | 35 (81%) | 14 (26%) |

*[5] These results refer to issues identified as important women's issues and their ranking by importance. Women ranked the top eight issues. Issues with an asterisk (*) were identified as an issue, but not prioritized in the top eight issues. Since different issues were identified by different groups, more than eight priority issues were named.*
*[6]Questionnaire results refer to the number and percentage of women responding positively that they did this activity or had this right.*
*[7]For the questionnaire - women's ownership of land*
*[8]For the questionnaire - use of family planning; only responses from eligible couples are included. For this indicator only, N=36 for group members in Nellur, 50 non-group members; 42 for group members in Yelenavadgi, 46 for non-group members; 15 group members in Khanapur, 21 non-group members*
*[9]For the questionnaire - willingness to protest against spousal abuse*

# Evaluation Findings: Women's Status

| | Yelenavadgi | | | | Khanapur | | |
|---|---|---|---|---|---|---|---|
| Issues/ Indicators | Rankings by importance [5] | | Questionnaire Results [6] | | Rankings by importance [5] | Questionnaire Results [6] | |
| | Group | Non-group | Group N=43 | Non-group N=46 | Wifes of Ag Group | Group N=17 | Non-group N=23 |
| Decision making | 1 | 1 | 39 (91%) | 35 (76%) | 5 | 5 (28%) | 6 (24%) |
| Property ownership[7] | 8 | * | 3 (7%) | 5 (11%) | 8 | 0 | 0 |
| Participation in politics | * | 7 | 27 (63%) | 10 (22%) | * | 4 (22%) | 1 (4%) |
| Girl child education | 4 | 3 | -- | -- | 7 | -- | -- |
| Family Planning[8] | 2 | 5 | 37 (88%) N=42 | 36 (78%) N=46 | 1 | 8 (53%) N=15 | 10 (48%) N=21 |
| Reproductive health | 5 | 6 | -- | -- | | -- | -- |
| Dowry awareness | 6 | 2 | -- | -- | * | -- | -- |
| Divorce | * | * | -- | -- | 3 | -- | -- |
| Violence against women[9] | 7 | 8 | 37 (86%) | 7 (15%) | 4 | 2 (11%) | 0 |
| Child marriage | -- | 4 | -- | -- | -- | -- | -- |
| Mobility | 3 | -- | 40 (93%) | 25 (54%) | 6 | 5 (28%) | 7 (28%) |
| Family size | -- | * | -- | -- | -- | -- | -- |
| Public protests | -- | -- | 30 (70%) | 17 (37%) | -- | 2 (11%) | 1 (4%) |

*[5] These results refer to issues identified as important women's issues and their ranking by importance. Women ranked the top eight issues. Issues with an asterisk (*) were identified as an issue, but not prioritized in the top eight issues. Since different issues were identified by different groups, more than eight priority issues were named.*

*[6]Questionnaire results refer to the number and percentage of women responding positively that they did this activity or had this right.*

*[7]For the questionnaire - women's ownership of land*

*[8]For the questionnaire - use of family planning; only responses from eligible couples are included. For this indicator only, N=36 for group members in Nellur, 50 non-group members; 42 for group members in Yelenavadgi, 46 for non-group members; 15 group members in Khanapur, 21 non-group members*

*[9]For the questionnaire - willingness to protest against spousal abuse*

# Evaluation Findings: Women's Status

**Women's Status Observations:**

Women in the three villages identified similar sets of issues related to women's status. These included decision-making, property ownership, participation in politics, girl-child education, family planning, reproductive health, divorce, and violence against women.

With regard to many of these issues, women said the situation had improved and the improvements were primarily due to group activities. However, women said that girl child education and participation in politics improved because of group activities as well as the efforts of the government.

The questionnaire data allowed triangulation of information and illustrated positive differences for group members in the areas of decision-making, participation in politics, family planning use, and protesting against spousal abuse.

Dowry was also identified as an issue in Nellur and Yelenavadgi. The groups all said that the problem of dowry was worsening, not getting better.

**Table 8: Reasons Cited by Women's Groups for Improvements[10]**

| | Issue | Improvements attributed to | | |
|---|---|---|---|---|
| | | Group | Other | Both |
| 1 | Women's reproductive health | Nellur Group Members<br>Yelenavadgi Group Members<br>Yelenavadgi Non-Group Members | | Nellur Non-Group Members |
| 2 | Child marriage | Nellur Group Members | | Nellur Non-Group Members<br>Yelenavadgi Non-Group Members |
| 3 | Decision making | Nellur Group Members<br>Nellur Non-Group Members<br>Yelenavadgi Group Members<br>Yelenavadgi Non-Group Members | | |
| 4 | Property ownership | Nellur Group Members<br>Nellur Non-Group Members<br>Yelenavadgi Group Members | | |
| 5 | Family size | Nellur Non-Group Members | | Nellur Group Members |
| 6 | Divorce | Nellur Group Members<br>Yelenavadgi Group Members | | |
| 7 | Participation in politics | Yelenavadgi Non-Group Members | Nellur Group Members | |
| 8 | Girl child education | Nellur Group Members<br>Yelenavadgi Group Members | Nellur Non-Group Members | |
| 9 | Family planning acceptance | Nellur Group Members<br>Nellur Non-Group Members<br>Yelenavadgi Group Members | | Yelenavadgi Non-Group Members |
| 10 | Violence against women | Nellur Group Members<br>Yelenavadgi Group Members<br>Yelenvadgi Non-Group Members | | |

*[10] Only the issues that were identified as positively changed are included here. In Khanapur, the comparison village, none of the issues identified were rated as improved, so there are no ratings from that group in the table. Also note that not all groups prioritized the same issues, so all issues were not rated by all groups.*

## Participatory Exercise 2: RH Historical Matrix*

### Objectives:

1. To identify key RH issues
2. To identify and analyze changes over time
3. To identify the factors to which women attribute the changes

### Steps:

- Explain the objectives of the exercise.
- With the group, list a few important RH issues and write them on cards (age at marriage, family size, etc.).
- Discuss with the people and identify RH issues. In case the participants fail to identify or delay, then complement with the list already prepared (see list below). Discuss each issue with the participants and then decide if it is important.
- Discuss and specify the changes in RH issues before and after three years of group formation, for example:

| RH issue | Before group formation | Three years after group formation |
|---|---|---|
| Family Planning | Only knew about tubectomy | Know about many methods |

- Classify the changes occurring after three years of group formation as improved, remains same, or getting worse.
- Discuss with the participants and decide reasons for changes and attribute them as due to group activities or external factors or both.
- Analyze the reasons for changes and document them.
- Repeat these steps for each of the identified issues.
- Summarize the results at the end of exercise and share with the participants.

### Materials needed:

Cards to list key RH issues; markers; tape; matrix (above) to identify status of issue before group formation and three years after group formation; an additional matrix like the one used in Exercise 1 to list and attribute improvements.

**Initial list of important RH issues:**

The following issues were identified to use in the field

1. Use of family planning methods
2. ANC/PNC care
3. Safe delivery practices
4. Awareness regarding reproductive tract infections
5. Alcoholism/Gambling
6. Access to government services with particular reference to ANM services

* *adapted from Caudill, Denise, "We Tried to Measure Ourselves and Find We have Progressed!", 1998, WN, BBFW and FPAN.*

# Evaluation Findings: Reproductive Health

**B. Reproductive Health**

The Reproductive Health Historical Matrix participatory exercise was conducted with women's group and non-group members in Nellur and Yelenavadgi, as well as with wives of agriculture group members in Khanapur. The women identified the key issues with regard to reproductive health, what the situation was three years ago, and what the situation is now. The results of these participatory exercises, along with the results of the questionnaire, are summarized in Table 9. Key findings from Table 9 are summarized as follows:

1. The use of antenatal care (two ANC visits or more) for group and non-group members is higher in Nellur (100% to 70%) and Yelenavadgi (88% to 100%) when compared to Khanapur (57% to 46%). However, PNC did not show the same pattern.

2. Awareness regarding sexually transmitted diseases and AIDS is also higher for group and non-group members in Neller and Yelenavadgi. From the questionnaire we see that 100% to 89% of the women in Nellur and 100% to 83% in Yelenavadagi have heard about AIDS, when compared to Khanapur where 78% to 40% have heard about AIDS. Those who have heard about STD's in Nellur are 100% to 79%, in Yelenavadgi 100% to 85% and in Khanapur 72% to 48%. In general there is improved awareness about transmission and prevention aspects of AIDS and knowledge of symptoms in Nellur and Yelenavadgi villages when compared to Khanapur.

3. The women's group and non-group members in Nellur and Yelenavadgi said that access to auxiliary nurse midwife services was improved. Most of the participants attributed the change to group activities, while the non-group members of Nellur said both the group and others (*anganwadi*[11] worker, PHC center) were responsible for the change. The two women's groups also pointed out their increased knowledge about the services that the ANM is to provide. They said that the use of the "health services map" or a guide listing services, costs, and hours of availability had been useful as a means to monitor ANM services and encourage referrals as necessary (see Appendix C).

4. The awareness regarding family planning methods was generally high in group members of Nellur and Yelenavadgi while in non-group members the awareness was also high but not as high as that of group members. In the comparison village, Khanapur, the family planning awareness was low in general, except for tubectomies.

The adoption rate of family planning methods in Nellur and Yelenavadgi were high in group members and also in non-group members. In Khanapur the adoption rate was much below that of the adoption rates in Nellur and Yelenavadgi. Tubectomy is the most popular family planning method followed by pills and condoms. It is of note that in Khanapur, tubectomy is almost the exclusive method of family planning.

While baseline data is not available for all women in the program villages, the team did examine records from the gynecology camps that

*"My own and my husband's ignorance made us to have more children, but I will not allow my daughters to repeat this."* Puttamma, Yelenavadgi Women's Group.

*"Until this day, we use a sickle or a stone to cut the umbilical cord. We put our hair in our mouths to ease the expulsion of the placenta."* Women in Khanapur

*"Before the gyne camps, we never knew that uterine prolapse and STIs were curable",* Group Member, Nellur Women's Group.

*"Early on in the group formation, we didn't have any knowledge about RH, but now we have the knowledge and discuss these issues with our husbands."* Group Member, Nellur Women's Group.

*"Most importantly, earlier we did not talk about RH issues with our group members, now we discuss them in our group and with other people in the village as well."* Group Member, Yelenavadgi Women's Group

*"Before the formation of the group, we had not heard about ANM services and her job responsibilities. Now we demand services from the ANM. All together, we have written a letter to a higher local authority, and we got the ANM to visit our village regularly. Now women participate in social issues, too."* Group Member, Yelenavadgi Women's Group

*"The ANM doesn't come here. We have no one to discuss these problems with."* Men's agriculture group, Khanapur

[11] *The* anganwadi *is the village worker of the Department of Women and Child Development whose duties include providing pre-natal education, assisting in supplying contraceptives, and bringing awareness about Family Planning.*

# Evaluation Findings: Reproductive Health

recorded users of family planning. In 1998 for the group in Nellur there were two family planning users; in the group in Yelenavadgi in 1998 there were three users. During the last gyne camps held in January 2001, in the Nellur group there were 14 (93% of group members) family planning users and in the Yelena-vadgi group there were 13 (86% of group members) women who were family planning users.

5. The adoption of safe delivery practices was impressive in Nellur and Yelenavadagi because of the support from gyne camp and trained TBAs.

In Nellur, 72% of non-group members and 64% of group members interviewed reported using trained TBA services and from 100% to 91% reported using services of the gyne camp. In Yelenavadgi, 91% of group members reported using TBA services compared to 87% of non-group members. One hundred percent of the group members used the gyne camp services compared to 93% of the non-group members.

In both villages, women were unanimous in attributing the progress to group activities. Khanapur didn't have access to these services.

In a sub-sample of women who had births in the past three years, there was a clear pattern of use of trained TBA services and trained medical assistance. Women in Khanapur were more likely to be assisted by untrained TBAs or family and friends.

Table 9, on the following pages, gives complete results of the reproductive health findings.

# Evaluation Findings: Reproductive Health

**Table 9: Reproductive Health Results**

| RH Issues | Results Nellur | | Results Yelenavadgi | |
|---|---|---|---|---|
| | RH Matrix and Discussions | Questionnaire | RH Matrix and Discussions | Questionnaire |
| **ANC/PNC Services** | | | | |
| Group members | Before: Pregnant women didn't go to doctor/ANM and were not taking TT injections, iron tablets or nutritious food.<br>Now: Improved due to the group | ANC- more than two visits - 100%<br><br>PNC- more than two visits - 100% | Before: Pregnant women didn't go to doctor/ANM. Didn't take TT injections, iron tablets or nutritious foods.<br>Now: Improved due to group activities | ANC- more than two visits 88%<br><br>PNC-more than two visits 82% |
| Non-group members | Before: Pregnant women didn't use doctor/ANM, TT-injections, iron tablets or nutritious food.<br>Now: Improved due the group. | ANC - more than two visits - 70%<br><br>PNC - more than two visits - 52% | Before: Women didn't use ANC/PNC services.<br>Now: Improved due to group activities. | ANC -more than two visits- 100%<br><br>PNC- more than two visits 53% |
| **Awareness regarding RH related diseases** | | | | |
| Group members | Before: People used to suffer from these diseases and rarely went to the doctor for treatment.<br>Now: Improved due to group | Know about AIDS-100%<br>Means of transmission:<br>Due to sexual intercourse - 100%<br><br>Prevention:<br>Use of condoms -98%,<br>Sex with one partner-98%<br>Do not know -2%<br><br>Know about STIs -100% | Before: Many people used to suffer from these diseases and didn't go to the doctor for treatment.<br><br>Now: Improved due to group and others. | Know about AIDS-100%<br>Means of spreading<br>Due to sexual intercourse - 100%<br>AIDS prevention:<br>Use of condoms -100%<br>Sex with one partner-100%<br>Do not know - 0%<br><br>Know about STIs -100% |
| Non-group members | Before didn't know about symptoms, prevention or treatment.<br><br>Improved due to group. | Know about AIDS-89%<br>Means of transmission:<br>Due to sexual intercourse - 71%<br><br>Disease control:<br>Condoms -60%<br>Sex with only one partner - 54%<br>Do not know - 23%<br><br>Know about STIs -79% | Before they had no knowledge about RH diseases. We thought white discharge was common and didn't consider it to be a disease.<br><br>Now improved due to the group. | Heard about AIDS-83%<br>Means of transmission:<br>Due to sexual intercourse - 72%<br><br>Disease control:<br>Condoms -63%<br>Sex with only one partner - 56%<br>Do not know - 9%<br><br>Know about STIs -85% |

# Evaluation Findings: Reproductive Health

**Table 9: Reproductive Health Results, continued**

| RH Issues | Results Khanapur | |
|---|---|---|
| | **RH Matrix and Discussions** | **Questionnaire** |
| **ANC/PNC Services** | | |
| Group members<br><br><br><br><br><br>Non-group members | Before: Services are not available. ANM doesn't visit and there is no trained TBA. We have no knowledge of TT and iron tablets.<br>Now: same situation exists. | Wives of Ag Group Members<br>ANC- more than two visits 57%<br><br>PNC-more than two visits 43%<br><br><br>Wives of Non-group members<br>ANC -more than two visits -46%<br><br>PNC-more than two visits- 62% |
| **Awareness regarding RH related diseases** | | |
| Group members<br><br><br><br><br><br><br><br><br><br><br>Non-group members | Before: For the control of white discharge, used leaves of acasia ariculiformis was given or mango stones fried in ghee and eaten for three days. We have little knowledge about STIs, but because of poverty, we don't take medical treatment.<br><br>Now: Same condition exists. | Wives of Ag Group members:<br>Know about AIDS-78%<br>Means of transmission:<br>Due to sexual intercourse -78%<br><br>Aids prevention: Use of condoms -56%,<br>Sex with one partner -56%<br>Do not know - 0%<br><br>Know about STIs - 72%<br><br><br>Wives of Non-Group Members<br>Know about AIDS-40%<br>Means of transmission:<br>Due to sexual intercourse - 40%<br><br>Disease control:<br>Condoms -24%<br>Sex with only one partner -24%<br>Do not know - 8%<br><br>Know about STIs -48% |

**Table 9: Reproductive Health Results, continued**

| RH Issues | Results Nellur | | Results Yelenavadgi | |
|---|---|---|---|---|
| | RH Matrix and Discussions | Questionnaire | RH Matrix and Discussions | Questionnaire |
| **Use of ANM Services** | | | | |
| Group members | Before: Lack of knowledge about ANM's duties, ANM didn't visit<br>Now: Improved due to group activity | ___________________ | Before: Lack of knowledge about ANM's duties. ANM didn't visit.<br>Now: Improved due to group. | __________________ |
| Non-group members | Before: Lack of knowledge about ANM's duties. ANM not visiting regularly and provide services.<br>Now: Improved due to group and government (Aganwadi, PHC, ANM) | _____________________ | Before: ANM rarely visited- only for special programs like polio immunization.<br>Now: Improved due to group activities. | __________________ |
| **Acceptance of Family Plannng** | | | | |
| **Group members** | Before: Lack of knowledge about family planning methods and their use. People had many children.<br>Now: Improved due to group activities. | **Method - Use rate**<br>Vasectomy - 3%<br>Tubectomy - 22%<br>Oral pills - 11%<br>IUD - 8%<br>Condoms - 14%<br>Laprosopy - 17%<br>Other - 3%<br>**Contraceptive Use: 78%** | Before: Lack of knowledge about family planning methods and their use.<br>Now: Improved due to group. | **Method - Use rate**<br>Vasectomy - 0%<br>Tubectomy - 57%<br>Oral pills - 10%<br>IUD - 12%<br>Condoms - 2%<br>Laprosopy - 7%<br>**Contraceptive Use: 88%** |
| **Non-group members** | Before: Lack of knowledge about family planning methods and their use.<br>Now: Improved due to group activities | **Method - Use rate**<br>Vasectomy - 2%<br>Tubectomy - 34%<br>Oral pills - 12%<br>IUD - 6%<br>Condoms - 10%<br>Laprosopy - 10%<br>**Contraceptive Use: 74%** | Before: We were not using family planning.<br>Now: Improved due to group and government programs (aganwadi, PHC center) | **Method - Use**<br>Vasectomy - 0%<br>Tubectomy - 37%<br>Oral pills - 11%<br>IUD - 9%<br>Condoms - 6%<br>Laprosopy -13%<br>Abstinence - 2%<br>**Contraceptive Use: 78%** |
| **Safe Delivery Methods** | | | | |
| **Group members** | Before: Delivery was risky, absence of trained TBAs, unhygienic conditions<br>Now: Improved due to group | Use of trained TBAs -72%<br>Use of gyne-camps-100%<br>Births in past 3 years (9):<br>Trained TBA 3 (33%)<br>Health Worker 0<br>Doctor 4 (45%)<br>Untrained TBA 1 (11%)<br>Family/Friend 1 (11%) | Before: Delivery was unsafe. Absence of trained TBAs and unhygienic conditions.<br>Now: Improved due to group. | Use of trained TBAs -91%<br>Use of gyne-camps-100%<br>Births in past 3 years (17):<br>Trained TBA 10(59%)<br>Health worker 1 (6%)<br>Doctor 5 (29%)<br>Untrained TBA 0<br>Family/Friend 1 (6%) |
| **Non-group members** | Before: Delivery was risky, no trained TBAs, unhygienic conditions, no immediate breast-feeding.<br>Now: Improved due to group and government efforts | Use of trained TBAs -64%<br>Use of gyne-camps-91%<br>Births in past 3 years (23):<br>Trained TBA 12 (52%)<br>Health worker 0<br>Doctor 5 (22%)<br>Untrained TBA 5 (22%)<br>Family/Friend 1(4%) | Before: We used traditional methods- unhygienic conditions, cut cord with stone.<br>Now: Improved due to group activities. | Use of trained TBAs -87%<br>Use of gyne-camps-91%<br>Births in past 3 years (19):<br>Trained TBA 7 (37%)<br>Health worker 6 (32%)<br>Doctor 3 (16%)<br>Untrained TBA 0<br>Family/Friend 3 (16%) |

**Table 9: Reproductive Health Results, continued**

| RH Issues | Results Khanapur | |
|---|---|---|
| | **RH Matrix and Discussions** | **Questionnaire** |
| **Use of ANM Services** | | |
| **Wives of agriculture group members**<br><br>**Wives of non-group members** | <u>Before</u>: Services are not available. ANM doesn't visit and there is no trained TBA.<br><u>Now</u>: Situation is the same. | _______________ |
| **Acceptance of Family Plannng** | | |
| **Wives of agriculture group members**<br><br>**Wives of non-group members** | Not identified as an issue | Wives of Agr Group Members<br>**Method - Use** rate<br>Vasectomy - 0%<br>Tubectomy - 53%<br>Oral pills - 0%<br>IUD - 0%<br>Condoms - 0%<br>Laprosopy - 0%<br>**ContraceptiveUse: 53%**<br><br>Wives of Non-group Members<br>**Method - Use** rate<br>Vasectomy - 0%<br>Tubectomy - 43%<br>Oral pills - 0%<br>IUD - 0%<br>Condoms - 5%<br>Laprosopy - 0%<br>**Contraceptive Use:48%** |
| **Safe Delivery Methods** | | |
| **Wives of agriculture group members**<br><br>**Wives of non-group members** | <u>Before</u>: Crude and unhygienic deliveries existed. Superstition like putting hair in mouth to facilitate expulsion of placenta. Newborns are breastfed only after three days. The umbilical cord is cut with a sickle.<br><u>Now</u>: No change in condition. | There are no trained TBAs in the village. Gyne camps are not held.<br><br>Wives of Ag Group Members<br>Births in past 3 years (7):<br>Trained TBA 0<br>Health worker 0<br>Doctor 0<br>Untrained TBA 3 (43%)<br>Family/Friend 4 (57%)<br><br>Wives of Non-group members<br>Births in past 3 years (13)<br>Trained TBA 0<br>Health worker 0<br>Doctor 2 (15%)<br>Untrained TBA 8 (62%)<br>Family/Friend 3 (23%) |

# Evaluation Findings: Reproductive Health

**Reproductive Health Observations:**

There have been substantial improvements in use of reproductive health services as noted by both the participatory exercise and the survey findings. Women in the groups, as well as non-group members, were using ANM, trained TBA, and gyne camp services. Group members had higher levels of knowledge regarding family planning methods, AIDS and STIs than non-group members. However, even the knowledge and practice levels of non-group members were higher than those of women in the comparison village of Khanapur.

For family planning use, it is of note that the contraceptive use rates in Khanapur for the wives of the agriculture group members and the wives of non-members (53%-48%), resembled those for rural Karnataka (56.6%, National Family Health Survey, 1998-1999). The rates observed among group and non-group members in Nellur (78%-74%) and Yelenavadgi (88%-78%) greatly surpass the rates for rural Karnataka.

It is also noteworthy that women consistently identified “social issues,” such as alcoholism and gambling, within the range of reproductive health issues. The broad definition of reproductive health has been consistently used in program activities and is reflected in these issues. Women also noted a change in superstition or fatalism—that is, a willingness to take action to resolve problems.

## Participatory Exercise 3: Capacity Evaluation

**Objectives:**

1. To understand priority capacities as identified by the group members
2. To analyze strengths and weaknesses of the group
3. To generate results that will be used in future exercises with the group

**Keep in Mind:**

- Make sure all group members are present
- Spend some time with group members to build rapport
- Try to ensure that small children will not enter and disturb the process
- Solicit each member's participation
- Three people are needed for each exercise: one to facilitate, one to document, and one to observe
- Prepare for the exercise by having all things ready with the facilitation team.

**Steps:**

- Ask the group members to first list the indicators for group capacity
- Write down the indicators on separate cards
- Ask the participants to prioritize the listed indicators taking care to include the important ones
- Introduce the scale of 1-5 (paise) to the participants
- Ask them to score for each capacity identified
- Identify the weak points and plan to address areas of weakness in the future
- Sum up the exercise and share with the participants the overall results

**Materials needed:**

Cards to list indicators; markers; tape; wall or board to post cards

## C. Capacity

In this section, the capacity of the women's groups and the capacity development of BSRDS in reproductive health were examined. The women's groups identified and rated their own capacities. The BSRDS Reproductive Health Worker also rated the capacities of the two groups and the ratings were compared.

In addition, BSRDS staff identified and rated their organizational capacities. They identified advantages and disadvantages of the integration of reproductive health. The cost of the reproductive health component was also examined.

### Rating of Women's Groups by Group Members

In Nellur and Yelenavadgi, capacity evaluation exercises were conducted with the group members. In these exercises, group members were asked to list, then prioritize, key capacities for the group. They then individually ranked themselves on how well they felt the group's capacity had developed. The results for the women's groups in Nellur and Yelenavadgi follow.[12]

**Nellur**: In this village 14 of the 15 group members attended the exercise. On the basis of their discussion, members were asked list indicators to measure the group's capacity.

Initially they listed ten capacities: 1) Savings and Credit, 2) Group Records, 3) Knowledge related to group activities, 4) Access to government services, 5) Unity and cooperation, 6) Second line leadership, 7) Leadership, 8) Loan repayment, 9) Attendance at meetings, and 10) Sustainability.

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[12] *The evaluation team assumed that the initial capacity of the groups was zero, since they did not exist prior to the establishment of the RH component. However, it would have been ideal to have a baseline self-assessment in order to compare change over time.*

# Evaluation Findings: Group and Organizational Capacity

They prioritized capacity indicators and chose seven on which to rate themselves. They used a five-point scale of 10 to 100 paise to rate their capacity. The results are presented in Table 10.

**Yelenavadgi**: Twelve of the 15 group members were present at the time of the exercise. From their discussion, they listed 14 capacities. After listing the capacity indicators on cards, all participants prioritized and selected five priority indicators by using tamarind seeds. The results are shown in Table 11.

When asked why members rated themselves so high, they said that they have a lot of awareness through different types of trainings organized by WN and BSRDS. Other comments from the groups included:

**Reproductive Health Activities**
Women said that with the help of the RH program in the village, everyone has come to know issues related to RH. They said that after integrating this program, most of the couples (group members) use family planning methods.

**Savings and Credit**
After forming the group, participants say they have come to know from their small savings that they can achieve anything. According to group members a remarkable change has been their liberation from moneylenders. Many participants say they have become free from moneylenders where earlier they borrowed from them extensively.

**Group Sustainability**
The groups said that even without external support (BSRDS), they would carry on their activities.
In Nellur, the women's group said

**Table 10: Group Capacity Rating by Nellur Women's Group**

| Indicator | 10 | 25 | 50 | 75 | 100 |
|---|---|---|---|---|---|
| 1. Unity and cooperation | | | | 64% (9) | 35% (5) |
| 2. Second line leadership | | | | 71% (10) | 28% (4) |
| 3. Responsibility | | | | 57% (8) | 43% (6) |
| 4. Group Records | | | | 50% (7) | 50% (7) |
| 5. Knowledge in group activities | | | | 35% (5) | 64% (7) |
| 6. Savings and credit | | | | 50% (7) | 50% (7) |
| 7. Sustainability | | | | 43% (6) | 57% (8) |

**Table 11: Group Capacity Rating by Yelenavadgi Group**

| Indicator | 10 | 25 | 50 | 75 | 100 |
|---|---|---|---|---|---|
| 1. Loan repayment | | | | | 100% (12) |
| 2. Access to government services | | | | 17% (2) | 83% (10) |
| 3. Unity and cooperation | | | | 17% (2) | 83% (10) |
| 4. Savings and credit | | | | | 100% (12) |
| 5. Knowledge in group activities | | | | 8% (1) | 92% (11) |

they would be able to hold gyne camps, send TBAs for training, give the group leader a small honorarium, and from their initial savings, group members would bear the cost of the doctor's honorarium, transportation, and incidentals. "Our group is strong."

Women's group members in Yelenavadgi also felt that they could continue many of their activities without the support of BSRDS. They would conduct gyne camps with individual savings and interest on loans earned. In addition, they could use their assets, like spraying pump and seed cum fertilizer drill, to earn income.

### Rating of Group Capacities by RHW

The team also asked the BSRDS RHW (Mahadevi Kavalagi) for her evaluation of Nellur and Yelenavadgi group capacities. She gave ratings very similar to those of the groups (Tables 12 and 13). According the RHW, knowledge about group activities was rated at 100% for the Yelenavadgi group. This was because of trainings and awareness campaigns. She felt that through gyne camps and other activities, the group has come to know what their responsibilities are and the responsibility of others as well. Overall, she said she felt that Yelenavadgi was the stronger group because of the responsibility for activities that they have taken on.

### Rating of NGO Capacity

BSRDS also rated its capacities with regard to where they are now, and where they were three years ago. Participating in this exercise were Subbanna Biradar, BSRDS Director, and other BSRDS staff, including Mallikarjun Biradar, Mallikarjun Kavalagi, and Mahadevi Kavalagi.

**Vision**: Subbanna described how the vision of the BSRDS has developed into integrated programming:

*"Before the RH component",* he said, *"we worked with only farmers and their family wasn't in the picture. Now the family as a whole is addressed and even the agriculture information and practices are more widely shared."*

**Planning**: The BSRDS team cited multiple trainings as a reason for their improvement here. The trainings were conducted by World Neighbors and other agencies as well.

**Implementation**: Similarly WN-I, as well as other partners, has provided training to support staff in implementation. Also, staff has become more

*"As group members we are closer than sisters and share our happiness and sorrow."* Chandamma, Yelenavadgi Women's Group.

*"The group has made us realize that we too have a voice."* Group Members of Yelenavadgi regarding having succeeded in getting the services of the ANM in their village.

*"This capacity exercise helped us to know more about our weaknesses and strengthen them."* Group Member, Nellur Women's Group.

**Table 12: Reproductive Health Worker Capacity Rating - Nellur**

| Indicator | 10% | 25% | 50% | 75% | 100% |
|---|---|---|---|---|---|
| 1. Unity and cooperation | | | | X | |
| 2. Responsibility | | | | X | |
| 3. Savings and credit | | | | X | |
| 4. Loan repayment | | | | X | |
| 5. Knowledge about group activities | | | | X | |
| 6. Access to government services | | | | X | |
| 7. Sustainability | | | | X | |

**Table 13: Reproductive Health Worker Capacity Rating - Yelenavadgi**

| Indicator | 10% | 25% | 50% | 75% | 100% |
|---|---|---|---|---|---|
| 1. Unity and cooperation | | | | X | |
| 2. Second line leadership | | | | X | |
| 3. Responsibility | | | | X | |
| 4. Record keeping | | | | X | |
| 5. Knowledge about group activities | | | | | X |
| 6. Savings and credit | | | | X | |
| 7. Sustainability | | | | X | |

# Evaluation Findings: Group and Organizational Capacity

experienced over time, greatly increasing their abilities to implement.

**Monitoring and Evaluation**: In this respect, the BSRDS team feels it has made a big improvement over the past three years. Before the integration of RH, they say they were weak. But with the WN training in participatory methods, they have greatly increased their capacity to monitor and evaluate their activities. They attribute this change to the WN training and support. They say other organizations haven't stressed this aspect like WN. The training in participatory methods for RH (particularly capacity ranking) was applied to other program areas as well.

**Sustainability/Resource Development:** Three years ago, BSRDS was a young organization and had less capacity to generate resources. Now they have successfully generated resources from the government through the Entrepreneur Development Program and the watershed programs. Subbanna says he is only rating it at 50% as it still needs to improve. (Currently, BSRDS has no other funding sources for RH).

**Leadership**: BSRDS has helped to establish two Federations and two baby NGOs. Subbanna is recognized as an able leader by other NGOs in the district. In terms of second line leadership, Mallikajun Biradar attends meetings in Subbanna's absence and other staff also fill in.

**Transparency/financial and administrative management:** They rate this at 100% and say that BSRDS has from the beginning been transparent. BSRDS does serve as a model for other NGOs.

**Table 14: BSRDS Capacity Rating**

| Capacity | 10% | 25% | 50% | 75% | 100% |
|---|---|---|---|---|---|
| Vision | | | 3 years ago | Now | |
| Planning | | | 3 years ago | Now | |
| Implementation | | | 3 years ago | Now | |
| Monitoring and evaluation | | 3 years ago | | Now | |
| Sustainability/Resource generation | | 3 years ago | Now | | |
| Leadership | | | | 3 years ago | Now |
| Transparency/financial and administrative management | | | | | 3 years ago; Now |
| Skilled, experienced staff | | | 3 years ago | Now | |
| Ownership of program | | | 3 years ago | Now | |
| Coordination with donors and other agencies | | | 3 years ago | Now | |

**Skilled, experienced staff:** Three years ago, not many BSRDS staff had a high level of experience or field exposure. Over the past three years, staff confidence and effectiveness have been built through trainings and cross-visits, many of them supported by WN.

**Ownership of program**: Over time staff has been given more responsibility, resulting in a stronger feeling of ownership. They have also developed more trust in the leadership.

**Coordination with donors and other agencies**: BSRDS is recognized in the local area as a leader and has linked communities with government services and banks. Seventy-five BSRDS groups have gotten loans from banks.

The advantages and disadvantages of integration of reproductive health were also discussed, as well as BSRDS priorities for its reproductive health work.

**Advantages of Integrating RH into Program Activities:**

1) Integrated development- holistic
2) Increased women's involvement- work with both men and women
3) Increased cooperation between staff members – ag and RH
4) Agriculture facilitates contact with wives of group members
5) Increased cooperation between men and women – gyne camps where men help

# Evaluation Findings: Group and Organizational Capacity

6) ANM services are well known in the communities now
7) Improved relations between men and women
8) Communities solve problems such as water/transportation
9) Women's groups share with men's groups- they met once every two months to share issues/concerns
10) It has built staff capacity through training "BSRDS is recognized as a resource in RH."
11) BSRDS has benefited from RH workshops and sharing with other NGOs.
12) The RH component has helped them achieve their mission of "socio-economic development of the poorest of poor."

**Disadvantages of Integrating RH into Program Activities**

1) Initial 3-6 months faced some problems as some members of the farmers groups were opposed to sending their wives to meetings.
2) Workload has increased for staff. Ag promoters are doing more RH work. Agriculture work is seasonal so there is time to do RH work.
3) RH work requires a lot of follow-up, particularly for family planning and gyne camps.
4) Although BSRDS hasn't had this problem, a lack of cooperation from the PHC center could be a problem.

**BSRDS Future Priorities for RH**

1) Integrate RH into other community groups
2) Facilitate access to laproscopies rather than tubectomies (issue of cost here).
3) Would like to expand to the more remote villages.
4) Would like to also cover adolescents
5) BSRDS wants to identify an OB/GYN to be a resource person

**Group and NGO Capacity Observations:**

Both women's groups rated their capacities highly. As these are established groups, almost three years old, it isn't surprising. Unity and cooperation, savings and credit, leadership, and knowledge of activities were give high ratings by the groups themselves as well as the RHW who supports them. It is clear from the groups' comments they have made substantial progress in these group capacities—from non-existent to their current high ratings. However, the team noted some discrepancies between their ratings and our record review of the groups' savings and credit activities. Neither of the groups had 100% repayment of loans and there were some gaps in their record keeping.

According to their perceptions, BSRDS has improved in all areas of key capacities. The biggest areas of improvement have been in skilled staff and monitoring and evaluation. BSRDS attributes the changes in monitoring and evaluation to WN India supported training.

Also of note is the capacity that BSRDS has developed in reproductive health. Three years ago it was an organization without experience in reproductive health, and now BSRDS is recognized at the district-level as a resource in the area. Government departments ask for Subbanna Biradar's input (Director BSRDS) as a resource person.

Although BSRDS staff cited many important advantages of incorporating reproductive health into its program, they also noted the increased workload. As stated earlier, while agricultural work is seasonal, RH is year-round and requires organization and careful follow-up.

The cost of the RH component was also examined. The annual budget for the RH component for BSRDS and the percentage of the annual budget for the WN program support for the RH component attributable to BSRDS support (primarily staff salaries and training costs) were combined. The total was $2,542.00.

| | |
|---|---|
| BSRDS support | $1,740.00 |
| WN Program support | 802.00 |
| **Total** | **$2,542.00** |

As the RH component supports 13 women's groups, this averages $196 per group. As each group has an average of 18 members per group, the annual cost is $10.86 per group member per year.

# Evaluation Tool: Integration

## Participatory Exercise 4A: Semi-structured Interviews (SSI) - RH with men's groups

### Objectives:

1. To assess the participation of men in the integrated program
2. To determine the awareness level of men's group members
3. To assess the benefits of integration of RH program with the existing livelihood programs

### Questions to be asked:*

- Have you heard of RH?
- Which are the RH related activities?
- What are the problems related to RH?
- Have you had contact/communication with RH groups? If yes, in what way?
- Have you heard of family planning methods? If yes, list them.
- What RH related problems do you have in your family?
- How do women support your work?
- Have you discussed improved DLA practices with the women?
- Are there changes in the women's status?
- Have you discussed with your wives the problems related to RH? If yes, list them.
- What are the benefits you've gained from the RH group?
- Do you know about spacing?

### Materials needed:

Matrix to list questions and responses (see Table 16, page 34):

| Questions | Responses from Men's Groups in Nellur | Responses from Men's Groups inYelenavadgi | Responses from Men's Groups in Khanapur |
|---|---|---|---|
| | | | |

## Participatory Exercise 4B: SSI-Agri with women's groups

### Objectives

1. To assess the participation of women in agricultural activities
2. To determine the awareness level in women's group members
3. To assess the benefits of integration of agricultural program

### Questions:*

- Have you heard of improved dry land agriculture (DLA)?
- Have you participated in DLA?
- Have you adopted improved DLA practices?
- Do you discuss seed treatment regarding the use of good seeds in your family?
- Do you discuss integrated pest management?
- Have you established live hedges?
- What type of communication do you have with the men's group?
- Has your group developed sustainability?

### Materials needed:

Matrix as in Exercise 4A to list questions and responses (see Table 17, page 35).

* The questions were developed by the team, based on the stated objectives of the evaluation.

# Evaluation Findings: Integration

**D. Integration**

**Men's Agriculture Group Members, Yelenavadgi**

*"My problem is my wife's problem and her problem is my problem. As a family we have to share."* Annarao Biradar, Group Leader, Men's Agriculture Group, Yelenavadgi

*"Our participation in selecting improved farming activities has made our husbands realize that we too can contribute for the betterment of our farming."* Women's group members, Yelenavadgi Women's Group

*"Before we had this (the women's) group, I never talked about reproductive health with my wife. Now I even discuss it with my sisters and other family members."* Nellur Men's Agriculture Group

*"Before the RH component, we worked with only farmers and their family wasn't in the picture. Now the family as a whole is addressed and even the agriculture information and practices are more widely shared."* Subbanna Biradar, BSRDS Director

Guided discussions were carried out both with women's group members and men's group members to better understand the relationships between the groups, the men's role in reproductive health, and the women's role in agriculture. The findings for Nellur, Yelenavadgi, and Khanapur are presented in Tables 16 and 17.

**Integration Observations:**

For Nellur and Yelenavadgi, there appears to be improved awareness and practices related to both RH and dry land agriculture (DLA) in both men's and women's groups. When compared to Nellur and Yelenavadgi, Khanapur has less awareness in either area.

In Khanapur, agriculture group members acknowledge there is a need to form a women's RH group. The Nellur and Yelenavadgi women's groups have developed some capacity to sustain their activities, facilitating the NGO phase out from their groups over the next year.

The men's groups in both Nellur and Yelenavadgi were well-informed about reproductive health issues and the activities of the women's groups. Women also cited examples of how men supported RH activities including assisting with the gyne camps and group meetings.

As the Khanapur agriculture group is relatively new (1 year), it makes comparison with Nellur and Yelenavadgi difficult. While the wives of members have some knowledge about improved DLA practices, there is obviously more knowledge and involvement in Nellur and Yelenavadgi. While the groups in Nellur and Yelenavadgi attributed their involvement in RH and agriculture to the interactions between the groups and improved communication between couples, it is difficult to attribute the changes in agriculture solely to the RH group.

# Evaluation Findings: Integration

**Table 16: Men's Responses to Reproductive Health Questions**

| Questions | Nellur Groups | Yelenavadgi Groups | Khanapur Ag Groups |
|---|---|---|---|
| 1. Have you heard of RH? | Yes | Yes | No |
| 2. Which are the RH related activities? | Gyne camps, ANC, PNC, FP, safe delivery | Gyne camps, TBA training, ANC, PNC | None |
| 3. Whate are the problems related to RH? | STI's, anemia, infertility, weakness | Unsafe delivery practices, STI's | Don't know |
| 4. What type of communication do you have with the RH groups? | We discuss the issues in our groups with them. We also support their activities and discuss issues in our families. | We discuss issues together. We discuss about RH related issues. Earlier we didn't discuss RH issues with our family members, now we do freely. | N/A |
| 5. Have you heard of family planning? If so, what methods? | Yes. Permanent: tubectomy, laproscopy, vasectomy; Temporary: condoms, pills, IUD, Depo | Yes. Permanent: tubectomy, laproscopy, vasectomy Temporary: condoms, pills, IUD, Depo | Yes.Tubectomy |
| 6. What RH related problems do you have in your family? | Infertility, weakness, anemia, discharge | STI's, infertility, weakness | Infertility, difficulty in delivery |
| 7. How do women support your work? | They support our farming activities like harvesting and weeding. | They support our farming activities like carrying food, seed treatment, etc. | They support. |
| 8. Have you discussed improved DLA practices with the women? | Yes<br>Example: Compost, manure, subsistence farming, IPM, and fall plowing | Yes<br>Example: compost, manure, subsistence farming, IPM, and fall plowing | Yes, we have discussed. |
| 9. Are there changes in women's status? | Yes<br>Example: Decision making in the family, savings, and education for girls. | Yes<br>Example: Decision making, savings and credit, and purchasing and selecting seeds | No |
| 10. What are the benefits you've gained from the RH group? | Awareness in family planning methods, RH issues, STI's, ANC, PNC, access to government services; ANM coming to the village | Awareness in family planning methods, RH issues, STI's, ANC, PNC, access to government services, ANM coming to the village | N/A |

**Table 17: Women's Responses to Agriculture Questions**

| Questions | Nellur Groups | Yelenavadgi Groups | Khanapur wives of Ag Group |
|---|---|---|---|
| 1. Have you heard of improved dry land agriculture (DLA)? Do you participate in DLA? | Yes, women do participate by doing lighter work like weeding, sowing, seed treatment, etc. | Yes, women do participate by doing lighter work like weeding and taking meals to our husbands in the field. | Yes, women participate, but to a lesser extent |
| 2. Have you adopted improved DLA practices? | Yes<br>Example: Sowing across the slope, establishment of live hedges, fall plowing, use of compost manure, IPM, use of improved implements. | Yes<br>Example: Sowing across the slope, establishment of live hedges, fall plowing, use of compost manure, IPM, use of improved implements, fruit tree planting. | Some people have adopted these practices. |
| 3. Do you discuss seed treatment regarding the use of good seeds in your family? | Yes<br>Example: We collect a good variety of seeds. | Yes<br>Example: We collect a good variety of seeds | Yes, we have discussed it. |
| 4. Do you discuss integrated pest management? | Yes<br>Example: Fall plowing, use of bird perches, subsistence farming, etc. | Yes<br>Example: Use locally available natural pesticides. | Yes, we have discussed it. (They didn't quote examples.) |
| 5. Have you established live hedges? | Yes. All farmers have live hedges. | Yes. All farmers have live hedges. | Only two farmers have established live hedges. |
| 6. What type of communication do you have with the men's group? | They meet once a fortnight to discuss issues and share information on activities. They also support us in our activities like gyne camps. | The groups meet periodically (varies) to discuss information and share information on activities. The men support us in our activities like group meetings and gyne camps | N/A |

# Evaluation Tool: Livelihood Ranking

## Exercise 5: Livelihood Ranking for Women Group Members

### Objectives:

1. To determine the distribution of group members in wealth categories
2. To identify any changes in wealth in the past three years

### Steps:

1. Select 2-3 informants, preferably group leaders or persons who know all group members well
2. Describe objectives
3. Ask participants to separate group members by two categories - *poor* and *better off*
4. After they complete the two lists ask them to define their criteria for *poor* and *better off*
5. Ask them to review the *poor* category and divide it into *poor* and *very poor*
6. Ask them to divide the *better off* category into *better off* and *much better off*
7. Discuss the criteria the used for these categories
8. Identify any individuals that have changed categories since the formation of the group and then discuss why

### Materials needed:

Cards with names of all group members; title cards: ***poor, very poor, better off, much better off***; markers; tape; wall, board, or floor to post cards.

*Woman carrying wood in Yelenavadgi*

*Reproductive health workers verifying questionnaires*

*Nellur Women's Group: Reproductive Health Historical Matrix Exercise*

# Evaluation Findings: Livelihood

**E. Livelihood Ranking and Savings and Credit**

To review the process and outcomes of the savings and credit component, the team reviewed the group documents and conducted livelihood-ranking exercises with women's groups in Nellur and Yelenavadgi.

**1. Livelihood Ranking**

Livelihood ranking was conducted with key informants from the Nellur and Yelenavadgi women's groups. The results were later cross-checked with BSRDS staff who verified them. The results from these exercises follow.

**Livelihood Ranking - Nellur Women's Group; 15 members**

For the classification of the members under these categories, criteria such as number of acres of field, house, and animals owned were taken into consideration.

The following three group members have moved from very poor to poor categories by taking loans from the group.
1. Rajbi- She has taken a loan to purchase a goat.
2. Hasinbi - She has started a coconut vending business in front of the mosque.
3. Iravva - She has taken a loan to purchase a goat.

Members who moved from poor to better off with group loans are
1. Radha - She has taken a flour mill on lease.
2. Irramma - She started vegetable vending.

Members who were very poor and remained the same are:
1. Saraswati - Her husband spends all his earnings on drink and she is working as a laborer.
2. Bhagyavanti - She is physically handicapped and she earns and looks after her parents.
3. Mohanbai - She works as a laborer and spends money for medical treatment.
4. Kallamma - She does not have any land, works as laborer, is a widow, and lives alone.
5. Renuka - Works as a laborer, has a big family, husband is a drunkard.
6. Indubai - Works as a laborer, has a big family, is in ill health.

Five members have increased their economic status as a result of loans from the group. While members acknowledge that these increases are not large, they also point out they do represent an improvement in quality of life.

*"I can identify each and every utensil the money leader took from our parents and grandparents and has in his house—just to provide a small loan."* Shantamma, Yelenavadgi Women's Group

*"While helping our fellow group members who are badly in need of help, we value the person, not the money."* Shantamma, Yelenavadgi Women's Group

*"I am more interested in my children's education and not being called 'well off'."* Pattamma, Yelenavadgi Women's Group

| Very Poor | Poor | Better Off | Well Off |
|---|---|---|---|
| Hasinbi<br>Kallamma<br>Renuka<br>Bhagyavanti<br>Indubai<br>Saraswati | *Rajbi*<br>Parakka<br>*Hasinbi*<br>*Iravva* | Bhimavva<br>*Irramma*<br>*Iradha*<br>Yellamma | Mehbubi |

*Nellur group members whose names are in italics have moved up a level.*

# Evaluation Findings: Livelihood

**Livelihood Ranking - Yelenavadgi Women's Group; 15 members**
For the classification of the members under these categories the following criteria such as number of acres of field, house, animals owned were taken into consideration. The group also considered the number of children in a household as influencing livelihood status.

The following group members have moved from very poor to poor categories by taking loans from the group.
1.Parakka - She has taken a loan to construct a house.
2. Shantamma - She has taken a loan for farming activities which resulted in increased yield.
3. Kallamma - She has taken land on lease for farming.
4. Mallamma - She has taken a loan from the group and with the awareness given has utilized the loan to her benefit.

Two members have moved from better off to well off.
1. Basamma - with loan taken does tailoring (sells).
2. Hanumavva - with the loan taken does sugarcane extraction.

Those remaining in the very poor category are:
1. Yellamma - has no land or house, works as laborer, husband is alcoholic.
2. Bhimavva - laborer, is a widow and has lost her daughter and son.
3. Radha - has lost her father and mother due to AIDS, works as a laborer and has to look after her sister.
4. Sharada - has no land or house, has to spend on her children's education.
5. Saraswati - has taken a loan for children's health.

| Very Poor | Poor | Better Off | Well Off |
|---|---|---|---|
| Yellamma<br>Bhimavva<br>Radha<br>Sarada<br>Saraswati<br>Mehbubi | *Parakka*<br>*Shantamma*<br>*Kallamma*<br>*Mallamma* | Puttamma<br>Bhagyavanti<br>Renuka | *Basamma*<br>*Hanumavva* |

*Yelenavadgi group members whose names are in italics have moved up a level.*

6. Mehbubi - She has taken a loan for her daughter's marriage; remains in same place.

Overall, six members have changed categories as a result of the group loans. Again, the changes are small but significant according to the women.

**2. Savings and Credit**

The team reviewed the records from two groups each in Nellur and Yelenavadgi, with the following results:

**Nellur Group #1 – Formed in 1998; 15 members**

For the most part, the group was saving regularly, although there were gaps during festival months when there were no savings. For most members, the savings were made up later. The loan distribution is as follows:

**Nellur Group #I**

| Purpose of loan | Number of loans | Amount of loans |
|---|---|---|
| 1) Health | 10 (37%) | 9600 (50%) |
| 2) Education | 1 (4%) | 500 (4%) |
| 3) Income generation | 3 (11%) | 2500 (13%) |
| 4) Goat purchase | 13 (48%) | 6500 (34%) |
| **TOTAL LOANS** | **27 (100%** | **19100 (100%)** |

*Remarks*
1. Most loans have been for goat purchases (48%) and health ( 37%)
2. Four have not repaid the loans
3. Members have taken more time repaying loans than originally agreed.
4. Rupees 776 was earned as interest
5. In several cases, because of necessity and seriousness (usually health-related), a few members received second loans though they have not repaid the original loan.
6. Improvement is needed in loan disbursement and repayment

**Yelenavadgi Group #1 - formed in 1998; 15 members**

Both groups were saving 25 rupees per month per person. The savings appeared regular.

**Yelenavadgi Group #I**

| Purpose of loan | Number of loans | Amount of loans |
|---|---|---|
| 1) Health | 6 (27%) | 7500 (26%) |
| 2) Assets | 12 (55%) | 7850 (27%) |
| 3) Income generation | 01 (4%) | 1000 (3%) |
| 4) Others | 03 (14%) | 12800 (44%) |
| **TOTAL LOANS** | **22 (100%)** | **29150 (100%)** |

# Evaluation Findings: Livelihood

*Remarks*
1. Loan records are well maintained
2. Interest rates are not uniform
3. Though marked profit because of improper loan repayment
4. People have spent the loan amount for other reasons and less on health (27%)
5. No one has taken a loan for education

**Livelihood and Savings and Credit Observations:**

There is evidence that the loans given by the group have had an impact on livelihood status. According to the evaluation findings, five group members from Nellur and six group members from Yelenavadgi have increased their livelihood status. While these changes are small (no one moved two categories), the changes are significant according to the women interviewed.

The findings from group record reviews and participatory exercises also demonstrate the range of needs that these women face. Loans are often taken for "non-productive" purposes such as household needs or health. These are judged as needed by the group. Borrowing from the group at lower interest rates allows women to avoid having to borrow from village moneylenders. (In Yelenavadgi, money lenders charged 5% per month, whereas the group was charging 3%).

While the women's groups rated their savings and credit activities as strong in the capacity section, there are areas for improvement with regard to regularity of savings and documentation. However, the decisions made with regard to loans were transparent and judged to be fair by group members. Women appear to have a strong sense of unity and compassion. For example, although several of the poorer women had not been able to repay their loans, group members were clear that in case of need (particularly for health) they would give them another loan whether they would be able to pay it back or not.

# Evaluation Results and Limitations

This section responds to the seven key questions posed at the beginning of the evaluation (page 9) and also provides a discussion of the limitations of the evaluation.

## A. Responses to Key Questions

***Key Question 1) How has the program affected the awareness (RH) of group and non-group members?***

The program has had a considerable effect on knowledge and use of reproductive health services, particularly as concerns ANC/PNC, RH-related diseases, and use of family planning for both group members and non-group members. In general, the program helped group members become more aware of RH issues. This effect was a little less in non-group members.

***Key Question 2) Did the program create a demand for government services, specifically reproductive health services?***

The evaluation demonstrates that the program has created a demand for government services in Nellur and Yelenavadgi. The participatory exercises indicated that both members and non-members of the women's groups were using ANM services for antenatal, postnatal, and family planning services. Information from the survey also indicates that women in RH group villages are using services to a greater extent than those where the program does not exist. Finally, the interview with the ANM for Yelenavadgi confirms that the demand for her services have increased.

*"There has been a remarkable change due to the women's group. Before women were not using ANC, getting tetanus toxoid injections or having their children immunized. They also didn't realize the symptoms of RTIs. The gyne camps have really helped women understand about these problems. Now, because of BSRDS work, women come to be treated for RTIs, UTIs and for ANC and PNC care*." Nirmala D. Lalii, ANM responsible for Yelenavadgi village.

**Table 18: RH awareness of group and non-group members**

| | Nellur | | Yelenavadgi | | Khanapur | |
|---|---|---|---|---|---|---|
| | Group | Non-group | Group | Non-group | Wives of group members | Wives of non-group members |
| More than two ANC visits | 100% | 70% | 88% | 100% | 57% | 46% |
| More than two PNC visits | 100% | 52% | 82% | 53% | 43% | 62% |
| Family planning use | 78% | 74% | 88% | 78% | 53% | 48% |
| Gyne camp use | 100% | 91% | 100% | 91% | N/A | N/A |
| Use of TBA services | 72% | 64% | 91% | 87% | N/A | N/A |
| Knowledge of STIs | 100% | 79% | 100% | 85% | 72% | 48% |
| Knowledge of AIDS | 100% | 89% | 100% | 83% | 78% | 40% |

***Key Question 3) What has been the role of the men's agriculture groups in addressing RH issues?***

From the discussion with both men's agriculture and women's RH groups, it is clear that the participation of men in addressing RH issues has helped significantly. Specifically, men were said to have assisted in the following ways:

- Cooperation and assistance in forming women's groups.
- Helping to address the social issues identified in the women's groups.
- Discussion and use of family planning methods both in groups and with spouses
- Supporting efforts to increase access to government services
- Discussing with women's groups AIDS and STIs and how to control them
- Supporting initiatives to improve women's status
- Helping organize gyne camps and encouraging their wives' participation

# Evaluation Results and Limitations

***Key Question 4) What has been the impact/outcome of program activities on reproductive health, savings and credit, and women's status?***

a) Reproductive Health
While, in terms of reproductive health, the scope of the evaluation was limited to the outcome level, there were substantial differences in reproductive health indicators between group and non-group members and those of the comparison village.

For family planning use, it is of note that the contraceptive use rates in Khanapur, the comparison village (53%-48%), resemble those for rural Karnataka (56.6%, National Family Health Survey, 1998-1999). The rates observed among group and non-group members in Nellur (78%-74%) and Yelenavadgi (88%-78%) greatly surpass the rates for rural Karnataka. This relationship is portrayed in Chart 1.

For ANC visits, there are also clear differences between the groups as demonstrated in the following graph. As shown in Chart 2, the women's group members are more likely to have more ANC visits than non-group members. Women in the comparison village of Khanapur are the least likely to have had ANC care. PNC visits were most frequent for group members, but women in Khanapur had a similar ratio of PNC visits compared to non-group members.

b) Savings and Credit and Livelihood
Table 19 illustrates the reasons for which loans were taken and the amount of the loans for two groups: one in Nellur and one in Yelenavadgi.

**Chart 1: Family Planning Use**

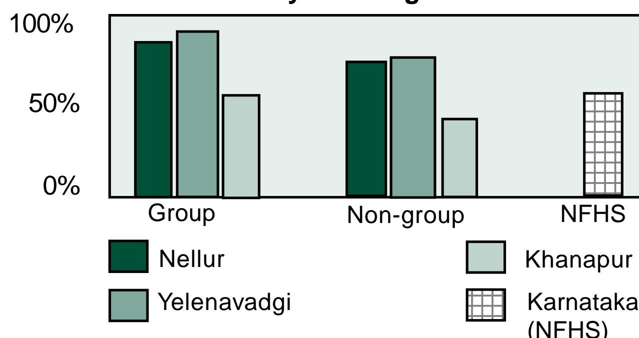



**Chart 2: ANC and PNC Use**

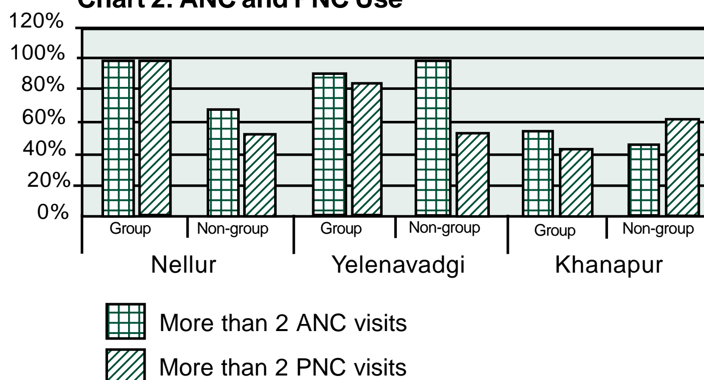



**Table 19: Savings and Credit Activities (all groups)**

| | Nellur | | Yelenavadgi | |
|---|---|---|---|---|
| Reason for Loan | # of loans | Amount of loans | # of loans | Amount of loans |
| Health | 10 (37%) | 9600 (50%) | 6 (26%) | 7500 (23%) |
| Education | 1 (3%) | 500 (4%) | 0 (0%) | 0 (0%) |
| Income Generation | 3 (11%) | 2500 (13%) | 2 (9%) | 2000 (6%) |
| Assets (goat rearing) | 13 (48%) | 6500 (34%) | 11 (48%) | 6850 (20%) |
| Other purposes | 0 (0%) | 0 (0%) | 4 (17%) | 15800 (49%) |

# Evaluation Results and Limitations

The following patterns were noted in terms of group loans.

1. Greater numbers of women have taken loans for health.
2. Fewer loans have been taken for income generation activities.
3. In the two groups, only one loan was taken for education.
4. In Yelenavadgi, four large loans were taken for other purposes (marriage and household repairs).

**Changes in Livelihood Status**

There is evidence that the loans given by the group have had an impact on livelihood status. According to the evaluation findings, five group members from Nellur and seven group members from Yelenavadgi have increased their livelihood status. While these changes are small (no one moved more than one category) the changes are significant according to the women interviewed.

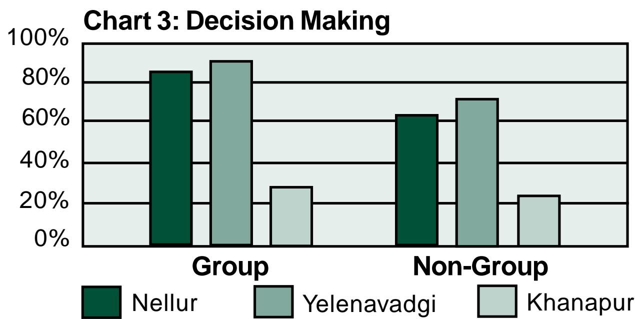
The findings from the group record reviews and participatory exercises also demonstrate the range of needs that these women face. Loans are often taken for "non-productive" purposes such as household needs or health however these are judged as needed by the group. Borrowing money from the group at lower interest rates allows women to avoid having to borrow from village moneylenders who charge much higher interest rates. (In Yelenavadgi, money lenders charged 5% per month, whereas the group was charging 3%).

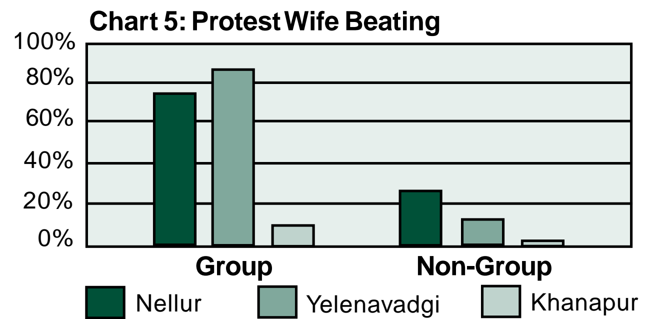
c) Women's Status

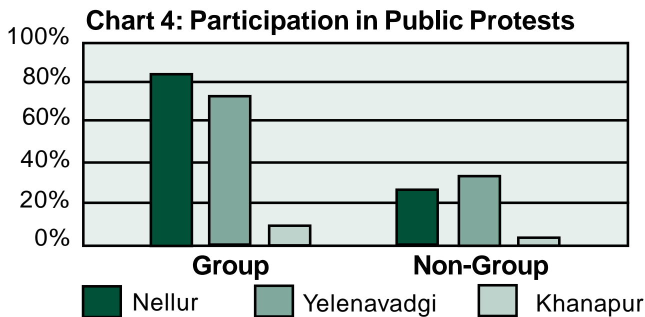
Women in the three villages identified similar sets of issues related to women's status. These included decision-making, property ownership, participation in politics, girl-child education, family planning, reproductive health, divorce and violence against women.

With regard to many of these issues, women in the two intervention villages said that the situation was improving (with the notable exception of dowry). Women said the reasons for improvement were primarily because of group activities. However, girl child education and participation in politics were said by some of the women to have improved because of group activities as well as the efforts of the government.

The questionnaire data allowed triangulation of information and illustrated positive differences for group members in the areas of decision-making, participation in politics, family planning use, and protesting against spousal abuse. The following graphs illustrate indicators of women's status, decision making, participation in public protests and attitudes toward protesting wife beating. The positive trends among group members are notable.



# Evaluation Results and Limitations

***Key Question 5) How does the livelihood distribution of the groups compare to that of the villages?***

*Due to time constraints, we were unable to address this question in the villages.*

***Key Question 6) What is the capacity of the groups to sustain activities?***

Both Nellur and Yelenavadgi groups have improved their capacities. Both of these groups are now in a position to sustain their activities with little outside support from BSRDS. As BSRDS phases out from these villages over the next year, they will have the opportunity to work with the women's group in a phased manner to ensure their capacities are at the necessary levels.

According to the groups, they have developed capacities through the following activities:

- Regular savings
- Loans to needy members
- Regular decision-making
- Loan repayment
- Awareness about RH and DLA activities
- Keeping records
- Developing second line leadership
- Assuming responsibility

The groups said without external support (BSRDS), they would carry on their activities.

In Nellur, the women's group said they would be able to hold gyne camps and from their initial savings, group members bear the cost of the doctor's honorarium, transportation, and incidentals. They also said that they would continue the honorarium for the group leader, but at a lesser amount.

***Key Question 7) What is the awareness and adoption of improved dry land agriculture (DLA) practices by women's group and non-group members?***

Questions were asked at Nellur, Yelenavadgi and Khanapur regarding awareness and adoption of improved DLA practices. At Nellur and Yelenavadgi, there is good communication on these issues between men and women because of the existence of both men's and women's groups. As a result, there appears to be improved awareness in women's group members regarding the following agricultural practices:

1. Fall plowing
2. Seed treatment
3. Subsistence farming
4. Live hedges
5. Use of compost manure
6. Growing of fruit trees

Women also said they used these techniques in their agricultural work. In contrast, at Khanapur, there is comparatively low awareness.

However since the DLA men's group is relatively new (one year) it makes comparison with Nellur and Yelenavadgi, where the groups are five years old, difficult.

## B. Limitations of the Evaluation

It is useful to note the limitations of this evaluation exercise. These include:

1) The evaluation was conducted during marriage season. This may have limited the participation of women in the villages visited. While the team adjusted its schedule to ensure maximum participation, there were significant demands on villagers' time to attend marriage ceremonies and this may have had an effect particularly on the participatory exercises.

2) The team's preparation time was very limited. Because of other demands on time and the cancellation of the consultant who had been scheduled to assist with the evaluation, the preparation for the evaluation was very limited. This particularly had an effect on the first week of the evaluation period, as the team had to plan almost at the same time as the training for data collection.

3) It was not possible to field test the questionnaire and modify it in advance of the data collection training. The lack of pre-testing meant that significant time was spent in answering interviewers' questions, adjusting the questionnaire, and practicing questionnaire administration.

4) There was no general baseline information available for this evaluation. The design of evaluation attempted to compensate by the addition of the comparison village and collecting perceptions of trends through the participatory exercises. Only in the case of family planning use for the women's groups was there clear baseline information.

5) While it was invaluable to have a comparison village, BSRDS was unable to match one with the same the length of time of the agriculture group with that of the RH villages. The agriculture group in Khanapur had only been established a year ago, compared to those in Nellur and Yelenavadgi that have been established for five years. This made comparison regarding agricultural practices and the role of women in agriculture difficult.

# Evaluation Results and Limitations

6) The entire analysis of the 22 questions on the questionnaire was not available to the team at the time of analysis or report writing. The team did an analysis of nine questions that were judged the most relevant. The team used this preliminary data to respond to the key evaluation questions (page 9).

7) In all the villages, the women participating in the participatory exercises were a sub-sample of those interviewed for the questionnaire. For the group members, Group 1 in Nellur and Group 1 in Yelenavadgi participated. The non-group members were self-selected. Thus the information from the participatory exercises is from smaller groups of women and may not be representative of the larger groups.

8) The sample for the questionnaire was purposeful in that women were selected based on being a group member or a non-member. As such, it may not be representative of the village as a whole.

# Lessons Learned and Conclusions

**A. Key Findings and Lessons Learned: Impact of Group Activities**

1. The role of men through the agriculture group in the formation of the women's groups and support for their activities has been invaluable. The agriculture group members helped to support the formation of the women's groups by encouraging their wives to participate and in some cases, convincing other men to do the same. They have also provided ongoing support in terms of assisting with the organization of gyne camps and regular discussion of issues, (RH, agriculture, and social issues), with the women's groups. Individually, they have also encouraged their wives to attend the gyne camps.

2. Where there are women's groups, there is increased awareness and improved RH practices compared to villages where there are no groups. This is clear from the evaluation findings. In villages where there are groups, even non-group members have higher rates of awareness regarding RH and improved use of services than women in villages without groups.

3. Women's groups appear to have had an impact on indicators of women's status, particularly decision-making, participation in politics, and protesting against spousal abuse. Women group members attribute these changes largely to the group, but also acknowledge the role of the government in politics and girl-child education.

According to the women, the groups have also provided women with the confidence to mobilize to undertake a variety of initiatives ranging from closing bars and gambling houses to civil disobedience to improve the water supply to the village.

4. There is evidence that the loans given by the groups had an impact on livelihood status for a third of the members. According to the evaluation findings, five group members from Nellur and seven group members from Yelenavadgi have increased their livelihood status. While these changes are small (no one moved two categories), the changes are significant according to the women interviewed.

5. The groups have had significant success in improving access to government services, particularly the services of the ANM. The groups wrote letters to the PHC centers, with the help of BSRDS, asking for regular ANM visits, and the ANMs have complied. The "health service map" has been useful in assisting BSRDS and the groups to ensure that key services are provided.

The groups, BSRDS and the communities have united to leverage government services, such as road repairs, bus services to villages, water supply, and *janata* houses (housing for the poor).

6. Both men and women report that there has been an increase in couple communication due to the groups. Improved communication was reported with regard to reproductive health, agriculture activities, as well as other issues such as girl-child education, drinking, gambling and violence against women.

7. As a result of group activities, unity has been increased in the villages. The group activities have brought people together to address common problems, like the need for government services.

8. The gyne camp services have been important in creating awareness regarding reproductive health issues, particularly reproductive tract infections and uterine prolapse. The continuation of gyne camp services is seen as a priority by group members and in Nellur, women have contributed from their savings in order to ensure the

camps continue after BSRDS phases out.

9. The role of the trained *daiyas* (TBAs) in increasing awareness regarding safe delivery practices as well as providing linkages to health services has been important. The ANM, PHC physician, and gyne camp doctor all report that the trained TBAs play a valuable role in ensuring that women get necessary services. A majority of women interviewed in Nellur and Yelenavadgi, both group and non-group members, report using trained TBA services.

10. Although BSRDS didn't have any experience in reproductive health, they were able to effectively implement the activities. In the district (Gulbarga), BSRDS is now seen as a resource for RH. BSRDS notes that the addition of the RH component has significantly contributed to their integrated development approach and has strengthened their relationship with village women.

11. A very positive result of the savings activity has been the decrease on dependence on moneylenders in the villages in case of emergencies. Women repeatedly noted that taking loans from the group, at lower interest rates, was of great assistance, particularly during emergencies (often health-related).

12. Awareness regarding STIs and AIDS has been increased through joint men and women group activities. The linkages between the men's and women's groups have allowed them to discuss sensitive issues that were not previously discussed openly. This has been particularly important with regard to STIs and AIDS and has facilitated partner treatment in the case of infections detected during the gyne camps.

13. BSRDS acknowledges the importance of trainings and cross visits in helping develop its capacity in reproductive health. These experiences have also contributed to improving staff capacity in other areas as well.

14. Community leaders (both men and women) and BSRDS staff have developed capacities to effectively implement, monitor and evaluate activities. These skills include technical knowledge, communication, and program management.

**B. Key Findings and Lessons Learned: The Evaluation Process**

1. The team felt they had increased their knowledge about the evaluation process and participatory methods as well as data analysis.

2. The principle of triangulation—comparing facts and figures using various methods—was found to be very useful.

3. The evaluation also underlined the importance of planning and pre-testing instruments, particularly the questionnaire.

4. The evaluation process required a great deal of teamwork.

5. The team noted a need for caution and privacy when asking sensitive questions.

6. Due to the evaluation, several members felt they had increased knowledge about report writing and facilitation skills.

7. The selection of villages for evaluation is critical. If a comparison is being done, villages need to be matched on basic characteristics.

# Lessons Learned and Conclusions

**C. Discussion and Conclusions**

The team noted the many strengths of the BSRDS RH component in discussing lessons learned. There were four suggestions for opportunities for improvement.

1. An area in which the program could be strengthened and which also is one of BSRDS' priorities is the increased participation of adolescents in activities.

2. The group record keeping needs to be improved in some areas, particularly gyne camps and savings and credit. During this last year of BSRDS support to the groups, additional time should be spent reviewing and helping to strengthen group record keeping.

3. The evaluation noted that knowledge and use of RH services were higher for group members than non-group members. The existing strategy for reaching out to non-group members has been to establish new groups. However, because of the difficulty with regarding to savings and the time constraints of women, it seems unlikely that all women in a village will be able to join a group. Thus, it is suggested that an alternative strategy be developed to help increase awareness about RH issues in non-group members. One idea is that each member agrees to share information regularly with another woman in a neighboring household.

4. As this evaluation was not able to examine in detail the effects of the RH program on agriculture, WN India should look for an opportunity to evaluate this aspect in the future. With WN India's strengths in agriculture, such a study would be a unique opportunity to address this important aspect of integrated programming.

The team felt there was a great deal of potential for replication of the integrated model in Karnataka and elsewhere. Although the predisposing factor of the presence of agriculture groups is limited, several basic factors such as the potential responsiveness of the government to NGO initiatives, the community interest, and the capacity of NGOs to work in integrated programs are widespread. It should be noted that WN-India is currently working with a partner (VISHALA) which has no agricultural activities and that this experience may be of comparative interest.

**For World Neighbors programs elsewhere, the team felt the following to be most applicable:**

1) The broad approach to reproductive health engages women, families and communities in a significant process of social change.

2) The gynecology camps and trained birth attendants can play an important role in initiating reproductive health service use.

3) Health service mapping has assisted community members to monitor the quality of government services.

4) The capacity building undertaken with women's groups seems to result in self-confidence that encourages women to address wider social issues.

5) The savings and credit activities assist women to gain access to cash for many basic needs, including health.

6) The support and involvement of the male agriculture groups provided a basis on which to develop dynamic women's groups.

7) The integration of reproductive health with other livelihood activities (sustainable agriculture and shepherding) betters communication between couples and involves women in decision-making.

# Appendix A – Questionnaire

## BSRDS RH EVALUATION

"Namaste, My name is _________ and I am working with _________. We are conducting this survey about the health of women and children in this village and we would very much like your participation.

We will be using this information to evaluate our program activities and anything that you say will be kept strictly confidential and not shown to other persons. We hope that you will participate as your experience is very important.

Do you have any questions?

Do you agree to participate? Yes ❒ No ❒

Interviewer's name ___________________ Date of interview: ❒❒❒❒❒❒

Village: ____________ Household number: ❒❒❒❒

Family name: ____________________ Street: __________________ Religion: ❒

Caste: __________ 1. SC 2. ST 3. Other

1. How many people are usually living in your household? ❒❒

| Line No. | Name | Relation with head | Sex M=1; F=2 | Age (completed years) | Marital Status | If age 6 years or more | |
|---|---|---|---|---|---|---|---|
| | | | | | | Education (completed years) | Occupation |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 01 | | | | | | | |
| 02 | | | | | | | |
| 03 | | | | | | | |
| 04 | | | | | | | |
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| 13 | | | | | | | |
| 14 | | | | | | | |
| 15 | | | | | | | |

**Religion:** Hindu=1; Muslim=2; Christian=3; Other=4
**Code for column 3:** Head =01; Wife/Husband=02; Son/Daughter=03; Son-in-law/Daughter-in-law=04; Grandchild=05; Parent=06; Parent-in-law=07; Brother/Sister =08 ; Brother-in-law/Sister-in-law=09; Niece/Nephew=10; Other related=11; Not related=12
**Code for column 6:** Currently married=1; Widowed=2; Divorced/Seperated/Deserted=3; Never married=4
**Code for column 8:** Cultivator=01; Agricultural labourer =02; Non-agricultural labourer=03; Business=04; Salary=05; Housework=06; Student=07; Not working=08; Other=09

# Appendix A – Questionnaire

2. Line number of (Respondent) woman in household list: ☐☐

Line number of husband in household list: ☐☐ (98, if husband is not a usual resident)

| Date of birth | Woman | Husband |
|---|---|---|
| | ☐☐ ☐☐ | ☐☐ ☐☐ |

| | Month | Year |
|---|---|---|
| 3. Date of your marriage | ☐☐ | ☐☐ |
| 4. Date of your effective marriage (Gauna)? | ☐☐ | ☐☐ |

5. **BIRTH HISTORY**

a. Have you ever given birth 1. Yes 2. No ☐ (If No, skip to Q.6)

b. If yes, please give DETAILS OF ALL PREGNANCIES

| Sl. no. | Month & year of pregnancy outcome | Ended in | Place of delivery | Birth attended by | Name of child | Sex | Still alive? | If no, month & year of death | Cause of death |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 01 | | | | | | | | | |
| 02 | | | | | | | | | |
| 03 | | | | | | | | | |
| 04 | | | | | | | | | |
| 05 | | | | | | | | | |
| 06 | | | | | | | | | |
| 07 | | | | | | | | | |
| 08 | | | | | | | | | |

**Codes:**
Column 3: Live birth=1; Spontaneous birth=2; Still birth=3; Induced abortion=4
Column 4: Home=1; PHC=2; Govt. hosp.=3; Pvt hosp.=4; Other=5
Column 5: Untrained dai=1 ; Trained dai=2; Health worker=3; Doctor=4;Family members /Friends only=5
Column 7: Male=1; Female=2
Column 8: Yes=1; No=2

6. a. Are you currently pregnant? Yes=1; No=2 ☐ ( If 5a= No and Q. 6a= No skip to Q11)
   b. If yes, Number of completed months ☐☐
   c. How many times you had gone for the ANC check up during this pregnancy? ☐
   d. How many tetanus toxoid (TT) injections have you received for this pregnancy? ☐
   e. How many iron folic acid (IFA) tablets have you taken for this pregnancy? ☐☐☐

# Appendix A - Questionnaire

**MATERNAL HEALTH**

7. Have you given birth in the past 3 years?
   Yes =1  No=2  (If No, skip to Q 11) ☐

8. If yes, during your last pregnancy
   a. How many times did you go for the ANC checkup? ☐

| Place of visit | Service provider | Month of pregnancy |
|---|---|---|
| ____________ | ____________ | ☐☐ |
| ____________ | ____________ | ☐☐ |
| ____________ | ____________ | ☐☐ |

   b. How many TT injections had you received? ☐  At which months? ____________

   c. Did you receive IFA tablets? Yes=1 No=2 ☐  If yes, how many? ☐☐☐

9. How many times you had gone for the PNC check up? ☐

| Place of visit | Service provider | Months after delivery |
|---|---|---|
| ____________ | ____________ | ☐ |
| ____________ | ____________ | ☐ |
| ____________ | ____________ | ☐ |

10. Did you want to become pregnant at that time? ☐
    a. Wanted at that time only
    b. Wanted little later
    c. Wanted no more children
    d. Cannot say

11. Family Planning Yes=1; No=2

| Family Planning Methods | Heard of it? | Used? | Duration of use (months) | Currently using? | If no, give reason for discontinuation |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Vasectomy | | | | | |
| Tubectomy | | | | | |
| Laproscopy | | | | | |
| IUD/Copper T | | | | | |
| Oral Pill | | | | | |
| Condom | | | | | |
| Periodic abstinence | | | | | |
| Withdrawal | | | | | |
| Other | | | | | |

Note: If column 2 is yes, go to column 3; otherwise skip to next method.
If column 3 is yes, go to column 4; otherwise skip to next method.
If column 5 is yes, skip to next method.

# Appendix A - Questionnaire

12. Interviewer has to check from the previous table that she is currently using any FP method, and write the method she is using ______________________

    a. If no, ask the reason for not using any method? ___________________________

    b. If currently using spacing methods OP or condom, ask place of supply ☐
       1. Government services
       2. Gyne camps
       3. Medical shops
       4. Other (please specify) ________________________________

13. Have you faced any gynecological or reproductive related health problems? ☐
    Yes=1; No=2 (If No, skip to Q 14)

    If yes, what type of problems ____________________________________

    ____________________________________

    Had you received any treatment for it? Yes=1; No=2 (If No, skip to Q14) ☐

    If received, from whom? ____________________________________________

14. Are you a member of any RH group? Yes=1; No=2 (If Yes, skip to Q 15) ☐

    If no, Is someone in your family a member of RH group? Who? ____________________________

15. Is your husband a member of an agriculture group? Yes=1; No=2 (If Yes, skip to Q 16) ☐

    If no, is someone in your family a member of agriculture group? Who? ____________________________

16. Have you taken loan from RH group or any other group? Yes=1; No=2 (If No, skip to Q 17) ☐

    If yes, what did you do with that money? ________________________

    Did it increase your income? Yes=1; No=2 ☐

    If yes, by how much? (Per year) ☐☐☐☐

    If no, why? _____________________________________________________ ☐

17. Do you discuss with your husband the RH issues discussed in the group? ☐
    (Yes= 1; No=2)

    Does your husband discuss with you about the agriculture activities discussed in the group? ☐
    (Yes= 1; No=2)

18. Have you ever discussed with your husband about any of the FP method? ☐
    (Yes= 1; No=2)

    Have you ever discussed with your husband about your family's size? ☐
    (Yes= 1; No=2)

# Appendix A - Questionnaire

19. **Women's empowerment** Yes=1; No=2

| | **Particulars** | **Yes/No** |
|---|---|---|
| 1 | Do you own land in your name? | |
| 2 | Do you have cash in your name? | |
| 3 | Do you own productive assets like an animal? | |
| 4 | Can you make small household purchases on your own? (<100 Rs.) | |
| 5 | Can you make larger household purchases on your own? (>100 Rs.) | |
| 6 | Can you take decisions related to your children on your own, like education or marriage? | |
| 7 | Can you involve in major household decisions? | |
| 8 | Can you move alone in your village? | |
| 9 | Can you go alone to other villages? | |
| 10 | Can you go alone to your mother's place? | |
| 11 | Can you go to your nearest market place alone? | |
| 12 | Do you involve in your village political activities? | |
| 13 | Do you participate in public protests? | |
| 14 | Can you agree for protesting against a husband who beats her wife? | |

20a. Have you heard of an illness called AIDS? Yes=1; No=2 (If No, skip to Q 21)
(Record all the answers )

If Yes, How is AIDS transmitted? (mark all mentioned)
1.Sexual intercourse
2.Needles/blades
3.Transfusion of blood
4.Mother to child
5.Other ______________________
6.Don't know

How one can avoid AIDS? (mark all mentioned)
1.Using condoms during sex
2.Sex with only one partner
3.Checking blood before blood transfusion
4.Sterilizing needles and syringes
5.Avoiding pregnancy if a woman has AIDS
6.Other_______________________________
7.Don't know

20b. Have you heard of any sexually transmitted infection? ☐
Yes=1; No=2

If yes, do you know the symptoms of it? ☐☐☐☐☐ (mark all mentioned)

1. Wound/Ulcers on genitals
2. Foul discharge/ white discharge
3. Itching/Irritation on genitals
4. Burning urination
5. Other____________________________

21. Agricultural Activities

a. Does your family have any land? Yes=1 ; No=2 (If No, skip to Q 21,d) ☐

b. If yes, does your family grow the following crops?

| Crops | Grow? (If NO, skip to next crop) | Use for household purpose? |
|---|---|---|
| Cereals | | |
| Pulses | | |
| Oil seeds | | |
| Vegetables | | |
| Fruits | | |

c. Do you follow improved agricultural practices? Yes=1; No=2 ☐
If yes,

1. Do you have contour live hedges in four yields? ☐
2. Do you practice fall plowing? ☐
3. Do you practice mixed cropping? ☐
4. Do you planted fruit trees in your field? ☐
5. Do you practice IPM? ☐
6. Do you apply compost in your field? ☐

d. Do you engage in agricultural activities? Yes=1; No=2 ☐
If No, skip to Q.22

If Yes, check which activities:

1. Sowing ☐
2. Weeding ☐
3. Harvesting ☐
4. Threshing ☐
5. Winnowing ☐

e. If yes, for how many months do you get to work? (If =1. skip to Q 22) ☐
1. 12 months
2. 9 -11 months
3. 6 -8 months
4. 3- 5 months
5. Less than 3 months

f. If it is not for 12 months, what do you do for the rest of the period? ☐
1. Non-agricultural work (Goundi, Brick making, etc)
2. Artisan (Pot making, Basket making etc)
3. Tailoring
4. Animal husbandry
5. House work
6. Other ________________________________

22. Are you helped by the following group activities? Yes=1; No=2

a. Have you got services from Gyne camp? ☐

b. Have you attended TBA Training? ☐

c. Do you attend group meetings regularly? ☐

d. Do you participate in Savings and Credit? ☐

e. Do you have access to Government Service? ☐

f. Have you benefited from trained TBAs? ☐

# Appendix B - Evaluation Training Schedule

4/26/01- Day One- Afternoon Session

| | |
|---|---|
| 1. Introductions – Subhash | 2:00 – 2:10 |
| 2. Icebreaker — Laxmi | 2:10 – 2:30 |
| 3. Objectives and key questions - Patil | 2:30 – 3:00 |
| 4. Expectations – Hallad | 3:00 – 3:15 |
| *Break* | *3:15 – 3:30* |
| 5. Questionnaire – Subhash | 3:30 – 4:15 |
| 6. Questionnaire Methodology - Cat | 4:15 – 4:30 |
| 7. Practice with Questionnaire | 4:30 – 5:30 |
| 8. Suggestions and Modifications – Patil | 5:30 – 6:00 |

4/27/01- Day Two

| | |
|---|---|
| 1. Review of Day One- Laxmi | 10:00 – 10:15 |
| 2. Clarifications and Modifications of Questionnaire- Patil | 10:15 – 11:00 |
| 3. Participatory Methodology - Cat | 11:00 – 11:15 |
| 4. RH Historical Matrix- Hallad and Laxmi | |
| Presentation | 11:15 – 11:45 |
| *Break* | *11:45 – 12:00* |
| Practice | 12:00 – 1:00 |
| Feedback | 1:00 – 1:15 |
| *Lunch* | *1:15 – 2:15* |
| 5. Capacity Evaluation- Patil | 2:15 – 3:45 |
| *Break* | *3:45 – 4:00* |
| 6. Women's Status- Dr. Subhas | 4:00 – 5:55 |
| 7. Evaluation of Day 2- Kellye | 5:55 – 6:00 |

4/28/01- Day Three

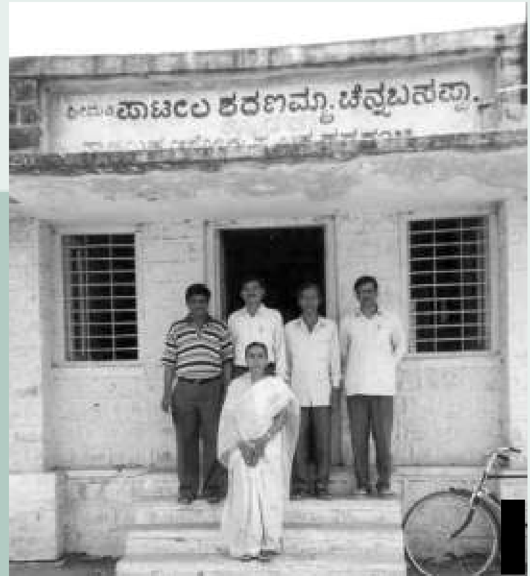
| | |
|---|---|
| 1. Review of Day 2- Laxmi | 9:00 – 9:15 |
| 2. SSI – Group Men – RH- Laxmi & Patil | 9:15 – 10:45 |
| *Break* | *10:45 – 11:00* |
| 3. SSI – Group Women – Ag -Dr. Subhash | 11:00 – 12:30 |
| 4. Questionnaire Revision & Clarification- Hallad | 12:30 – 1:30 |
| *Lunch* | *1:00 – 2:00* |
| 5. Wealth Ranking- Hallad | 2:00 – 2:45 |
| 6. Gallery Walk- Dr. Subhash | 2:45 – 3:00 |
| (RHW's copy steps for participatory exercises) | |
| 7. Calendar Presentation- Patil | 3:15 – 4:00 |
| *Break* | *4:00 – 4:15* |
| 8. Wrap–up - Dr. Subhash | 4:15 – 5:00 |
| 9. Evaluation – Kellye | 5:00 – 5:15 |

# Appendix C - Health Service Maps

In the WN-India Karnataka program, linkages with health services are essential. One way in which the women's groups learn about the Ministry of Health services that are available in their area is through health service maps. These maps, or guides, were developed by Laxmi Madras, WN RH Consultant. They describe in detail the location of the health services, the staff, the hours, the costs and the types of services provided by various levels of the Ministry of Health nearest each village. Thus community members know and can monitor the services that should be available at each level.

Health service maps can be developed for many levels of health care. Below are examples of the health service maps for Nellur, outlining 1) services provided at the nearest primary health care center (PHC), and 2) services provided by the auxiliary nurse-midwife (ANM) outreach worker. A health service map could also be done to describe services provided at the referral hospital.

Name of organization: BSRDS
Village: Nellur
PHC Center: Kadaganchi
Distance from village: 7 kilometers
Transport available: Yes
Cost of transport: Rs.6



**Information about Kadaganchi PHC Centre**

No. of doctors on duty: One

Doctor on duty: 8am to 12 noon
3pm to 5pm

Staffing pattern:

| | |
|---|---|
| Male health workers | Three |
| ANMs | Three |
| Staff nurse | One |
| 1st division assistant | One |
| Pharmacist | One |
| Clinical officer | One |
| Cleaners | Two |

Area covered by PHC: 13 villages (Nellur, Kadaganchi, Dharmawadi, Basavantwadi, Aalur, Vijapur, Bamanhalli, Ladachincolli, Ladachincolli Tanda, Dannur, Dannur Tanda)

Operating theatre: Yes
Surgery preformed: Tubectomy only- once a month
Emergency equipment/treatment: None. Serious emergencies are referred to Gulburga, Alanda government hospital.
Number of in-patient beds: 13
ANC, PNC & Immunization clinic: Thursdays
Subcenters: 3

# Appendix C - Health Service Maps

**ANM Services:**

Area covered: 5 villages (Nellur, Donnur, Donnur Tanda, Ladachincolli, Ladachincolli Tanda)

Services: Identifying and registering of pregnant women
Immunization
Provides information on family planning methods
Supplies contraceptives
Provides ANC/PNC
Distribution of ORS packets
Provides information about MTP

Frequency of visits to villages: Once a week (4 times a month)

ANC Services: Identifying and registering pregnant women
Administering TT injections
Providing IFA tablets (iron- folic acid)
Providing information about nutrition
Physical check for anemia (eyes)

Emergency obstetrical care: No

Refers emergencies to: Gulberga/Aland government hospital

Antenatal IFA tablets: 100 tablets for pregnant women

Postnatal IFA tablets: If woman diagnosed as anemic- 100 tablets

Information about family planning:
1) Permanent- Tubectomy, vasectomy and laproscopy
2) Temporary- condoms, oral pills and IUDs

Contraceptives provided by ANM: oral pills, condoms; refers for permanent methods and IUDs

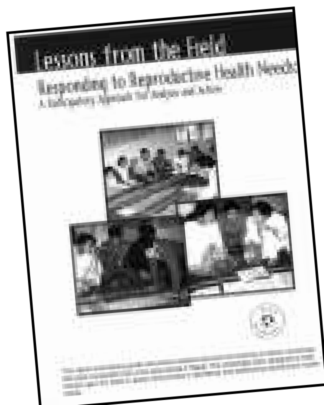
Takes medical kit to village: Yes

Equipped with emergency drugs: No, the Ministry of Health has not supplied her with the necessary drugs

Safe delivery kits:
Earlier the ANM provided. Currently there is a shortage from the MOH and she does not provide them. She gave them to pregnant women at 7th or 8th month or to the TBA.

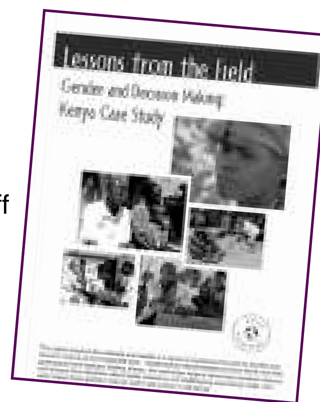
TT injection schedule: 1st injection at 3rd month
2nd injection at 5th month
if a woman gets pregnant within one year of last delivery, she gets a one booster dose at the 5th month.

# More Lessons from the Field



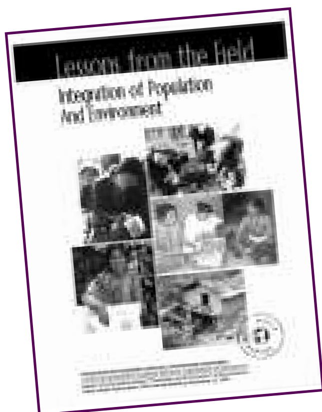

### Responding to Reproductive Health Needs: A Participatory Approach for Analysis and Action (2001)

This report and training guide documents experiences from two training of trainer workshops that were conducted over a two year period in Nepal. The workshops were designed to help trainers gain the skills to assist communities in identifying and addressing reproductive health needs. The guide is well illustrated with graphics and photos, and includes 15 training exercises with clear explanations of procedures for facilitating the workshops. 54 pages, available in English, Spanish, and French. $10.00, plus shipping.




### Gender and Decision Making: Kenya Case Study (2000)

This report presents the methods and results of a series of workshops focused on gender and decision making at the household level. Conducted by World Neighbors' staff with participants from Makueni District, Kenya, the workshops helped community members discuss and analyze how decisions about family resources and childbearing were being made, and what impact these patterns had on men's and women's well-being. 22 pages, available in English. $5.00, plus shipping.



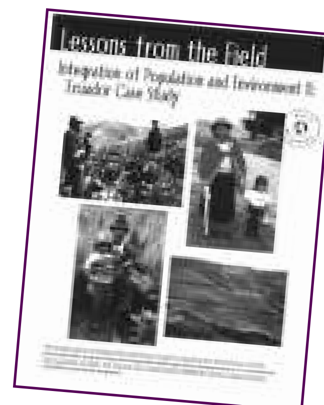

### Integration of Population and Environment (1998)

This collection of articles explores the creative ways in which World Neighbors and other organizations are addressing population and environmental issues at the community level. Articles include case studies of integrated programs as well as discussions on organizational needs and funding trends.

These papers were originally presented at the American Public Health Association's 125th Annual Meeting in 1997. The authors represent a range of organizations involved in efforts to link population and environment, including Population Action International, The Summit Foundation, The University of Michigan Population-Environment Dynamics Project, World Neighbors, and World Wildlife Fund. 69 pages, available in English. $5.00, plus shipping.

### Integration of Population and Environment II: Ecuador Case Study (1998)

This publication presents the findings of a three-year Operations Research Project carried out in partnership by World Neighbors and the Ecuadorian family planning organization CEMOPLAF. The results support a compelling argument for implementing an integrated approach which combines reproductive health and agricultural/natural resource management programming to address population and environment issues at the community level. Published by the University of Michigan Population-Environment Fellows Program. 26 pages, available in English. **FREE!**

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World Neighbors is a grassroots development organization working in partnership with the rural poor in hundreds of villages throughout Asia, Africa, and Latin America. World Neighbors brings people together to solve their problems and meet their basic needs. By supporting community self-reliance, leadership, and organization, World Neighbors helps people address the root causes of hunger, poverty and disease.

World Neighbors affirms the determination, ingenuity, and inherent dignity of all people. By strengthening these fundamental resources, people are helped to analyze and solve their own problems. Success is achieved by developing, testing, and extending simple technologies at the community level and by training local leaders to sustain and multiply results.

Program priorities are food production, community-based health, family planning, water and sanitation, environmental conservation, and small business.

Founded in 1951 and rooted in the Judeo-Christian tradition of neighbor helping neighbor, World Neighbors is a non-sectarian, self-help movement supported by private donations. World Neighbors does not solicit nor accept U.S. government funding.

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