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End-term impact assessment report – Draft for discussion

HFF's Community Health Facilitator Project

Nov 2016

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Executive Summary

Introduction

Axis Bank Foundation (ABF) was set up in 2006 with an objective of working with the marginalized sections of society to bring them out of poverty and vulnerability. Over the last decade, ABF has evolved as an organization and has streamlined its projects and programmes to focus on key thematic areas – Sustainable Livelihood, Education and Highway Trauma.

In 2012, ABF funded Healing Fields Foundation (HFF) to support the training of community women as Community Health Facilitators (CHFs) in Assam, Bihar, Chhattisgarh, Odisha and Uttar Pradesh. While HHF-CHF project within ABF's organizational setup is housed under the livelihood vertical, the project's primary aim is to help improve community health awareness and outcomes.

Under the project, selected resident women are trained over a twelve month period (training (6 months) and internship (6 months)) to become CHFs. These CHFs during the training period conduct health education sessions for community members; they receive a fixed stipend of INR 500 from months 7-12. The health sessions focus on increasing awareness among women and girls on health issues, and hygiene and sanitation practices. Additionally, they also draw incentives from selling of sanitary napkins, mobilising village cleanliness drives (a Goonj Initiative), mobilizing villagers for construction of toilets, etc.

ABF financial grant of INR 1.18 Cr to HFF for a period of four years, was to facilitate the training of the CHFs. ABF engaged Deloitte to ascertain the end-term impact assessment of the CHF intervention.

Context setting

The overall health status of India has seen marked improvements over the last six decades. However, the health indicators for India continue to be significantly poorer in comparison to those of the OECD countries. Further, vast disparities in health indicators and disease burden are seen across the country's length and breadth and the worst performing states are concentrated in the northern belt. The table below gives a summary of select health indicators in the country.

Indicator	India	Highest	Lowest
Birth Rate[1]	21.4	27.6 (Bihar)	14.7 (Kerala)
Death Rate[1]	7	8 (Odisha)	4.1 (Delhi)
Infant Mortality Rate (IMR)	44	59 (Madhya Pradesh)	12 (Kerala)
Maternal Mortality Ratio (MMR)[1]	167	300 (Assam)	61 (Kerala)
Under-Five mortality rate (U5MR)[1]	49	73 (Assam)	12 (Kerala)

The poor health of the country's people can be mainly attributed to the large population, poverty, and unequal distribution of basic services (infrastructure and personnel). This situation gets complicated further because of illiteracy and low health awareness levels, less than 1% public spending on health, high proportion of out of pocket expenditure on health and poor health insurance penetration (due to a large unorganized workforce).

The economic burden of illness is huge and can be summarized from a finding of a World Bank report that suggests that every year about 22 lakh Indians temporarily fall below poverty line because health issues.[2] Further, an OECD briefing report (2012) highlights that about 60% of health spends in India are out of pocket. Both urban and rural population incurs debts or sell-off assets during hospitalization (World Bank). Research studies validates this problem statement and points out that 70% of the common illnesses that

[1] SRS data estimates for 2013, accessed from http://niti.gov.in/content/
[2] Background papers - Financing and Delivery of Health Care Services in India, National Commission on Macroeconomics and Health, MoFW, GoI (August, 2005)

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require hospitalization is preventable through basic health education, sanitation, hygiene and appropriate nutrition and access to affordable health financing.

Since health of an individual or a community is the outcome of multiple factors (income and education being most important non-biological factors influencing health), any improvements in health require interventions in multiple sectors for sustainable outcomes. The ABF funded HFF CHF project is one such example of a hybrid models that looks at improving the health related awareness levels of the CHF while also introducing an income generation aspect.

Methodology

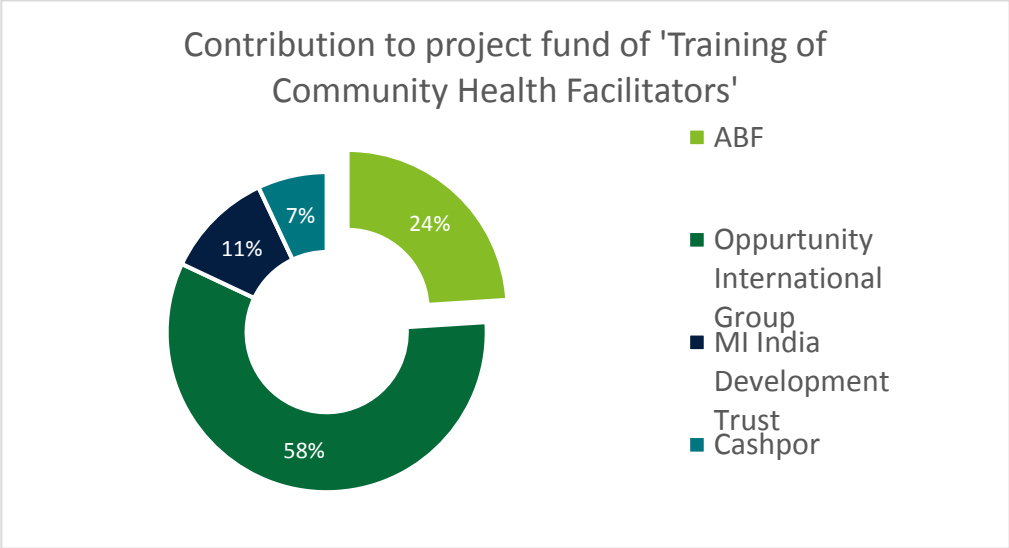
An impact assessment study is a measure of the outputs and outcomes brought about in the lives of the beneficiaries as a result of an intervention. The study design adopted for the current engagement employed both qualitative and quantitative research methods. Since the CHF project had a strong focus on women and empowerment, a gender lens was applied in ascertaining the impact of the project on multiple stakeholders. The assessment mainly relied on primary data collected during the course of the 2 month engagement, certain baseline data (CHF and community) available with HFF was also analysed. The first phase covering one district in Uttar Pradesh and two in Bihar was conducted from 19th to 22th September, 2016. Field visits to the remaining two districts in Uttar Pradesh were made during 13th to 15th October, 2016.

Sampling: The primary unit of analysis was the CHF trained by HFF. ABF funded batches launched through 2011 - 2014 served as the sampling universe for the study. A multi stage sampling technique was used to arrive at a 10% sample of CHFs from the 2100 CHFs trained during the period.

Data collection methods: The study tools employed for data collection included desk review, survey method, Key informant Interviews (KII), focus group discussion (FGD) and case study.

Program implementation:

The CHF training is a 12 month training programme that includes training in the initial six months, followed by a six month internship.



Axis Bank Foundation (ABF) sanctioned INR 1.18 crore for the project 'Training of Community Health Facilitators' spread across a four year period (2012-16) accounts for 24% of the project cost. The other funding partners are Opportunity International Group (58%), MI India Development Trust (11%) and Cashpor (7%).

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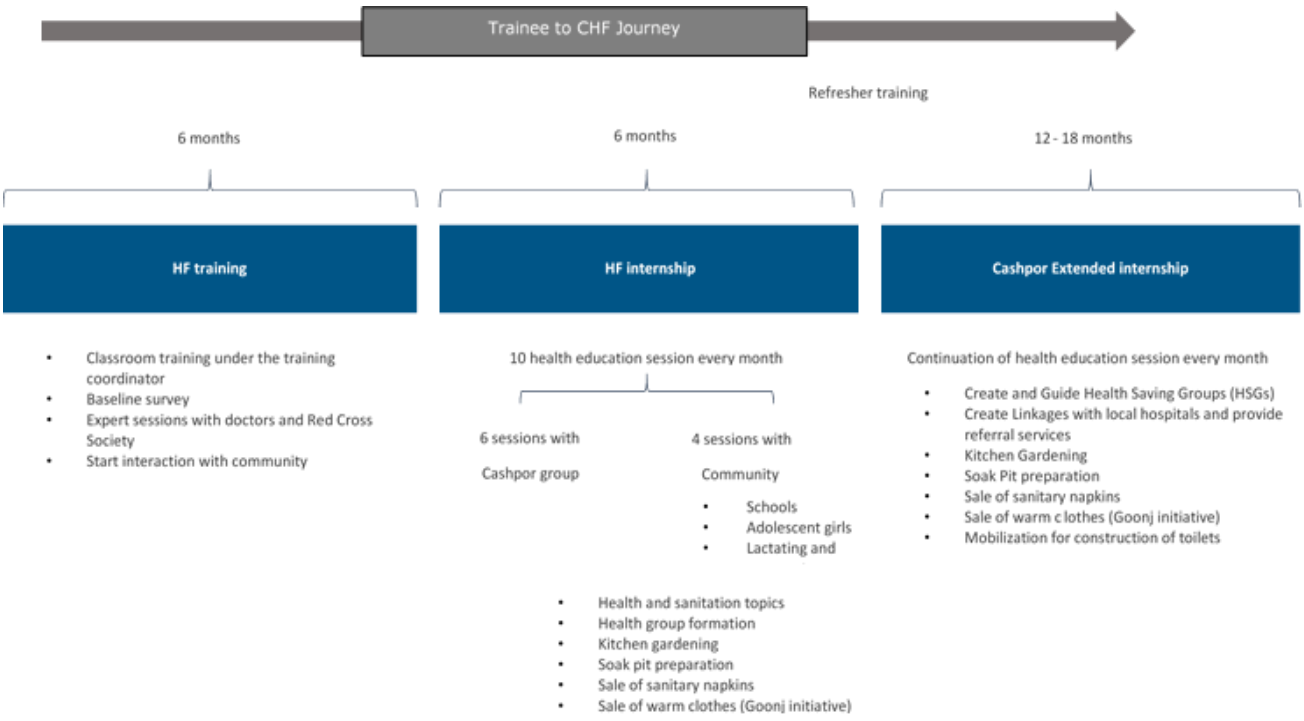
The programmatic lifecycle is as shown in the figure below:



Four day classroom training sessions are conducted for the CHFs by Training Coordinators (TC) during first 6 months of the training programme. In addition to the TCs, specific sessions are also conducted by subject matter experts (doctors). St John's Ambulance and Red Cross Society conduct a First Aid training session in the 5th month. During the initial six months, the CHFs are educated about hands washing technique, importance of personal and environmental hygiene, common illnesses and its management, menstrual hygiene management (MHM) etc. From the 7th month onwards (HFF internship) each CHFs work at the field level and conduct health education sessions, 10 per month, for a total of 250 families (60% Cashpor client, 40% general community). They also conduct MHM sessions and sanitary napkin demonstrations for adolescent girls at schools. In addition to the training programme mentioned below, the CHFs complete various projects to develop a more intensive understanding about a certain topic of interest.

Type of session	**No. of meetings**	**Locations**	**Month**	**Topics**
General	6	Cashpor meetings	1	Health and nutrition
		Shiv Charcha	2	Personal, environmental hygiene and kitchen gardens
		General Gatherings	3	Vector borne diseases
			4	Water borne and air borne diseases
			5	Lifestyle illness
			6	Hygiene and nutrition
Specific Topics	3-4	School		School health, hygiene & Nutrition
		Anganwadi / Sub center		Pregnancy, lactation & 0-3 years children care
		School/or adolescent girl gathering in the village		Adolescent health, nutrition & menstrual hygiene
Flexible Session (As per requirement)	1	Village / any suitable location		Addiction for youth
				Disease specific session
				Any topic from the above group that needs to be repeated

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Source: Healing Fields internal document

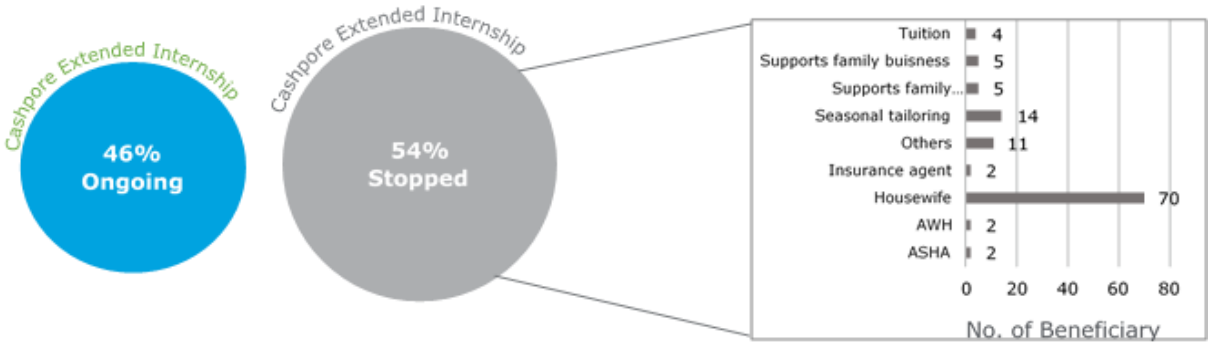
The CHFs are paid a monthly stipend of INR 500 by HFF during 7-12th months of the training programme. In addition to the stipend, they get INR 25 from Cashpor for every toilet constructed under their recommendation, INR 3 per sanitary pad packet sold and income from selling warm clothes during winters.

Key Findings

Direct Impact

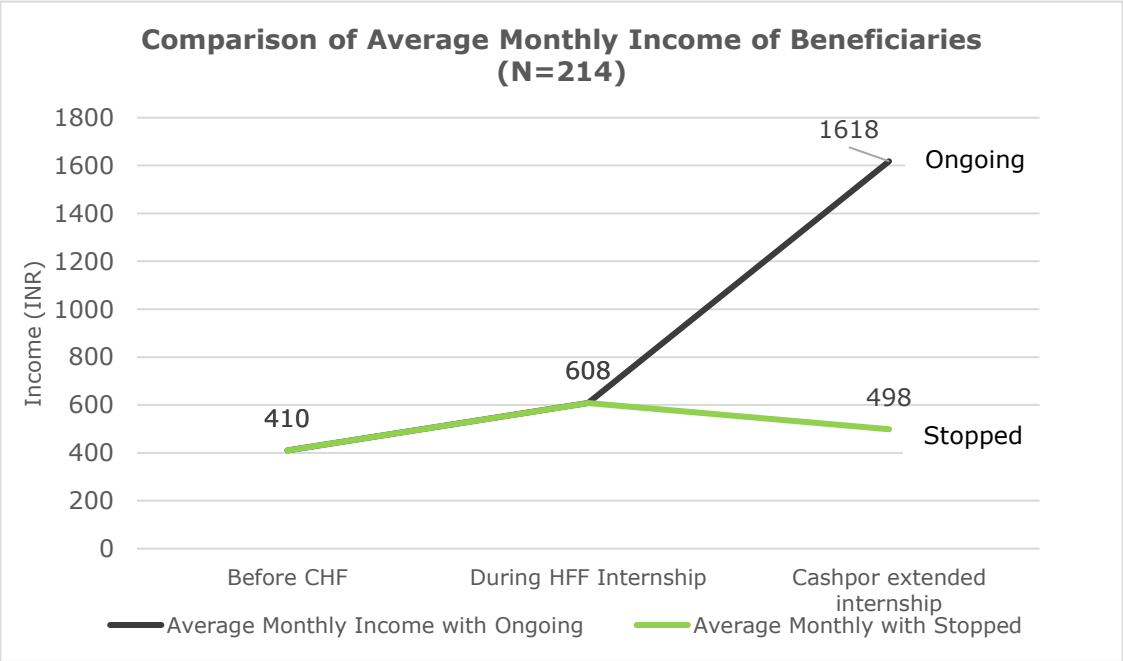
The CHFs included in the study were from training batches launched till 2014 and had completed their one year ABF supported training conducted by HHF. On completing the ABF supported training, the CHFs were given an option of an extended internship, comprising of 15 modules to be completed over 12 to 18 months, from Cashpor.

The study sample included a fair mix of CHFs who were still continuing with the Cashpor extended internship and those that had completed the same.



53% of the 214 had completed their extended internships with Cashpor at the time of the study. Majority (62%) women from this group had gone back to taking care of household chores with no regular or fixed income.

- **Income generation**



Before the CHF training, majority women (70%) were primarily engaged in house work or supported the family's agriculture or business and did not earn cash. The current average monthly income (from all sources) is INR 1,618/- for those CHFs who are still continuing with the Cashpor extended internship. The

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current average monthly income is INR 498/- for those CHFs who are no longer employed in the extended internships. The CHF training did give them an avenue for earning – the survey results show an average increase of 48% and 333% in monthly incomes during the HFF internship and the Cashpor extended internships respectively.

- **Savings**

All members had a saving bank account. 40% CHFs reported to saving INR 200-500 of their monthly incomes in S/A's. 30% respondents have invested an annual premium of INR 1000 in the Cashpor pension. Other popular saving instruments were Recurring Deposits and LIC plans.

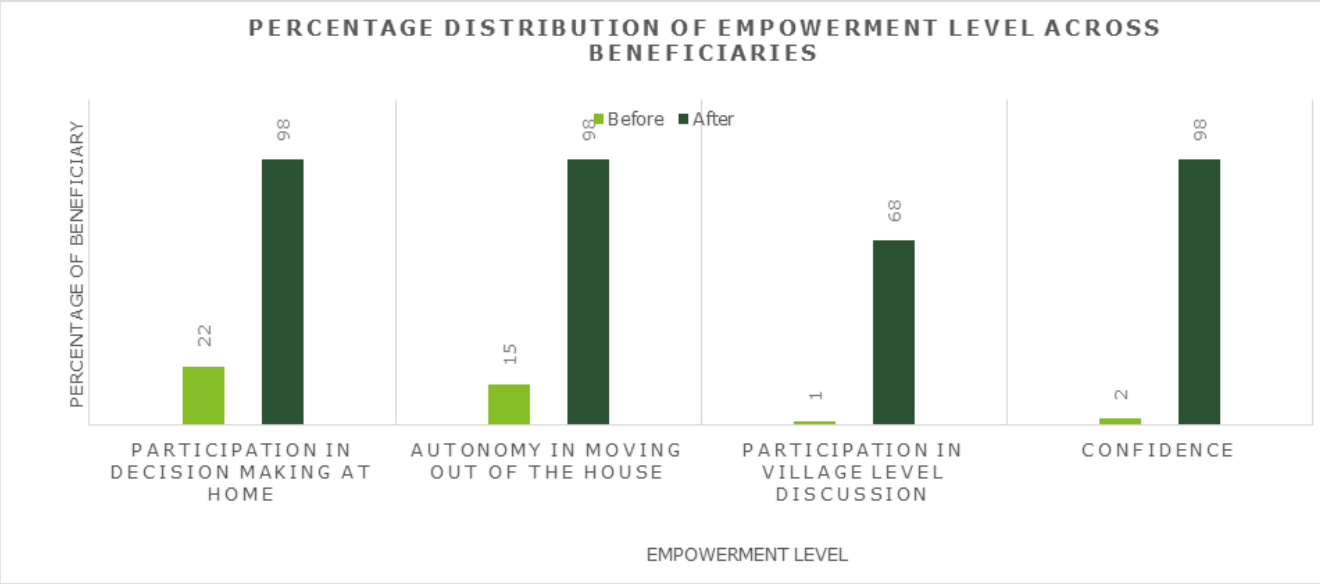
- **Health Impact**

70% CHFs mentioned the presence of a toilet at home – an increase of 30% in comparison to the pre training levels. Close to a threefold increase was seen in numbers of CHFs using soap to wash hands post the training. The table below gives a snapshot of the survey results of the change in certain health promoting behaviours reported by CHFs after undergoing the training.

Activity	**Before training**	**After training**
Hand wash before preparing food	25%	99%
Hand wash before eating	25%	99%
Use of toilet	31%	76%
Use of Soap	33%	94%
Purification of drinking water- Boiling water	12%	88%
Wearing footwear	63%	99%
Balanced diet	9%	97%
Use of mosquitos net	42%	93%

Similarly, all the CHFs (except the 1% who had undergone hysterectomy or had attained menopause) reported to using a sanitary napkin after the CHF training. This is an increase of about 75% in comparison to pre training levels. CHFs attributed decrease in reproductive tract and urinary infections to safer menstrual hygiene management practices. The CHFs reported a 50-60% reduction in their health expenses after the training

- **Empowerment and Social Mobility**



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The survey results showed an increase in confidence levels of all the CHFs after the training. Majority (85%) women mentioned that before the training, their movement outside home was restricted – Cashpor meeting would be the only place when they ventured alone and they attended the meeting in a 'ghungat'. Only 22% and 1% CHFs reported to any participation in decision making at home and discussions at the village level before undergoing the training. The graphic above represents the changes in various empowerment indicators after the completion go the training.

Indirect Impact

The community members (Cashpor clients and other women) included in the assessment had positive things to say about the health sessions conducted by the CHFs. The community women mentioned during FGDs that they had attended health talks conducted by the respective CHF where topics such as hygiene practices, safe menstrual hygiene management – how to use cloth safely during periods, hand washing protocol and its importance, managing certain conditions at home – especially pain management, preparing ORS, etc. were discussed. The women reported to having improved knowledge about balanced diet and cooking techniques, management of common illnesses and menstrual hygiene management. They reported a decrease in the incidence of diarrhoeas, common colds and fever, and RTIs because of better hygiene and sanitation.

Key Recommendations:

The CHF project even in a short time has shown significant changes at the CHF as well as at the community level in terms of changes in crucial practices affecting health outcomes. Based on the findings and observation from field, the following are some of the key recommendations that will ensure effectiveness and sustainability of the initial positive outcomes.

- Relook at the duration of hand holding/monitoring support given to the CHF and a more intensive engagement with the general community
- More sustainable source of livelihood for the CHFs – potential tie ups with other local NGOs, government departments, etc.
- Potential affiliations and certification through recognized bodies such as NSDC, etc. to ensure quality standards as well as increase employability of CHFs
- Alternate model for production and distribution of sanitary napkins
- Introduction of risk pooling or health insurance for CHFs
- Linkages with the public health system to avoid duplication and also to facilitate referrals
- Standardization of operational definitions for baseline collection

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Table of Content

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1. Introduction

1.1 Background

Axis Bank Foundation

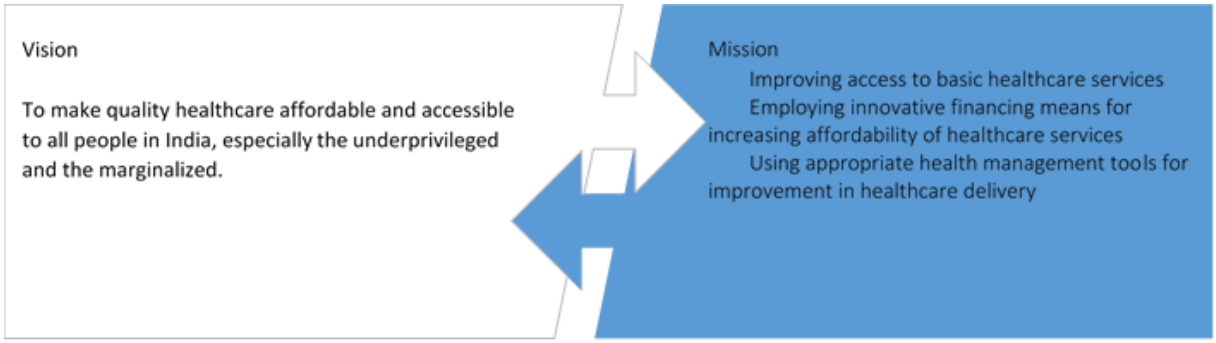
Axis Bank Foundation (ABF) set up as a Public Trust in 2006 engages in Corporate Social Responsibility initiatives of Axis Bank. The ABF funded initiatives are streamlined under thematic areas of Sustainable Livelihood, Education and Highway trauma care. The broad mandate of these initiatives is to improve the quality of life of socio-economically weaker and vulnerable sections of the population. ABF partners with credible non-profit organizations whose missions are aligned with its own social responsibility goals to achieve its mandate.[3] The Foundation has grown to support projects in 26 states across the country, with a presence across 239 districts including 75 most backward districts. In FY 2015-16, the Foundation had supported 64 projects. These projects are aligned with Section 135 in Schedule VII Companies Act 2013 and the global development framework as specified under Sustainable Developmental Goals.[4]

ABF has partnered with Healing Fields Foundation for training Community Health Facilitators (CHF) across five states of Bihar, Uttar Pradesh, Odisha, Chhattisgarh, and Assam.

Implementing Partner of ABF – Healing Fields Foundation

Healing Fields Foundation (HFF), founded in 2000, is a registered society and is led by Ashoka Fellow Mukti K Bosco. HFF has created benchmarks and evaluation measures for improving accessibility and affordability of healthcare services to the poor in various parts of India.[5] The organisation through various partnerships and projects strives at making quality healthcare affordable to the poor, marginalised and unprivileged sections of the society.[6]

HFF addresses health needs of communities by developing health education and health financing models that aim at empowering grassroots women to take responsibility of their wellbeing. The vision and mission of Healing Fields provides pathways for accessable, affordable and quality healthcare.[7]



[3] http://www.axisbankfoundation.org/partners/livelihood.aspx accessed 10.10.2016
[4] ABF-Healing Fields Proposal 31-8
[5] http://www.healing-fields.org/healing-fields/index.php accessed 10.10.2016
[6] Document provided by ABF- Outline for ABF-proposal for financial support submitted by HFF November 2011
[7] Healing Fields Foundation website Accessed on 10.10.2016 http://www.healing-fields.org/healing-fields/mission_vission.php

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The main objectives of Community Health Facilitator project (CHF) are:

1. To better the hygiene and health care facilities in selected villages across Bihar, Uttar Pradesh, Odisha, Assam ad Chhattisgarh.
2. To develop a relevant and efficient health education model.
3. To effectively intervene and empower the women at the grassroots to take responsibility for the health and wellbeing of their community.

ABF – Healing Fields Foundation CHF project

ABF partnered with Healing Fields Foundation in April 2012 and the supported the training of CHFs across five states till March 2016. The ABF – HFF Community Facilitators project is housed under the thematic area of Sustainable Livelihoods of ABF's grant making portfolio. In addition to the livelihood component, the CHF project's primary design focuses on improving community health outcomes. The CHF project is implemented by HFF in close association with strategic partners - micro finance companies such as Cashpor.

Under the CHF project, community women are selected and are provided training to act as 'agents of change' in the villages. The CHF through health education sessions, creates at the community level an understanding about personal and environmental hygiene, diseases, behaviour change practices and health financing schemes, etc.

One year CHF training programme

The trainee CHFs post induction into the program undergo an intensive training for an initial six months (four day training every month) followed by an internship in the ensuing six months.

The training module curriculum is as follws:

Month	Topic	Days
Month 1	• Healthcare in India, National Health Programs • Basics of communication • Baseline survey • Water & sanitation • Personal & environmental hygiene • Nutrition	5 days
Month 2	• Review of previous month's program • Basic Human Anatomy • Understanding disease and prevention of disease • Common illnesses/diseases/symptoms • Introduction to healthcare expenditure • WATSAN & CLTS techniques	4 days

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	• Project planning & project assignment – handwash project, menstrual hygiene survey, pregnancy – care & nutrition, breastfeeding, soakpit construction, kitchen garden, complementary feeding, anemia, enrollment to Government Insurance schemes like RSBY, toilets	
Month 3	• Review of previous month's program • Common illnesses among children • Mother & Child health • Health of adolescent girl • Women's health & reproductive health • Kitchen gardens	4 days
Month 4	• Review of previous month's program • Men's health • Geriatric health • Health financing • Methods of health education • Field visit	4 days
Month 5	• Review of previous month's programs • Structuring the community health fund and management of fund • Lifestyle diseases • Convergence of services at community level	4 days
Month 6	• Review of previous month's programs • Diseases related to nutrition & food intake • Low cost nutritious recipes with commonly available foods • Administration of drugs • Home remedies to common health problems • Gender • Mental illnesses • Assessment & feedback • Project presentation • Introduction to internship	4 days
Internship for 6 months with Cashpor	• 6 sessions on general topics at Cashpor meetings, (General) community level training on personal & environmental hygiene; 3-4 sessions on specific topics at school, Anganwadi/Sub-Centre & adolescent girl gathering in village on hygiene , nutrition, ANC & PNC, adolescent health & menstrual hygiene; 1 flexible session in village on addiction, disease specific topic • Initiation of Health Savings Groups • Initiation of micro enterprise • Roll out of micro enterprise	6 months

The CHFs during the internship of the trainign period have access to multiple income of sources – monthly stipend of INR 500, profit earned from sales of sanitary pads (at the rate of INR 3 per packet sold), and incentives (from Cashpor) for mobilizing families for construction of toilets.

As part of the livelihood component of the project, HFF has set up a Sanitary Napkins Production (SNP) unit in Bihar. HFF has set up this semi automatic manufacturing unit at Buxar that employs eight local women (8 non CHFs and 1 CHF).[8] The product - Mesa napkins (branded by HFF) are

[8] Outline for Axis Bank Foundation Proposal for Financial Support submitted by Healing Fields Foundation November 2011

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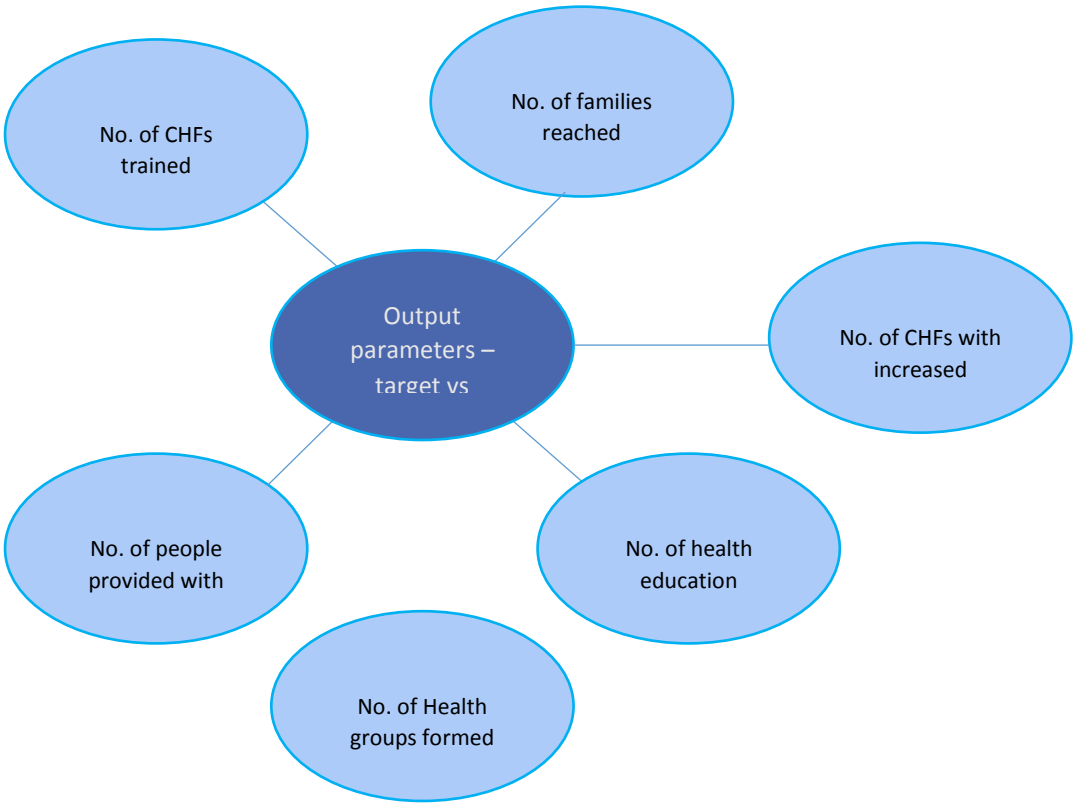
marketed and sold by the CHFs. The CHFs purchase a Mesa packet at INR 12 and sell it to the community at the rate of INR 15 per packet.

The output parameters for the CHF project are as follows[9]:



Deloitte's Role

ABF has approached Deloitte for conducting an End-term impact assessment of the HFF – CHF project.

Scope of Services

ABF supported the project for four years and an extension for six months was granted bringing the project to completion on March 2016. ABF has engaged Deloitte to ascertain the impact of its support to the project from April 2012 – March 2016.

Scope of the assessment is defined below:

- Analyze the impact of the initiative against the baseline livelihood indicators available with ABF
- Documentation of the project's best practices.
- Reporting beneficiary, activity and programme wise impact as per ABF's tracking template.

[9] Document shared by ABF- ABF/WB/223/2015-16

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2. Context setting: health & its economic burden

2.1 Definition of health

A widely accepted definition coined by the World Health Organization (WHO) in 1948 defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

While the WHO definition of health lays a lot of emphasis on complete wellbeing, the attainment of such a state may be impossible to obtain for most people and hence the definition has come under a lot of scrutiny over the last few decades. For practical purposes, various indicators and measures of health have been used to quantify the health status at the individual or population level; these take in to account illness or disability. In addition to mortality and morbidity measures, a lot of research has gone into developing composite health indices such as Disability Adjusted Life Year (DALY), Healthy Life Expectance (HALE), etc. that measure the burden of disease by accounting for time that is lived in less than optimal health levels.

2.2 Health status of India

India with its 1.2 billion people and more than 7% economic growth rate is considered as an emerging superpower in the developing world. While the overall health indicators for the country have improved radically since independence, the health indicators in India remain lower than the averages reported from the OECD countries. For example, while in 2012 the average life expectancy at birth in India had more than doubled since what it was in 1947, at 66 years it was lower than the 80 years in most OECD countries. Despite the increasing numbers of cancers and other non-communicable diseases, 253 deaths per 100,000 persons in India die due to infectious diseases[10], many of these deaths are perhaps preventable.

Further, alarming regional discrepancies are seen with respect to health indicators and disease burden across the country with the rural areas performing not as well as their urban counterparts. While according to a World Bank database, the national average MMR is 174[11] Uttar Pradesh and Bihar have the worst performance in maternal health indicators according to the Annual Health Survey 2012-13. The same source reports MMR in excess of 300 maternal deaths per 100,000 live births in certain regions in Assam, and Uttar Pradesh. The table below shows the variances in health status along select indicators.

Indicators	India	Highest	Lowest
Birth Rate[11]	21.4	27.6 (Bihar)	14.7 (Kerala)
Death Rate[11]	7	8 (Odisha)	4.1 (Delhi)
Infant Mortality Rate (IMR)	44	59 (Madhya Pradesh)	12 (Kerala)
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[10] http://www.livemint.com/Politics/pHCS4KW8ZnFqIUqRllLVFN/Five-charts-that-explain-Indias-healthcare-crisis.html, accessed on 10/10/2016
[11] World Bank data. http://data.worldbank.org/indicator/SH.STA.MMRT, accessed on 12/10/2016
[12] SRS data estimates for 2013, accessed from http://niti.gov.in/content/

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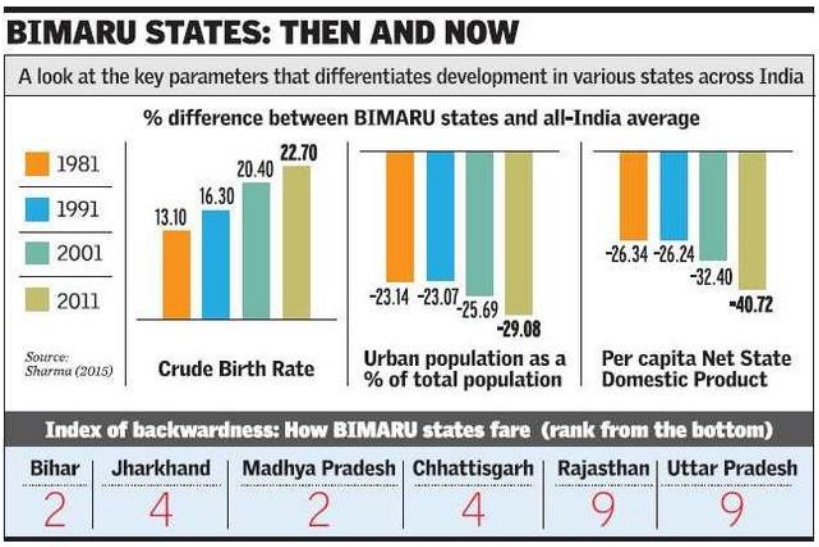

Source: The Hindu

The table above shows that the health indicators are worst among members of the Empowered Action Group (EAG) states. Further, scrutiny of the larger data sets will reveal that all the eight states - Bihar, Jharkhand, MP, Chhattisgarh, Orissa, Rajasthan, UP and Uttaranchal fare poorly on the health indicators. These states (undivided before year 2000), except Odisha, were rightly called the 'BIMARU states' by demographer Ashish Bose in his paper authored in the 1980s. The health burden in these states can be attributed to the higher fertility rates contributing to 'unmanageable population growth' and disproportionate development activities.

Other than the large population, poverty, and unequal distribution of services through the country, the following crucial factors are thought to be further complicating health situation and adding to the disease burden in India:

- Illiteracy and low health awareness levels
- Low public spending on health
- Poor availability of trained doctors, nurses
- Inadequate health infrastructures, especially in rural areas
- High proportion of out of pocket expenditure on health and poor health insurance penetration

2.3 Economic implications of health

The factors determining the health of an individual have complex relationships. While some of these are the genetic and biological factors that cannot be altered, others such as the socio-economic and environmental ones are amenable to changes. Similarly, the health of an individual influences certain socio-economic parameter at an individual as well as at the community level.

Empirical evidence suggests strong associations between health and education levels of its people, and economic outcomes. Studies conducted by Bloom, Canning and Sevilla (2004) [13]show significant positive effects of health on GDP per capita growth. This could be because healthy workers can be more productive – working longer hours while not losing work days because of sickness. Similarly on the other hand, being financially better off gives better access to resources such as food, education and healthcare that have better health outcomes.

[13] The effect of Health on Economic Growth: A Production Function approach – World Development Vol. 32, No. 1, pp. 1-1, 2014 http://www.ppge.ufrgs.br/giacomo/arquivos/eco02072/bloom-canning-sevilla-2004.pdf

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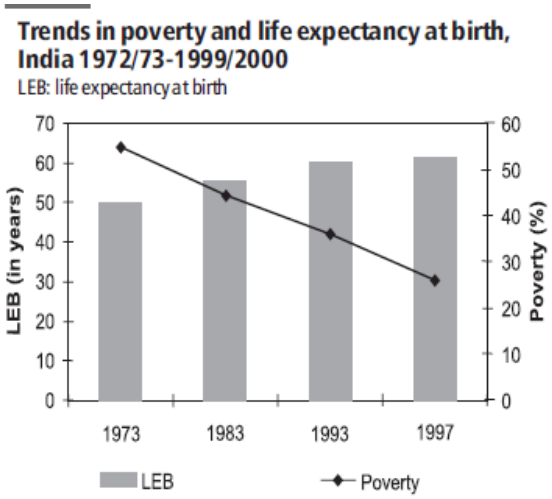
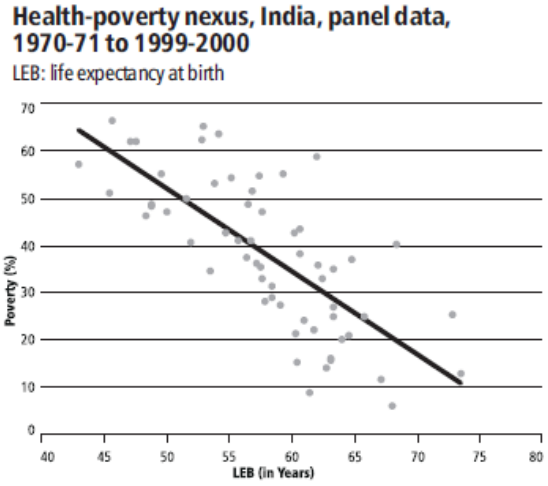
Improvements in health can also bring about declines in the poverty. In a country like India where more than 70% of the workforce is in the unorganized sector where their own bodies are the livelihood earning asset, sickness could lead to not only loss of wages but also lead to an inability to access essential health care. The absence of adequate public spending on health care infrastructure and services and a large unorganized sector means that majority of the expenditure in episodes of illnesses are out of pocket. According to an OECD briefing report, in 2012, 60% of health spends were out of pocket in India.





Source: Background papers - Financing and Delivery of Health Care Services in India, National Commission on Macroeconomics and Health, MoFW, GoI (August, 2005)

Rough computations by the World Bank, using National Sample Survey (NSS) data, suggest that health issues cause about 22 lakh Indians to temporarily fall below the poverty line each year

The NSS for India for 1995-96 also reveal that when the poor fall sick, they delay treatment till absolutely necessary and even when they do decide on treatment they often have to sell property or assets for the same or seek loans from unofficial sources.[14]

Empirical evidence shows that the multicausal web that contributes to an community's health and hence a health intervention should be looked at beyond just provision of curative services. It makes sense to look at convergence of different activities to bring about improvments in the health of the country's vast population. The ABF funded HFF CHF project is one such example of a hybrid models that looks at improving the health related awareness levels of the CHF while also upskilling her and providing her with opportunities for income generation, updating her skills in developing kitches gardens, soak pits, etc.

[14] Financing and Delivery of Health Care Services in India by Ministry of Health and Family Welfare Government of India, 2005

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3. Approach & Methodology

3.1 Project approach

The research design adopted for the impact evaluation of the CHF project employed a mix of quantitative and qualitative research methods. The study design comprised of primary and secondary research components and was in line with the scope and objectives of the engagement. Since the CHF project had a strong focus on women and empowerment, a gender lens was applied in ascertaining the impact of the project on multiple stakeholders.

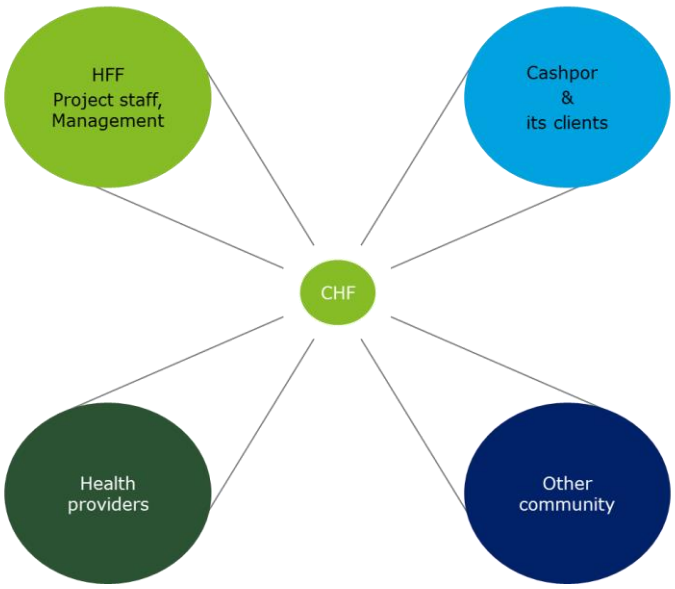
3.2 Study design

An impact evaluation for development programmes is carried out to assess how the intervention under review has affected the outcomes either positively or adversely. The impact is measured on either intended or unintended beneficiary and could be a direct or indirect effect of the project implementation[15].

The end-term impact assessment of ABF's support to HFF's CHF project being an evaluation exercise adopted a mix of qualitative and quantitative research methods to understand the changes brought about in the lives of the primary (CHF) and secondary (community) beneficiaries. Before undertaking the first hand field interactions, a thorough review of the project documents was conducted to understand nuances of the implementation models and the outputs/outcomes expected from the project. Further, a secondary analysis of the CHF and the community baseline data available with HFF was conducted for the selected sample.

The primary research component involved interactions with direct and indirect beneficiaries, and other crucial stakeholders associated with the project. A detailed mapping of the various stakeholders associated with the project was completed to identify the key interactions required for the evaluation. The figure gives a listing of the key stakeholders associated with the project.

Stakeholder mapping



[15] International Fund for Agricultural Development (IFAD), Evaluation Manual, Feb 2015

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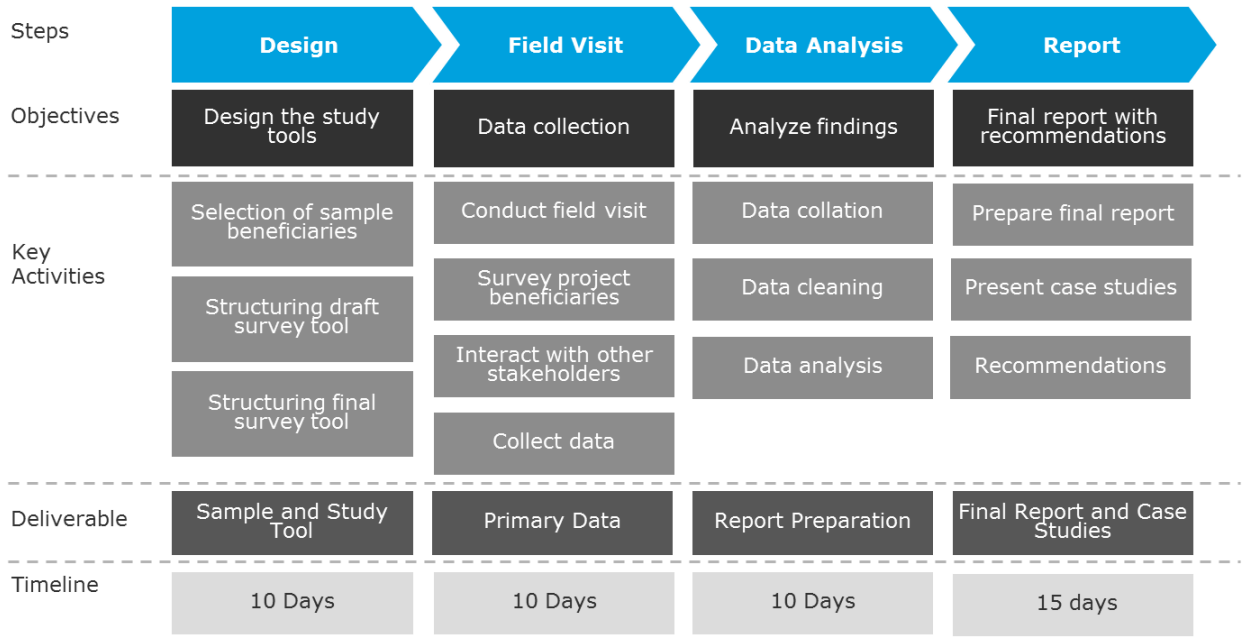
The various activities of the impact assessment can be grouped into four phases – Design, Field visit, Data analysis, and Report writing. The figure below gives a detailed listing of the various activities under each of the four phases.



Field level stakeholder interactions

Field visit for the primary research component was conducted by two member teams in two phases. The first phase covering one district in Uttar Pradesh and two in Bihar was conducted from 19th to 22th September, 2016. Field visits to the remaining two districts in Uttar Pradesh were made during 13th to 15th October, 2016.

3.3 Sampling

The unit of analysis in this end-term review of ABF support to the CHF project was the CHF trained by HFF. CHF trained with ABF support in batches launched during the 2011 – 2014 period served as the sampling universe for the study. A multi stage sampling technique was used to arrive at a 10% sample of CHFs from the 2000 CHFs trained during the period. Though a consultative process with ABF, it was decided to include only the CHFs trained from Bihar and Uttar Pradesh in the study sample as they comprised the larger beneficiary clusters.

At the first level, number of respondents at the state level was determined using proportionate sampling technique. In the next step, districts across Bihar and UP with the highest numbers of CHF trained during the project period from 2011-2014 were identified using purposive sampling. Inputs from HFF were also considered while finalising the districts included in the study. Since all the CHFs in the sampling universe had completed their one year training with HFF and were not currently directly associated with ABF or HFF, only those that had continued with the Cashpor extended internship were being tracked by HFF and hence could be contacted for participation in the assessment. Hence the actual respondents in each district were identified and selected through purposive sampling to ensure a mix of CHFs across batches.

Study sample details

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Sample size	200	Uttar Pradesh – 110 CHFs Bihar – 90 CHFs
CHF batches	**Batch name**	**Launch Year**
	Bhabua – Sasaram 1st batch	2012
	Bhabua – Mohaniya 2nd batch	2013
	Bhabua – Dehri 3rd batch	2014
	Bhabua – Chandauli 4th batch	2014
	Buxar 1st batch	2010
	Buxar 2nd batch	2011
	Buxar 3rd batch	2012
	Buxar 4th batch	2014
	Balia – Balia 1st batch	2013
	Balia – Ghazipur 2nd batch	2013
	Balia – Sikandarpur 3rd batch	2014
	Balia – Rasra 4th batch	2014

3.4 Study tools

Desk review

A thorough desk review was undertaken to get a comprehensive understanding about the ABF supported CHF project along lines of the objectives of the project, beneficiary coverage and implementation model employed. Some of the documents reviewed as a part of this exercise were:

- Healing Fields Foundation's Proposal to ABF for Financial Support to CHF project
- Healing Fields Background Paper prepared and shared by HFF
- CHF baseline data available and maintained by HFF for the ABF supported project

In addition to the above, an analysis was conducted of the community baseline data available with HFF to understand the change brought about by the CHF intervention. The data set used for this comparison was the pre-post community survey conducted by the CHFs included in the study.

Primary research

A multitude of tools were used in the assessment based on the nature and completeness of data available with the implementing organization. The table enumerates the various data collection instruments employed during the primary research phase.

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Stakeholder	Quantitative	Qualitative
CHF (Primary beneficiary)	Survey	FGD, Case Study
Community (Indirect beneficiary) - Cashpor clients - Other community - women/girls	-	FGD
Other stakeholders - Healthcare providers (Doctors, ASHAs, AWWs, etc.) - HFF staff and management - Cashpor management	-	KII

Case study

A case study may be defined as "as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used." [16]

Case study method has been used in the study to bring out the changes and impact of the project. Sales of sanitary napkins could be considered as a sustainable soured of income for the CHFs. Hence a case study approach was selected to gain an understanding about the various aspects that affect demand, production and sales of the sanitary napkins.

Focus Group Discussions (FGD)

In a focus group discussion, group of individuals, not more than 10, from a similar background or with similar experiences talk about a certain topic or concept. The discussion is guided by a researcher who acts only as a moderator for the discussion. After introducing the topic of discussion, the moderator allows for a free flow of thoughts, ideas and opinions among the participants. Participants are allowed to disagree or contradict each other's accounts as this only helps in getting insights into various thought processes and experiences related to a particular issue. A second researcher usually observes and documents the whole discussion – verbal as well as nonverbal connotations are made note of.

KII with Field Coordinator (FC) in Khaimur Block, Bihar

Key Informant Interviews (KII)

Key informants are individuals who are thought to have critical firsthand information or insights about the subject under study. In the current study, the health care providers, HFF senior project staff and HFF management were identified as the Key informants who were critical to implementation the CHF project.

FGD with CHFs in Chandauli, Bihar

The research team followed a set of guidelines containing questions on the event/subject under study while interviewing the key informants. The information gathered

[16] Zainal, Z. (2007). Case study as a research method. *Jurnal Kemanusiaan bil.9*.

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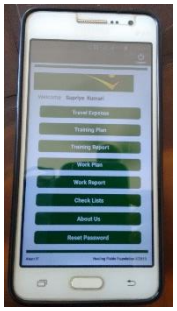
from these key informants was used to further explore concepts/ issues and validate information across different stakeholders.

Survey

A survey is a method of gathering information by means structured interviews or questionnaires. The standardized survey tools allows for consistency of data collected irrespective of who is asking the questions.

In the current engagement, a survey questionnaire was customized to gather information on the income and livelihood indicators, as well as to records changes in health behaviors and empowerment levels.

Survey form filling in Buxar, Bihar

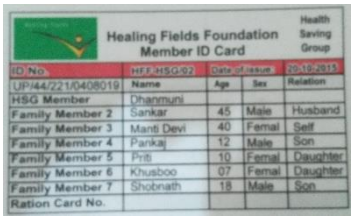


App based MIS developed by ATOM IT for Healing Fields

Use of Whatsapp groups for internal communication and reporting

KII with Mr. Pradeep, Program Manager - Operations

CHF showing her Meeting Minutes Register



Health Savings Card

KII with Hospital Administrator

FGD with Cashpor team

KII with Mr. Deepak Gupta, Project Manager - Training

Form filling at Chandauli

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4. Programmatic review of HFF project

4.1 Programmatic review of ABF-HFF CHF project (Training of Community Health Facilitators)

Sub-Pillar	Parameters	Status/Findings
Inputs - program design and planning	Grant	Axis Bank Foundation (ABF) has sanctioned INR 1.18 crore for the project 'Training of Community Health Facilitators' spread across a four year period (2012-16). Besides ABF which is contributing 24% of the project cost, the other funding partners are Opportunity International Group (58%), MI India Development Trust (11%) and Cashpor (7%). Budget utilization of ABF grant from 2012 to start of financial year 2015-16 stands at 81%. Out of the total grant, 85.50% has been utilized for programmatic cost and 14.50% for administration. Cost of training a CHF for a year, as reported by HFF is approximately INR 30,000 – 35,000. Since the project is focused on health care including sanitation and hygiene, there has been convergence with Government Schemes such as Indira Awas Yojana (IAY), BPL/APL schemes for toilet construction thus leveraging on the available subsidy through the government run scheme. The line items supported through ABF funding are as below: Health education related costs •Training costs of the CHFs including training material/IEC, travel costs of facilitators/faculty, communication expenses, stipend to CHFs in field, First Aid program (does not inclue project staff salaries Livelihood development related costs •Transportation of raw materials for SNP

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	Human resource	Healing Fields Foundation has a vertical hierarchical structure with a clearly defined chain of command. The three arms of the project are Strategy & Development, Operations and Special projects. Under Strategy & Development division, there are two wings – a) Finance, HR & Admin b) Training & operations including Audit, MIS and Communication. Under the Special Projects division, there are project specific teams. The project Operations reporting structure are provided in the diagram below (Blue dotted lines indicate reporting pattern. The organisation has clearly defined responsibilities and reporting structure, details of which are provided in the annexures. There are 3 field coordinators and 1 training coordinator per region. The Assistant Program Manager oversees 3-4 regions
	Staff	The Program Manager training mentioned that at present there are 2619 trained CHFs on field (trained under ABF funding), 28 field coordinators, 13 Training coordinators, 4 APM and one program manager operations and program manager training each. Each training batch is actively led by both the **Training and Operations Manager** who work in tandem with each other and oversee components including CHF training, pre/post test conducted after each training session, internship stipend and also staff training/refresher which is need based. In case of ongoing batches at three or more locations, Assistant Program Manager lends support. His/her role is to oversee components related to livelihood aspect. Each batch has one **Training Coordinator (TC)** and one Field Coordinator (FC) who is the primary contact for CHFs. TC is required to be a graduate/PG/MSW with two to three years field experience. Knowledge of English is mandatory as training manuals are in English. The staff should have a Smart phone as MIS and monitoring is done via dedicated mobile apps created specifically for HF. The induction process entails that the recruited TC undergoes Training of Trainer (ToT) which is for two weeks. The manual takes them through the CHF training protocols. The recruits are provided field experience for three weeks followed by four days training in the head office at Hyderabad. They are taken through the organization processes, reporting system, monitoring processes and are mentored/handheld by experienced employees. The TCs earn on an average INR 12,000 along with travel food and stay expenses that are reimbursed according to actuals with an upper limit for each. They also have a 5-20% self-appraisal system. Only women are recruited as **Field Coordinators (FC)**. They are required to be a graduate, with good communication skills, work experience and should have local references. Induction training includes field level orientation over two week's period followed by one week training at HO. During the induction period, the FCs also develop basic computer skills. Training on operating the mobile app for daily reporting is also provided. The

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		remuneration for a FC is INR 6000/month (in hand, after PF deduction), plus TA/DA and phone allowance. Recruitment of staff is done through Devnet and internal referencing; local residents are given a preference for field level jobs. Staff attrition is minimal, largely found at the field level rising due to personal reasons.
	Staff training	Refresher courses on a yearly basis are designed as per specific needs emerging in the field and the Project Manager nominates project staff for the same. Interactive methods such as role play, games, power point presentations followed by small group discussions are employed. Capacity building is conducted at HO Hyderabad once in six months and includes issues such as gender sensitization, technical understanding about kitchen garden/soft pits, handling community queries, convergence with government schemes, etc. Interactive pedagogy such as role play and power point presentations are used
Activities - programme implementation	Implementation model	During HFF initial pilot on community based health insurance in the undivided Andhra Pradesh, a need for awareness generation on health issues was identified. As a part of this pilot in 2004-05, 39 Community Organisers were trained, over a 9 month period, in association with MV Foundation. The introduction of this grassroots cadre of health workers was seen to have an impact on the health knowledge and behaviour in the community. The same model was scaled from 2009 onwards in Andhra Pradesh. In 2011, Cashpor approached HFF with a proposal for incorporating a health component within its existing support to Micro Finance Groups. The initial model of 9 months training was tweaked to structure a 12 month training programme for the trainees – four day contact programme for 6 months followed by a 6 month internship with Cashpor. The Community Organisers are called Community Health Facilitators under the revised programme.

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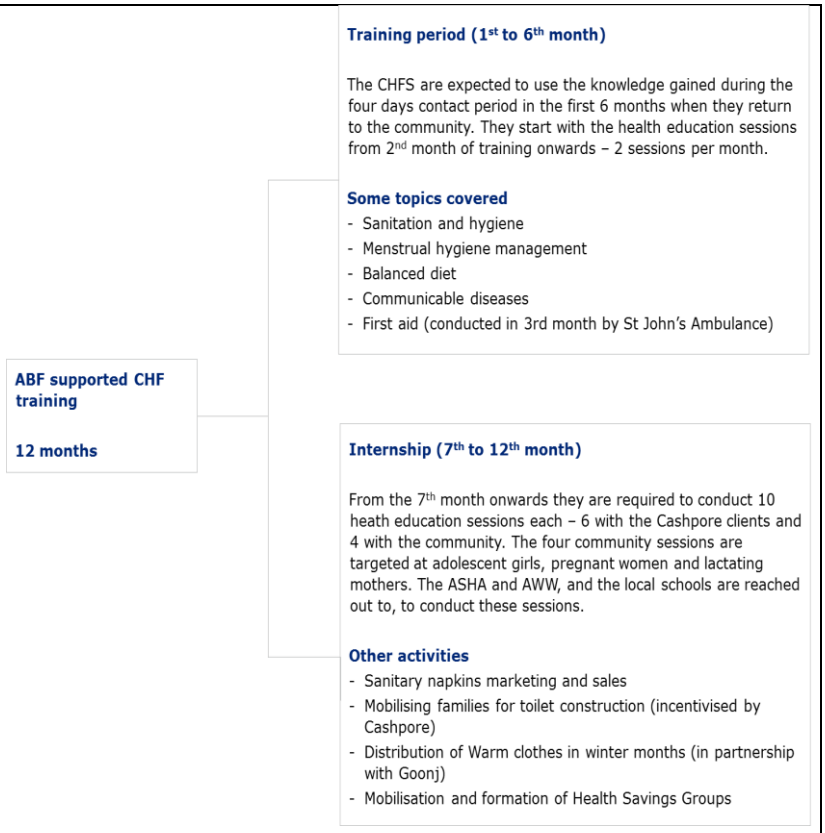

To make the beneficiary women accountable for the investment being made, a refundable monthly fee of INR 100 is collected from them during the initial 6 months of training. The CHFs are given a fixed honorarium of INR 500 per month during the internship period. They also earn additional income from sales of sanitary napkins (INR 3 per packet sold) and mobilizing families for toilet construction (INR 25 per toilet built under Cashpor scheme).

The CHFs take 10 **heath educations sessions** every month (6 for Cashpor and 4 for general community) on improving health and sanitation behaviour. The topics covered under these sessions are listed below:

Type of session	No. of meetings	Locations	Month	Topics
General	6	Cashpor meetings	1	Health and nutrition
		Shiv Charcha	2	Personal, environmental hygiene and kitchen gardens
		General Gatherings	3	Vector borne diseases

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				4	Water borne and air borne diseases
				5	Lifestyle illness
				6	Hygiene and nutrition
		Specific Topics	3-4	School	School health, hygiene & Nutrition
				Anganwadi / Sub center	Pregnancy, lactation & 0-3 years children care
				School/or adolescent girl gathering in the village	Adolescent health, nutrition & menstrual hygiene
		Flexible Session (As per requirement)	1	Village / any suitable location	Addiction for youth
					Disease specific session
					Any topic from the above group that needs to be repeated

Source: Healing Fields internal document

Additionally they help the community members in building soak pits to prevent waterlogging and the consequent spread of diseases and kitchen gardens to enable complete nutrition and savings in grocery purchase.

The CHFs also supports the community in the following activities:

Networking with local health providers and functionality of the health card: The CHF assists the FCs and TCs in identifying potential local health providers, chemists and labs that could through an agreement with HFF give discounts to the families served by them. The families are given a health card, with names of all members. This is required to be presented at the time of billing to avail the discount. This networking as reported by HFFs has not taken off as per plan. The TC mentioned that the delay is mainly because convincing and negotiating with health providers

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takes long times. Another reason was that the community lost interest in the scheme after the delivery of cards was delayed indefinitely.

Health Savings Group: The CHFs also help form Health Groups (HGs) and convert the HGs into Health Savings Groups (HSG) once they reach a certain social and organizational strength. These groups start saving a certain sum mutually agreed in a locked box wherein the box is with one member and the key with another to avoid misappropriation of funds. The members saving in this group can loan an amount at a 2% interest rate only for OPD or health related issues. After the collective amount reaches INR 5000, INR 4200 is withdrawn and distributed back equally to all the members which again is instructed to be used only for health related expenditure. The members of these groups can also avail discounts from networked hospitals and health care providers.

The CHF maintains the financial register for these HSGs and the members pay her INR 2/member/month for the same. She also helps monitor the spending pattern.

However, project staff and few CHFs informed the Deloitte team that Health Saving groups could not be operational as community women were reluctant to contribute INR. 20/month.

Project work: During the training period, every CHF chooses to work on an elective project in addition to the routine responsibilities. The projects that they can choose from are as follows:

Project Title	**Target Group**		**Key points**
1	Hand wash Project	School children	Pre survey on hand wash practices, education to children and teachers and parents, hand wash demonstration, follow up at school and home ensure availability of soap and water. Post survey
2	Menstrual hygiene survey	Adolescent girls	Pre survey on MHM practices, education to the girls, teachers and mothers, demonstration of sanitary napkins use and disposal, follow up, making the napkins available to the girls, post survey

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		3	Pregnancy - Care and Nutrition	Pregnant women	Pre survey, referrals to ASHA & ANM, educating the pregnant women, mothers, mother in laws and husbands, follow up for ANCs, IFA tablets, TT injections, awareness about institutional delivery. Post Survey
		4	Breastfeeding	Lactating women	Pre survey, education on colostrum feeding and EBF, diet for lactating mothers, counselling mothers and mother in laws, follow up. Post survey
		5	Soak Pit	10-20 households	Pre survey. Education and awareness creation. Demonstration of soak pit. Follow up at the community helping them in building the soak pit. Post survey
		6	Kitchen gardens	10-20 households	Pre survey, awareness about kitchen gardens & soak pits, helping the communities build soak pits, sourcing of seeds for kitchen gardens, helping community in planting, follow up. Post survey
		7	Complementary Feeding	Mothers of infants	Pre survey on current feeding practices. Educating the mothers, demonstration of low cost nutritious complementary foods, follow up. Post survey
		8	Anemia	Adolescent girls & women	Pre survey. Education and awareness creating through group sessions and

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					individual counselling, referral to ASHA & ANM for iron tablets, demonstration of iron rich recipes with locally available foods, follow up. Post survey
		9	Enrollment to Government Insurance scheme like RSBY	20-30 households in the community	Pre survey on enrollment status and health expenditure. Awareness creation and education. Linkage and ensuring enrollment. Educating the families on the benefits and utilization, follow up. Post survey
		10	Toilets	10-20 households in the community	Pre survey. Educating the families on environmental sanitation and need for toilets. Creating awareness on Government subsidy and MFI loans. Linkages to PHED
		Source: Healing Fields internal document			
	Certification of training	The CHFs get a 1 year internship certificate from HFF at the completion of the training and internship program. They also get a First Aider certificate from Red Cross that is valid for 3 years.			
	Other components (non ABF funded but affecting CHF responsibilities)	**Sanitary napkins production (SNP) unit** Although this component was not funded by ABF, marketing and sales of sanitary napkins is a core responsibility of the CHF. Besides improving health outcomes for women as a safe alternative for menstrual hygiene management, the napkins are a source of additional income and sustainable income for the CHFs. After the CHF training was completed, all the 48 women from the Buxar 1st batch were informed about the SNP project and the training programme for the same. The seven day training was to happen at Ellaru and all the costs and arrangements were being made by HFF. The Sanitary Napkins Production (SNP) unit was established in 2012 and is currently located in an industrial shed in Buxar district of Bihar. The unit runs within a rented premises and employs 11 women – 1 CHF (supervisor) and 10 MFG members, and is operational from 9 am – 5 pm on six days of the week			

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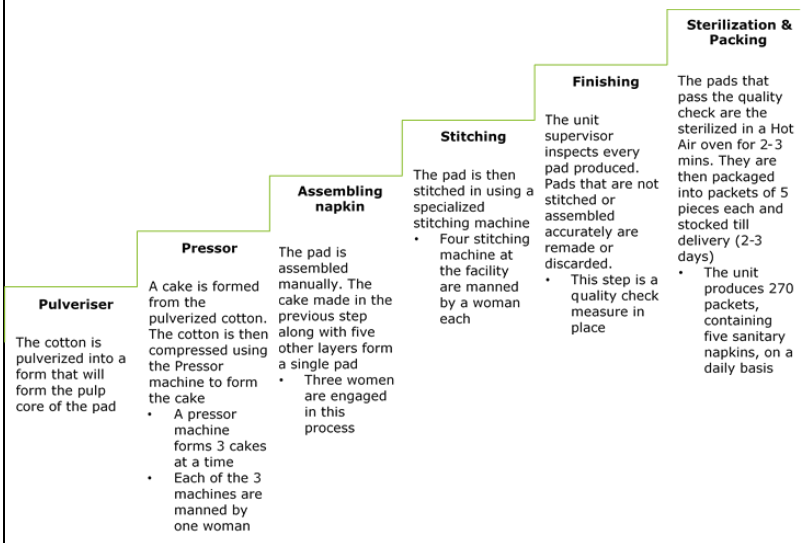
		(weekly off on Sunday). The diagram below describes in brief the process involved in producing a packet of the 'Mesa' sanitary napkins.  The supervisor is a CHF who was a member of the team that started the production unit 4 years back. She along with two other CHF had undertaken the training from Gulzar Agencies in Ellaru, near Vijayawada in what is now Telagana State. The pads initially used to be sold wrapped in paper however based on the demand of the customers and the CHFs that sell them, a call was taken to brand and sell them in a more appealing package. 'Mesa', short for Mera Sathi, was the name decided in consultation with all CHFs. The Mesa napkins are sold only through the CHF channel. The women employed at the SNP come from marginalized and vulnerable households – they had no source of income before being employed at the SNP. They are identified by the CHFs from among their MFGs or community. To counter the erratic power supply in the region, the SNP has a generator back up. The current monthly production capacity of the unit is 6500-7000 packets. The pads are distributed and sold by CHFs across 15 locations in Bihar and UP – Buxar, Ballia, Ghazipur, Chapra, Siwan, Kushinagar, Gorakhpur, Mirzapur, Sonbhadra, Sasaram, Khaimur, Rohatas, etc. The packet is being sold to a CHF at INR 12/- while the cost of production is well above INR 2/-. The CHF sells to the adolescent girls and women in the community for INR 15/-, thus making an INR 3/- margin per packet sold.
	Beneficiary Identification	In the annual planning, in consultation with Cashpor, the districts in which the new CHF training will be launched are decided. Every district in which Cashpor is operational has a Regional manager (RM) who oversees functioning of 24 branches. Each branch has 80 – 100 centres or micro finance groups of 25 women members each. The criteria for shortlisting potential beneficiaries of the CHF programme are defined by HFF and presented in figure below.

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		• Cashpore client in the district selected for intervention • Married woman aged 21 – 45 years • Educated at least up to 8th and can read and write in the local language • Resident of the village in which she will work • No other CHF exists within a 5 km radius of the shortlisted beneficiary Mandatory Desirable • Good connect with the community she lives in and ability to reach out to different groups within and outside her village • Good communication skills • Demonstrated leadership qualities • Past experience of community mobilisation In consultation with the RM, the 24 branches in a district are divided into six groups which will serve as the universe of selection of the three CHF training in that particular district. Since 2015, categorization into four branches are done to allow for a CHF to get a larger playing field and a chance to earn a higher income. Based on a ratio of 1 CHF for every 250 households in the village, the area/branch managers are instructed to identify 55 eligible women to be trained as CHF from each of the 6 categories of branches.
	Beneficiary selection	The beneficiary selection process is presented in the figure below: Beneficiary selection process **Step 1** District to launch CHF training finalized in consultation with Cashpore • Annual exercise **Step 2** Shortlist of 55 clients eligible for CHF training submitted by respective Area/branch managers for a particular batch in a district • Shortlisting done based on criteria decided by HFF **Step 3** Orientation of the 55 shortlisted women by HFF • This is followed by an interview of the interested women as a final step to select a beneficiary that will start with CHF training – Till 2015, training started immediately after selection process. – From 2014, while first 4 days contact program was split into 2 days each. While the selected candidates continued to get trained for 2 days immediately after selection, rest of the 2 days training was conducted after 15 days. Average time between steps - 25 days Most drop outs are experienced in the first month of training. Hence to maintain a batch size of 50 CHF till the end of training period, 55 women are usually enrolled in the first month. Dropouts are usually due to lack of family support, pregnancy, discomfort in traveling, etc. The interview of the shortlisted candidates is conducted to assess their interest in working in their community as a CHF.
	Responsibilities/ expectation from the CHF	During the selection process, the expectation and responsibilities of a CHF during the one year training period are elaborated to the trainees. These, as stated by HFF are as follows[17]: - Trainee has to bear the travelling expenses for attending the training during the first 6 months

[17] CHF project related documents shared by HFF on 4/10/2016

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		- During the 6 months of training trainees need to pay a nominal fee of INR 100 every month - Each trainee has to conduct pre and post baseline survey with 30 households, and also specific project based survey every month - Trainees have to complete community based projects on a suitable topic - During the internship each trainee has to conduct 10 HE sessions every month at the community for which she will be paid INR 50 per session - Community mobilization programs and camps during internship - Trainees have to create awareness and initiate water, sanitation and renewable initiatives in the villages - Should have acquired requisite skill in imparting Health Education using adult learning techniques. - If the trainee does not have a toilet in her house she should construct it by end of the training". The fees collected during the tenure of the training programme are refunded to the beneficiary only if completed documentation i.e. pre-post survey of 30 families, village register containing information of 250 families benefitted by health sessions, and project work is submitted by the CHF at the end of CHF program. Further, HFF makes it clear to the women that no job can be assured at the end of the 12 month training period.
	Documentation done by CHF	Documentation required to be completed by every CHF: 1. Baseline of 30 families (50% Cashpor members + 50% other community members) - The pre and post project survey is completed in the first and twelfth month of the HFF training. - Since a lot of data collection issues were seen in the manual entry on a pen-paper survey, HFF has provided tablets to CHFs for reducing this error since 2016. 2. Village registers for 250 families (150 Cashpor members + 100% other) - Only socio economic data recorded and hence not updated 3. Meeting minutes registers - Details of the proceedings of the health session recorded - Usually a 10-15 minute discussion ensues after the Cashpor branch manager has completed with his/her money collection. - For validation purpose, signatures of 5-6 members is taken. If the FC is attending the session, she too signs on the register. - In case of sessions held in the community, the school teacher signs when the session is organized at the high school level. The AWW/ASHA hesitate to sign on the register. The FC is usually present for the community meetings Entries on the village registers are verified by the FC.

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	Monitoring of the project	**Programmatic monitoring:** The Field Coordinator (FC) is responsible for direct supervision and providing handholding support to the CHFs in her district. Each FC has 62-65 CHFs under supervision and visits are made on a rotation basis during the initial training period to observe the sessions being conducted. She reviews the registers being filled out by the CHF and also gives feedback in cases where tasks are not completed effectively. The Programme Manager (operations) oversees the work of the FCs – on a daily and weekly basis. The FCs are required to share with the Operations manager their plan for the day at the start of a working day and the status of planned activities at the end of the day through Whatsapp. Further inputs about the weekly plan along with a daily update on every CHF's progress is made into a mobile app based MIS developed by Atom IT. The app has a check list for - baseline survey, health education, project, village register, internship, health savings, Livelihoods. The MIS is reviewed by the internal MIS monitoring team at HO in Hyderabad on a regular basis. In addition to the above, conference calls are scheduled once a week – at field level and senior management level. Field visits are conducted by senior management on monthly and quarterly basis. Every staff has a 90 days plan prepared by the Program manager operations which is further divided into monthly, weekly and daily plan. These plans are monitored by the Assistant Program Managers for their particular regions. **Financial monitoring:** HFF's board has representation from eminent individuals with various industry and corporate backgrounds – this has resulted in sound financial controls and processes to be established at the organization. A financial policy has been adopted that guides the processes for procurement and expenditure. Since CHF project is funded by multiple donors, several checks are in place to ensure that the budget plans sent by the TC before a CHF training workshop are approved and funds released based on the allocations permitted by various funders/budget heads. Most of the financial transactions, even the CHF payments, are made through direct transfers.
	Reporting of the project	**Internal reporting:** Monthly reports are done in excel format – as against target set and batches launched; kitchen gardens; toilets constructed. The field coordinator visits the CHF every month to collect information on each of the themes. The monthly report is shared by the Project Manager by the 26th – 28th of each month. Quarterly review meeting are held where presentations are made to understand the work progress. **Reporting to ABF:** A monthly report focusing mainly on the targets achieved is shared with the ABF PM managing the project. The quarterly and half yearly reports are more detailed and contain narrative accounts of the project's achievement and case studies of beneficiaries. ABF is very proactive in giving feedback about the reports and the ABF PM in charge visits the training for batches supported by ABF at least once.

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Outputs

Project coverage

State	CHFs trained	Launch Year					
		2010/11	2012	2013	2014	2015	2016
Assam	200			100	100		
Bihar	929	96	174	134	261	164	100
Chhattisgarh	100			100			
Odisha	164	100	64				
Uttar Pradesh	1226			110	432	373	311
Total	2619						

Total number of CHFs trained	2,619
Total number of villages/blocks/districts covered	2,296
Total number of families supported	654,750
No. of health sessions conducted in community	172,100
No. of Health groups formed	2,800
No. of families accessing the health savings scheme	42,000
No. of community toilets constructed	14,500
Number of families mobilized for toilet construction	14,500
Number of families mobilized for warm clothes	5,979
Number of sanitary napkins packets sold	75,000

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5. Key findings

This chapter is based on the analysis of data collected and observations made during the field visits conducted by Deloitte teams over 2 phases From September to October 2016. First hand data to understand the processes and direct impact of the CHF intervention collected from HFF management and project staff, Cashpor management, and key stakeholders such as health experts have been presented in the following sections.

Additionally, the indirect impact of the CHF intervention has been documented based on primary interactions with community. The pre and post intervention data of select families, that availed of the health education and other services from the CHFs, and available with HFF was analysed to quantify the impact and substantiate the narratives captured from field.

5.1 Study sample

As a part of the primary data collection the teams engaged with 214 CHFs that attended trainings in Chandouli (UP), Balia (UP), Sasaram (Bihar) and Buxar (Bihar). The results reported in this section and the direct impact section of this chapter is for the entire 214 participants in the study sample, unless mentioned otherwise.

The CHFs included in the study were residents of 13 districts across Bihar and Uttar Pradesh. The table below gives a frequency distribution of the CHFs along their district of residence.

District	No. of CHFs
Bhabua	7
Chandauli	26
Khaimur	10
Rohtas	22
Buxar	31
Bhojpur	11
Chanduali	9
Kaimur	4
Araria	1
Ghazipur	11
Balia	78
Barun	1
Mau	3
Total	**214**

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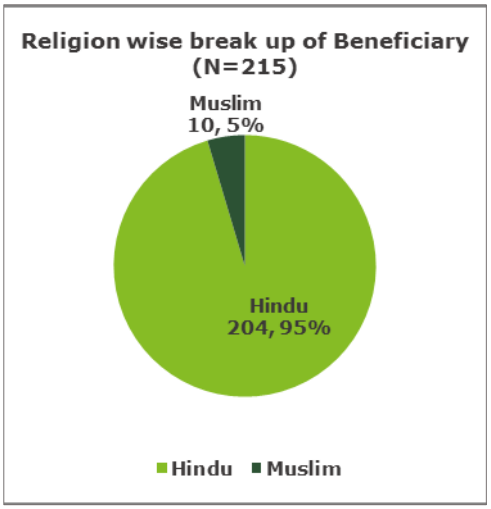
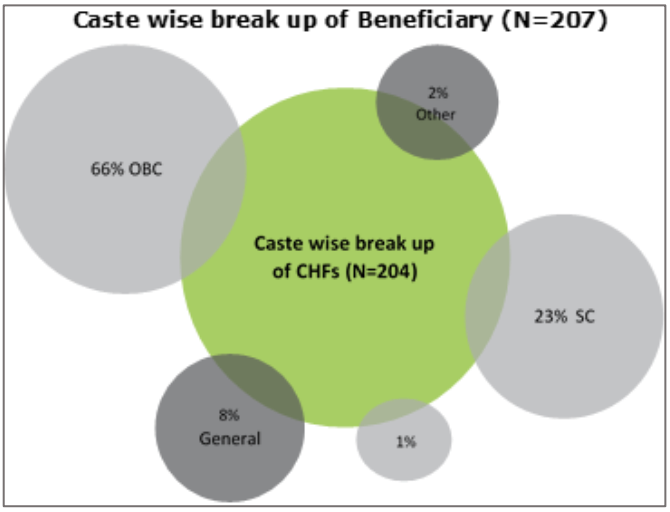
Demographic characteristics

The reported age of the CHFs included in the study was in the range of 23 – 60 years. The average CHF was a 30 year old married Hindu woman mostly belonging from a backward community. It should be noted that only married women were selected to be trained as CHFs to ensure that the learnings are practiced in the household and consecutively realized at the intervention village level. A very small percentage (1%) of CHF were widowed.

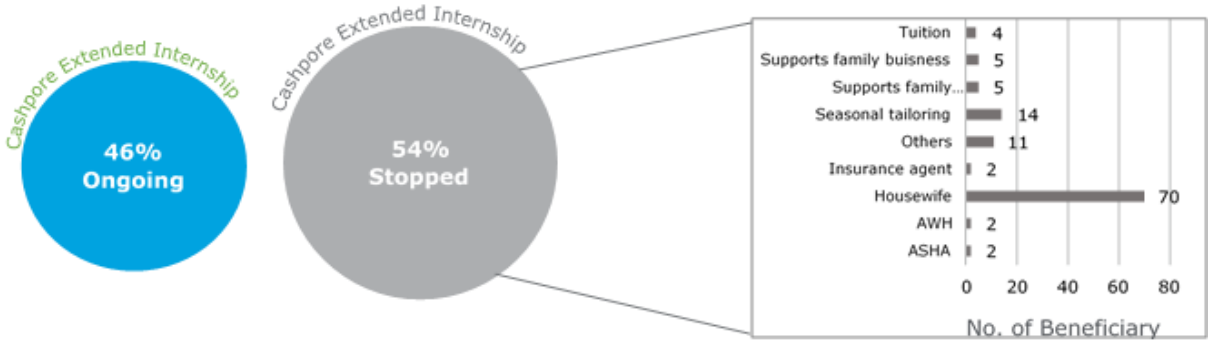




Current occupation

As mentioned in the sampling plan of the Methodology Chapter, the CHFs considered for inclusion in the study were from training batches launched till 2014. On completing the ABF supported training, the CHFs are given an option of participating in an extended internship, from Cashpor, comprising of 15 modules to be completed over 12 to 18 months.

The study sample included a fair mix of CHFs who were still continuing with the extended internship from Cashpor and those that had completed the same. 54% of the 214 that had completed (stopped) their extended internships with Cashpor at the time of the study.



Education levels

Since only women educated till 8th grade or higher were eligible to undergo the CHF training, all the respondents, except one had completed schooling at that level. The graphic on the following page gives a detailed representation of the education levels of all the 217 CHFs that were included in the study. While majority (29%) of the respondents had completed high school (SSC), 26% and 24 % had completed HSSC and middle schooling respectively. Only one CHF had completed her education only till Grade 7 and was selected in the programme because of the aptitude seen in her to learn new skills and deliver on the CHF responsibilities.

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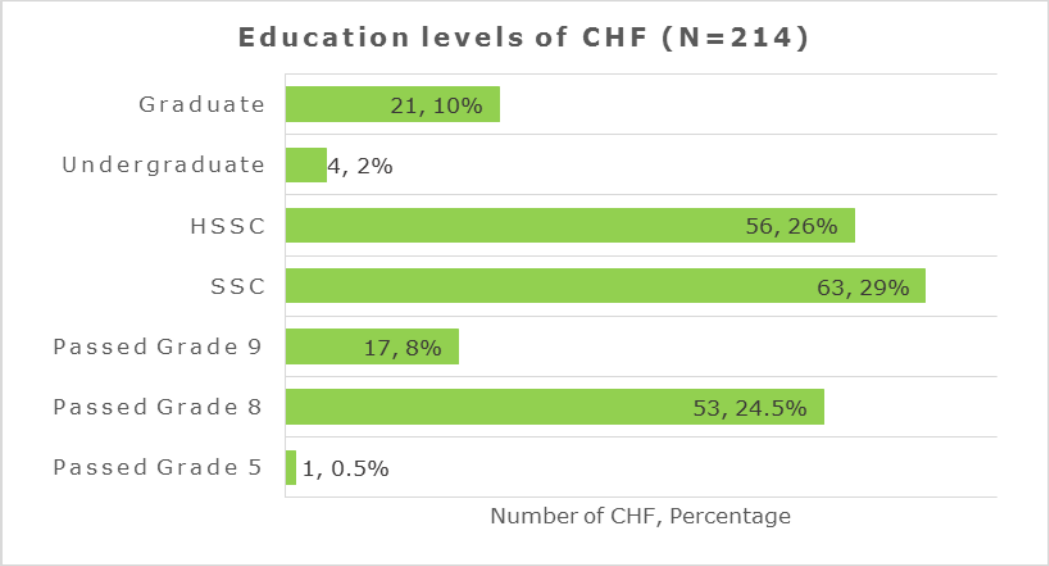
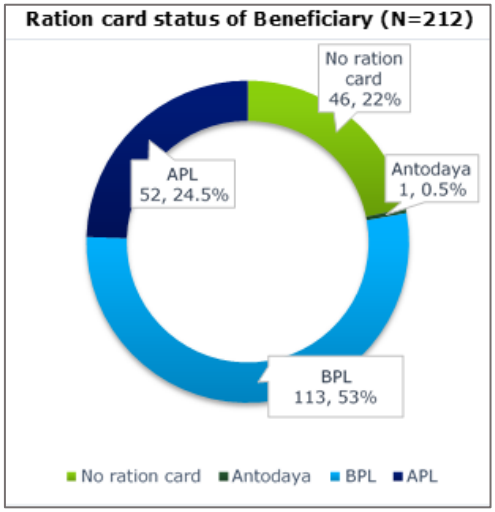
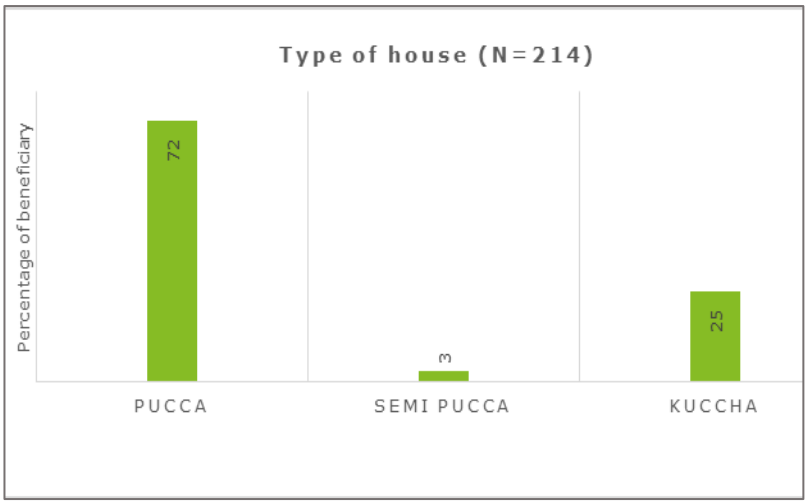


Financial status (based on type of ration card held)

Majority (53%) CHFs had BPL cards, while 24.5% of them had APL card. A significant proportion of 22% did not possess ration cards while only one of the respondents reported to being in the Antodaya (poorest of the poor) category.





Type of houses:

Similarly, 72% of the CHFs included in the sample lived in homes with pucca structures while only 25% lived in kuccha houses.

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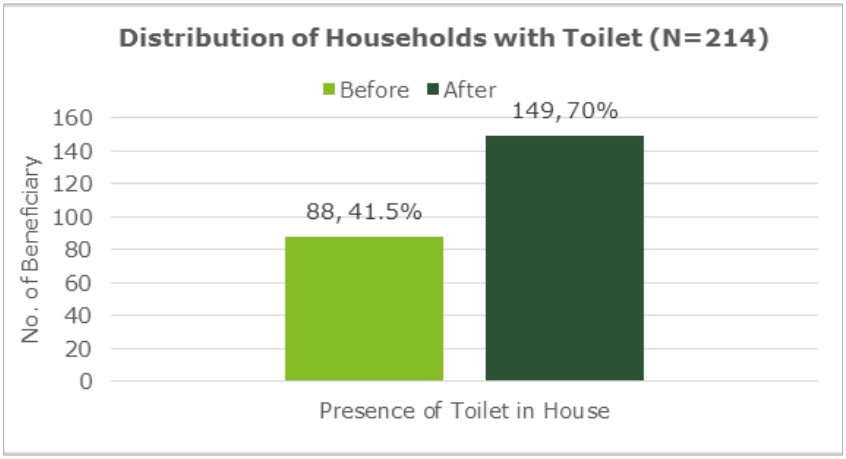
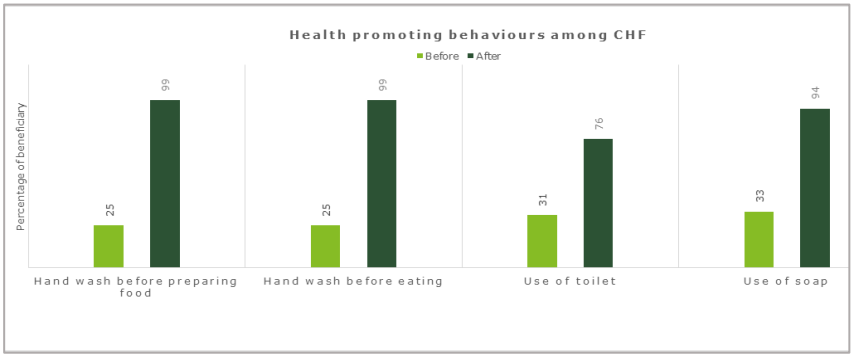
5.2 Direct impact:

The ABF support to the CHF training has had a twofold impact on its direct beneficiaries – CHFs. The primary objective of the training was to enhance the knowledge about health promoting behaviours among the beneficiary women. A second component to the programme was to give the trained CHF an opportunity to earn a regular income.

Health related outcomes

Aspect	Findings
Health promoting behaviors	**Hygiene and sanitation:** One of the primary focus areas of the CHF training is improving the sanitation and hygiene related practices among the CHF. The idea was for the CHF to lead by example by constructing a toilet within her house, building soak pits and adopting other clean habits such as washing hands with soap before eating and handling food, and after using the toilet.  The graphic above shows that the number of CHF households with toilets increased by almost 30% after the CHF training. Many of the women reported taking a loan from Cashpor to facilitate toilet construction.  A large proportion of CHFs during the interactions mentioned that prior to joining the CHF training, they would use mud or ash to wash their hands and had no idea about the negative repercussions of this habit. As the chart above indicates, there has been a significant increase (40-50%) in the numbers of CHFs using soap while taking bath, to wash hands before handling food, before eating, and after using the toilets after undergoing the training. **Other healthy practices** – Purification of drinking water: The number of CHFs using water purification methods such as boiling had increased to

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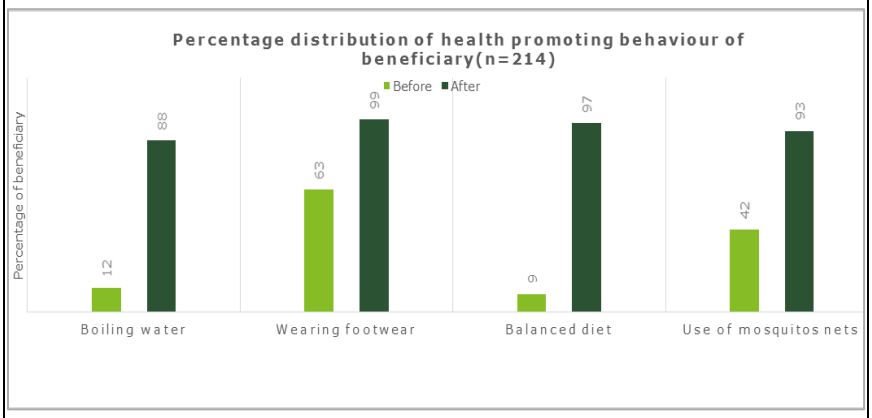
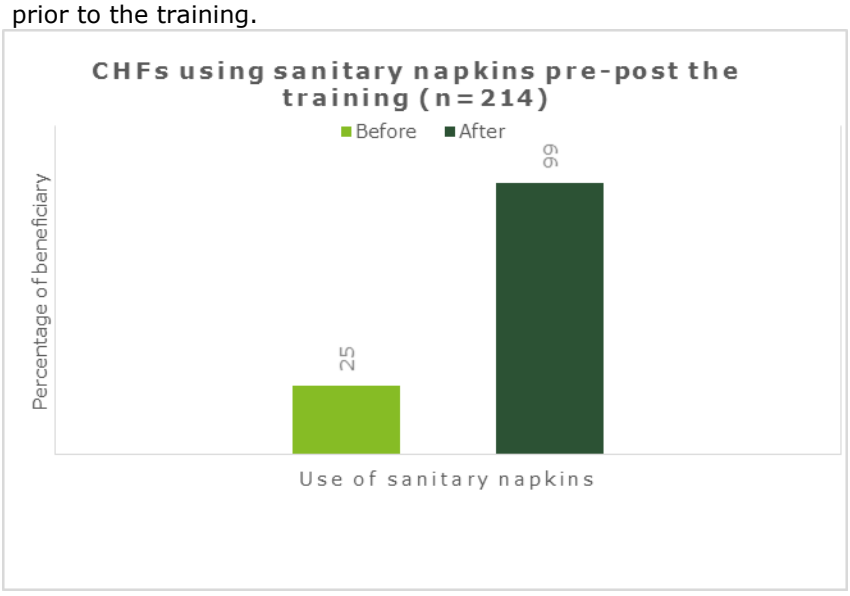
	88% compared to the 12% at the commencement of training. They mentioned that earlier they would drink directly water drawn from the hand pump. A few CHFs reported to increasing depths of their private bore wells to more than 60-80 feet when they learnt about the possibility of contamination of ground water table at shallow depths of 30-40 feet during the training. About 10% CHFs also reported to using RO water for drinking and cooking purposes.  – Knowledge about balanced diet: 97% of the CHFs reported to be aware about the importance of eating a balanced diet and mentioned that they now had the knowledge of locally available and affordable sources of vitamins and minerals. The graph above shows the increase in numbers of CHFs adopting habits of wearing footwear while going outdoors or using mosquito nets to prevent disease or injuries.
Disease burden	A content analysis of the narratives provided by the participating CHFs revealed that the incidence of minor illness episodes such as diarrhea, viral fevers, skin conditions, etc. has decreased. They reported that their children remain healthy because of the cleanliness that they maintain and the nutritious food included in their daily diets.
Reproductive and sexual health	**Menstrual hygiene management**: Majority of the respondents stated that they did not use safe hygiene products such as pads prior to the training. 

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<table>
<tr><td></td><td>5-6 CHF reported a decrease in the vaginal discharges, repeated urinary tract infections following the use of sanitary napkins. They all use the Mesa napkins made at HFF's Sanitary Napkins Production unit in Buxar. They were happy with the quality of the product but complained about the irregular nature of the supply of the pads.

Family planning practices:

<table>
<tr><th>Use of family planning method</th><th>Before (N=187)</th><th>After (N=182)</th></tr>
<tr><td>Yes</td><td>24 (13%)</td><td>36 (20%)</td></tr>
<tr><td>No</td><td>88 (47%)</td><td>28 (15%)</td></tr>
<tr><td>Tubal ligation or hysterectomy</td><td>75 (40%)</td><td>80 (44%)</td></tr>
</table>

A look at the table above shows that the number of CHFs using any family planning method increased by only 7% post the CHF training. Majority women reported to abstinence as the birth spacing method they used. The family's preference for a male child was a reason that the women would continue to have children till a son was born. The CHF included in the study had 2-6 children.

About 40% women had already undergone sterilization operation before joining the training. Most of these women already had 3 or more children before opting for surgery. Of the 5 women that had undergone surgery after enrolling for the CHF training, one mother of 6 children was able to convince her husband to let her undergo sterilization after undergoing training.</td></tr>
<tr><td>Health seeking behaviours</td><td>A majority CHFs during the FGDs mentioned that they now have knowledge about home remedies to use in case of minor illnesses. They try out some of these remedies and then seek medical help in case the complaints did not resolve in a couple of days or were aggravated. Their preference was for a private medical practitioner as they perceived their service and care delivered to be of superior quality.

Health expenditure: Based on the information on health related expenditure shared by 169 CHFs, the average HH expenditure on health was INR 5,592. The respondents mentioned that their health expenses had reduced up to 50-60% after the training. This they attributed to the reduction in the incidence of illnesses especially among children.</td></tr>
</table>

Financial outcomes

The financial outcomes mentioned in this section are based on comparisons with a retrospective 'before CHF' training income/occupation mentioned by the respondents during the survey.

Aspect	Parameters	Findings
4.1.1 Average income	Pre-CHF status	- Majority (70%) women were housewives prior to the intervention. Few of them earned small incomes from giving tuitions while some were engaged in seasonal work such as agriculture (non-cash), tailoring, pottery, etc. - Of the 30% women that earned some kind of wage, the range of monthly wages was between INR 80 to INR 5500 - All the women were members of Cashpor micro finance groups and had taken loans in the range of INR 10000 – 30000 to be repaid within 2-3 years at 2% monthly interest rates.

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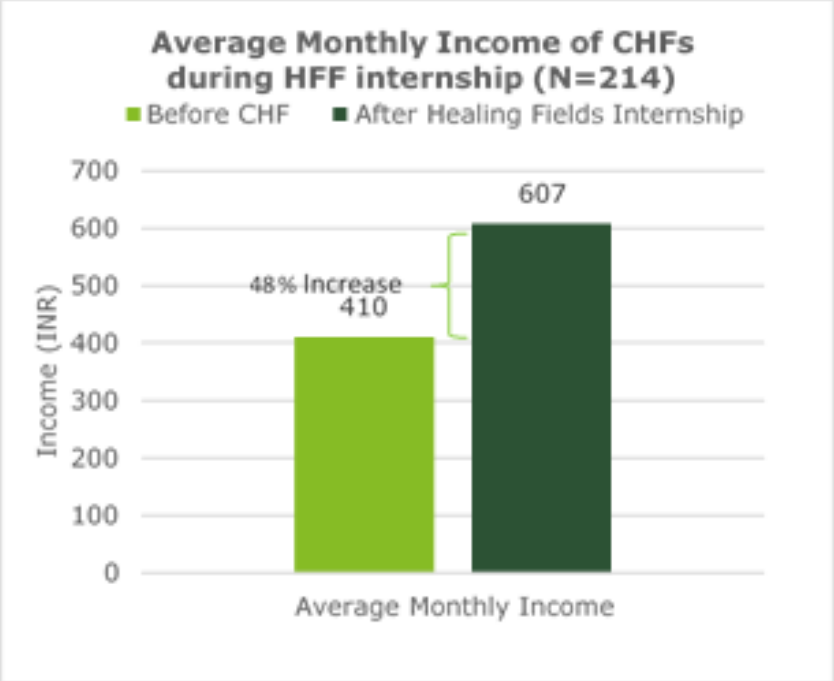
	HFF internship	- The focus of the internship was to conduct 10 health education sessions, increasing awareness and marketing of sanitary napkins and sales of warm clothes (in association with an NGO called Goonj). The CHFs mobilize the community on behalf of Goonj for a cleanliness drive in their village. The community pays a nominal amount for purchase of warm clothes from Goonj which is given to the CHFs as an incentive for the mobilization work. Some other activities where smaller number of CHFs were involved were MHM Survey and Akandajyoti eye camps where they received additional incentives. - Average stipend received for 6 months across beneficiaries were found to be INR 2,956/- i.e. a CHF earned an average monthly stipend of INR 490/- - All the respondents earned an additional average income of INR 438/- from sales of sanitary napkins during internship. - 67 CHFs were involved in the Goonj 'Warm Clothes' initiatives in winter months and earned an average of INR 492/- as their incentive for mobilizing the community towards the village cleanliness drive. The incentive amount was recovered by selling the warm clothes at a rate of INR 2-5 depending upon the size of clothes. - 8 CHFs from Buxar and Bhojpur districts had additionally earned from INR 2,500/- and INR 6,331/- from MHM survey and Akhandjyoti respectively. - As shown in the graph below, an increase of 48% in the average monthly income (from all sources) of CHFs was observed during the HFF internship 
	Extended Cashpor internship	- All the CHFs completing the HFF internship were given the option to join Cashpor for an extended internship of 15 modules (15 -18 months). A CHF would get assigned to 10-20 Cashpor microfinance groups with whom she would conduct health meetings. - As shown in the graph below, an increase of 333% in the average monthly income (from all sources) of the CHFs was observed during the Cashpor internship

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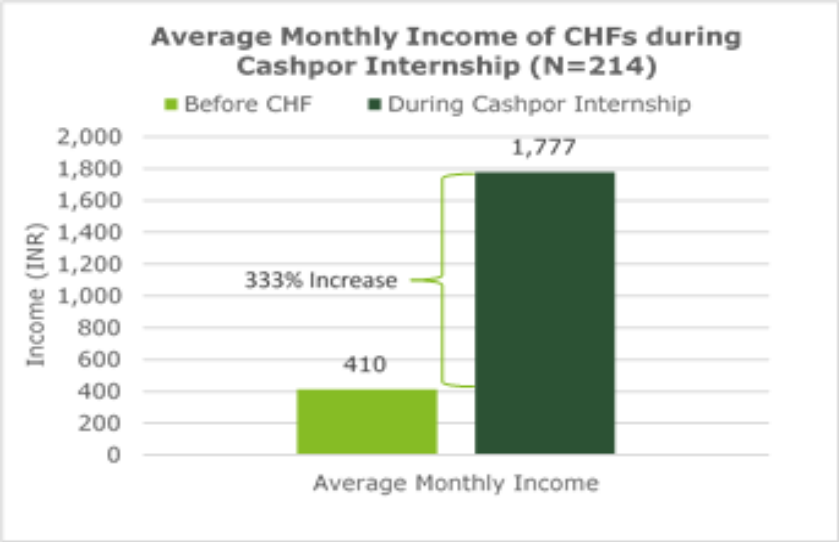

- The CHFs earned a regular average monthly income of INR 1679 as stipend for the health sessions conducted (INR 100 per session) and from the sale of sanitary napkins (INR 3 per packet sold).
- 34 CHFs had earned an additional average income of INR 4,335/- during the year by mobilizing families for toilet construction (Cashpor would pay INR 25/- as incentive for every loan taken for toilet construction)
- 12 respondents earned on an additional average income INR 477/- by conducting the Goonj drive during the winter months
</td>
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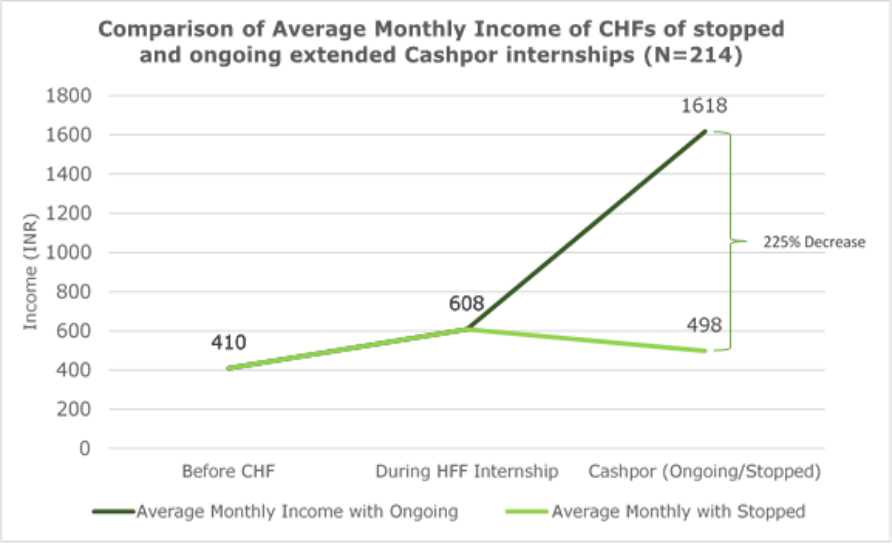
<tr>
<td></td>
<td>Current</td>
<td>
- 115 (54%) CHFs had completed their extended internship with Cashpor. Of these only 45 (39%) had some source of regular income.
- Majority (62%) women from this group had gone back to taking care of household chores with no regular or fixed income. These women mentioned that while there was a demand for sanitary napkins, the sales (and income from this) had got affected due to irregular supply. Many CHFs mentioned that since the regular health sessions had stopped, they had also lost contact with their regular customers of the sanitary napkins. The graph below shows the Before-After change in average income of the CHFs


- The survey indicates a drop of 225% in the average monthly income of the CHFs after completion of the Cashpor internships.
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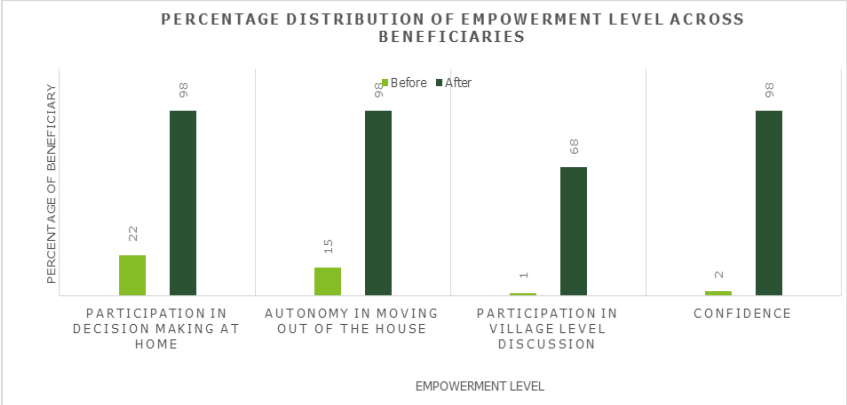
Expenditure patterns		- The respondents mentioned that now that they had money in hand, they used a major proportion of it to educate their children. They reported to contributing to the school fees, tuition fees and some even mentioned that they could enroll their children into a 'better quality' private school because of the incremental household income. - The CHFs also used up their earning to meet domestic expenses, repayment of loan, health related expenses, and on self
Savings		- Since all the respondents were members of microfinance groups under Cashpor, they all had a savings account before enrolling for the CHF training. 40% CHFs reported to saving INR 200-500 of their incomes in S/A that could be easily accessed in case of exigencies. - 66 CHFs reported to contributing annual premium of INR 1000/- towards Cashpor Pension Scheme - Other forms of popular savings instruments were Recurring Deposits (INR 200-500/-) and LIC plans for 33 and 27 CHFs respectively - Only 10% women reported to having savings in Fixed Deposit schemes and SHGs (INR 20-25/-)

Changes in empowerment levels

Aspect	Findings
Empowerment and social mobility	The survey findings revealed that the CHFs confidence levels had increased after undergoing the CHF training.  - Majority women mentioned that before the training, their movement outside their homes was restricted and Cashpor meeting would be the only place when they ventured outside alone without their husband or older child. They would step out and attend the meeting in 'ghungat'. - There has been an over 80% increase in the CHFs reporting autonomy in moving out of the house. - Similar increases have been seen in the CHFs participation in decision making at home – 98% of them reported to their spouses, in laws and children taking their opinion in all household matters including financial decisions. - Up to 68 % of CHF reported to participation in village level discussion. The common narrative was that since they had started conducting health education sessions, they were referred as 'madamji' and the community members (especially women) would approach for health related advise. - The beneficiaries were concerned about continued avenues for income generation after completing the Cashpor internship

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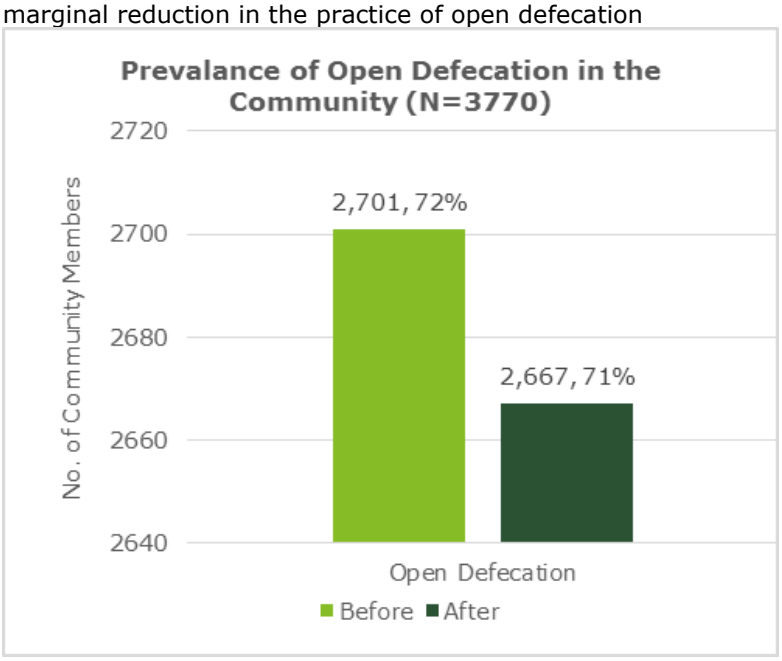
5.3 Indirect impact

The community members – Cashpor clients and other women, from both Bihar and UP districts were included in FGD to understand the level of engagement with the CHF and the impact of the intervention. All the women mentioned that they had attended health talks conducted by the respective CHF where topics such as hygiene practices, safe menstrual hygiene management – how to use cloth safely during periods, hand washing protocol and its importance, managing certain conditions at home – especially pain management, preparing ORS, etc. were discussed. While the sessions in Buxar had stopped some 6 months back, the sessions in Bhabua/Sasaram and Balia were ongoing.

Aspect	Findings
Health promoting behaviors	- About 10 of the community women across locations had grown kitchen gardens with the CHF's support. They had grown tomatoes, spinach, bottle gourd, okra, etc. in the kitchen gardens. Those with bigger lands had even grown guava and pomegranates. They were now able to each vitamins rich fruits and vegetables without spending too much money on it. - The women now wash vegetables before cutting them and avoided draining water from rice – they used cooking techniques to preserve the nutrients present in food. - The respondents also mentioned about changes in hand wash habits – they all used soap instead of the mud or ash used earlier and touched food only with clean hands. - The women in Buxar had participated in a village cleanliness drive under Goonj initiative that helped to control the air quality in their village temporarily. - An analysis of the community data available with HFF shows a marginal reduction in the practice of open defecation  - The number of households using some means of water purification has increased by 30%.

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	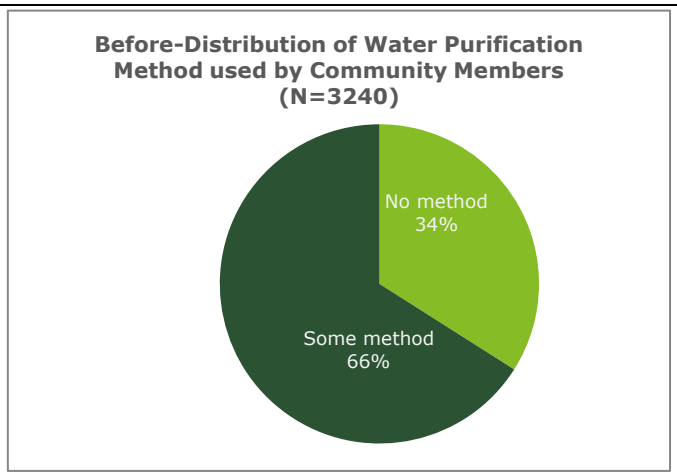 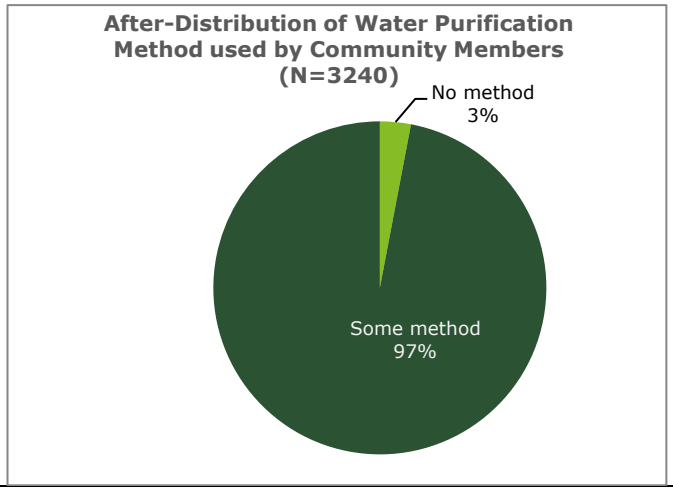
Disease burden	- Incidence of diarrheal diseases and RTIs reportedly decreased because of increased health awareness levels
Reproductive and Sexual health	- All the women had used the Mesa napkins. About half of the women included in the FGD were illiterate and stated that they were not aware about the importance of safe menstrual management practices till before the CHF session. - They were all happy about the quality of the Mesa pad – they even equated it with the commercially available ones. They all preferred the HFF pad over the subsidized ones sold by the ASHA. One of them stated that – using a napkin keeps them tension free about any leakages, especially when at school. - They are now aware that safe menstrual management helps to keep away infections that can in the long run even lead to infertility/sterility. - Dispose the used napkins in the nearby nullah.
Health seeking behaviours	- They know about home remedies that can be used to manage common illnesses which has reduced expenses related to health to a certain extent - The women citing apathy of the public delivery system said that they preferred private doctors. - A Health Savings Group was formed at Balia – the 25 members contributed INR 22/- each on a monthly basis. The lending, at 2% monthly interest, will commence once a saving of INR 5000/- is accumulated. Loan will be given out to members only in case of health emergencies for which they would earlier take loans from the local 'sahukar' at a 10% monthly interest.
Non health impact	- 100% enrolment in schools mentioned the community members during focus group discussions - Adolescent girls attends schools even during menstruation, highlighted the female participants in the discussion

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5.4 Success stories

Saleha, 36 years and resident of Jagdishpur village in Bhojpur district, was part of Buxar 2nd batch that was launched in May 2011. Before joining the CHF training, she was a housewife who would complement the household income by taking up odd tailoring jobs and would earn an average of INR 700 a month.

She seized the opportunity of income generation when a representative of her Cashpor branch informed her group about the CHF training being conducted by Healing Fields. At the time of the study, Saleha had completed her training and was working as a CHF with Cashpor (extended internship) till Feb 2016. Towards the end of the internship, she took sessions for 18 groups and earned another INR 80 from sales of sanitary napkins on a monthly basis.

Making use of the health knowledge she gained during the CHF training, she used to refer patients requiring medical/surgical interventions to doctors (private because of local preference). These doctors have now started giving her a commission for the referrals requiring surgery and are very happy with her work.

Talking about the impact of the CHF training, she says "no one from the village recognised me earlier. Since the time I became a CHF, 3 - 4 women come home to seek advice on a daily basis." She says that initially her in-laws were resistant to the idea of her working and undergoing a residential training. "I explained the importance of women being financially independent and they eventually relented. Today they are very proud of my achievements when the community respectfully call me 'madam'."

She continues to sell Mesa sanitary napkins to women in her community whenever they are in stock. However, she is concerned about her future after the Cashpor internship stopped in Feb 2016.

Phulkumari, 30 years, resident of Rampur village in Buxar has been working as a CHF since October 2014. A trainee from the Buxar 4th batch that was launched in Oct 2014, she is currently pursuing her extended internship with Cashpor. She comes from a BPL household and prior to the training she was a housewife, despite completing her SSC. As a Cashpor CHF, she currently earns a monthly income of INR 1100, of which INR 100 is from sales of Mesa napkins.

She sells the Mesa napkins for INR 15 for a pack of 5 while the ASHA sells napkins for INR 7 for a pack of 6. She stated that women were initially resistant to buying sanitary napkins that were costlier than the ones sold by ASHA. She asked the women to try the product and pay only if they were satisfied. She also conducted a demo in the local high school with the ASHA's support. All the adolescent girls bought the napkins. Slowly the demand increased. She mentions of selling her entire stock of up to 100 packets in a single day. She however reports that the irregular supply of napkins has affected the demand and popularity.

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Seema Devi is a CHF trained from the Bhabua - Chandauli 4th batch that was launched in Sep 2014. The 32 year old Seema is married and lives with her family in Hesuda village of Chandouli district in Uttar Pradesh.

She says that the knowledge acquired during the training has helped her in adopting health promoting behaviors and persuading her children in doing the same. Giving examples of this, she says, earlier she did not know much about locally available nutritious vegetables. Currently, her training helps her cook nutritious and balanced meals for her family. Although she was associated with Cashpor for a few years even before 2014, she took a loan from Cashpor to build a toilet after the training drew attention to health related side-effects of open defecation.

Seema has also been able to help the community with her enhanced knowledge about health. She gave an example of a case that she encountered during the CHF training. "I got to know of a lady in labour who was told by a private doctor that surgery is the only option without assigning any reason for it. The family approached me for advice. I was able to convince the family to take the expecting mother to the government hospital for a second opinion. The lady gave birth to a healthy baby without any surgical intervention."

Despite this, Seema feels that initially there were challenges in mobilising people for changes in habits and behaviours. They are more receptive to the information she gives now, she concluded. She proudly reports that today, even the village Pradhan (leader) contacts her in case of any health issue and takes her advice/counsel about issues that could impact the entire village.

Asha Devi aged 31 years has studied up to 8th std. lives with her spouse and four children in village Sayad Raja. Her husband has a small shop of garment stitching and earns around INR 15000/month. She completed HFF training in 2014-15 and shared that in the initial six months the training was conducted four days a month and covered topics round entire health life cycle - health, cleanliness, diet/nutrition, communicable diseases, immunization, menstrual hygiene and importance of ante-natal and post-natal care. She started taking health sessions in the second month and initially faced challenges such as capturing the group's interest and gaining their attention. She was guided by the Field Coordinator on responding to community queries and gradually developed confidence on conducting sessions and handling the Q/A.

Currently Asha is working under an extended internship with Cashpor. She conducted 11 health education sessions per month and earned INR13, 200 last year. She earned additional amount of INR 300 by selling approximately 100 sanitary napkin packets. She also helps her husband in his shop by taking on stitching assignments. Last year Asha had taken loan of INR 5000/ from Cashpor for installing gas connection and repair of toilet. Her elder son is completing Diploma while three younger children are in school.

Asha shared that HFF training has led to incremental behaviour changes at home such as washing hands before preparing food, improved hygiene practices, balance diet planning, etc. She has been able to save in the pension scheme and has used her income for educating her children and for health expenses. She said with tremendous sense of pride that she is addressed as 'madam' in the community and people listen to her during the sessions. Her spouse is happy that she goes out and is able to contribute to the family income. She maintains the household expense account. She has aspirations that her daughter unlike her will not get married before 21 years and will continue her education.

CHF from Rohtas district, Bihar
Ranju Devi 28 years from village Sonaura, studied up to SSC and completed HFF training in Bhabua-Dehri 3rd batch, September 2014. Her husband is a framer and also has poultry earning around INR 1,80,000/annum. Before HFF training, she was a home maker and currently post training she is working under extended internship with Cashpor. She conducted 15 health sessions last year and earned INR 18,000 last year. She also sold 200 sanitary napkin packets and earned INR 600 last year.

Ranju has used her salary to contribute towards her children's education, and saves INR 1000 under the pension Scheme. She came to know about Cashpor through HFF and had taken a loan

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of INR 18,000 for helping her husband buy poultry. She said the household expenditure on health has reduced as compared to last year as small changes have been adopted by family such as drinking boiled water, improved hygiene practices. Ranju shared that earlier she was like a 'frog in a well' where her worldview was limited to her household work and her family.

After the CHF training, her confidence level has improved tremendously and she gets more respect at home as an earning member of the household. In addition to having a means of livelihood, she also feels a sense of achievement in contributing to improved sanitation and hygiene condition of the village. She says that young girls are increasingly using menstrual hygiene products and also included dietary changes such as having one glass of milk and one egg daily. Women in the community have started kitchen gardens and grow seasonal vegetables like bottle gourd, bitter gourd, etc. which is largely used for - household consumption.

5.5 Voice from field

With the CHF training, I was able to convince pregnant women in my village about the benefits of taking IFA tablets during pregnancy - Mansha Devi, Masauni, Chandouli, Bhabua – Chandouli 4th batch

Women grow bitter gourd, brinjal, cucumber, green chillies. They use for household consumption and sell in case of excess - Kavita Devi, Rohtas. Bhabua-Dehri 3rd batch Sept 2014

A scorpion bit my small niece. I used her basic first aid knowledge to make a small incision at the site with a new blade to allow the infected blood to drain out. I tied a tourniquet proximal and distal to the bite and rushed the girl to the hospital. The doctor in the emergency room praised me for the quick thinking and first aid provided - Rinku Devi, Bhabua – Dehri 3rd batch, Sep 2014

People eat more green vegetables, use less spice in food. There is more awareness about health. Even if women use cloth, they use clean cloth - Rita Devi, Chandauli. Chandauli 2014-15

The community contacts me when the ASHA is not reachable. I helped one woman who was in labour and was not progressing beyond 3 finger dilatation. I was able to counsel the family to take the women for an institutional delivery - Kiran Devi, Bhaluhi, Khaimur, Bhabua – Mohaniya 2nd batch

Increased awareness about institutional delivery, women go to government hospitals. Earlier they use to go to quacks - Urmilla Devi, Chandauli. Chandauli 2014-15

Initially went to Cashpor meeting covering her face with a ghungat. Now she is more confident and goes out on her own. The incidence of diseases in her family has reduced - even her children know the importance of washing hand and at times teach other students in their schools –Savita, Chitrabuj, Bhabhua – Chandouli 4th batch

Her children and husband have now started taking her seriously and take her advice while taking any decisions – Parvati Devi, Dudhari, Bhabua-chandouli 4th batch

Her sister's DIL got injured after a tile from the roof fell on her head. Sushma was able to clean the wound, administer basic first aid and took her to the hospital. The patient received 7 stiches – Sushma Devi, Damodarpur, Bhabua, Bhabua-chandouli 4th batch

Now she is respected in the society - earlier no one recognized her – Phulkumari, Rampur, Buxar 4th batch

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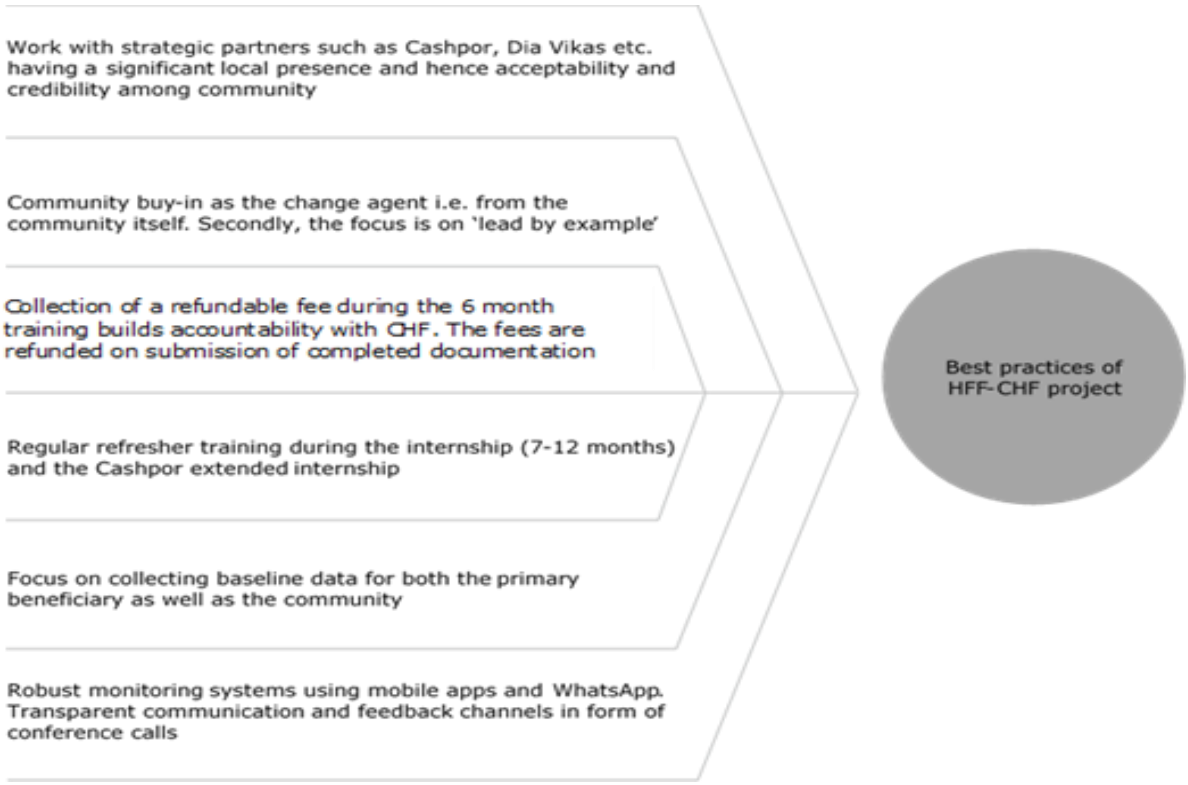
5.6 Best practices

The primary focus of the CHF training programme is health awareness generation at two levels:

- Train community women as CHF level and develop her as a change agent
- Deploying a cadre of these CHFs who would increase awareness about health among their peers in the community

Despite the strong focus on BCC through IEC, a livelihood generation aspect has been introduced into the programme with an understanding that the CHF would be investing considerable time and effort to conduct the health awareness sessions and hence has to be compensated accordingly.



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6. Key recommendations

Aspect	Findings	Recommendation
Model – sustainability of outcomes	The two pronged objectives of the intervention - improving community's health outcomes by promoting awareness about health while providing a livelihood source (stipend for session and sanitary napkins sales) for the CHFs. It was observed that on completion of the one year training and the Cashpor extended internship, the CHFs stopped venturing out actively. With the irregular supply of sanitary napkins, they had very limited contact with the women whom they counseled earlier. Further, primary target audience for the CHFs throughout have been only Cashpor clients and even the HFF local presence at the regional level ends within 2-3 years of the first intervention. Bringing about behavior change takes time and significant handholding and monitoring. On the income part, for majority CHFs this was their first opportunity at earning cash for work. They had shown significant changes in personality as well as social mobility because of their financial independence. During interactions, it was observed that the financial component was a primary reason for most of them to continue the health work. Majority of them were keen on working further and in upskilling. However, majority of those who had completed their internships, had gone back to relying on their husbands for financial support even for the most trivial reasons.	To bring about a positive and sustainable behavior change at the community level, monitoring and handholding for longer durations is required. While the frequency of contact can be reduced after the initial intensive phase of 2-3 years, some engagement with a fixed community is required for at least 5 years or till majority village achieves a minimum level on health related indicators. Alternately, it is recommended that the focus of the CHFs engagement with larger community (other than Cashpor) can have equal weightage for a larger visible change. A more sustainable source of livelihood for the trained CHFs is required to keep them motivated to put to good use the knowledge that they have acquired and also to ensure her financial security. Since the Cashpor clients demand for the health talks, options of them contributing for the CHFs honorarium can be considered in consultation with the partner. Simultaneously, alternate job linkages for the CHFs on completion of training with local NGOs working on health and related issues can be considered.
Standardization of operational definition and baseline	The CHF baseline data showed variance especially in the income related data. This could have been because of lack of standardized operational definitions – secondly the larger project had a primary health focus. Secondly, for a health related project, it becomes imperative to collect specific health related	Standardization of certain common indicators such as income, savings, and expenditures, etc. can help ABF in accurate reporting at the portfolio level. The data capture matrix for livelihood projects can in the future also contour other project specific indicators to

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	baseline data – in this case at the CHF and community level (sample). This would have enabled ABF to get a holistic understanding of the impact its funding.	understand the integrated impact of the project.
Certification	The CHFs on completion of the yearlong training are provided HFF certificate and First Aid Certificate from St John's Ambulance and Red Cross. Currently, few CHFs included in the study were employed as ASHA's in the public health system. Other secondary stakeholders also mentioned that Certification from a recognized body could help the CHFs to get better job opportunities with other health care providers in the region.	Potential affiliation with the Sector Skills Council under the National Skill Development Corporation (NSDC) would assure quality standards and hence increase the potential for alternate avenues for employability of the CHFs on successful completion of the course. Since the project is operational in states where there is tremendous shortfall of qualified health personnel, potential for such tie ups can be explored with the respective health departments by HFF
Sanitary napkins	The SNP unit currently faces challenges in meeting the huge demand for sanitary napkins primarily because of the technology that is being used. This gets compounded because of the delays in supply of raw materials and also because of gaps in quality control. This irregular supply of napkins has hampered customer loyalty for the brand/products despite the majorly positive opinion about the product. Further, the inadequate supply also limits the sustainable income that the CHF could have in the current model of the project.	The CHFs are already part of microfinance groups. The feasibility of introducing mini Sanitary napkin production unit at a district/block level should be looked at which, while giving a livelihood option to the local women could also improve the production capacity and reduce distribution costs. An alternative to this could be outsourcing the manufacturing – consider tie ups for subsidized products with FMCG companies under CSR umbrella.
Health insurance component	While the fact that a disease episode causes serious economic stress to the household was acknowledged, the CHF herself did not have access to any instrument that would safeguard her family in such an event. The women were not aware of or did not subscribe to any UHI schemes such as the RSBY.	HFF should make some kind of a risk pooling or health savings scheme compulsory for the CHF. Linkages to government health insurance schemes for the BPL should be facilitated for the eligible women.
Linkages with the public delivery system	The CHFs worked as a cadre parallel to ASHA in the village. While some form of collaborative work happens with the AWW while conducting demonstrations on sanitary napkins, MCH issues, etc., these are not formalized. In fact tension with the ASHA was reported by some CHFs – as the ASHAs felt like they were losing	There should be some form of buy in for the program from the district health authorities. The responsibilities of the ASHA should not be duplicated by the CHF - communication channels should be set up for more synergistic work environment where in the CHF complements or supplements the ASHA's work.

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	out on the JSY incentive when CHFs took women for deliveries. Similarly, the tie ups with the health centres and district hospitals for medical interventions was not seen.	Referral mechanisms should be put in place to include the public health delivery infrastructure and personnel.
Sustainability of the initiative CHFs	After the completion of the Cashpor extended intervention, the survey revealed that the CHFs stop working and other few continue the work they used to do before becoming CHFs. Most CHFs did not have clarity about the role in the community and income generation options after the Cashpor programme	A long term plan for the CHFs needs to be carefully created accounting for all future possibilities. The veteran CHFs can potentially be made stakeholders of this planning process so that there is a continuity of responsibility and tasks that keeps them motivated.

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Annexure I: ABF impact template

Details required from the sample study

(Table 1)

Beneficiaries in the corresponding income range								
Income range	Baseline Data*			After intervention**			Increase in average annual income	
	No	%	Average Income	No	%	Average Income	Amount	%
0-12,000	188	88	1,794	23	11	9,770	7,976	445
12,001- 36,000	21	10	21,771	169	79	19,436	2,335	11
36,001-60,000	5	2	51,600	19	9	44,674	-6,926	-13
60,001-84,000	-	-	-	3	1	68,450	-	-
84,001-100,000	-	-	-				-	-
Over 100,000	-	-	-				-	-
Total	214	100	4,918	214	100	21,325	16,407	333

*Based on retrospective baseline collected during survey
**Income during Cashpor internship

(Table 2)

Total No. of beneficiaries till Mar 2015	214
Average annual income per beneficiary before the intervention	4,918
Average annual income per beneficiary after the intervention	21,325
Increase in average annual income	16,407
Increase in Average income (in %)	333

Data as per NGO partners records

(Table 3)

Beneficiaries in the corresponding income range (2012-2015)								
Income range	Baseline Data			After intervention			Increase in average annual income	
	No	%	Average Income Annual	No	%	Average Income Annual	Amount	%
0-12,000	1928	100	1,584	1928	100	15,480	13,900	877
12,001- 36,000	-	-	-	-	-	-	-	-
36,001-60,000	-	-	-	-	-	-	-	-
60,001-84,000	-	-	-	-	-	-	-	-
84,001-100,000	-	-	-	-	-	-	-	-
Over 100,000	-	-	-	-	-	-	-	-
Total	1928	100	1,584	1928	100	15,480	13,900	877

(Table 4)

Total No. of beneficiaries till Mar 2015	1928
Average annual income per beneficiary before the intervention	1,584
Average annual income per beneficiary after the intervention	15,480
Increase in average annual income	13,900
Increase in Average income (in %)	877

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Before – After data of selected sample beneficiaries

Sr. no.	Name of respondent	CHF income - NGO baseline (A)	CHF income - Survey retrospective baseline (B)	Post intervention income - during Cashpor internship (C)	Increase in income	
					Increase in amount (C-B)	% Change
1	Aarti Devi	12000	32400	53700	21300	66
2	Aarti Devi	0	0	19330	19330	19330
3	Aarti Devi	0	0	21480	21480	21480
4	Amrita Devi	0	0	17700	17700	17700
5	Anita Devi	0	0	22320	22320	22320
6	Asha Devi	0	0	18720	18720	18720
7	Asha Devi	0	12000	31920	19920	166
8	Asha Devi	0	0	16230	16230	16230
9	Asha Devi	NA	0	18000	18000	18000
10	Asha Kumari	0	18000	34230	16230	90
11	Babita Devi	0	0	17880	17880	17880
12	Bebi Devi	0	12000	49300	37300	311
13	Baijanti Devi	0	0	21720	21720	21720
14	Bebi Devi	0	0	19350	19350	19350
15	Champa Devi	0	0	13200	13200	13200
16	Chanadrabala Devi	0	0	20040	20040	20040
17	Chanchala Devi	0	24000	17790	-6210	-26
18	Chinta Devi	0	0	17700	17700	17700
19	Daulat Devi	0	12000	38070	26070	217
20	Gauri Devi	0	12000	28470	16470	137
21	Geeta Devi	0	0	15300	15300	15300
22	Geeta Devi	0	0	16500	16500	16500
23	Geeta Singh	NA	0	8400	8400	8400
24	Imriti Devi	0	0	28600	28600	28600
25	InduDevi	0	6000	27120	21120	352
26	Kalavati Devi	0	0	29550	29550	29550
27	Kamini Devi	0	0	18780	18780	18780
28	Kanchan Devi	0	0	29580	29580	29580
29	Kanti Devi	0	0	24900	24900	24900
30	Kavita Devi	0	0	20760	20760	20760
31	Kiran Devi	0	6000	28950	22950	383
32	Krishnavati	0	0	10950	10950	10950
33	Krishnavati Devi	0	3600	10050	6450	179
34	Lakshmi Devi	0	0	22600	22600	22600
35	Lakshmina Devi	0	0	10200	10200	10200
36	Lalita Devi	0	0	15300	15300	15300
37	Lalmani Devi	0	0	14550	14550	14550
38	Laxmi kumari	0	4800	20940	16140	336
39	Madhuri Devi	0	6000	20700	14700	245

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40	Manjidan Khatun	NA	4800	30600	25800	538
41	Manju Devi	0	0	17430	17430	17430
42	Manju Devi	0	0	20700	20700	20700
43	Manju Devi	0	18000	22420	4420	25
44	Mansha Devi	0	0	12630	12630	12630
45	Maya Devi	NA	9600	23000	13400	140
46	Meena	0	24000	47700	23700	99
47	Meena Devi	0	0	22950	22950	22950
48	MeeraDevi	0	0	11250	11250	11250
49	Muni Begam	0	18000	39000	21000	117
50	Munni Devi	0	12000	27250	15250	127
51	Murahi Devi	0	12000	33500	21500	179
52	Nasima Banu	0	0	17430	17430	17430
53	Nitu Devi	0	0	18180	18180	18180
54	Nisha Devi	0	0	37350	37350	37350
55	Parvati Devi	0	0	22950	22950	22950
56	Parvati Devi	0	0	39430	39430	39430
57	Phul Kumari	0	0	39700	39700	39700
58	Phulkumari	0	0	21030	21030	21030
59	Poonam Devi	0	0	24900	24900	24900
60	Poonam Devi	0	36000	14800	-21200	-59
61	Pramila Devi	0	12000	17300	5300	44
62	Pranshila Devi	0	18000	36960	18960	105
63	Prema Devi	0	14400	47550	33150	230
64	Prinky Devi	0	0	15420	15420	15420
65	Pushpa Devi	0	0	19080	19080	19080
66	Radhika Devi	0	0	18180	18180	18180
67	Ramavati Devi	0	0	53100	53100	53100
68	Rani kumari	0	15600	42160	26560	170
69	RaniDevi	0	0	22230	22230	22230
70	Ranju Devi	0	0	22950	22950	22950
71	Reena Devi	0	2400	26100	23700	988
72	Rekha Devi	0	0	13920	13920	13920
73	Rekha rani	0	0	18450	18450	18450
74	Renu Devi	0	0	25320	25320	25320
75	Renu Devi	0	20400	20280	-120	-1
76	Reshma Devi	NA	0	16230	16230	16230
77	Rinku Devi	0	6000	27960	21960	366
78	Rinku Devi	0	18000	20280	2280	13
79	Rita Devi	0	0	20100	20100	20100
80	Rita Devi	0	0	17880	17880	17880
81	Rita Devi	0	0	18900	18900	18900
82	Rita Devi	0	0	14470	14470	14470
83	Rita Devi	0	0	23980	23980	23980
84	Ruby Devi	0	0	16600	16600	16600

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85	Ruhi Devi	NA	0	15030	15030	15030
86	Ruksana Khatun	NA	48000	73830	25830	54
87	Saleha Khatun	0	8400	48580	40180	478
88	Samim Banu	0	0	25800	25800	25800
89	Sandhya Devi	0	0	15000	15000	15000
90	Sandhya Devi	0	12000	33080	21080	176
91	Sangeeta Devi	1800	0	21030	21030	21030
92	Sanju Devi	0	0	0	0	0
93	Saraswati	0	24000	15300	-8700	-36
94	Saraswati Devi	0	0	21380	21380	21380
95	Sarda Devi	0	0	24900	24900	24900
96	Sarita Devi	0	0	29080	29080	29080
97	Sarita Devi	0	0	18600	18600	18600
98	Savita	0	0	15480	15480	15480
99	Savita Devi	0	0	19980	19980	19980
100	Savita Sharma	0	0	17600	17600	17600
101	Seema Devi	0	0	13620	13620	13620
102	Seema Devi	0	5400	26700	21300	394
103	Shail Kumari	0	0	25800	25800	25800
104	Sharada Devi	0	0	17650	17650	17650
105	Shobha Singh	0	0	20880	20880	20880
106	ShushmaDevi	0	0	17700	17700	17700
107	ShushmaDevi	0	0	18420	18420	18420
108	Sima Devi	0	0	19200	19200	19200
109	Sima Devi	NA	12000	34230	22230	185
110	Sita kumari	0	0	17160	17160	17160
111	Soniya Devi	0	0	14100	14100	14100
112	Suman Devi	0	0	21300	21300	21300
113	Suman Devi	0	0	16560	16560	16560
114	Sundari Devi	0	18000	44750	26750	149
115	Sunita Devi	0	18000	40950	22950	128
116	Sunita Devi	0	2400	11400	9000	375
117	Sunita Devi	0	48000	70320	22320	47
118	Sushila Devi	0	0	10620	10620	10620
119	Tetra Devi	NA	12000	24450	12450	104
120	Tetra Devi	0	0	24300	24300	24300
121	Uma Devi	0	12000	13600	1600	13
122	Urmilla Devi	0	0	22950	22950	0
123	Usha gupta	0	0	21000	21000	0
124	Vandana	0	36000	45960	9960	28
125	Vimla Devi	0	0	25780	25780	25780
126	Aarti Varma	0	12000	27900	15900	133
127	Anita Devi	0	0	13500	13500	13500
128	Anita Singh	12000	0	13800	13800	13800
129	Arti Gupta	0	0	13200	13200	13200

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130	Asha Devi Madhesia	0	0	18240	18240	18240
131	Bebi Khatun	0	0	13200	13200	13200
132	Chandravati Devi	0	0	9720	9720	9720
133	Chandu Devi	0	0	15570	15570	15570
134	Gauri Varma	0	0	21000	21000	21000
135	Geeta Devi	0	0	17700	17700	17700
136	Gyanti Devi	0	0	10890	10890	10890
137	Hemlata Devi	0	0	15000	15000	15000
138	Indu Chauhan	0	0	14400	14400	14400
139	Jaishree	0	0	22150	22150	22150
140	Kalavati Devi	0	4500	20100	15600	347
141	kanchan Varma	0	0	15510	15510	15510
142	Kaushalya Devi	0	0	15420	15420	15420
143	Kiran Devi	0	0	9090	9090	9090
144	Kiran Dubey	0	0	10500	10500	10500
145	Kusumlata Tiwari	0	0	13920	13920	13920
146	Lalbachi	NA	48000	61200	13200	28
147	Lalita Devi	0	66000	10800	-55200	-84
148	Laxmi Devi	0	18000	33900	15900	88
149	Maju Devi	0	30000	43350	13350	45
150	Mamta Devi	NA	0	13200	13200	13200
151	Manju Devi	0	0	17100	17100	17100
152	Manju Devi	0	0	17760	17760	17760
153	Manju Devi	9600	18000	20580	2580	14
154	Manju Gupta	0	12000	9900	-2100	-18
155	Maya Gupta	0	0	10350	10350	10350
156	Maya singh	0	960	14400	13440	1400
157	Meena Devi	0	0	15600	15600	15600
158	Meera Devi	0	0	17400	17400	17400
159	Meera singh	0	0	18000	18000	18000
160	Mira Devi	0	0	9468	9468	9468
161	Munni Devi	0	14400	27000	12600	88
162	Munni Gupta	0	0	15090	15090	15090
163	Naintara Suresh Yadav	0	0	10440	10440	10440
164	Nirmala Devi	0	0	15600	15600	15600
165	Nirmala Devi	0	7200	21180	13980	194
166	Nirmala Gupta	0	4800	9600	4800	100
167	Nisha sharma	NA	12000	28500	16500	138
168	Parvati Devi	0	0	13200	13200	13200
169	Phulwanti Devi	12000	0	17400	17400	17400
170	Pinku Devi	0	12000	12000	0	0
171	Pinky Devi	0	0	17640	17640	17640
172	Poonam Devi	0	0	16050	16050	16050
173	Pramila Devi	0	0	10560	10560	10560
174	Pushpa Devi	0	0	15900	15900	15900

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175	Pushpa Devi	0	0	13950	13950	13950
176	Pushpa Devi	0	0	15000	15000	15000
177	Pushpa Devi	0	0	15750	15750	15750
178	Pushpa Devi	0	12000	16800	4800	40
179	Pushpa Sharma	0	12000	15000	3000	25
180	Ranjana Devi	0	0	16140	16140	0
181	Ranju Sharma	0	0	14790	14790	0
182	Reena Devi	0	12000	29220	17220	144
183	Reena Shilpkar	0	0	17160	17160	17160
184	Rekha Maurya	0	0	16800	16800	16800
185	Rinku Devi	0	0	16500	16500	16500
186	Rita Devi	0	0	14700	14700	14700
187	Sail Kumari	0	6000	18510	12510	209
188	Salama Khatun	0	6000	16230	10230	171
189	Sambha singh	0	0	14400	14400	14400
190	Sandhya Devi	NA	0	15600	15600	15600
191	Sangita Maurya	12000	0	15300	15300	15300
192	Sangita Yadav	0	0	15750	15750	15750
193	Sanju Gupta	NA	0	13575	13575	13575
194	Sarda Devi	0	0	15300	15300	15300
195	Sarita Devi	0	0	13950	13950	13950
196	Savita Sharma	0	12000	26400	14400	120
197	Savitri Devi	0	0	16800	16800	16800
198	Shanti Devi	0	0	15000	15000	15000
199	Shanti Devi	0	0	14280	14280	14280
200	Sita Devi	0	0	15300	15300	15300
201	Soni Devi	0	0	14760	14760	14760
202	Suman Sharma	0	0	8400	8400	8400
203	Sumitra Bishkarma	0	12000	18300	6300	53
204	Sunaina Devi	0	1200	15600	14400	1200
205	Sunita Devi	0	0	15540	15540	15540
206	Sunita Devi	0	0	10530	10530	10530
207	Sunita Devi	0	0	9600	9600	9600
208	Sunita Khushwaha	0	24000	43200	19200	80
209	Sushila Devi	0	1200	17520	16320	1360
210	Tetari Devi	0	0	17950	17950	17950
211	Urmila Devi	0	0	18000	18000	18000
212	Usha Devi	0	0	13800	13800	13800
213	Usha Devi	0	48000	57990	9990	21
214	Usha Singh	0	0	15600	15600	15600

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Annexure II: Stakeholder coverage

List of beneficiaries covered by FGDs during the study

Sr. No.	Name of Beneficiary	Batch	Village	Education
1	Geeta Devi	Chandauli 2014-15	Bewar	8th
2	Amruta Devi	Chandauli 2014-15	Jaoli	HSC
3	Chandrabala Devi	Chandauli 2014-15	Raithan	8th
4	Lalmali	Chandauli 2014-15	Sarai pakwan	HSC
5	Sushila Devi	Chandauli 2014-15	Itwa	
6	Suman Devi	Chandauli 2014-15	Itawa	8th
7	Kamini Devi	Chandauli 2014-15	Gopalpur	HSC
8	Lakshmi Devi	Chandauli 2014-15	Sayaadraja	Graduation
9	Poonam Devi	Chandauli 2014-15	Machnahata	SSC
10	Rita Devi	Chandauli 2014-15	Subash Nagar	8th
11	Pushpa Devi	Chandauli 2014-15	Digwat	SSC

List of Community members covered by FGDs during the study

Sr. No.	Name	Age	Education	Cashpor member
1	Aarti Devi	40	8th	Yes
2	Sangeeta Devi	38	9th	Yes
3	Vimla Devi	35	SSC	Yes
4	Muni Khatun	18	Graduation Ongoing	Yes
5	Razia Khatun	19	Graduation Ongoing	Yes
6	Suman Kumari	20	HSC	Yes
7	Tabassum Jahan	21	HSC	Yes
8	Neha Kumara	30	7th	Yes
9	Tamanna Khatun	22	Graduate	Yes
10	Tarannum Khatun	25	HSC	Yes
11	Shabnam parveen	17	Graduation Ongoing	No
12	Shabnam begam	30	5th	No
13	Naheeda	17	SSC	No
14	Shahina Parveen	22		No
15	Naziya Khatun	17	HSSC	No
16	Nasmun Khatun	40		No
17	Nayin Jahan	35	5th	No
18	Chandini Khatun	14	SSC	No
19	Farzana Khatun	15	SSC	No
20	Hena Khatun	16	HSSC	No
21	Raziya Khatun	26	5th	No
22	Rosy Khatun	16	SSC	No
23	Nusrat Parveen	22	BA	No

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24	Sahami Khatun	40		No
25	Nazma Khatun	40		No
26	Ulfat Khatun	35		No
27	Nazia Khatun	30	5th	No
28	Rahana Khatun	35		No
29	Ansari Khatun	35	SSC	No
30	Kulsum Begum	38		No
31	Najma Khatun	16	SSC	No
32	Nazreen Khatun	16	SSC	No
33	Roshni Khatun	16	SSC	No

List of HSG members interacted with

Sr. No.	Name	Age	Education	Cashpor member
1	Sharada (President)	41		Yes
2	Sunaina (secretary)	63		Yes
3	Manju Devi	36		Yes
4	Anita Devi	25		No
5	Poonam Devi	30		No
6	Adiya Devi	23	8th	No
7	Saraswati	60		No
8	Leelavati	52		Yes
9	Manbaravati	45		Yes
10	Bhuchan	25		No
11	Bechari	40		Yes
12	Chanda	45		Yes
13	Asha Devi	45		No
14	Anita Devi	30		Yes
15	Ram Sawari	35		Yes
16	Durgawati	40		Yes
17	Srikanti	38	6th	Yes

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List of staff interactions

Sr. No.	Villages/ Location	Stakeholders	Type of Stakeholder	Type of interaction	Contact No.
1	Telephonic	Ms. Gayatri Prashanth	GM New Initiatives, Healing Fields Foundation	KII	9900724114/040-23232841/42
3	Buxar, Bihar	Supriya Kumari	Field Coordinator	KII	9470830476
4	Buxar, Bihar	Usha Devi	Field Coordinator	KII	9199497473
5	Balia, UP	Dilip Kumar Gupta	Project Manager - Training	KII	9455356232
6	Balia, UP	Deepak Singh	Hospital Administrator, Asharfi hospital	KII	9532512765
7	Buxar, Bihar	Pradeep Kumar Rai	Programme Manager - Operations	KII	
8	Sasaram, Bihar	Ruchi Kumari	HFF field coordinator	KII	9507655576
9	Buxar, Bihar	Ashish	HFF Manager	KII	
10	Balia, UP	Musharat	Training coordinator	KII	
11	Buxar, Bihar	Dr. Srinivas	General Surgeon (resource for CHF training)	KII	
12	Balia, UP	Dr. MK Singh	GP (BAMS) (resource for CHF training)	KII	
13	Balia, UP	Shashikala Tiwari	HFF field coordinator	KII	9170472764
14	Varanasi, UP	P. S. Hooda	Deputy - Managing Director – Cashpor Micro Credit	KII	9717707771
15	Varanasi, UP	Giriraj Singh	Head Health – Cashpor Micro Credit	KII	9794954666

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Annexure III: List of abbreviations

ABF	Axis Bank Foundation
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antinatal Care
ANM	Ancillary Nurse Midwife
APL	Above Poverty Line
APM	Assistant Program Manager
ASHA	Accredited Social Health Activity
AWW	Aanganwadi Worker
BPL	Below Poverty Line
CHF	Community Health Facilitator
CLTS	Community-Led Total Sanitation
CSR	Corporate Social Responsibility
DALY	Disability Adjusted Life Year
DAY NRLM	Deendayal Antyodaya Yojna – National Rural Livelihoods Mission
EAG	Empowered Action Group
EBF	Exclusively Breastfed
FC	Field Coordinator
FD	Field Deposit
FGD	Focus Group Discussions
GDI	Gender Development Index
HALE	Healthy Life Expectance
HCO	Health Community Organizer
HDI	Human Development Index
HE	Health Education
HFF	Healing Fields Foundation
HG	Health Group
HIV	Human Immunodeficiency Syndrome
HO	Head Office
HSG	Health Saving Group
HSSC	Higher Secondary School Certificate
IAY	Indiraawas Yojna
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IFAD	International Fund For Agricultural Development
IMR	Infant Mortality Rate

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KII	Key Informant Interview
MFI	Microfinance Institution
MHM	Menstrual Hygiene Management
MIS	Management Information System
MMR	Maternal Mortality Rate
MoFW	Ministry of Family and Welfare
MSW	Master of Social Work
NFHS	National Family Household Survey
NGO	Non-Government Organization
OBC	Other Backward Category
OECD	Organisation for Economic Co-operation and Development
OPD	Out-Patient Department
PG	Post Graduate
PHC	Primary Health Center
PHED	Public Health Engineering Department
PNC	Postnatal Care
PRA	Participatory Rural Appraisal
RD	Recurring Deposit
RM	Regional Manager
RSBY	Rashtriya Swasthya Bima Yojana
SC	Schedule Caste
SHG	Self Help Group
SNP	Sanitary Napkins Production
SSC	Secondary School Certificate
ST	Schedule Tribe
TC	Training Coordinator
ToT	Training of Trainer
TT	Tetanus
U5MR	Under-Five Mortality Rate
WATSAN	Water and Sanitation
WHO	World Health Organization

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Engagement team

Mr. Vedamoorthy Namasivayam
Senior Director – India Public Sector Leader

- Engagement partner
- Project supervisory role
- Expert inputs on report

Ms. Shubha Srinivasan
Director

- Engagement manager
- Project supervisory role
- Report editing

Dr. Priya Kantak
Senior Consultant

- Field team lead
- Final report compilation
- Engagement SPOC for ABF and HFF

Dr. Rama Sridhar
Senior Consultant

- Field team member
- Report writing: Introduction and Field observations

Mr. Elton Merwyn Vaz
Analyst

- Field team member
- Data entry
- Report writing: Sections on field observations

Mr. Rinku Shrivastav
Analyst

- Data analysis

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