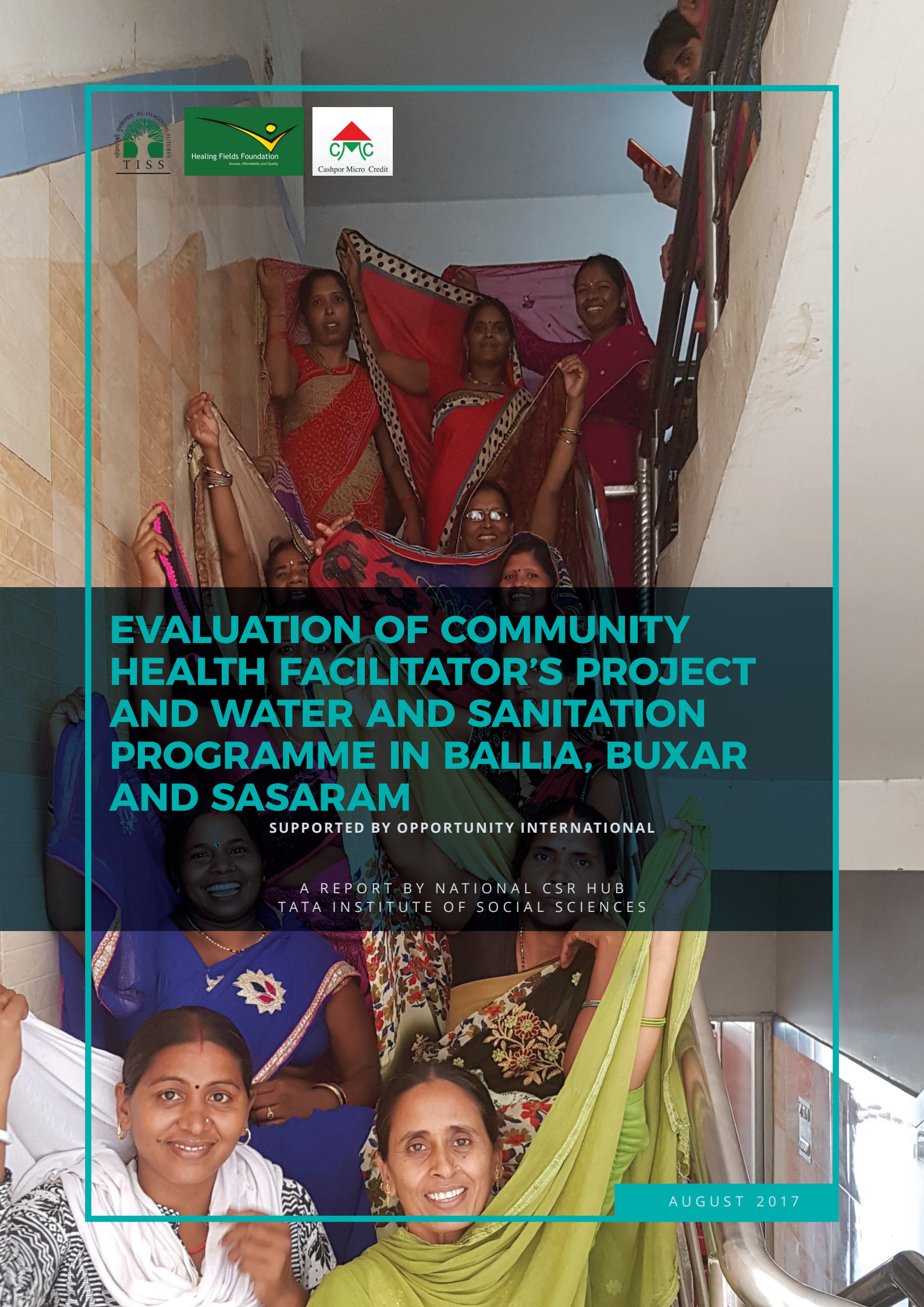

EVALUATION OF COMMUNITY HEALTH FACILITATOR'S PROJECT AND WATER AND SANITATION PROGRAMME IN BALLIA, BUXAR AND SASARAM

SUPPORTED BY OPPORTUNITY INTERNATIONAL

A REPORT BY NATIONAL CSR HUB
TATA INSTITUTE OF SOCIAL SCIENCES

AUGUST 2017

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ACKNOWLEDGMENT

The evaluation of Healing Fields Foundation's Community Health Facilitator's project and CASHPOR Micro Credit's Water and Sanitation programme supported by Opportunity International in Ballia, Buxar and Sasaram would not have been possible without the hard work and dedication of many people. First and foremost, we would like to thank the Community Health Facilitators (CHFs), village level functionaries and community members who generously offered their time to participate in our focus groups, interviews, and transect walks.

The evaluation team would like to thank Healing Fields Foundation and its partners for giving the Tata Institute of Social Sciences an opportunity to conduct an evaluation of the Community Health Facilitator programme in the states of Uttar pradesh and Bihar. Special thanks to Ms. Mukteshwari Bosco and Ms. Gayathri Prashanth for giving invaluable support, detailed understanding of the programme and encouraging us to think creatively about the evaluation. The team is also grateful to Ms. Giriraj Singh and Mr Prem Singh Hooda from CASHPOR for their invaluable insights from the start of the evaluation and for giving us support and inputs throughout the evaluation and also sharing the loan data of the CHFs. We would like to also thank Mr. Manas Bid and Ms. Padma Rajpal from Dia Vikas for their support.

The TISS team would like to also express gratitude to all the HFF staff members who have relentlessly worked alongside the team throughout the study and for providing useful feedback and information during the process. We would like to especially thank Mr. Dilip Kumar, Mr. Rajneesh Tiwari, Mr Sudhanshu Kumar, Mr. Pradeep Rai and field supervisors for coordinating logistics and helping us to do the data collection smoothly.

We thank our data collection partner, Giri Institute of Development studies, for handling a challenging data collection within a limited time. Last but not the least, we would like to thank the local field investigators whose hard work and dedication ensured that the data collection was completed in a timely manner in spite of challenges in the field. They worked very hard in the field during the extreme summer. We truly appreciate their efforts.

LIST OF ABBREVIATIONS

AJEH:	Akhanda Jyoti Eye Hospital
ANM:	Auxiliary Nursing Midwifery
ASHA:	Accredited Social Health Activist
AVRDC:	Asian Vegetable Research and Development Center
BCG:	Bacille Calmette Guerin
CASHPOR:	CASHPOR Microcredit
CHF:	Community Health Facilitator
CHE :	Community Health Entrepreneurs
FGD:	Focus Group Discussion
FINISH:	Financial Inclusion Improves Sanitation & Health
HE:	Health Education
HFF:	Healing Fields Foundation
HH:	Household
IFA:	Iron Folic Acid
LM:	Lactating Mothers
MFI:	Micro Finance Institutions
NGO:	Non-Governmental Organisation
NRHM:	National Rural Health Mission
OI:	Opportunity International

PHC:	Primary Health Centre
CHC:	Community Health Centre
PRA:	Participatory Rural Appraisal
PHED:	Public Health Engineering Department
RRDC:	Research And Rehabilitation Development Centre
RTI:	Respiratory Tract Infection
SC:	Scheduled Caste
ST:	Scheduled Tribe
OBC:	Other Backward Classes
SEA:	Self Employment in Agricultural activities
SENA:	Self Employment in Non Agricultural activities
SMART:	Self-Monitoring, Analysis, and Reporting Technology
SNP:	Sanitary Napkin Pad
TT:	Tetanus Toxoid
UP:	Uttar Pradesh
UTI:	Urinary Tract Infection
WASH:	Water, Sanitation and Hygiene
WATSAN:	Water and sanitation
VHSNC:	Village Health Sanitation and Nutrition Committee

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EXECUTIVE SUMMARY

INTRODUCTION

With a population of 104 million, Bihar is the second most populous state in India, next only to Uttar Pradesh. Nearly 90% of its population lives in rural areas, compared to 72% in the country as a whole.

The major health and demographic indicators of the State like infant mortality rate, maternal mortality ratio, total fertility rate, etc. are much higher in Bihar than the all India level and reflect a poor health status in the State. The Human Development Index in Bihar is one of the lowest. There are substantial gaps in sub-centers, primary health centers, and a very large gap in community health centers along with shortage of manpower, drugs and equipments necessary for Primary Health Care and woefully inadequate training facilities. Other factors affecting the health status include: very high fertility rate; low level of institutional deliveries and a high level of maternal deaths; very low coverage of full immunization; low level of female literacy; and poor status of family planning programme.

In April 2005, the Indian government launched the National Rural Health Mission (NRHM) with a vision to comprehensively improve the country's public health delivery system. While the programme consisted of multiple components, a main provision of NRHM was the introduction of a cadre of village-level Community Health Workers known as Accredited Social Health Activists (ASHAs). The ASHA acts as an interface between the community and the public health system. ASHA is the first port of call for any health related demands for the deprived sections of the population, especially women and children, who find it difficult to access health services. Studies have shown a remarkable increase in access to healthcare after the introduction of the ASHA. However universal access and coverage is still a distant dream and a work in progress.

It is in this context that the CHF programme was launched. In order to bring its client out of poverty faster, with a view to reduce expense on health of its clients families, CASHPOR decided to create health awareness among its all 1 million clients in a phased manner through CHFs. For that CASHPOR sought the help of an expert in this field i.e HFF for training its client to become CHFs. The programme trains and deploys women, who are CASHPOR's MFI clients to lead their own communities toward better health through education, improved access and affordability of quality care and delivery of products and infrastructure. Empowerment of the CHFs and providing them with income-generation opportunities is also an important goal of the programme.

ABOUT HEALING FIELD FOUNDATION, CASHPOR MICROCREDIT AND ITS PARTNER ORGANIZATIONS

Healing Fields Foundation (HFF), a non-profit organization, registered in Hyderabad, Telangana, is recognized as a pioneer in the areas of Community Healthcare, Community Health Education and Health Financing. HFF is a partner of Opportunity International. HFF's vision is *'to make quality healthcare affordable and accessible to all people in India, especially the poor, underprivileged and marginalized'.* The programme strives to build a system locally of trained, accountable Community Health Facilitators who can fill the gap in healthcare access with building an ecosystem within the community through the knowledge in nutrition, hygiene, prevention of illness including common as well as communicable illnesses, creating access to building toilets, as well as use their first aid skills.

CASHPOR Microcredit is a poverty focused, not for profit Company that provides microfinanceexclusively to Below Poverty Line women in eastern U.P. and Bihar. CASHPOR targets Below-Poverty-Line women, prim arily in the northern states of Bihar and Uttar Pradesh, providing micro-credit and other services to communities there. Dia Vikas , a subsidiary of Opportunity International Australia , has partnered with CASHPOR since 2008. CASHPOR was one of the first microfinance institutions to b ecome SMART Certified, a symbol of its commitment to social impact. CASHPOR Micro Credit is also one of Opportunity's largest microfinance partners in its global network.

HFF partnered with CASHPOR Microcredit to give Water and Sanitation Loans (WATSAN) loans for hand pump and toilet construction facilitated by the CHF. Work in the district of Ballia, Buxar Work in the district of Ballia, Buxar and Sasaram has been funded by the Scottish Government through Opportunity International, a non profit organization with a global presence including offices in the United Kingdom and Australia. Healing Fields Foundation and CASHPOR along with their partner agencies commissioned an external evaluation of the Community Health Facilitator (CHF) programme to TISS National CSR hub.

OBJECTIVES OF THE STUDY

THE EVALUATION WAS UNDERTAKEN WITH THE FOLLOWING OBJECTIVES:

- To assess the impact of the programme on the CHFs (who are CASHPOR's MFI clients and have undergone the health training): To identify the improvement in their confidence, social and economic status, as well as to compare the situation of women before and after receiving training to become CHFs.
- To assess the increase in community members' health knowledge through the CHFs
- To assess the situation in the villages trained by the CHFs regarding their health knowledge, access to healthcare, access to sanitation facilities and access to sanitary napkins.
- To study the behavioral changes as a result of CHF intervention in the target villages.
- To review and clarify the theory of change based on evaluation findings
- To gain knowledge of the challenges and context-specific factors influencing the effectiveness of the health project, to compile a list of lessons learned and recommendations for future initiatives with a road map for the future.

RESEARCH DESIGN

A mixed method approach - with qualitative and quantitative methods - was used to meet the objectives of the study. The tools used for the study were:

1. Transect walk
2. Focus Group Discussion with CHF
3. Focus Group Discussion with the village community
4. Semi structured interview with important village functionaries (ASHA worker, PHC staff, village sarpanch or panchayat leaders)
5. Structured interview for the households in the village where CHF is working
6. Structured interview for the CHF in the village

SAMPLING STRATEGY

The proposed sampling of the study was 5%, derived from the total universe of 1328 villages (and CHFs) for meeting the objectives of the study. Hence, 35 villages in 3 districts - Ballia, Buxar and Sasaram - were selected for data collection. Based on proportion of CHFs trained in each district, a sample of 12 villages was selected in Ballia, 11 in Buxar and 12 in Sasaram.

LIMITATIONS OF THE STUDY

Due to budget and time constraints, in each district, a convenience sample of the villages was taken in which villages were selected from 2 consecutive blocks to reduce travel time. Moreover, only villages that were close to the highway were selected and no control group was selected. Hence, the findings are not representative of all intervention villages and CHFs.

Household interviews were conducted to gain perspectives of the CHFs' work at the household level and to supplement the data collected through FGDs. Again, it is important to note that the number of households selected were too small for the findings to be representative of the village population. Due to small sample sizes, no significance tests could be conducted.

Since the available secondary data (Census, 2011) are old and the structure of the villages would have changed in last six years, putting weight to the dataset was not deemed appropriate.

DATA COLLECTION AND ANALYSIS

After development, translation, pilot testing and finalization of the tools, the field team comprising of 6 field investigators and 1 field supervisor from the Giri Institute of Development Studies were trained in data collection by the TISS research team for 2 days. One research officer from TISS was also on the field for overall supervision. The data collection was completed in 1 month. The field team was monitored by the TISS team on a daily basis.

Upon completion of data collection, data entry was undertaken. This was followed by data cleaning and analysis of quantitative data using SPSS. Qualitative data were transcribed and analyzed for convergent themes.

AREA PROFILE

A brief profile of the 35 sampled villages is presented below. It is important to note that convenience sampling used in the selection of villages, where only those villages that were close to the highways were selected. Hence, the village profile presented below is not representative of all intervention villages.

- **Population:** Five villages in Ballia, 4 villages in Buxar and 7 villages in Sasaram had a population of less than 4000 people. Six villages in Ballia and Buxar had a population between 4000 and 8000, while 3 villages in Sasaram were quite large and had a population of over 8000.
- **Number of households:** Over half the sampled villages in Ballia and Sasaram had less than 600 households, while 8 villages in Buxar had over 600 households.
- **Source of water:** Hand pumps for domestic use and private taps for drinking water were the most commonly used sources of water.
- **Scarcity of water:** Water scarcity was reported in 5 of the sampled villages of Ballia and 7 of sampled villages in Sasaram, while no sampled village in Buxar reported water scarcity.
- **Type of toilets in villages:** Azamgarh was the only district in which three villages reported having no toilets. Pit toilets and septic toilets were most common type of toilets constructed in the households in all 3 districts.
- **Sources of water :** Hand pumps were the most frequently used source for domestic purposes.
- **Distance to source of water:** Community members reported travelling 0 to 300 metres to fill water. Two villages in Ballia and one village in Sasaram reported travelling 500 to 600 metres.
- **Type of toilets in households:** In the sampled villages that had toilets, septic toilets were the most common type of toilets constructed in the households of Ballia and Sasaram, whereas in Buxar households, pit toilets were the most common.
- **Community toilets:** Over three quarters of the sampled villages in all the three districts do not have any community toilets.
- **Electricity:** All the sampled villages had electricity for at least a few hours every day.
- **Number of schools in the village:** All villages were found to have at least 1 school. Two villages in Buxar had more than six schools.
- **Cooking Fuel:** LPG was most commonly used for cooking, along with wood and kerosene also used sometimes.
- **Distance from a health facility:** Over half of the sampled villages in Ballia and three quarters in Sasaram shared that the closest health facility was more than 4 kms away. In Buxar, over half of the sampled villages reported being less than 4 kms away from a health facility.
- **First point of contact for illness:** Villagers mainly consult a doctor during illness. Some villages in Ballia and Buxar also reported consulting the CHF during illness.

Since the sampled villages were close to the highway, they had better connectivity, due to which they may be infrastructurally better than more remote villages.

IMPACT ON THE CHF

ABOUT THE CHF PROGRAMME

HFF has a rigorous and well established programme for training women to become the Community Health Facilitators and ultimately become change agents for health care and hygiene practices in their communities.

1. **Selection of CHFs:**

   HFF reaches out to the women in the villages with the help of its partnerCASHPOR microcredit. A stringent process is followed which includes compliance with criteria regarding age and educational qualifications, position in the community as well as geographical location. HFF selects approximately 70 women for a batch. Since some women drop-out due to personal reasons, a batch of about 50 is retained. Even if a batch has a higher number of CHF trainees, the crux remains that there is to be only one CHF for every 300 households.

2. **Training of CHFs through contact sessions for 6 months:**

   HFF trains the women through 2-3 day sessions per month. Training includes topics related to health and disease, nutrition, menstrual hygiene, prevention of illnesses, first aid, government programmes and health financing.

3. **Six month internship:**

   The training is followed by a 6 month internship where the the CHF conducts 10 health awareness sessions per month, earning a stipend of Rs. 50 per session. During these sessions, the CHF also promotes the use of sanitary napkins, toilets, hand pumps, making kitchen gardens and soak pits. Thus, the CHF also has an additional income from the incentives gained on sanitary napkin sale and CASHPOR microcredit loan on toilets and hand pumps during the internship.

4. **Six month extended internship through CASHPOR:**

   Once the CHF finish their internship with HFF, the CHFs take an extended Internship of 6 months with CASHPOR microcredit. During this period, CHF creates awareness in 250 families of only CASHPOR clients in 10-12 villages.

SOCIO-ECONOMIC PROFILE OF THE CHFS

The profile of the sampled CHFs is presented below:

- **Caste:** Nine CHFs in Buxar and six in Sasaram belong to Other Backward Class (OBC) while Ballia had half the sampled CHFs belonging to other (general) class (an overview of the caste system in India has been provided in Chapter 1 of this report). Five CHFs in Sasaram belonged to the Scheduled Caste while 3 in Ballia belonged to Scheduled Tribe.

- **Occupation before becoming a CHF:** Of all the 35 CHFs who were a part of the study, all CHFs in Ballia, 11 in Sasaram and 7 in Buxar reported being housewives. Interestingly, though the CHFs were CASHPOR clients and mostly took loans for the family business (which they may have been part of), they have not reported it as their occupation. The income earned from the business was also not reported by them as their income, perhaps because it was considered as family income.

- **Education:** Most of the CHFs had completed 8th-10th standard.

- **Primary occupation of the CHFs' households:** The primary occupation of the households to which these CHFs belong is mainly self-employment in non-agricultural activities such as masonry and carpentry, labour and in agricultural activities.

- **Monthly income of CHFs' households:** Five CHFs' households in Ballia, 3 in Buxar and 1 in Sasaram have a monthly income of less than Rs. 5000 per month, while 8 CHFs' households in Buxar and 11 in Sasaram earned over Rs. 5000 per month. The average income of CHFs' households was around Rs. 7800 per month.

- **Age of the CHF:** Majority of the CHFs are over 30 years old.

From the socio-economic profile of the CHFs presented above, it is seen that the HFF supports women from low income households, imparts knowledge and gives them the skill set required to be independent.

DECISION TO BECOME A CHF

CHFs shared that their reasons for joining the programme included: an opportunity to use their education to benefit their communities, to learn more about health related matters and impart this knowledge to their children, and to earn money. Many CHFs stated that they joined work not only for monetary benefits but to challenge the social system and break stereotypes. They wanted to be able to create an identity for themselves.

The majority of the sampled CHFs had been associated with the programme for 3 to 4 years, with about a quarter having been associated for 5 to 7 years.

CHALLENGES FACED AS A CHF

CHFs had to overcome a lot of challenges in order to get trained and then work in the communities. Some of the challenges included:

- **Social -** The majority of CHFs are middle-aged women who are housewives and belong to low income families. As a result, they faced difficulty in gaining support from their families and community members.
- **Distance -** The CHFs had to travel large distances for the training programme and in spite of accommodation being provided during the trainings, some of them had to return home everyday to fulfill their family responsibilities.
- **Transportation -** The CHFs also found it difficult to avail affordable transportation to reach the training venue.
- **Financial -** CHFs shared that did not they get financial assistance to travel to the training centre. This was a constraint for many of them. They did not find the payment adequate for conducting the health sessions.
- **Conducting health sessions -** CHFs also faced challenges in organizing health sessions with the community. Since they did not give out any medicines or monetary benefits, the CHFs found it hard to gather people for the sessions. Slowly, they began to take women in confidence. They began to use social occasions such as prayer meetings to organize women and give them information. Additionally, they were also viewed with suspicion by some community members.

Despite these challenges, the CHFs continued to work in the communities with lot of dedication and commitment.

CHANGES IN THE CHF

Most CHFs reported undergoing a transformation process after having participated in the training programme. The changes reported by them, included:

- **Health awareness :** Most CHFs reported better awareness and practice of handwashing, improved hygiene amongst themselves and their families, better awareness of environmental and lifestyle factors that impact health, early identification and care of anemia, awareness of home remedies and preliminary treatment or first aid for small accidents, snake bites, diarrhoea, etc.

- **Income :** Many CHFs reported that they did not have an individual income before they joined the programme because in spite of being CASHPOR clients, they may have taken loans for the family business and did not treat this income as their personal income. However, most of them reported earning Rs. 1200 to Rs. 1900 as their income after joining the programme. Since the CHFs had completed their training, internship and extended internships, most of them reported that their incomes are now lesser than when they were part of the programme.

- **Confidence :** CHFs also reported increased confidence in terms of being able to speak in public about village issues, being able to talk to village level functionaries, moving freely outside without a ghunghat (veil).

- **Accountability and responsibility :** CHFs shared that that they feel a sense of accountability and responsibility as a result of their work. Earlier they were confined to their homes and were responsible for only their homes, but now they feel that it is up to them to look after the community health and well-being.

- **Respect and recognition :** Perhaps one of the biggest changes that CHFs observed was the way in which they were viewed by their family and community members; they were now treated with respect and their opinions were sought on important matters.

- **Mobility :** As housewives, majority of the CHFs were confined to their homes. However, they now stepped outside the house more regularly.

CHFs' PERCEPTION OF THE IMPACT OF THEIR WORK

CHFs felt that they had been able to be of most help in creating health awareness and providing first aid to community members. Some CHFs had succeeded in convincing community members regarding the importance of building toilets. They had also convinced girls and women to use sanitary napkins for better menstrual hygiene and were beginning to see increased use of sanitary napkins in their villages. CHFs had also convinced pregnant women to get regular vaccinations and new mothers to feed colostrum to their infant. Many CHFs had facilitated loans for toilet construction and hand pumps. They felt that the community members' response to CASHPOR loans was mostly good.

CHFs' ideas for future employment included starting a microenterprise for making papad, making pickles, making pearl necklaces, sticking bindis, establishing kitchen garden in their houses. Some CHFs would also like to undergo more training on "using weighing scale, measuring BP and fever devices etc."

Most CHFs had a positive feedback for the programme - they liked the training and the trainers. However, a recurring theme of concern among the CHF was the future of the programme and continuation of their work as CHFs with a sustainable income.

REASONS TO DROP OUT OF THE CHF PROGRAMME

Some women who had dropped out of the programme mid-way, shared that this was due to lack of substantial income, travel cost incurred and problems in travelling to distant places. The family members also pressurized the CHF to leave the programme once they realised the trials and tribulations faced for a meagre income. However, even though their engagement was short, they also reported the positive impact that the programme had made in terms of increase in their awareness and confidence.

IMPACT OF CHFs' WORK ON THE VILLAGE COMMUNITY

A profile of the household interview respondents is given below:

- **Caste:** Over 50% of the responding households in Buxar and Sasaram were from Other Backward Class; remaining households mostly belong to the Scheduled Caste and other or general class. In Ballia, over 74% of the responding households were from Other Backward Class and Scheduled Caste, with almost 22% from other or general class.

- **Respondent living in village since birth or after marriage :** In Ballia and Buxar, around 70% of the respondents had been residing since birth, whereas in Sasaram, 85% had moved to the village after their marriage.

- **Household assets:** A large number of respondents had access to electricity, fan, television and mobile phone. Some also had scooter or motorcycle. Interesting, over 50% of the households in Ballia and Sasaram and over 70% in Buxar had toilet facilities.

It is important to keep in mind that since only 7-10 households were selected for interviews in each village, the profile of households presented above, is not representative of all households in the sampled villages.

AWARENESS OF CHF's WORK

Household respondents from Buxar and Sasaram, were mostly familiar with all the different tasks that the CHF undertakes, the main ones being health education, sale of sanitary napkins, forming health savings groups, facilitating loans for water purifier, LPG and toilet construction. In Ballia, respondents seem to know the CHF mainly for health education, provision of warm clothes and sale of sanitary napkins. Community members felt that the CHF plays an important role in raising awareness about health related matters and education, and goes above and beyond to ensure the health and wellbeing of community members.

When asked about how often the household members communicated with the CHFs, majority said that they communicated with her once a week to once every fortnight.

IMPACT OF CHF'S WORK AS PERCEIVED BY COMMUNITY MEMBERS

Village community members felt that the CHF impacted them in several ways:

- **Health Awareness:** When asked if they had attended any health awareness sessions, over 60% of respondents in Ballia, over 70% in Buxar and over 87% in Sararam said that they had attended them and most of them found the information to be good or excellent. Villagers testified to the utility of the health sessions, saying they receive helpful information about hygiene, loan opportunities, staying healthy, and education for their children.

- **Menstrual Hygiene:** CHFs had conducted special sessions with girls and women to explain the importance of menstrual hygiene and use of sanitary napkins. Majority of the respondents from Buxar and Sasaram reported using sanitary napkins, while amongrespondents from Sasaram cloth use was more prevalent . Women reported feeling more comfortable in discussing their doubts with the CHF and buying sanitary napkins from her.

- **Preventive healthcare and hygiene:** Respondents seemed to wash hands, follow diet advice, use sanitary napkins and practice kitchen gardening more commonly from the advice given by the CHFs. Many respondents felt that there was improvement in their family's health as a result of following the CHF's advice. Some also reported better hygiene among family members and in the home.

- **Health savings groups:** CHFs also facilitate the formation of health savings groups in the villages. Around 63% of households in Ballia, 55% in Buxar and 66% in Sasaram were part of the health saving groups in their village. Some were not aware of the saving group, while some felt that they did not incur much health care expenses to be a part of the group.

- **First aid and healthcare:** The CHFs have helped their communities in the times of a medical emergency. They are often the first point of contact and provided preliminary care and first aid to the village communities. CHFs have also spread indigenous knowledge and low cost home remedies that people can take advantage of.

- **Use of toilets:** CHFs encourage community members to use toilets for better hygiene and preventive healthcare. Men reported going to open fields for defecation or use toilets constructed through their own funds in all 3 districts. In Buxar, almost 70% of the women and children use toilets, mostly built from their own funds, some built from CASHPOR loans or public toilets. In Ballia and Sasaram too, almost 50% of the women and children were using toilets from their own funds or CASHPOR loans or public toilets.

- **Microfinance loans:** Community members shared that the CHFs talking about the importance of clean water and toilets for better sanitation. She makes the community aware of the perils of open defecation and health risks due to unclean water. Through the encouragement and support of CHF, some WATSAN infrastructure has been built in which CASHPOR microcredit loans have been used completely or partly in some cases and other sources of funds such as government schemes have been used.

- **Other social changes:** CHFs has also tried to generate awareness on other issues such as domestic violence and school education. Some women also felt that the CHF was a role model for them, since she had managed to overcome social and cultural barriers by stepping outside the house and doing work.

THEORY OF CHANGE AND REALISTIC EVALUATION

One of the major objectives of the study has been to spell out the theory of change for the CHF programme. The framework of realistic evaluation was also used to gain a better understanding of the contextual factors that impact the theory of change of the CHF programme.

The theory of change for the programme is roughly based on Knowledge-attitude- practice (KAP) model wherein the CHF becomes the mode of communication of knowledge subsequently leading to change in attitude and behaviour. There are also microfinance loans, available for water and sanitation purposes of hand pump and toilet construction, that the CHF facilitates along with sale of low cost sanitary napkins, construction of soak pits and kitchen garden. However, the CHF programme works in an open, active and social environment that impacts the functioning of the programme.

The following observations were made regarding the programme outcomes based on the findings of the study:

1. **Impact on the CHF:** The impact of the CHF programme has largely been very positive on the CHF who has been transformed from an ordinary woman in the village:

- CHFs are being able to overcome social and financial barriers in order to complete the training programme
- CHFs have increased mobility and health knowledge
- CHFs are becoming confident
- CHFs are starting to play an active role in decision-making at the household and community level
- CHFs and their families follow better hygiene and healthcare practices
- CHFS gain recognition in professional and social space
- CHFs have increased financial status

However, two outcomes that could not be ascertained through this study were whether:

- CHFs have increased sustainable employment opportunities post the completion as the programme: The CHFs have not been able to earn enough through the sale of sanitary napkins and the incentives from the CASHPOR loans since the number of napkins sold and loans facilitated are not large in number. As a result, many CHFs, have not been able to continue their work on a regular basis.
- CHFs have an improved health status: The health status of the CHF is not tracked by programme as such; but most of them do report improved health and hygiene practices at personal and family level as a result of having participated in the programme.

2. **Impact on the community where the CHF works –** Since the CHFs had worked in the community for 3 to 7 years, the following outcome were observed in the community:

- Community members had awareness of basic health and hygiene practices.
- Community members had access to preliminary healthcare through the CHF.
- Community members said that they had made changes in their hygiene practices such as hand-washing, paying attention to their diets, using sanitary napkins. Improved health infrastructure such as toilets and hand pumps were also seen in many households. Use of toilets by some community members was also observed.

The contextual factors that impact the outcomes of the programme can be summarised as follows:

1. **Acceptance of the CHF as a change agent:** The CHFs are women from low income households and not highly literate; these factors along with their gender has posed challenges in their acceptance as knowledge disseminators and agents of change by the community, where some of them were also viewed with suspicion by community members. Many CHFs shared that they had overcome their initial barriers and are now respected in the community after having associated with the programme for 3 to 7 years. However, with them not being able to continue their work on a regular basis, the CHFs and the community have started questioning their role as an agent of change in the long run.

   Some of the sampled CHFs belonged to Other Backward Classes and other or general class, that are generally considered to be better off than Scheduled Caste and Scheduled Tribes in terms of socioeconomic status. These CHFs from Other Backward Classes and other class could have gained easier acceptance into the community, as opposed to their Scheduled Caste counterparts.

   Another factor to be taken into consideration is that the CHFs largely work with women who have marginal decision making powers and no financial independence due to the patriarchal system. These women are mostly dependent on men for day to day decisions. As a result, the men need to accept the CHF (as an agent of change) and her advice in order that women in the households are able to make behaviour changes.

2. **Behavioural change towards health and hygiene:** An assumption made by the programme model is that increased knowledge of good health and hygiene practices and availability of financing will lead to behaviour change in terms of utilization of toilets, drinking water purifiers and sanitary napkins. However, it takes time and continuous social messaging and marketing by the CHF to impact the negative traditional practices of health and hygiene. The CHFs from the three districts that were part of this study, have been associated with the programme for 3 to 7 years. Many of them have been able to create awareness and subsequent attitude and behavior change in some community members as a result of having worked for so many years.

   Another factor impacting behavior change outcomes is the size and location of the village; larger villages and those located closer to urban centres, with better infrastructure facilities, may find adoption of behavioral changes easier than smaller and more remote villages.

RECOMMENDATIONS

TISS would recommend the following to strengthen and scale the programme:

1. **Sustain the CHF for a longer period of time.**
2. **Prioritize the functions of CHF by giving specific interventions.**
3. **Give refresher training with added modules and supervisory support.**
4. **Give travel allowance to CHF during training and field visits.**
5. **Maintain computerised data for all interventions and specific indicators of HFF-CASHPOR.**
6. **Use of technological device such as tablets for maintaining data and training purposes.**
7. **CHF can become a committee member of VHSNC in NRHM.**
8. **CHF can become a social auditor for preventive health by reporting any premature deathsin the village community and the reasons for death and the usage of WATSAN facilities.**
9. **Establish sanitary napkin production unit in a cluster.**
10. **Establish linkages with Public and Private sector company engaged in CSR for production and distribution of MESA sanitary napkin.**
11. **Increase the loan amounts for Water and Sanitation loans of CASHPOR Microcredit along with a lower interest rate.**
12. **Appoint at least one or two human resources for establishing linkages with government and public and private companies.**

CHAPTER 1

INTRODUCTION

With the population of 104 million, Bihar is the second most populous state in India, next only to Uttar Pradesh. Nearly 90% of its population stays in rural areas, compared to 72% in the country as a whole.[1] As per Census 2001, the population of Scheduled Castes (SC) and Scheduled Tribes (ST) of Bihar stands at 13,048,608 and 758,351 respectively, constituting 15.7 % and 0.9 % of the total population (82,998,509) of the State. The growth of SC and ST populations during the decade of 1991-2001 was estimated at 30.7 % and 32.4 %, which is higher than the rate of growth of total population (28.6 percent). Both the Scheduled Castes and Scheduled Tribes are predominantly rural; with 93.3 and 94.6 per cent of them residing in rural areas respectively.[2] Nearly, 40% of Bihar population lies below the poverty line, the highest in India.[3]

1. PWC, Healthcare Vision 2018, A Roadmap for Bihar, Sep 2012
2. SC and ST Welfare Department, Government of India, Aug 2012
3. World Bank Report, Bihar: Towards a Development Goals

1.1 HEALTH AND HEALTHCARE IN RURAL BIHAR

The major health and demographic indicators of the State like infant mortality rate, maternal mortality ratio, total fertility rate, etc. are much higher in Bihar than the all India level and reflect a poor health status in the State. The Human Development Index in Bihar is one of the lowest. In Bihar, there are substantial gaps in sub-centers, primary health centers, and a very large gap in community health centers along with shortage of manpower, drugs and equipments necessary for Primary Health Care and woefully inadequate training facilities. Other factors affecting the health status include: very high fertility rate; low level of institutional deliveries and a high level of maternal deaths; very low coverage of full immunization; low level of female literacy; and poor status of family planning programme.[4]

State has launched a variety of programmes to reduce morbidity and mortality rates and these programmes are at various stages of implementation. These programmes broadly cover the following: Janani Evam Bal Suraksha Yojana under the overall umbrella of the National Rural Health Mission (NRHM), Anaemia Control Programme, Blindness Control Programme, Vitamin – A Supplementation Programme, Routine Immunization, Programme for Elimination of Iodine Deficiency Disorders, Revised National Tuberculosis Control Programme (RNTCP), National Leprosy Eradication Programme, Kala-azar Eradication Programme, etc.[5]

4. Government of India, New Delhi, Bihar: Road Map of Development In Health Sector, Aug 2007
5 . Government of India, New Delhi, Bihar: Road Map of Development In Health Sector, Aug 2007

1.2 ABOUT THE SOCIAL SYSTEM

India largely (barring parts of North East and few tribes) is a **patriarchal society**. In a patriarchal system[6], the head of family/household is usually a male who is also the primary breadwinner. Over the years, women who have constantly been oppressed through the system become a part of the system as patriarchy's agents. For example, the elder woman in the household/family usually supports the patriarch and propagates oppression over the younger women in the household. The head of the household exercises decision making and financial power.

In a patriarchal system, women's main role is to bear and rear children and undertake the household chores. The system is oppressive to women as the women have no financial independence and even their mobility outside the household is monitored. For example - In rural parts a woman is always accompanied by a man whenever she steps outside the house. Women in the rural parts are not encouraged to learn driving or even cycling. This is especially true for the married women and young girls who have started menstruating. They are completely dependent on a man from their family for their mobility, finances and daily needs.

6. C.N. Shankar Rao, Principal of sociology,"Caste; estates and class"

Being a woman in a patriarchal system is challenging as the system resists and discourages women if they try to step outside their stereotyped roles. A woman health worker will face more challenges in working with the community because her acceptance as a spokesperson and a change agent will not be easy. For example - If a CHF advises a pregnant woman for institutional delivery or recommends regular visits to the hospital, the men in her family may not allow it as they are the decision-makers.

In India, there has been a rigid **caste system** based on occupation in which the relative place of a caste was determined by its traditional occupation. The caste system in Hinduism, the majority religion in India is the cause of major structural and social inequality. Many castes are traditionally associated with an occupation, such as high-ranking Brahmans or "learned" priests; middle-ranking warriors (Kshatriyas), traders (Vaishyas), farmers and artisan groups, such as potters, barbers, and carpenters; and very low-ranking "Untouchable" leatherworkers, butchers, launderers, and latrine cleaners.. There is some correlation between ritual rank on the caste hierarchy and economic prosperity. Members of higher-ranking castes tend, on the whole, to be more prosperous than members of lower-ranking castes. Many lower-caste people live in conditions of great poverty and social disadvantage. The chastity of women is strongly related to caste status.[7] People belonging to certain castes (considered upper castes) are often the ones in monetary and socially powerful positions such as land ownership and wealth. The scheduled caste are considered inferior in status and social position stemming from their (historical) occupational status and religious beliefs. Since most CHFs belong to the SC community, the upper caste women in the villages were not very receptive of their work.

Scheduled Castes (SCs) and Scheduled Tribes (STs) are among the most disadvantaged socio-economic groups in India. People from Scheduled Castes (SCs) – otherwise known as dalits – are socially excluded in India, still facing discrimination on the basis of their position at the very bottom of the Indian caste system. As a result, dalits find themselves excluded from many aspects of day-to-day life including health services, economies and educational establishments. SCs makeup 16.6% of India's population (Census, 2011) although this percentage is higher if dalits who have converted to other religions, such as Christianity or Islam, are included.[8] Other Backward Class (OBC) is a collective term used by the Government of India to classify castes which are socially and educationally disadvantaged. It is one of several official classifications of the population of India, along with Scheduled Castes and Scheduled Tribes (SCs and STs).[9]

Data from the National Family Health Survey-III (2005-06) clearly highlights the caste differentials in relation to health status. The survey documents low levels of contraceptive use among the Scheduled Castes and the Scheduled Tribes compared to higher castes. Reduced access to maternal and child health care is evident with reduced levels of antenatal care, institutional deliveries and complete vaccination coverage among the lower castes. Stunting, wasting, underweight and anaemia in children and anaemia in adults are higher among the lower castes. Similarly, neonatal, postnatal, infant, child and under-five statistics clearly show a higher mortality among the SCs and the STs. Problems in accessing health care were higher among the lower castes. The National Family Health Survey-II (1998-99) documented a similar picture of lower accessibility and poorer health statistics among the lower castes. It is widely recognised that the determinants of health are social and economic rather than purely medical. The poor health of people from the lower castes, their social exclusion and the steep social gradient are due to the unequal distribution of power, income, goods and services. Caste is inextricably linked to and is a proxy for socioeconomic status in India. The restricted access of those from the lower castes to clean water, sanitation, nutrition, housing, education, healthcare and employment is due to a toxic combination of poor social policies and programmes, unfair economic arrangement and exploitative politics.[10]

7. US Library and Congress, Varna, Caste, and Other Divisions
8. PACS, Socially Excluded Groups, 2016
9. www.quora.com
10. K.S. Jacob, The Hindu, Caste and inequalities in Health, 2009

1.3 PUBLIC HEALTH SYSTEM AND DELIVERY OF PUBLIC HEALTHCARE AND ISSUES

In Bihar, Community Health Centres (CHCs) are absent and Primary Health Centres (PHCs) serve at the population of one lakh while Additional Primary Health Centres (APHCs) are formed to serve at the population level of 30,000. The absence of CHC and the specialized healthcare it offers has put a heavy toll on PHCs as well as district and sub district hospitals. Moreover various emergency and expert services provided by CHC cannot be performed by PHC due to non availability of specialized services and human resources.[11]

[12]Bihar is one of the 18 high focus States to be covered under NRHM. Before NRHM Bihar was a part of empowered Action Group (EAG) States. Under NRHM there is a manifold increase in allocation in the health sector. Significant improvements are being made by the government through: increasing staff at PHCs by relocating from lower level facilities, improving attendance of doctors by installing telephones in PHCs and contracting a call centre to monitor their presence, public private partnerships for laboratory diagnostics, radiology, mobile medical services and hospital maintenance.

The Infant Mortality Rate (IMR) for Bihar decreased from 61 in 2005 to 48 in 2010 while Bihar recorded a sharp drop in Maternal Mortality Rate (MMR) from 371 in 2001-03 (SRS 01-03) to 261 in 2007-08 (SRS 07-08). The percentage of institutional deliveries has also increased from just 4 percent in 2006-07 to 51% percent in 2011-12. Bihar has also successfully implemented the Polio Eradication Programme. In 2011-12, the average number of patients visiting government hospitals in a month was 8404, compared to 1819 in 2006.[13] In spite of these radical steps towards improvement a lot remains to be done to improve infrastructure, quality and accessibility of healthcare in Bihar.

11. NRHM, District Health Society Buxar, District Health Action Plan, 2012-13
12. Government of India, SC and ST Welfare Department, Aug 2012
13. Government of India, SC and ST Welfare Department, Aug 2012

HEALTHCARE IN BUXAR

In 2011, Buxar had population of 1,706,352 of which male and female were 887,977 and 818,375 respectively. In 2001 census, Buxar had a population of 1,402,396 of which males were 738,354 and remaining 664,042 were females. Buxar District population constituted 1.64 percent of total

Maharashtra population.[16]

The chart below shows the healthcare delivery system in the district.

SUBCENTRES
161
PUBLIC HEALTHCARE CENTRES
39
CHCS
0
SUB-DIVISIONAL HOSPITALS
1
DISTRICT HOSPITALS
1

Source: Rural Health Statistics, 2014-15[17]

16. Buxar population census , 2011
17 Government of India, Ministry of Health and Family Welfare Statistics Division, Rural Health Statistics, 2014-15

STATE HEALTH PROFILE

SR NO.	ITEM	BIHAR	INDIA
1	Total population (Census 2011) (in million)	103.8	1210.19
2	Decadal growth	25.07	17.6
3	Crude birth rate	28.9	22.8
4	Crude death rate	7.3	7.4
5	Total fertility rate	3.7	2.6
6	Infant mortality rate	48	47
7	Maternal mortality ratio	261	212

Source: Ministry of Health and Family Welfare: State Health Profile Bihar 2011[14]

HEALTHCARE DELIVERY SYSTEM	TOTAL NUMBERS AS OF 2015
Sub-centres	9729
PHCs	1883
CHCs	70

Source: Rural Health Statistics, 2014-15[15]

14. PWC, Healthcare Vision 2018, A Roadmap for Bihar, Sep 2012

15. Government of India, Ministry of Health and Family Welfare Statistics Division, Rural Health Statistics, 2014-15

HEALTHCARE IN SASARAM

As per provisional reports of Census India, population of Sasaram in 2011 is 147,408; of which male and female are 77,599 and 69,809 respectively.

The chart below shows the healthcare delivery system in the district.

SUBCENTRES
152
PUBLIC HEALTHCARE CENTRES
36
CHCS
0
SUB-DIVISIONAL HOSPITALS
1
DISTRICT HOSPITALS
1

Source: Rural Health Statistics, 2014-15[18]

HEALTHCARE IN BALLIA

Ballia district is one of the districts of Uttar Pradesh state , India . Ballia district is a part of Azamgarh Division situated in eastern Part of Uttar Pradesh. According to the 2011 census Ballia district has a population of 3,223,642.The district has a population density of 1,081 inhabitants per square kilometre (2,800/sq mi) . Its population growth rate over the decade 2001-2011 was 16.73%. Ballia has a sex ratio of 933 females for every 1000 males, and a literacy rate of 73.82% as per Census 2011.

The chart below shows the healthcare delivery system in the district.

SUBCENTRES
367
PUBLIC HEALTHCARE CENTRES
83
CHCS
15
SUB-DIVISIONAL HOSPITALS
0
DISTRICT HOSPITALS
2

Source: Rural Health Statistics, 2014-15[19]

18,19 - Government of India, Ministry of Health and Family Welfare Statistics Division, Rural Health Statistics, 2014-15

1.4 NEED AND ROLE OF COMMUNITY HEALTH WORKERS

Cost and access to medical care remain problems for universal scope and coverage. This is particularly severe in developing countries such as India. Doctors are few and concentrated in cities and towns. According to the Medical Council of India (MCI) there are around 9.29 lakh doctors registered in the Indian Medical Register. The council assumes that around 80 per cent availability of doctors at one time, it is estimated that around 7.4 lakh doctors may be actually available for active service. It gives a doctor-patient ratio of 1:1674 against the WHO norm of 1:1000, when every year around 55,000 doctors and 25,000 PG doctors are graduating from various colleges.[20] The nurse-to-people ratio in 2014 was one nurse for 1,100 people, while the World Health Organisation recommended ratio is one nurse per 500 people.[21]

In such a scenario, the most disadvantaged and marginalised communities that live in remote areas or the fringes of cities and towns, are disengaged from quality health care. Community Health Workers were thought of as a partial-answer to these challenges. Community Health Workers are lay health workers who live in the communities they serve and act as a link between those communities and the public healthcare system. Their main task is to promote healthcare seeking behaviour through the provision of information and assistance, to ensure that health services that have a high potential to reduce mortality and morbidity are used by intended beneficiaries.[22] In India, in 1977, the Janata Government launched the Community Health Worker (CHW) scheme, which focussed on CHWs selected by the community, having education upto 6th standard, and who were trained informally in the PHCs for 3 months. They were paid a stipend during training and an honorarium of Rs. 50/- per month after the training, when they began work[23]. These CHWs were named Village Health Guides. The scheme was subject to a number of mid course reviews

20. Neetu Chandra Sharma, "Grim picture of doctor-patient ratio, 1 doctor for 2,000 people", India Today, April 29 2016.
21. Kaniza Garari, "Nurses do not get their due", Deccan Chronicle, Jan 21 2014
22 Tanvi Rao, Impact of Community Health Workers on childhood immunisation: Evidence from India's ASHAs, 2014

due to issues with non-payment of honorarium, lack of professional enthusiasm, non-replenishment of kits etc and finally became non-functional after a litigation was filed by the CHWs for enhancement of honorarium.

In April 2005, the Indian government launched the National Rural Health Mission (NRHM) with a vision to comprehensively improve the country's public health delivery system. While the programme consisted of multiple components, a main provision of NRHM was the introduction of a cadre of village-level Community Health Workers known as Accredited Social Health Activists (ASHAs). While complex and multi-tiered, the public health set-up in India, prior to 2005, was considered too outstretched to provide outreach. At the time, existing health personnel included (i) Auxiliary Nurse-Midwife (ANM) and sometimes a male Multi-Purpose Worker (MPW) who worked out of health sub-centres, catering to a population of up to 4,500 individuals (approximately five villages), and (ii) an Anganwadi Worker who worked at the village-level but was focused on supplementary feeding services for children under six years of age. Given the pressures of a vast population, it was felt that another village-level worker was needed, to assist the ANM and the Anganwadi Worker in their tasks and to mobilise households in the utilisation of health services. ASHA workers are women selected from the village itself to which they belong. Her role is to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions. One of the key components of NRHM is to provide every village in the country with a trained female community health activist. ASHA acts as an interface between the community and the public health system. ASHA is the first port of call for any health related demands for the deprived sections of the population, especially women and children, who find it difficult to access health services. About 8.94 lakhs of ASHAs have been recruited till 2013-14 [24]. Studies have shown a remarkable increase in access to healthcare after the introduction of the ASHA. However universal access and coverage is still a distant dream and a work in progress.

In order to address the issues pertaining to lack of sanitation and hygiene, absence of toilets, early pregnancies, poor menstrual hygiene and lack of access to sanitary napkins, HFF launched the Community Health Facilitator (CHFs) programme in the year 2009 in Andhra Pradesh. The objective of the programme includes training and deploying women to lead their own communities toward better health through education, improved access and affordability of quality care and delivery of products and infrastructure that promote health as well as empowering these women with opportunities for income-generation and financial self-sustainability. HFF has furthered its programme in partnership with CASHPOR in order to reach the most rural and deprived women and communities.

23 Community Health Workers: A brief policy overview
http://www.sochara.org/sites/default/files/Community-Health-Worker-brief%20summary.pdf

24 Shalini Kelkar and Meerambika Mahapatro, Community Health Worker: A Tool For Community Empowerment, 2014

1.5 DESCRIPTION OF THE REPORT

The report begins with an introduction.
Chapter 2 describes the research design, methodology and sampling framework for the study.
Chapter 3 provides an overview of the areas where the study was conducted.
Chapter 4 ocuses on the impact of the programme on the women who have been transformed into a CHF from the village. It reviews the changes in her financial autonomy, social status and decision making after deciding to be the Community Health Facilitator.
Chapter 5 focuses on the impact on the villages that have received health information through the CHF, got water and sanitation loans for preventive health care and accessed basic health care such as first aid and sanitary napkins.
Chapter 6 assesses the theory of change based on the findings of the study.
Chapter 7 presents the conclusion along with recommendations to strengthen the programme and make it sustainable in the long run.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 CONTEXT OF THE STUDY

Healing Fields Foundation (HFF), a non-profit organization, registered in Hyderabad, Telangana, is recognized as a pioneer in the areas of Community Healthcare, Community Health Education and Health Financing. HFF's vision is *'to make quality healthcare affordable and accessible to all people in India, especially the poor, underprivileged and marginalized'*. HFF is led by Ms. Mukteshwari Bosco, an Ashoka Fellow of 2009. HFF focuses its activities on the improvement of healthcare with no bias against any caste, creed, religion or gender.

CASHPOR Microcredit is a poverty focused, not for profit Company that targets Below-Poverty-Line women, primarily in the northern states of Bihar and Uttar Pradesh, providing micro-credit and other services to communities there. Dia Vikas has partnered with CASHPOR since 2008. CASHPOR was one of the first microfinance institutions to become SMART Certified, a symbol of its commitment to social impact. CASHPOR Microcredit is one of Opportunity's largest microfinance partners in its global network.

In order to bring its client out of poverty faster, with a view to reduce expense on health of its clients families CASHPOR decided to create health awareness among its all 1 million clients in a phased manner through CHFs and sought the help of HFF for training its client to become CHFs.

HFF and CASHPOR Microcredit started implementing the Community Health Facilitator (CHF) programme with various partner organizations in India since 2010 and have so far trained more than 3,000 women as Community Health Facilitators, including 978 women in Bihar funded with support from the Scottish Government. The programme strives to build a system locally of trained, accountable Community Health Facilitators who can fill the gap in healthcare access with their first aid skills and knowledge of treatment options.

The programme aims at empowering marginalised and disadvantaged women from some of the most interior parts of the country in states which score extremely low on Human Development Index and low health indicators. These women benefit from the acquisition of a new skill set, gainful employment, dignity and respect within their community while becoming leaders and changemakers in the field of Community Rural Healthcare. The CHFs also engage in income-generating activities that duly provide needed health products, through the sanitary napkin production and sale programme, distribution of renewable energy products and others. The unique features of the programme include:

Scalable health education system	*Economic empowerment through health microenterprises*
Innovative health financing model	*Community level health infrastructure development*

Having access to a vast network of reliable local women health facilitators with last mile connectivity to their village peers is a critical asset to rolling out other health solutions in these rural locations. Currently, the programme is funded by a consortium of national and international donors described below.

About Opportunity International: Opportunity International is a global NGO with a mission to provide financial solutions and training that empower people living in poverty to transform their lives, their children's futures and their communities. Since 2012, the organization has steered health interventions with the aim of contributing to improved health practices that lead to lower rates of illness and increased resilience for families living in poverty.

About Dia Vikas: Dia Vikas is a subsidiary of Opportunity International. Dia Vikas was established in 2008 to increase social investment in the Indian microfinance sector and to promote best practices in developing financial solutions for people living in poverty. Dia Vikas has achieved this goal by supporting the growth and development of 12 microfinance institutions in India that were previously underserved. With funding, guidance and support from Opportunity, Dia Vikas has grown to reach over 3 million families across 19 states of India.

Funding and support has been provided for the work implemented in Ballia, Buxar and Sasaram by Opportunity International including its offices in the United Kingdom, Australia, and Indian subsidiary Dia Vikas. Funding support was also provided by the Axis Bank Foundation. In particular this report focuses on efforts funded by the Scottish Government through Opportunity International UK.

2.2 REVIEW OF CHF PROGRAMME THROUGH PREVIOUS EVALUATION STUDIES

Based on the available studies on the CHF programme by Healing Fields Foundation in partnership with CASHPOR, a significant amount of improvement with regard to better access to health services, positive behavioural change (among CHF's family and community), CHF's recognition as a first point health resource, improvement in health indicators, increased institutional deliveries have been noted as a result of continuous health education efforts by the CHFs within the community. Some of the major programme outcomes in different geographical locations have been:

1.

IMPACT ON HEALTH BEHAVIOUR

In terms of direct impact in promoting positive health behaviours, toilet-use has been found to have increased by 30% accompanied by considerable rise in the use of soap - while bathing, before handling food, before eating, and after using the toilets after the CHFs underwent the training. Water purification practice increased up to 88% as compared to 12% (Baseline) and 97% of the CHFs reported to be aware about the importance of eating a balanced diet. Disease burden has considerably decreased. In case of reproductive and sexual health, while only 25% respondents were earlier using sanitary pads, post programme intervention, it has been found that 97% of the target population has been using them. A considerable decrease in UTI-related infections and vaginal discharge was also noted. Health seeking behaviour has changed and beneficiaries now seek medical help in case of need. In 2013, HFF partnered with the Akhand Jyoti Eye Hospital (AJEH) in Bihar in order to create awareness about eye health. AJEH trained CHFs identified by HFF in screening and mobilising the community towards eye camps. Under this programme, eye check-up camps were organised and patients were identified according to their needs and were then referred to AJEH for further treatment at a discounted price. Incentives were given to CHFs for referrals. (Source - End-term Impact Assessment Report (Deloitte, 2016); Community Health Facilitator Programme, Livelihood Experiences Report (HFF, 2015))

2.

CONSTRUCTION OF TOILETS

As well as being educated about the importance of improved water and sanitation methods, community members have been encouraged to access funding from a range of sources to improve infrastructure such as toilets or water pumps. This has included funding for 17,369 loans used for building toilets and 16,281 loans for water purifiers.

With the help of Public Health Engineering Department subsidy (PHED), 40 toilets have been constructed under HFF's pilot programme in Kanpur Village in Ithari block of Buxar district while more than 8000 toilets were constructed under Finance Inclusion Improves Sanitation and Health (FINISH). CASHPOR identified and selected CHFs and trained them for facilitating construction including advancing the process of loan. Incentives were given by CASHPOR to CHFs based on the number of loans mobilised as well as the number of toilets constructed. (Source- Community Health Facilitator Programme, Livelihood Experiences Report (HFF, 2015)).

CASHPOR along with WATER. Org has started a sanitation awareness programme in 2016 and have further trained all CHFs for this programme and also executed Swachh Bharat Abhiyan rallies to promote sanitation in the entire community. They have now initiated approximately 8000 WATSAN loans.

3.

INCREASE IN ANTENATAL CHECK-UPS

As reported between September 2013 and February 2014 in Buxar, 62% of respondents went for at least one antenatal check-up, as compared to only 34% at the time of Baseline marking an increase of 28%. 74% of lactating mothers reported that they breastfed their baby on the day of the birth as compared to only 27% in the Baseline. 17% respondents took the recommended 100 I.F.A tablets as compared to only 9% in the Baseline. The percent of lactating mothers and pregnant women taking one TT injection had risen to 80% and those taking two injections to 58% compared to 65% and 43% in the Baseline respectively. (Source - Impact Assessment of Health & Education among CASHPOR BPL clients in India (CASHPOR Micro Credit, 2014))

4.

INSTITUTIONAL DELIVERY

An increase to 80% from a baseline of 30% clients was recorded as more lactating mothers shared that they had availed institutional deliveries with 66% giving birth in government hospitals and 15% delivering in private hospitals in the Buxar region. *(Source - Impact Assessment of Health & Education among CASHPOR BPL clients in India (CASHPOR Micro Credit, 2014))*

5.

INCREASED SALE OF SANITARY NAPKINS

Data indicates that active involvement of CHFs with the community has increased the sale of sanitary napkins which means more women and girls have become aware about the use of sanitary napkins. This reflects an increase in reach and visibility of the project within the communities through CHF intervention *(Source- Community Health Facilitator Programme, Livelihood Experiences Report (HFF, 2015)).* Since January 2016, CASHPOR has also started to supply sanitary napkins to CHFs to increase the livelihood opportunities for them.

6.

CATARACT CARE

With the involvement of 41 CHFs, 44 camps were arranged and incentives for cataract care were shared by the team of CHFs. An average of 80 patients attended a camp. Total number of cataract referral was 965 and a total of 605 surgeries were conducted. Average earning per CHF was Rs, 2000 per month. *(Source- Community Health Facilitator Programme, Livelihood Experiences Report (HFF, 2015))*

7.

INCREASED IMMUNIZATION

According to the Impact survey of 2014, BCG vaccinations increased to 37% from 12%, Polio vaccinations increased to 17% from 12% and DPT vaccinations increased to 27% from 15%. *(Source - CASHPOR Micro Credit, 2014)*

8.

FINANCIAL OUTCOMES

CHFs have been earning through their marketing and sales of sanitary napkins as well as through the extended CASHPOR internships in Bihar and UP. Since all the respondents were the members of microfinance groups under CASHPOR, they all hold a savings account and started saving some some portion from their earnings. There is a great change in the empowerment level as the CHFs now are part of the decision-making process in their homes and this has also helped in somewhat curbing the ghunghat (covering the face) practice in the communities. *(Source - End-term Impact Assessment Report (Deloitte, 2016))*

9.

INDIRECT IMPACT

There is a change in health promoting behaviours in the form of developing kitchen gardens with the help of CHFs. There is a change in hand wash habits and incidence of diarrhoeal diseases and UTIs have reportedly decreased. In the case of non-health impact, there has been a 100% enrolment rate of children in the schools. *(Source - End-term Impact Assessment Report (Deloitte, 2016))*

10.

ACCESS TO WARM CLOTHES

In 2012, under the warm clothes programme in partnership with GOONJ, 17,500 people were reached and gradually, the number increased to 22,500 in 2013 and to 24,500 in 2014 in the states of Bihar and UP. This became a part of the extended internship programme work for the CHF. Similarly, the clothes distributed year-wise increased from 18,777 in 2012 to 24,500 in 2014. Number of CHFs increased from 105 to 166 from 2012 to 2014 and average earnings increased from Rs. 250 to Rs. 500 per CHF from 2012 to 2013. While 219 CHFs were involved in this internship, 2628 centres and 52,560 clients were covered. Average earnings of CHFs were Rs. 1,200 per month during this extended internship programme period. *(Source- Community Health Facilitator Programme, Livelihood Experiences Report (HFF, 2015))*

2.3 OBJECTIVES OF THE STUDY

Healing Fields Foundation and CASHPOR Microcredit along with their donor partners, selected the National CSR Hub, TISS to undertake an evaluation of its CHF programme in Ballia, Buxar and Sasaram.

THE OBJECTIVES OF THE STUDY ARE:

- To assess the impact of the programme on the CHFs (who are CASHPOR's MFI clients and have undergone the health training): To identify the improvement in their confidence, social and economic status, as well as to compare the situation of women before and after receiving training to become CHFs.
- To assess the increase in community members' health knowledge through the CHFs
- To assess the situation in the villages trained by the CHFs regarding their health knowledge, access to healthcare, access to sanitation facilities and access to sanitary napkins.
- To study the behavioral changes as a result of CHF intervention in the target villages.
- To review and clarify the theory of change based on evaluation findings
- To gain knowledge of the challenges and context-specific factors influencing the effectiveness of the health project, to compile a list of lessons learned and recommendations for future initiatives with a road map for the future.

2.4 RESEARCH DESIGN

A mixed method approach was used to meet the objectives of the study. The use of both quantitative and qualitative methods helped in assessing the objectives of the study, including the health awareness of the CHF and community members, and provided an insight into the context-specific factors and challenges that impacted the programme. The use of various tools also allowed triangulation and verification of the data.

The tools used for the study are:

1. Transect walk -

A transect walk is essentially a PRA tool that will help the researchers to build a rapport with the community, create a resource map and establish the context of each village.

2. Focus Group Discussion with CHF -

A focus group discussion with the CHFs will help the researchers in getting a better understanding about the CHFs and their work, the challenges they face in carrying out the work and what improvements they suggest in the programme. It also has scope to discuss the changes that the decision and work of becoming a CHF has brought in their lives and families and their future plans.

3. Focus Group Discussion with the village community -

A focus group discussion in each of the sampled villages that the CHFs are working will bring forth the view of the villagers on the work of the CHF and the changes that have been brought about through her work.

4. Semi structured interview with important village functionaries ***(ASHA worker, PHC staff, village sarpanch or panchayat leaders)*** **-**

This tool will help the researchers to understand the work of the CHF, her role in the community and the impact of her work as viewed by community leaders.

5. Structured interview for the households in the village where CHF is working -

This interview schedule will help the researchers to understand the profile of the households, their health awareness and practice, and status of utilization of CASHPOR loans.

6. Structured interview for the CHF in the village -

This interview will help the researchers to understand the profiles of the CHFs, their health awareness and the number of incentives received by them through the CASHPOR loans facilitated by them. It will also assess any changes in income of the CHF.

2.4.1 SAMPLING STRATEGY

The proposed sampling of the study was 5%, derived from the total universe of 1328 villages (and CHFs) for meeting the objectives of the study. Hence, 35 villages across 3 districts - Ballia, Buxar and Sasaram - were selected for data collection. This report focusses on the CHF programme in the districts of Ballia, Buxar and Sasaram, which was funded by Scottish Government, through Opportunity International. Based on proportion of CHFs trained in each district, a sample of 12 villages was selected in Balia, 11 in Buxar and 12 in Sasaram.

The tools described in the section above were administered in the 35 villages as shown below:

SAMPLE SIZE FOR EACH TOOL

SR	TOOL NAME	TOTAL
1	Transect Walk	35
2	FGDs with the CHF	4
3	FGDs with the village communities	35
4	Semi structured interviews with village level functionaries	35
5	Structured interview for the households in which CHF works (7-10 households per village)	306
6	Structured interview with the CHF of the village	35

The study involved structured interviews with 7 to 10 households selected randomly in each village. Care was taken to ensure that households from different parts of the villages and caste were selected, so that households with socio-economic differences were also included.

2.4.2. DATA COLLECTION

After the finalization of the inception report, the tools were translated in Hindi, pilot tested in the field and further refined based on the feedback of the pilot test.

Next, the field team from GIDS, consisting of 6 field investigators and 1 field supervisor, was trained for two days in Patna by the TISS research team for data collection using the final study tools. The data collection was started in all 3 districts simultaneously by a team of 2 field investigators each, whose work was reviewed by the field supervisor on a regular basis. One research officer from TISS was also on the field for overall supervision. Additionally, the field staff was monitored by two project officers from the TISS team to ensure quality control. The field teams covered one village in approximately 2 days. The entire data collection was done over a period of one month.

2.4.3. DATA ANALYSIS

The data processing began with manual checking of structured and semi-structured questionnaires and data entry in SPSS. The entered data were first cleaned for skip logic on certain questions. After data were cleaned, statistical analyses were conducted as follows:

- Percentages and frequencies were calculated for nominal variables. Cross tabulation of the nominal variables was done with the district variable.
- Average scores were calculated for continuous variables.
- For the semi-structured interviews, open-ended responses from the interviews were transcribed and analyzed to identify convergent themes.
- Focus group discussions were transcribed and translated and then analyzed to identify convergent themes.

2.4.4. LIMITATIONS AND CHALLENGES

Due to budget and time constraints, in each district, a convenience sample of the villages was taken in which villages were selected from 2 consecutive blocks to reduce travel time. Moreover, only villages that were close to the highway were selected and no control group was selected. Hence, the findings are not representative of all intervention villages and CHFs.

Household interviews were conducted to gain perspectives of the CHFs' work at the household level and to supplement the data collected through FGDs. Again, it is important to note that the number of households selected were too small for the findings to be representative of the village population. Due to small sample sizes, no significance tests could be conducted.

Since the available secondary data (Census, 2011) are old and the structure of the villages would have changed in last six years, putting weight to the dataset was not deemed appropriate.

2.4.5. ETHICAL CONSIDERATION

During the research utmost care was taken to maintain the respect and dignity of the participants. Oral consent of the participants was obtained prior to the study and the respondents were not forced or coerced in any manner to participate in the study. Care was also taken to ensure the confidentiality of the research data.

CHAPTER THREE

AREA PROFILE

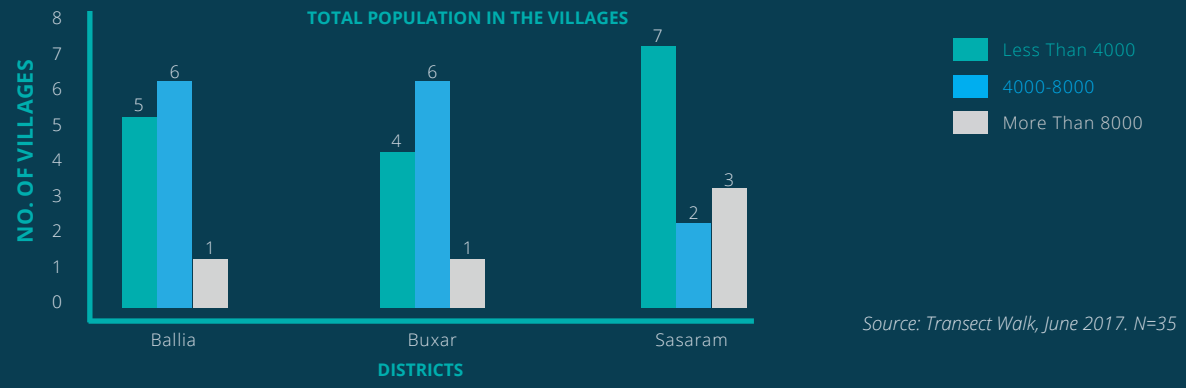
3.1 PROFILE OF VILLAGES COVERED IN THE STUDY

The study was carried out in 35 villages of 3 districts - Ballia, Buxar and Sasaram. As discussed in the methodology section of the report, 12 villages were selected from Ballia, 11 villages from Buxar and 12 villages from Sasaram.

This section presents the profile of the 35 villages including population and number of households, status of water scarcity, types of toilets constructed, presence of community toilets, schools and hospitals near the village and number of hours of electricity.

It is important to note that a convenience sample of the villages was taken for the purpose of the study in which villages were selected from 2 consecutive blocks and only those that were close to the highway were selected. Hence, the profile of villages in this chapter are not representative of all intervention villages.

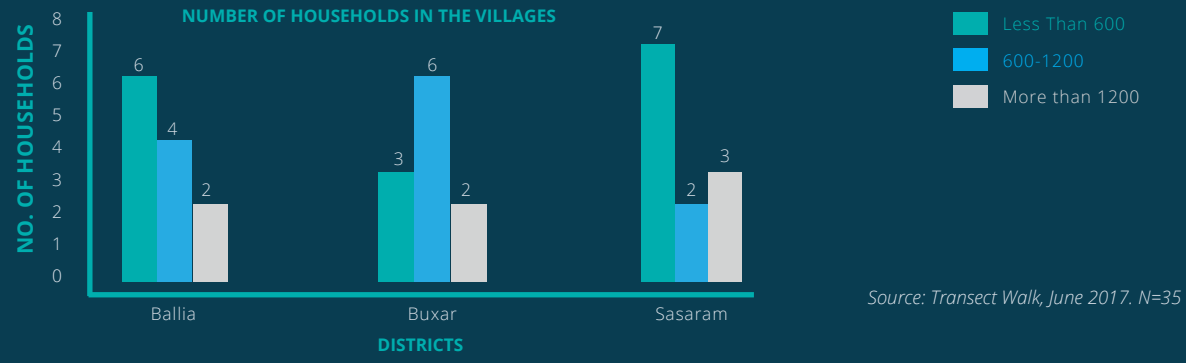
Figure 3.1 shows the **population** distribution in the sampled villages. It is seen that 5 villages in Ballia, 4 villages in Buxar and 7 villages in Sasaram had a population of less than 4000 people. Six villages in Ballia and Buxar had a population between 4000 and 8000, while 3 villages in Sasaram were quite large and had a population of over 8000.



Source: Transect Walk, June 2017. N=35

Figure 3.1: Population of the villages

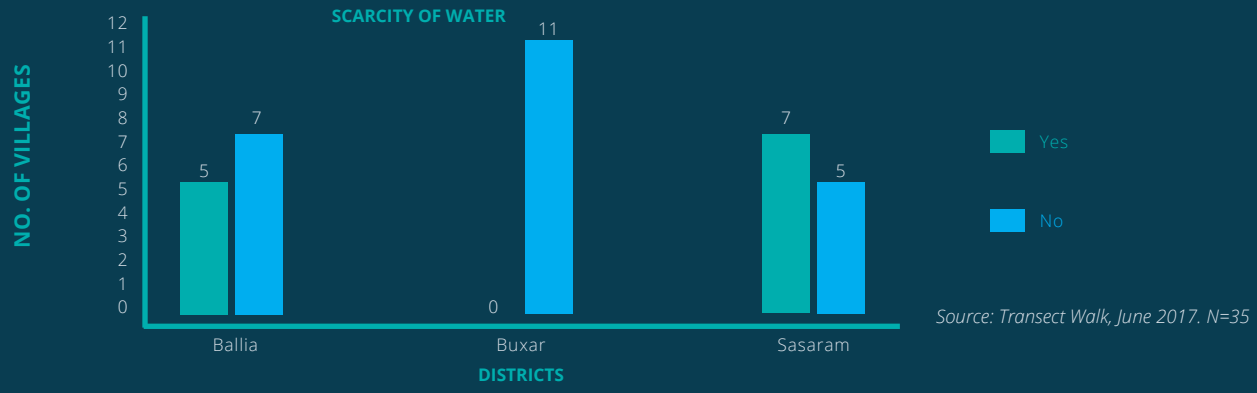
Figure 3.2 shows the **number of households** in the sampled villages. It is seen that over half the sampled villages in Ballia and Sasaram had less than 600 households, while 8 villages in Buxar had over 600 households.



Source: Transect Walk, June 2017. N=35

Figure 3.2: Number of households in the villages

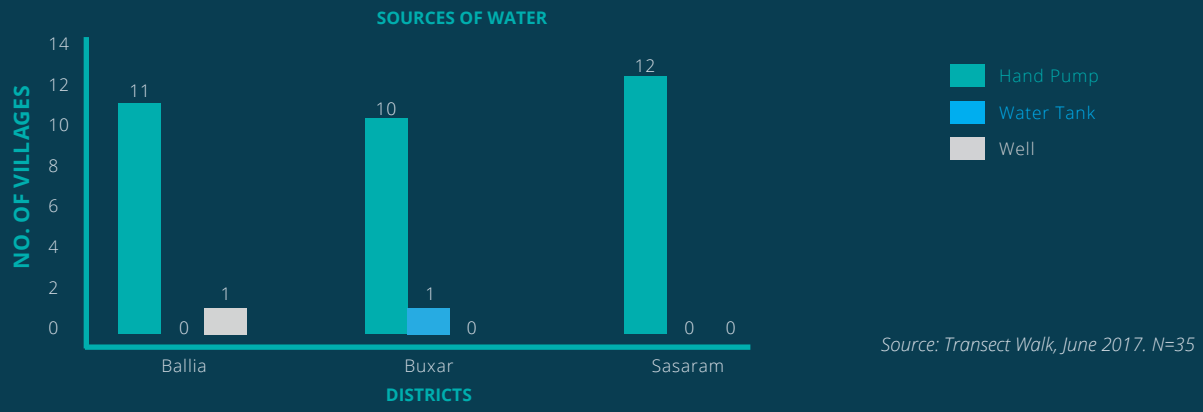
Figure 3.3 shows that **water scarcity** was reported in 5 of the sampled villages of Ballia and 7 of sampled villages in Sasaram, while no sampled village in Buxar reported water scarcity.



Source: Transect Walk, June 2017. N=35

Figure 3.3: Water scarcity in the villages

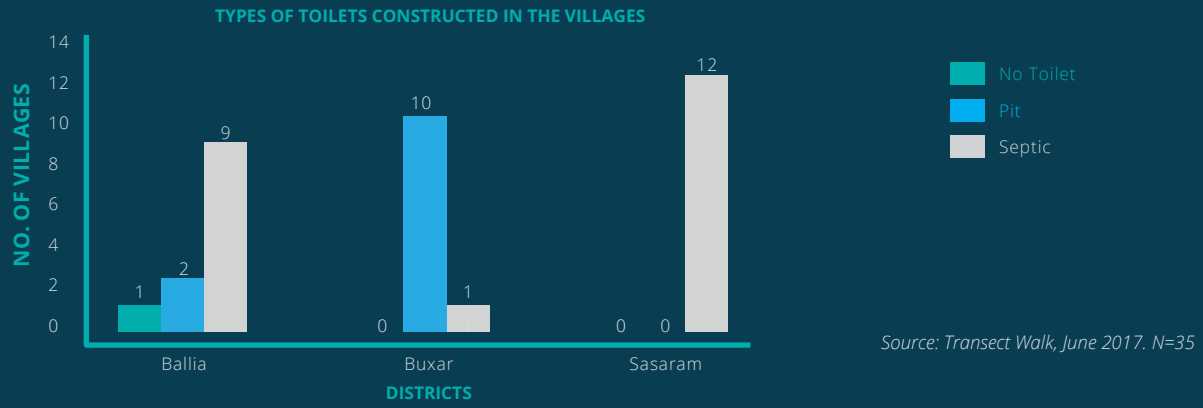
Among **sources of water**, hand pumps were the most frequently used source for domestic purposes as shown in the figure 3.4 below. In most sampled villages, community members reported travelling 0 to 300 metres to fill water. Two villages in Ballia and one village in Sasaram reported travelling 500 to 600 metres.



Source: Transect Walk, June 2017. N=35

Figure 3.4: Sources of water

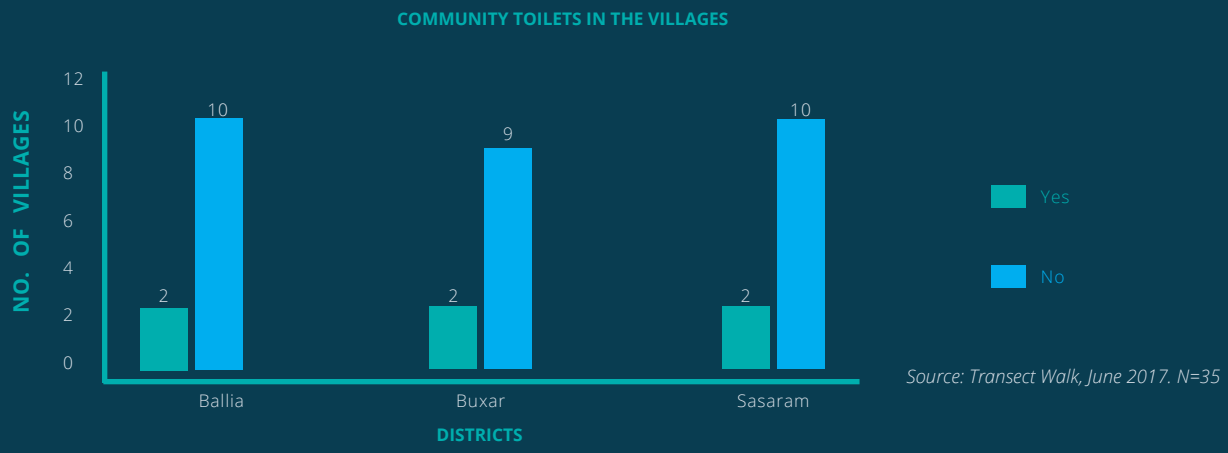
Figure 3.5 shows that in the sampled villages that had toilets, septic toilets were the most common **type of toilets** constructed in the households of Ballia and Sasaram, whereas in Buxar households, pit toilets were the most common.



Source: Transect Walk, June 2017. N=35

Figure 3.5: Types of toilets constructed in the villages

From Figure 3.6, it is seen that over three quarters of the sampled villages in all the three districts do not have any community toilets.

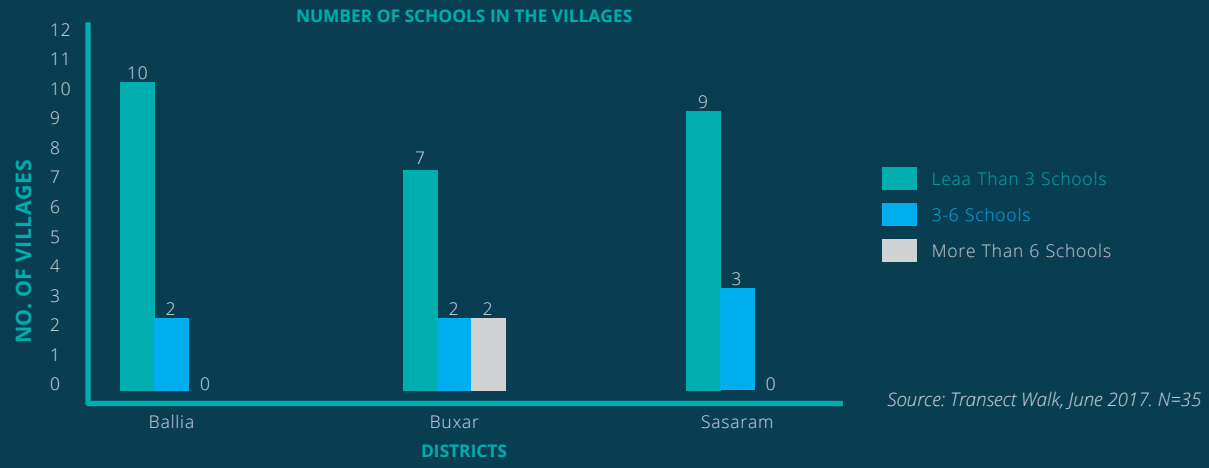


Source: Transect Walk, June 2017. N=35

Figure 3.6: Community toilets in the villages

All the sampled villages had **electricity** for at least ten hours every day. Except three villages in Ballia and one in Buxar that had 10-12 hours of electricity, all other sampled villages in all three districts had over 12 hours of electricity per day. Villagers indicated that they were able to use the electricity for domestic purposes.

Figure 3.7 shows that all villages had at least one **school**. Two villages in Buxar had more than six schools - these were larger villages and at least had primary and secondary schools. Villages also shared that many schools have **separate toilets** for boys and girls, although two villages in Ballia, one in Buxar and two in Sasaram do not have separate toilets.

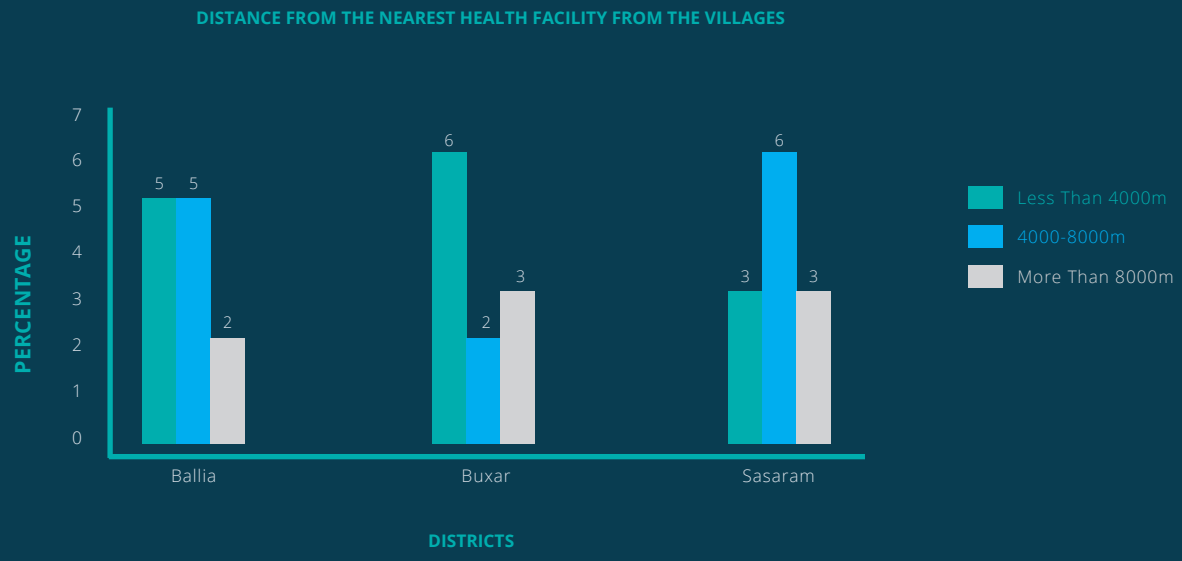


Source: Transect Walk, June 2017. N=35

Figure 3.7: Number of schools in the villages

With regards to **fuel used for cooking,** LPG was primarily used in all the sampled villages. Wood, kerosene and coal are the other fuels used.

Villagers mainly consult a doctor during illness . Some villages in Ballia and Buxar also reported consulting the CHF during illness. It is seen from the figure 3.8 that over half of the sampled villages in Ballia and three quarters in Sasaram shared that the closest health facility was more than 4 kms away. In Buxar, over half of the sampled villages reported being less than 4 kms away from a health facility.



Source: Transect Walk, June 2017. N=35

Figure 3.8: Distance of nearest health facility from the villages

From the profile presented above, it is seen that since the sampled villages were close to the highway, they had better connectivity, due to which they may be infrastructurally better than more remote villages.

CHAPTER FOUR

ANALYSIS OF THE IMPACT ON CHF

This chapter begins with an overview of the CHF programme and then specifically delves into the findings of the study with regards to the sampled CHFs - their socio-economic profile and the impact of the programme on them.

4.1 ABOUT THE CHF PROGRAMME

HFF and CASHPOR have a rigorous and well established programme for training women to become the Community Health Facilitators and ultimately become change agents for health care and hygiene practices in their communities.

CASHPOR Microcredit first decides the areas/ regions in view of resources available for this programme to be launched and then HFF and CASHPOR select women in those areas who would go on to become the 'health change agents' in their community. The first batch of this training began in Buxar in 2009. This sections describes in detail the training procedure of HFF to transform an ordinary woman into a CHF.

HFF begins the process of reaching out to the women in the villages through its partner CASHPOR Microcredit. CASHPOR Microcredit staff inform women coming to their centres about the CHF programme and encourage them to apply for its selection process. These women who are already members of the CASHPOR Microcredit are shortlisted based on a pre set criteria and interviewed and selected to begin their CHF training programme.

Figure 4.1 provides an overview of the CHF programme, the internship and the extended internship provided by CASHPOR microcredit.

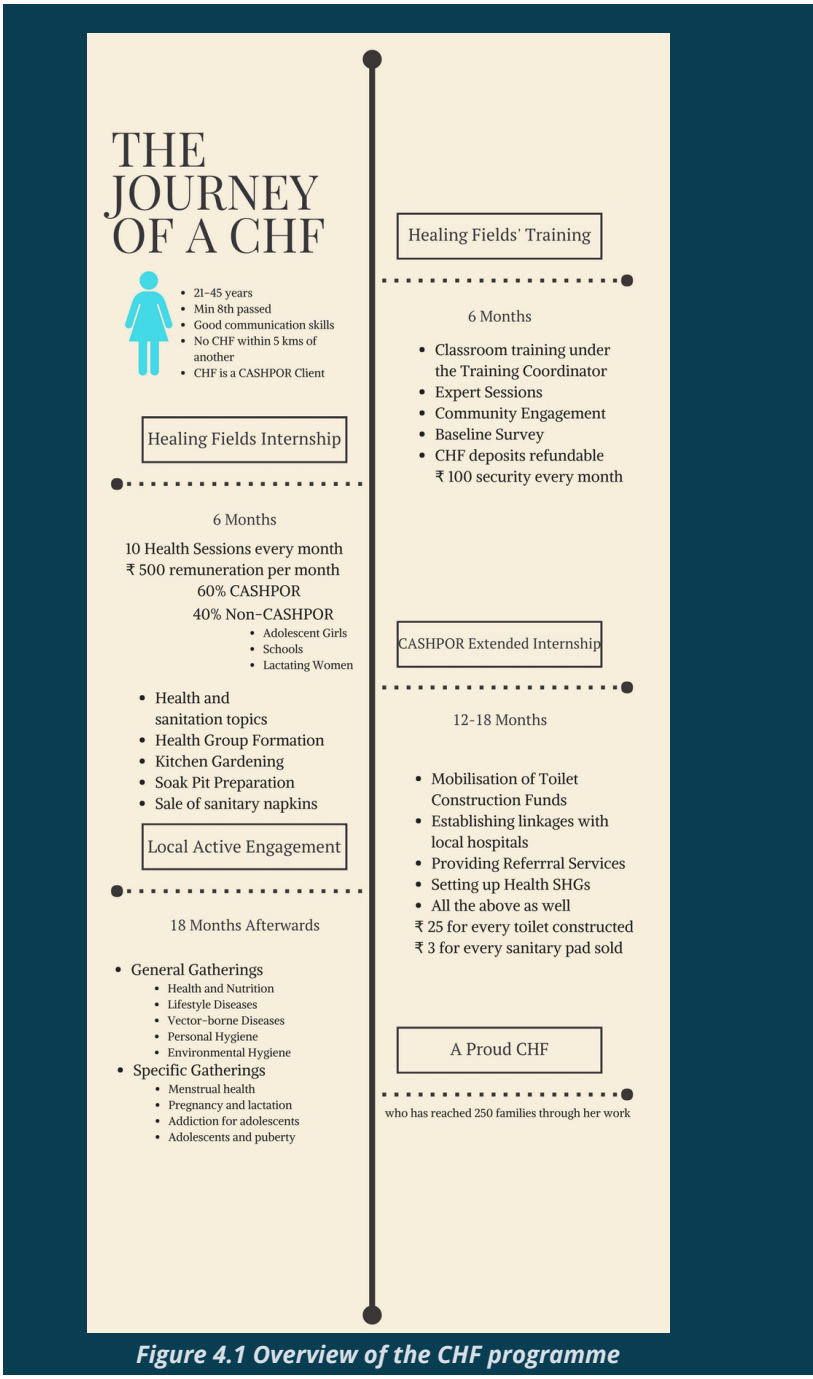


Figure 4.1 Overview of the CHF programme

The selection process begins with identification of women from marginalized communities to be trained as a community health facilitator. A stringent process is followed which includes compliance with criteria regarding age and educational qualifications, position in the community as well as geographical location. The compulsory criteria to be followed while selecting the CHF is as follows:

- *Age between 21-45 years*
- ***Education** - Minimum 8th standard completed. If not, then the CHF should be able to at least read and write fluently in local language. This criteria has been kept as the CHF needs to further undertake surveys and maintain village register.*
- *CHF has to be selected in a "flower" manner, which means that the CHF is located in the center and her targeted homes are spread around her location such that she can easily cover them.*
- No CHF is in the range of 5 km from the existing CHF (to avoid repetition of households)

Women with good communication skills, those with already established good relations with the community are given preference. Approximately 70 women are selected for a batch. Since some women drop-out due to personal reasons, a batch of about 50 is retained. Even if a batch has a higher number of CHF trainees, the crux remains that there is to be only one CHF for every 250 households.

The CHFs are given 6 month contact sessions on various topics by field staff and guest faculty such as doctors from local government or private facilities, Staff from Public Health Engineering department and members from Red Cross. Training includes topics related to health and disease, nutrition, menstrual hygiene, prevention of illnesses, first aid, government programmes, pregnancy and childbirth, Adolescent health, Domestic Violence, addictions and health financing. During the six months of these contact sessions, (4 days a month followed by specific assignments to be implemented in their villages) the CHFs give Rs. 100 each month as their contribution to the training receive.. Once they finish the six months of training programme, the security deposit is returned to the CHF if they have completed all the assignments, and village registers. After the first 6 months of training the CHF begin to earn income through a monthly stipend.

After the completion of 6 month training, 6 months of internship begins for the CHF. During the internship, CHFs go out into their local communities, primarily in CASHPOR Microcredit centers and also other avenues such as shiv charchas, schools or anganwadi centers and conduct a total of 10 health education sessions on various topics learnt during the training period. A nominal stipend is given to the CHF of Rs. 50 per health education session. This amounts to a monthly stipend of INR 500 per month for the 10 sessions conducted in a month. Out of the 10 health education session, 60% are with CASHPOR Microcredit clients and 40 % are with non CASHPOR clients. During this period, the CHF reaches about 250 families in her village.

Additionally, the CHF also engages in other work for better healthcare in the community, including:

- Creating awareness on sanitary napkins and selling of MESA and AAYUSHI CASHPOR sanitary napkins to women in the menstrual age. The CHF earns an incentive of Rs. 3 from each packet sold in addition to the stipend.
- Building of toilets and hand pumps for access to basic sanitation and clean water through CASHPOR microcredit loans or other government schemes available for building toilets. The CHF gets an incentive of INR 25 for every household that takes a loan for building a toilet or hand pump.
- Encouraging households to make kitchen gardens and consume vegetables from them.
- Building soak pits for cleanliness in the community. This is a part of their work on health education and does not include any additional remuneration.

Thus, the CHF also has an additional income from the incentives gained on sanitary napkin sale and CASHPOR loans on toilets and hand pumps during the internship.

HFF gives two certificates to the women who complete their training. One of them is from the Red Cross Organisation for completing a 4 day first aid training which is offered by Red Cross and the other from HFF after they complete their training period of 12 months.

Once the CHF finish their 6 month internship, they take an extended Internship of 6 months (part of training extended refresher) with CASHPOR Microcredit. During this period, the CHF reaches out to CASHPOR's MFI clients from other villages. HFF and CASHPOR support the graduated CHFs with economic empowerment opportunities such as manufacturing and distributing sanitary napkins, facilitating toilet construction, acting as doctor-patient facilitators and undertaking health-care surveys as well as other surveys amongst other activities. Thus, women who become CHF and complete their one and a half year period of engagement could remain engaged with the work of change in healthcare behaviour. However, given the need for CHFs to have a more sustainable source of income, HFF in partnership with Stanford's Emergency Medicine Services Department has recently launched the Basic Care Practitioner (BCP) programme for strengthening the work of the CHF and giving her a more sustainable livelihood.

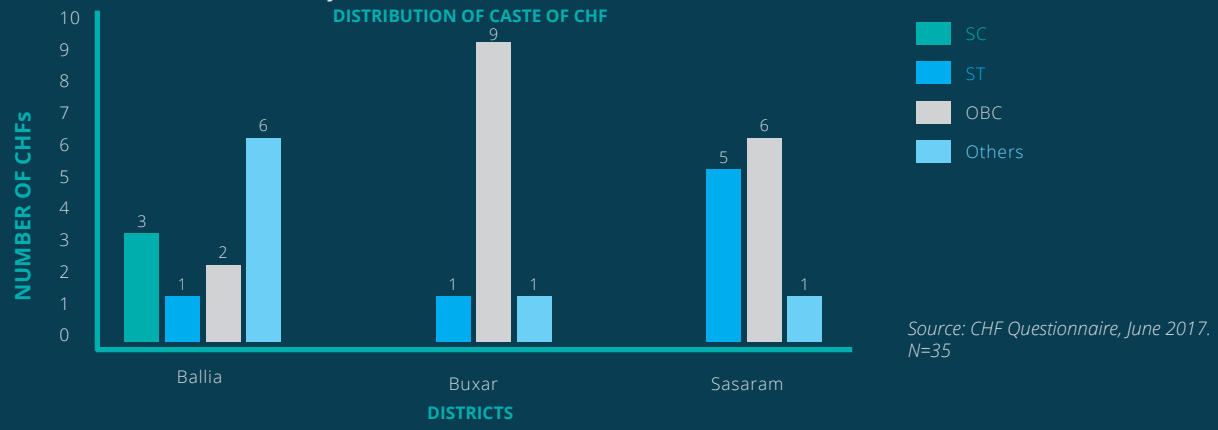
BASIC CARE PRACTITIONER (BCP)

Women who are already working as CHF in the community for sometime after the completion of their training are encouraged to apply for the BCP training programme by HFF in collaboration with Stanford's Emergency Medicine Services Department. This programme gives advance training to the CHF on basic first aid for specific conditions in a phased manner and also begins to train them with simple medical devices such as Blood pressure apparatus, pulse oximeters and thermometers. The aim of this training programme is to make the CHF an easily accessible and reliable para skilled health worker for the village rather than only a health facilitator for a village.

4.2 SOCIO-ECONOMIC PROFILE OF THE SAMPLED CHFs

One of the objective of Healing Fields Foundation and CASHPOR Micro-credit is to provide livelihood opportunity to the women in the villages belonging to poor households through the work of CHF.

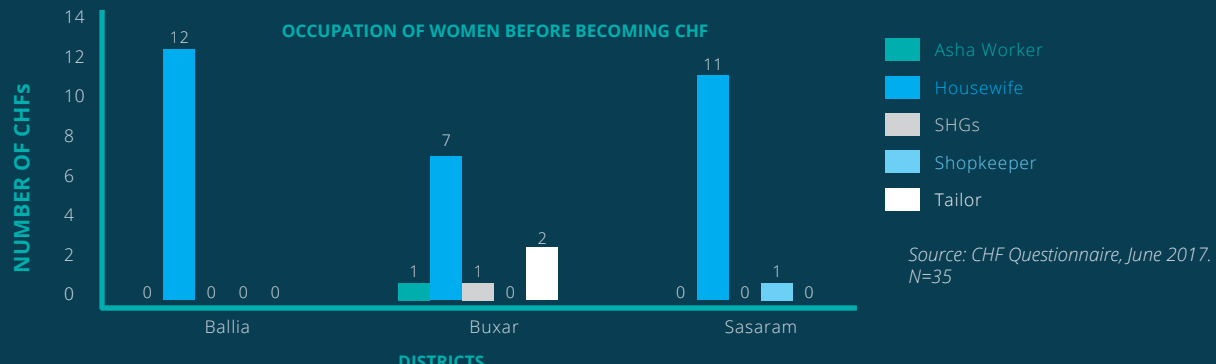
The figure below shows the **caste** distribution of the CHFs. Nine CHFs in Buxar and six in Sasaram belong to Other Backward Class (OBC) while Ballia had half the sampled CHFs belonging to other (general) class (an overview of the caste system in India has been provided in Chapter 1 of this report). Five CHFs in Sasaram belonged to the Scheduled Caste while 3 in Ballia belonged to Scheduled Tribe. Caste continues to be a dominant factor in rural India impacting economic status. Caste and poor economic status are fundamentally tied to the hierarchical social structure of the Indian society.



Source: CHF Questionnaire, June 2017. N=35

Figure 4.2: Caste of the CHFs

The figure below shows the **occupation** of the women before they became CHFs. Of all the 35 CHFs who were a part of the study, all CHFs in Ballia, 11 in Sasaram and 7 in Buxar reported being housewives. Interestingly, though the CHFs were CASHPOR clients and mostly took loans for the family business (which they may have been part of), they have not reported it as their occupation. The income earned from the business was also not reported by them as their individual income, perhaps because it was considered as family income.

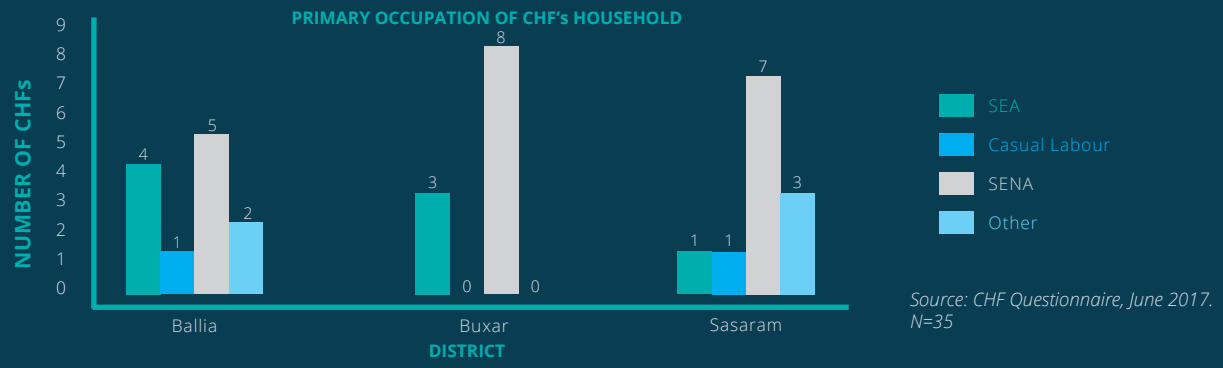


Source: CHF Questionnaire, June 2017. N=35

Figure 4.3: Occupation of the women before becoming a CHF

In terms of **education**, most CHFs had completed 8th-10th standard.

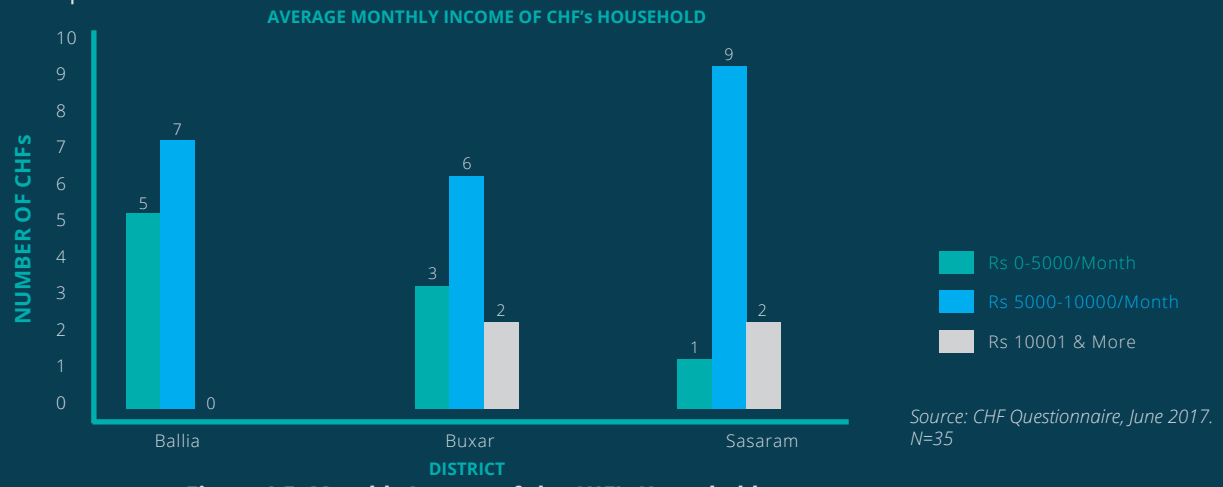
The figure below shows that the **primary occupation of the households** to which these CHFs belong is mainly self-employment in non-agricultural activities such as masonry and carpentry, and self-employment in agricultural activities.



Source: CHF Questionnaire, June 2017. N=35

Figure 4.4: Primary occupation of the CHF's Household

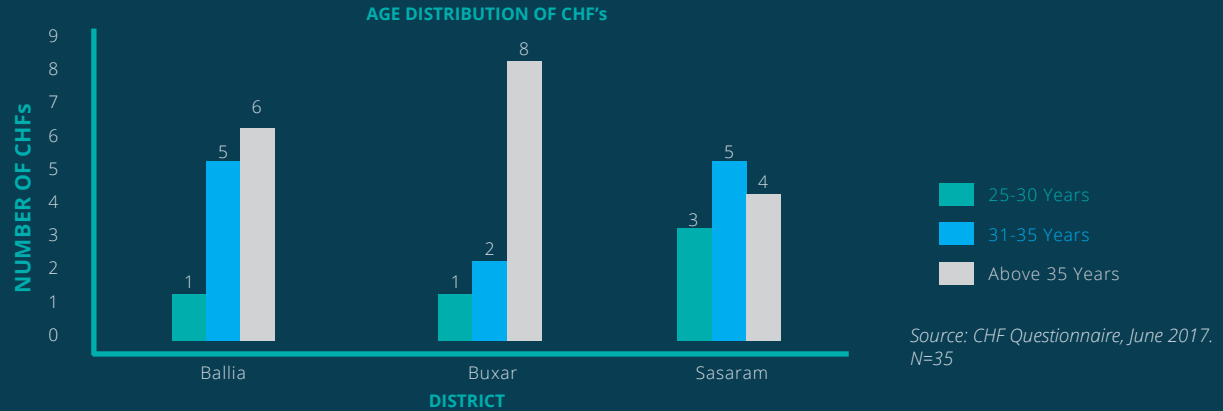
The figure below shows the **income** the CHFs ' households. Five CHFs' households in Ballia, 3 in Buxar and 1 in Sasaram have a monthly income of less than Rs. 5000 per month, while 8 CHFs' households in Buxar and 11 in Sasaram earned over Rs. 5000 per month. The average income of CHFs' households was around Rs. 7800 per month.



Source: CHF Questionnaire, June 2017. N=35

Figure 4.5: Monthly Income of the CHF's Household

The figure below shows the **age** distribution of the CHFs. It is seen that majority of the CHFs are over 30 years old.



Source: CHF Questionnaire, June 2017. N=35

Figure 4.6: Age of CHF

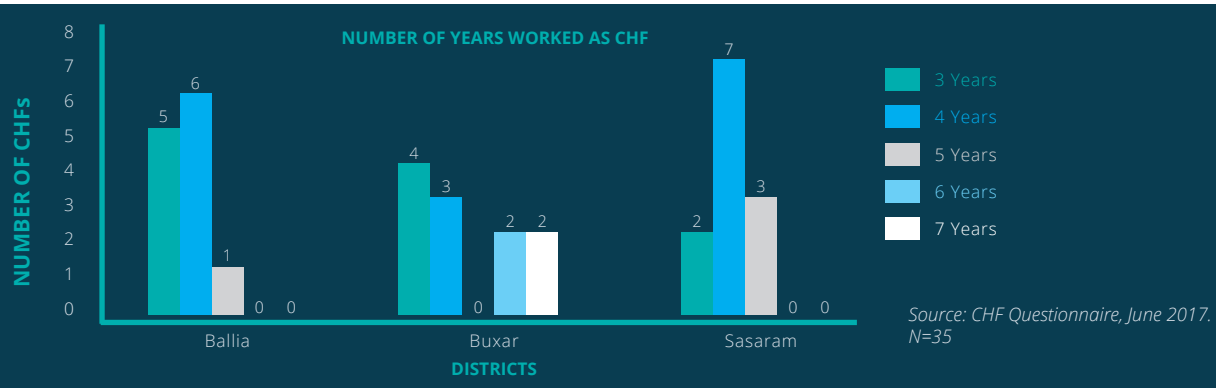
4.3 DECISION TO BECOME A CHF

CHFs shared that their CASHPOR Micro Credit managers informed them of the CHF programme when they went to inquire about or deposit installments for the loans. They were told that they only needed an education up to class 8 or literate enough to write and read to qualify for the programme. The opportunity to use their education to benefit their communities, to learn more about health related matters and impart this knowledge to their children, and to earn money inspired the CHFs to apply for the programme. Many CHFs stated that they joined work not only for monetary benefits but to challenge the social system and break stereotypes. They wanted to be able to create an identity for themselves.

The majority of the sampled CHFs had been associated with the programme for 3 to 4 years, with about a quarter having been associated for 5 to 7 years.

> "There are many ways to work and earn money but my motivation was to earn money with dignity." -CHF

> "My husband was against my working. He felt that he is earning well and I don't need to get a job. I told him that I'm not doing this for money. I want to educate myself, learn new things and I get bored sitting idle at home. All our kids are grown up so there's no issue there." -CHF



Source: CHF Questionnaire, June 2017. N=35

Fig 4.7 Number of years worked as CHF

4.4 CHALLENGES FACED AS A CHF

The decision to become a CHF was a courageous one for most of them. They encountered a number of challenges while they started undergoing the training to become CHFs. Many fought at home with their husbands to give them 'permission' to participate in the training, several had never stepped out of their village and did so for the first time travel to distant places to reach training centres. Almost all had to bear the indecent taunts of their community and extended families as they stepped out of their homes alone, travelled long distances and stayed at "hotels".

The table below highlights some of the challenges faced by the CHFs.

Table 4.1: Difficulties faced by CHFs during training

What type of difficulties did you face during training of CHF?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
No support from family	2	16.7	0	0	3	25
Training sessions were long	1	8.3	0	0	2	16.7
Training location was far from home	8	66.7	8	72.7	8	66.7
Difficulty in understanding the training material	1	8.3	1	9.1	1	8.3
Facing difficulties in managing home and other responsibility	1	8.3	2	18.2	4	33.3
No problem faced	3	25	1	9.1	0	0

Source: CHF Questionnaire, June 2017. N=35

THE CHALLENGES FACED BY THE CHFS WERE LARGELY:

SOCIAL

The majority of CHFs are middle-aged women who are housewives and belong to poor families. As a result, they faced difficulty in gaining support from their families and community members. The CHFs faced many challenges from community. A woman in a patriarchal system is not expected to work professionally. If she attempts to do so, she is discouraged and looked down upon. If the work involves movement outside home it is seen in negative light so much that a woman's character is questioned. Moving out from home and working in a society which is patriarchal was the biggest challenge for the CHF.

> In the beginning, lot of from the village were questioning the venue of our training. There were rumours that we visit hotels and are also cougth in hotels. with all these speculations, we went to work against all odds. And noe people look up to us. - CHF

FAMILY

Some of the CHFs received opposition from family members when they took the decision to become CHFs. Immediate family members such as husband, children and in laws of many CHFs were hesitant to let them venture out of the house as they felt that their household duties would be neglected or not taken care of properly. However, the CHFs still persisted in their training and convinced their family members to allow them to go for training and work in the community successfully juggling home and work responsibilities. In some CHFs' household there was a positive change as their husbands and children slowly began to support the CHFs by helping her with cooking meals or cleaning their homes.

> "Initially, when I discussed with my family about becoming a CHF, my mother in law was totally against the idea. She would say that the kids are small and will be neglected with a working mother. I convinced her that I could manage both work and kids efficiently and then started working. She would still disapproved every time I got late from work." - CHF

> "At first, my husband was very sure that I won't be able to do it. I'm from nuclear family and health is also challenge for me, and then there is the responsibility of kids. But then he left it to me to decide how I would like to manage everything else while working." - CHF

> "My kids used to ask me to not go and work. They sometimes faced issues with getting food on time and studies. If I don't stay at home, meals and studies are affected. Still, I stepped out." - CHF

DISTANCE

The CHFs had to travel large distances for the training programme and in spite of accommodation being provided during the trainings, some of them had to return home everyday to fulfill their family responsibilities.

TRANSPORTATION

The CHFs also found it difficult to avail affordable transportation to reach the training venue. Since they could not ride bikes, they often used private transportation available only on main roads, for which some CHFs would have to walk several kilometers.

FINANCIAL

As seen in the table below, many CHFs shared that they did not face much difficulty in paying Rs. 100 for the training but some of them did find it difficult to bear the cost of traveling great distances to get to the training site.

Table 4.2: Difficulty in paying for the CHF training

Did you have any difficulties in paying Rs.100 per month for the training?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
YES	3	25	2	18.2	2	16.7
NO	9	75	9	81.8	10	83.3

Source: CHF Questionnaire, June 2017. N=35

As shown below (Table 4.3), many of the CHFs in Ballia and Buxar expressed that the pay for organising a session in the community was low, while the CHFs in Sasaram found it adequate. Those that found it low said that they have to put in more efforts and invest more than what they get. They do it anyways because they get to move out of the house and build an identity in the community.

Table 4.3: Adequacy of money during internship or for conducting meetings

Are you getting adequate money during internship or while conducting meeting?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
YES	5	41.7	2	18.2	12	100
NO	7	58.3	9	81.8	0	0

Source: CHF Questionnaire, June 2017. N=35

The table below (Table 4.4) shows some of the major reasons why the CHFs don't find the pay to be adequate. Additionally, the payment is often not done in time and since the payment comes in the bank accounts, the CHFs need to travel to the bank to check if the payment has been credited. Overall, it is not profitable and money is not a motivational part of the programme.

Table 4.4: Reasons for inadequacy of payment made to CHFs

If the payment was not enough, what was the reason?	DISTRICT					
	BALLIA (N=6)		BUXAR (N=8)		SASARAM (N=0)	
	N	%	N	%	N	%
Put in more efforts than payment received	3	50	3	37.5	0	0
Payment is more than expenses towards becoming a CHF	6	54.5	8	88.9	0	0
Payment does not contribute majorly to HH income	11	100	8	88.9	2	0
Others Specify	1	8.3	0	0	0	0

Source: CHF Questionnaire, June 2017. N=35

CONDUCTING HEALTH SESSIONS

CHFs also faced challenges in taking health awareness sessions in their villages when they started working; these challenges are shown in the table below.

Table 4.5: Challenges faced by CHFs while organizing health sessions in the community

What were the challenges faced during organizing the health sessions in the community?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
Community could not be mobilized to attend the session	3	27.3	2	18.2	4	33.3
Village community did not pay attention to the sessions	4	36.4	6	54.5	8	66.7
Village community faced difficulties in understanding	4	36.4	4	36.4	5	41.7
Any other issues	1	9.1	0	0	0	0
No difficulty faced	2	18.2	3	27.3	1	8.3

Source: CHF Questionnaire, June 2017. N=35

Many CHFs shared that initially there was a lot of reluctance among the community members to come and sit for the health awareness sessions. Most women in the community would run away saying that had their household chores to attend too. Slowly, they began to take women in confidence. They began to use social occasions such as prayer meetings to organize women and give them information. They would ask the village women to listen for a few minutes and if she disliked the talk then she could leave. Initially, some women would ask what they would get in return for these meetings and CHFs explained that if they apply the suggestions given in the meeting, their families would have better health; there is no monetary incentive but good health will save the money of the villagers' households. Some men would be curious about the topics of the meeting and would disrupt them thinking they are giving some illicit advice to the women.
The CHFs have successfully overcome these challenges.

> There were initial problems in organizing community meetings but not anymore. Now everyone offers to be part of it. Earlier, they would make excuses of household chores or cooking but now they all are accustomed to it. Some people thought that we are here to misguide the women, then we confronted them and asked to join and decide for themselves if we are talking the right things or not.
> -CHF

4.5 CHANGES IN CHFs AFTER UNDERGOING TRAINING

1. HEALTH AWARENESS

The CHFs are imparted training to increase their knowledge in preventive health care, hygiene, nutrition menstrual hygiene and other topics over a duration of 6 months. Based on the average pretest and posttest scores shared by HFF, it is observed that there is an increase in knowledge of the CHFs.

With regards to washing hands, the CHFs' responses are shown in the table below. Most CHFs are aware that washing hands is important before dealing with food and water and after touching objects that could potentially carry germs.

> After getting associated with this, even we have improved a lot. Earlier we used to wash hand just like that. Now, we take time to wash our hands with either soap or ash.
>
> -CHF

Table 4.6: CHFs' responses to when hands should be washed

When do you wash your hands?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
Before preparing meals	12	100.0	7	63.6	11	91.7
Before eating food and after using toilet	12	100.0	11	100.0	11	91.7
Before giving medicine	10	83.3	4	36.4	9	75.0
Before feeding food to the children	12	100.0	8	72.7	9	75.0
Before filling drinking water vessels	10	83.3	3	27.3	9	75.0
After cleaning animal dung and bird droppings around and inside the house	12	100.0	9	81.8	9	75.0
After working with mud and fertilizers in the field	11	91.7	6	54.5	8	66.7
All of the above	10	83.3	3	27.3	10	83.3

Source: CHF Questionnaire, June 2017. N=35

CHFs also reported improvements in their own hygiene and that of their families.

Many CHFs were aware that environmental and lifestyle factors could have a bearing on one's health, as shown in the table below.

Table 4.7: CHFs' responses to what factors impact health

What factors impact your health?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
Hereditary issues	1	8.3	3	27.3	11	91.7
Before eating food and after using toilet	12	100	10	90.9	12	100
Daily lifestyle	5	41.7	7	63.6	9	75
All of the above	2	16.7	3	27.3	9	75

Source: CHF Questionnaire, June 2017.

When asked about what one should do when they have diarrhoea, the CHFs' responded as shown in the table below. CHFs mainly suggested taking ORS as the treatment for diarrhoea.

Table 4.8: CHFs' responses on how to treat Diarrhoea

What basic treatment you administer during diarrhoea?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
Drink more water	0	0	2	18.2	0	0
Drink less water	0	0	0	0	1	8.3
Taking ORS	12	100	11	100	12	100

Source: CHF Questionnaire, June 2017.

All the CHFs were able to correctly identify symptoms of anemia such as whiteness in eyes, paleness of skin, and weakness. CHFs also reported increase in their knowledge of nutrition and incorporating dietary changes in their households.

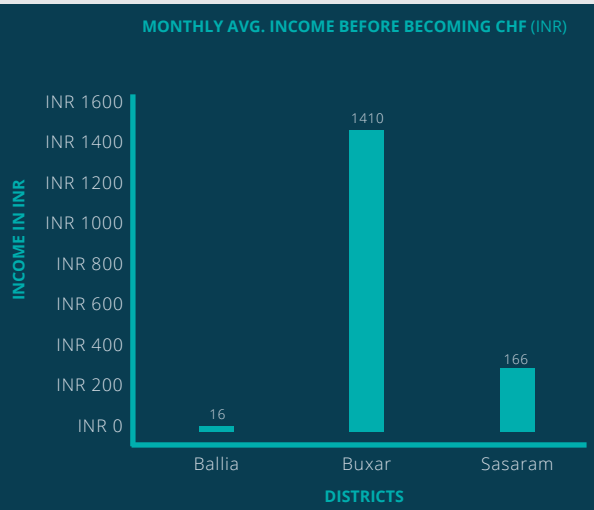
> My daughter never liked green vegetables. Now that I have told her the benefits of it and she might get iron deficiency and anemia, she started eating them and this is a big change.
> - CHF

Some CHFs also shared that their children imitate them for all the healthy practices that they follow like waking up early in the morning, taking bath, taking meals on time.

CHFs use their knowledge in first aid to provide preliminary first aid to their families and villagers. Some CHFs shared that they feel like "doctors" while tying bandages for broken bones, treating burns and minor infections, saving persons who had consumed poison or were bit by a snake or scorpion. CHFs feel proud of their work since they are able to help other people.

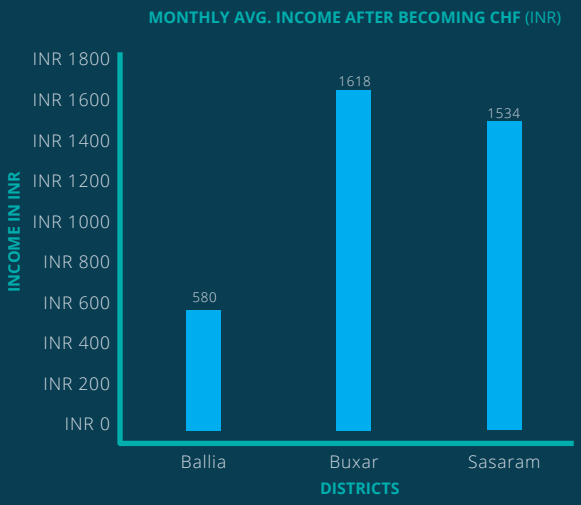
2. AVERAGE MONTHLY INCOME

The CHFs were asked regarding their monthly income before becoming CHF and their current income. Following figures represent ranges of average monthly income before and after becoming CHFs and their current average monthly income.



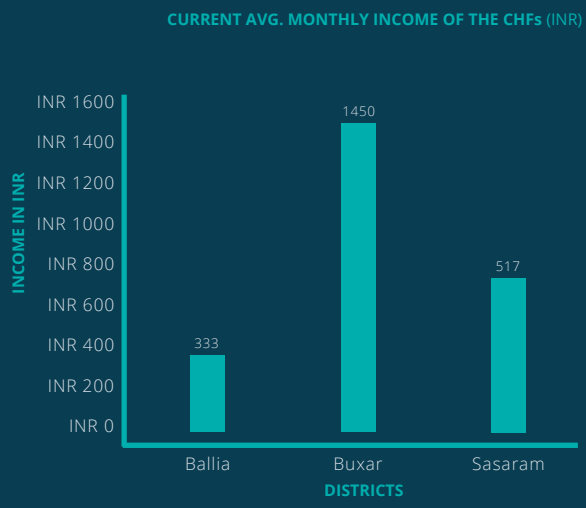
Source: CHF Questionnaire, June 2017. N=34

Figure 4.7: Average monthly income before becoming a CHF



Source: CHF Questionnaire, June 2017. N=32

Figure 4.8: Average monthly income after becoming a CHF



Source: CHF Questionnaire, June 2017. N=34

Figure 4.9: Current average monthly income of the CHFs

It is observed that most of the CHFs reported not having an individual income before joining the programme. This is because though the CHFs were CASHPOR clients, they mostly took loans for the family business (which they may have been part of) but they did not report it as their own occupation and whatever they earned was considered as part of the family income. But after joining the programme, majority of the CHFs earned an average monthly income of Rs. 580 in Ballia, Rs. 1618 in Buxar and Rs. 1564 in Sasaram. This income was viewed by CHFs as their individual income since it was regular, was more substantial and helped them to meet their own expenses. This increase in income also helped the CHFs to gain financial autonomy as they did not have to ask money from their husbands to fulfill their own needs.

However, after the programme, a lot of CHFs were not able to earn an income on a regular basis. As a result, there is a drop in income and the current average monthly income is Rs. 333 in Ballia, Rs. 1450 in Buxar and Rs. 516 in Sasaram.

3. CONFIDENCE

When asked about how comfortable CHFs felt in speaking about village issues, over 80% of them said they felt very comfortable about voicing the concerns of the village in public. However, this was not the case before they became CHFs, as seen in the tables below. As the CHFs started taking more sessions, they started becoming more comfortable with speaking in public.

Table 4.9: CHFs' responses to whether they were comfortable to talk about village issues in public

Are you comfortable to talk about any concerns of the village in public?	DISTRICT					
	BALLIA (N=11)		BUXAR (N=10)		SASARAM (N=11)	
	N	%	N	%	N	%
Very comfortable	9	81.8	8	80	8	801
Somewhat comfortable	1	9.1	2	20	2	20
Not comfortable	1	9.1	0	0	0	0

Source: CHF Questionnaire, June 2017.

Table 4.10: CHFs' responses to whether they were comfortable to talk about village issues in public before becoming a CHF

Were you comfortable to talk in public about any concerns of the village before becoming a CHF?	DISTRICT					
	BALLIA (N=12)		BUXAR (N=11)		SASARAM (N=12)	
	N	%	N	%	N	%
YES	3	27.3	2	20	2	20
NO	8	72.7	8	80	8	80

Source: CHF Questionnaire, June 2017.

CHFs are being recognized for their interpersonal skills; they feel comfortable talking freely in front of others, they feel effective when speaking with the Pradhan (village chief). Imparting knowledge to others has boosted the self-esteem of the CHFs and has contributed to their "identity development".

CHFs also shared that they used to wear a *ghunghat* (veil) while going out but now they go out and even speak to men without a *ghunghat.*

4. ACCOUNTABILITY AND RESPONSIBILITY

CHFs shared that that they feel a sense of accountability and responsibility as a result of their work. Earlier they were confined to their homes and were responsible for only their homes, but now they feel that it is up to them to look after the community health and well-being. They feel a sense of purpose and that they are doing something meaningful in their lives.

5. RESPECT AND RECOGNITION

> People appreciated our work and motivated us to do more and it really made us happy and we felt proud of ourselves to work for our village and community and we were treated with more respect. Everybody stated using respectful salutations like "Didi" which literally means elder sister. The respect and acceptance was my motivation to continue.
> -CHF

As a result of their work in the communities, CHFs report feeling respected in their communities. While most interviewed CHFs shared that their opinion was sought by their family when buying a big item even before they became CHFs, their opinions and suggestions are now also being heard by village level functionaries such as panchayat leaders, ASHA workers, ANM, and school teachers.

Some examples of support cited by the CHFs included:

- Support from village functionaries for rallies on health awareness
- Support from school teachers to promote hand washing in schools
- Working with ASHA to promote vaccination of children

CHFs garner a lot of respect from the community for their work. Being able to establish an independent identity of their own has been one of their greatest achievements. To be recognised in the community as a person of importance has given their confidence immense boost.

For the village women, CHFs have now become role models. Village women seek CHFs' advice and their counselling especially in health. This has given immense boost to CHFs' confidence. It a matter of pride for them to be respected and regarded highly in the community.

6. MOBILITY

Since most of the CHFs reported being housewives prior to joining the programme, they were mostly confined to their households. Most of them had rarely gone outside their village. However, since becoming CHFs, most of them shared that they step out of the house more often, from 1-2 times a week to everyday.

A Muslim women who had decided to become a CHF shared that she hardly left the house and never even emoved her *burqa (veil),* but after becoming a CHF, she started going out of the house, to distant places too, often with her veil removed.

Table 4.11: CHFs' mobility in terms of stepping out from home for work

Mobility of CHFs in terms of stepping out from home for work	DISTRICT					
	BALLIA (N=11)		BUXAR (N=10)		SASARAM (N=11)	
Don't step out	0	0.0%	0	0.0%	0	0.0%
1-2 days per week	7	63.6%	9	90.0%	3	27.3%
3-4 days per week	2	18.2%	1	10.0%	2	18.2%
Almost every day	2	18.2%	0	0.0%	6	54.5%

Source: CHF Questionnaire, June 2017.

4.6 CHFs' PERCEPTION OF THE IMPACT OF THEIR WORK

1. HEALTH AWARENESS AND PROVISION OF FIRST AID

Conducting health awareness sessions has been the thrust of the work carried out by the CHF. Additionally, some CHFs also reported helping villagers with first aid, treatment of infections, tying bandages, administering first aid to persons who had consumed poison and were bitten by scorpions. CHFs believe that all the insights they have gained from the programme have had a positive impact on their communities, their families, and themselves. CHFs shared that they have worked at many levels of preventive healthcare that have saved lives such as drinking ORS water for diarrhoea treatment. Village communities and CHFs' own families began to cook more nutritious meals from the information that has been shared by them. They also started boiling drinking water. Fewer people fall sick in the community as instances of diarrhoea have decreased and there is greater awareness around AIDS, as reported by the CHFs.

> My neighbor suffered from a head injury and there was no one at her place. I went to her place and put a bandage across her head and gave her first aid.
> -CHF

Some CHFs shared that they had conducted school sessions with the children about importance of washing hands. Now every child in the school washes the hands before eating. Some CHFs have worked as caretakers to women and other villagers in times of need. A CHF shared how she was aware of the need of hospital checkups and got a neighbour's kidney stone treated as her family members were not ready to take her to the hospital. The CHF motivated the woman's family to get her operated upon removing their misconceptions and fear of surgery by explaining negative aspects of not getting operated upon.

2. INCREASED USE OF SANITARY NAPKIN BY ADOLESCENT GIRLS AND YOUNG WOMEN

The CHFs also faced challenges when it came to educating dolescent girls and young women on the use of sanitary napkins. Since talking about menstruation, female hygiene, sex is considered a taboo in India, women in general are discouraged to talk about it. Through regular meetings, rapport building, home visits, regular counselling of girls and other women family members, CHFs have established a relationship with the girls and women. Now, the women come to them to discuss their problems.

In order to motivate girls to start using sanitary napkins the CHFS repeatedly conducted sessions in schools, paid personal visits to their home, engaged in conversations with older women in the family and convinced them that use of sanitary napkins is necessary for girls' reproductive health. Increased number of girls have started using sanitary napkins. Many CHFs themselves had never used sanitary napkins before the CHF training but now they had started using them.

3. MATERNAL HEALTH

CHFs have also generated awareness among pregnant women regarding getting vaccinated regularly and importance of institutional deliveries.

4. INCREASED FEEDING OF COLOSTRUM

Lactating mothers used to dispose the first milk (colostrum) after delivery thinking that it was not safe for the baby. But after the CHF explained the importance of colostrum, women have started feeding the colostrum to the baby.

5. CONSTRUCTION OF TOILETS IN THE VILLAGE

The CHFs shared that initially they faced challenges when it came to explaining the importance of building toilets for better health and hygiene, since open defecation is a socially accepted practice in the villages. However, some CHFs had succeeded in convincing community members regarding the importance of building toilets.

6. ACCESS TO LOANS

CHFs help facilitate loans from CASHPOR Micro Credit for their clients for toilet construction, hand pumps, water purifiers and LPG cylinders. The CHFs shared that the loan process from CASHPOR is easy and usually the loan is given within a week. If loan is taken from different sources, only then there is difficulty. The CHFs help the MFI clients of CASHPOR throughout the loan application process and also try to arrange funds from other sources when needed. The loan is usually approved within a week.

The table below shows the number of households that the CHFs facilitated through the loan application process.

Table 4.12: Number of WATSAN loans facilitated by CHFs

Number of households who took WATSAN loan for following items through the CHF	DISTRICT		
	BALLIA (N=12)	BUXAR (N=11)	SASARAM (N=12)
Number of Households taken loan for hand pump	99	267	26
Number of Households taken loan for construction of Toilet	1438	2214	3783

Source: CHF Questionnaire, June 2017.

However, some of the CHFs shared that they had not received any incentive amount for the loan that they facilitated. The CHFs were also asked what they thought was the perception of the villagers towards the loans.

Their responses are summarized in the table below. Majority of the CHFs felt that the perception for the loans given by CASHPOR loans was mostly good among the villagers.

Table 4.13: Opinion of villagers regarding WATSAN loans as per the CHF

Opinion of villagers towards WATSAN loan as perceived by CHF	DISTRICT					
	BALLIA (12)		BUXAR (11)		SASARAM (12)	
Good	9	75.0%	9	81.8%	8	66.7%
Average	1	8.3%	1	9.1%	4	33.3%
Poor	2	16.7%	1	9.1%	0	0.0%

Source: CHF Questionnaire, June 2017.

The reasons for villagers not taking the loans were mainly the loans being too expensive, people not feeling the need (in case of hand pump/water purifier) or people being habituated to defecating in the open (in case of toilets).

4.7 CHFS IDEAS ON FUTURE EMPLOYMENT

> All we want to say is that whatever work we get – big or small, we should get it regularly. Why? People should not be able to point fingers that she was working for a year or two and then she has been sitting idle at home. When husband asks what kind of job is this, that you are jobless at times, then it is very difficult to answer.
> -CHF

The CHFs want to continuously be associated with the programme in any (big or small) capacity. They have overcome a lot of challenges in order to become a CHF. After struggling so much, they don't want to sit at home again. By being unemployed, they have become a subject of mockery for people who had earlier questioned their decision of stepping out of the house and working.

When asked what they would like to do in the future, CHFs shared the following:

- The CHF have been sitting at home for some time now and want more awareness and training. They were also very keen on getting knowledge about "weighing machine, measuring BP and fever devices etc."
- By spreading awareness within their society, they could create a savings group and also establish a micro enterprise to get a regular source of income; like making papad, making pickles, making pearl necklaces, sticking bindis, establishing kitchen garden in their houses. They can do such similar small tasks to earn a living.

4.8 CHFs' FEEDBACK FOR THE PROGRAMME

> There were certain roadblocks too like we were scared when we were asked to do public speaking. We used to get anxious and confused about what to say. There was nervousness and throat used to go dry.
> -CHF

CHFs appreciated the training programme and felt that they gained a lot of practical knowledge which they found very interesting. They felt that the biggest takeaway from the training programme was the practice of speaking openly and without fear in public.

The CHFs saw the training programme as a platform to socialize. Most of these women, before they became a CHF, had been confined to their homes except for medical emergencies or events like weddings. Training was an opportunity for them to step out, and this was the biggest highlight of the programme as per the CHFs.

The training also helped the CHFs to connect with each other whom they were meeting for the first time, and build a support system to share their experiences with each other. The CHFs felt that the training batch had built a solidarity network among them. They could share all their challenges and troubles and seek each other's help. Over time, the CHFs have formed life long relationships with each other.

The CHF were also very appreciative of the trainers of the programme; they were very good and supportive. The CHFs attribute all their success in the community to the trainers of the programme. CHFs shared that if they did not understand a concept, the trainers would repeat things, as many times as needed.

However, a recurring theme of concern among the CHF was the future of the programme. The income they get is sporadic from the loans and the sale of sanitary napkins and they wish to work further for the health and wellbeing of their community. Some CHFs mentioned that the villagers also ask them why they are not conducting meetings anymore. They want the work from the programme to be sustainable and engaging to keep their confidence going.

With CASHPOR also introducing AAYUSHI sanitary napkins for CHFs to sell and earn an income and with the BCP programme also being offered, CHFs may be able to continue their work in the community to some extent. This would however require further evaluation.

4.9 CHFS' PERCEPTION OF DIFFERENCE BETWEEN THEM AND ASHA WORKERS

When asked about the difference between them and an ASHA worker, CHFs shared that one major difference was that the ASHA worker is contracted by the government while they are not. The CHF spreads health awareness and talks about menstrual hygiene. They also help with procuring loans for constructing hand-pumps and latrines which the ASHA workers do not. The workload of CHF is more than the ASHA worker.

Few interviewed CHFs shared that the ASHA workers were against them because they thought that the CHF will take over their work. However, the CHFs mentioned that they do not harbour any ill-feelings towards them. They make the ASHA worker understand that they are both working towards the wellbeing of their community.

4.10 REASONS TO DROP OUT OF THE CHF PROGRAMME

Women who had joined the CHF programme but then left the programme mid-way during training or after engaging for a small period of time also mentioned that the awareness and confidence they gained from the programme was one of the best takeaways. Many of them wanted to continue the training or working for the CHF programme but left the programme mid-way due to lack of substantial income or travel cost incurred and problems in travelling to distant places. The family members also pressurized the CHF to leave the programme once they realised the trials and tribulations faced for a meagre income.

Many women have reported a positive impact from the training programme even if they attended for a short period of time. For example, a woman from Ballia was working very actively as a CHF during her training period. Although the woman dropped out of the CHF programme at a later stage due to her personal reasons, her skills of working among the community members were noticed by a local leader and she was encouraged to join a political campaign by the leader. She is now an active member in politics and was hopeful of contesting elections, to thereby increase women representation in local government. Thus, even women who had dropped out of the CHF programme, had experienced a positive impact. Other women who had dropped out of the programme also reported more confidence in their daily lives from the CHF training received.

CHAPTER FIVE

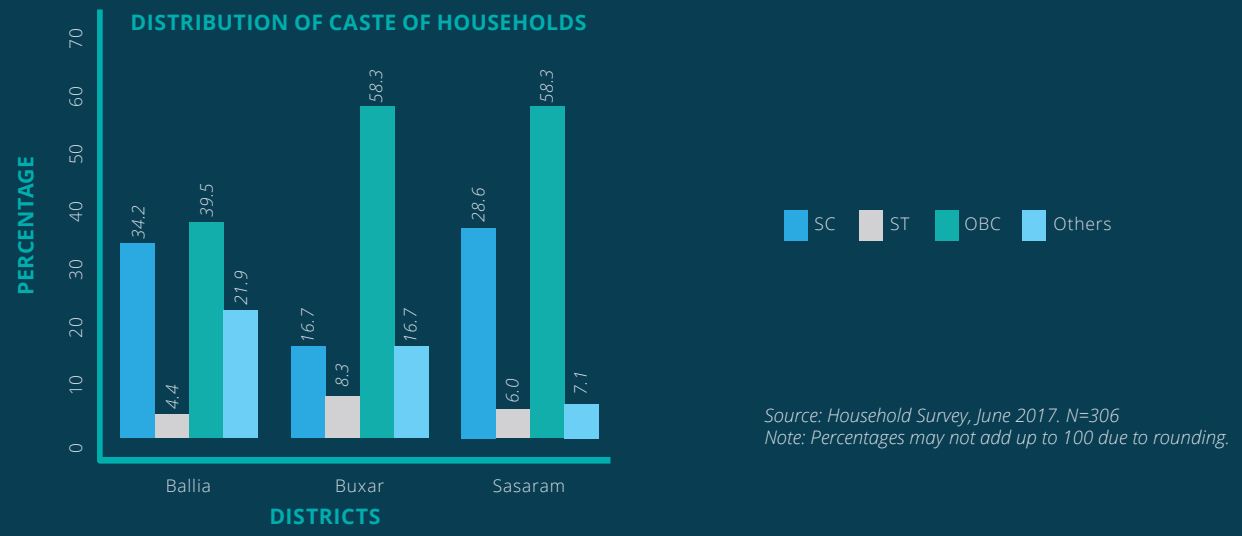
IMPACT OF THE CHF'S WORK ON VILLAGE COMMUNITY

This chapter provides an overview of the villages where the CHFs live and work, and the status of the village communities in terms of health awareness and behavior, sanitation and hygiene. It also delves into the villagers' perceptions of the CHF and the impact of her work in the villages.

5.1 HOUSEHOLD PROFILE

This section provides a broad overview of the profiles of the households surveyed for the study. It is important to keep in mind that since only 7-10 households were selected for interviews in each village, the profile of households presented above, is not representative of all households in the sampled villages.

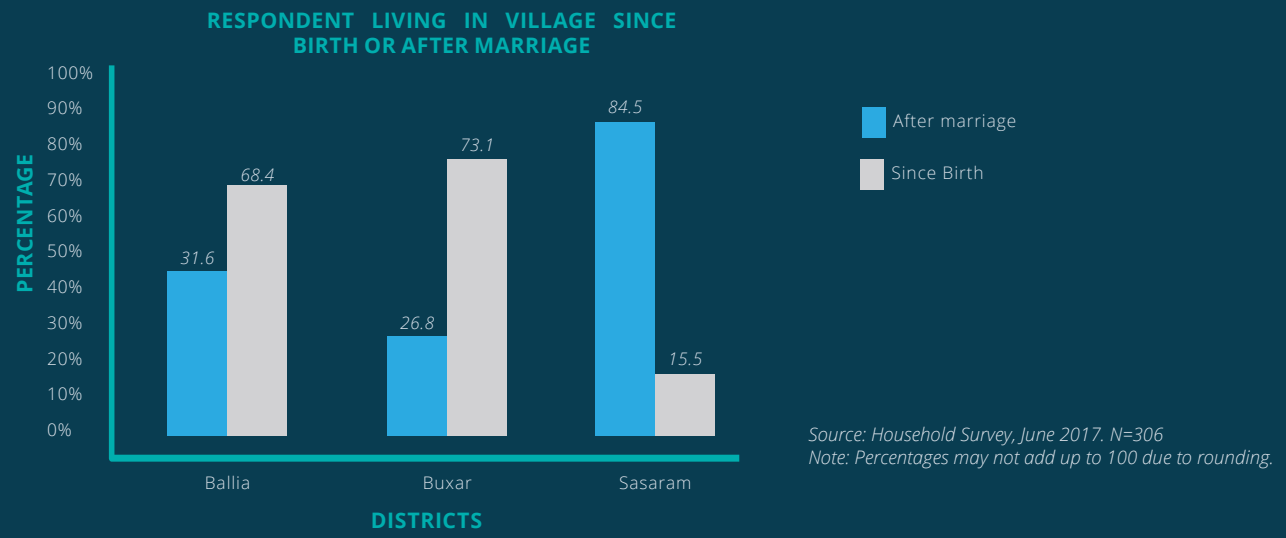
The figure below shows the breakup of the households covered in the study by **caste.** It is seen that over 50% of the responding households in Buxar and Sasaram were from Other Backward Class; remaining households mostly belong to the Scheduled Caste and other or general class. In Ballia, over 74% of the responding households were from Other Backward Class and Scheduled Caste, with almost 22% from other or general class.



Source: Household Survey, June 2017. N=306
Note: Percentages may not add up to 100 due to rounding.

Figure 5.1: Caste of the Interviewed Households

The respondents from the households were asked about **whether they had been living in the village since birth or after marriage.** In Ballia and Buxar, around 70% of the respondents had been residing since birth, whereas in Sasaram, 85% had moved to the village after their marriage.



Source: Household Survey, June 2017. N=306
Note: Percentages may not add up to 100 due to rounding.

Figure 5.2: Respondent living in village since birth or after marriage

In terms of household assets, the respondents reported having the assets shown in the table below. A large number of respondents had access to electricity, fan, television and mobile phone. Some also had scooter or motorcycle. Interesting, over 50% of the households in Ballia and Sasaram and over 70% in Buxar had toilet facilities.

Table 5.1: Household Assets

Household Assets	DISTRICT					
	Ballia (N=114)		Buxar (N=108)		Sasaram (N=84)	
	N	%	N	%	N	&
Access to electricity	94	82.5	102	94.4	74	88.1
Have Fan	86	75.4	97	89.8	64	76.2
Have Refrigerator	14	12.3	27	25.0	1	1.2
Have Washing Machine	5	4.4	5	4.6	0	0.0
Have Radio	10	8.8	11	10.2	2	2.4
Have Television	59	51.8	69	63.9	35	41.7
Have Computer	5	5.4	7	6.5	1	1.2
Access to internet Connection	3	2.6	44	40.7	0	0.0
Have Scooter/Motor Cycle	43	37.7	55	50.9	11	13.1
Have Car	9	7.9	7	6.5	1	1.2
Toilet Facilities	57	50	77	71.3	49	58.3
Have landline Phone	2	1.8	4	3.7	0	0.0
Have Mobile Phone	112	98.2	106	98.1	82	97.6

Source: Household Survey, June 2017

5.2 AWARENESS ON CHFS' WORK

Majority of the community members from the villages where the CHFs worked were familiar with them. When asked about what work the CHF does in their village, the respondents shared responses summarized in the table below.

Table 5.2: Work done by CHFs in the villages

Responses of households for work done by CHF	DISTRICT					
	Ballia (N=114)		Buxar (N=108)		Sasaram (N=84)	
	N	%	N	%	N	&
Give us health education	102	89.5	99	91.7	81	96.4
Gets us loan for water purifier, toilet construction	13	11.4	75	69.4	71	84.5
Forms health saving group	22	19.3	69	63.9	56	66.7
Sells sanitary napkins	39	34.2	67	62.0	61	72.6
Provides warm clothes	56	49.1	28	25.9	12	14.3
First Aid	2	1.8	6	5.6	5	6.0
Soak-pit	4	3.5	10	9.3	5	6
Do not know exactly what CHF do	10	8.8	0	0.0	4	4.8

Source: Household Survey, June 2017

As seen above, respondents from Buxar and Sasaram, were mostly familiar with all the different tasks that the CHF undertakes, the main ones being health education, sale of sanitary napkins, forming health savings groups, facilitating loans for water purifier, LPG and toilet construction. In Ballia, respondents seem to know the CHF mainly for health education, provision of warm clothes and sale of sanitary napkins.

CHFs were viewed as valuable and approachable members of the community. Community members felt that the CHF plays an important role in raising awareness about health related matters and education, and goes above and beyond to ensure the health and wellbeing of community members. The CHF is closely associated with CASHPOR microcredit that she is often identified as "Cashpor didi" or even "CHF didi" in some places.

When asked about how often the household respondents communicate with the CHFs, over 84% in Sasaram and 54% in Buxar, communicated with the CHF at least once a week. In Ballia, 34% household respondents seemed to interact with the CHFs once a week, while the remaining mainly interacted once in a fortnight or a month. In Buxar also, 40% of the respondents shared that they interacted with the CHF once in a fortnight or a month. This is the frequency of communication currently, when CHFs have already completed their training and internships.

Table 5.3: Frequency of communication with the CHF

How often respondent communicates with CASHPOR Didi (CHF)	DISTRICT					
	Ballia (N=114)		Buxar (N=108)		Sasaram (N=84)	
	N	%	N	%	N	&
Once in a week or less frequently	39	34.2	58	53.7	71	84.5
Once in a fortnight or less frequently	47	41.2	21	19.4	6	7.1
Once in a month or less frequently	22	19.3	22	20.4	4	4.85
Once in 3 months or less frequently	2	1.8	3	2.8	2	2.4
Once in 6 months or less frequently	1	0.9	1	0.9	1	1.2
Never	3	2.6	3	2.8	0	0.0

Source: Household Survey, June 2017

5.3 IMPACT OF CHF'S WORK

HEALTH AWARENESS

When asked if they had attended any health awareness sessions, over 60% of respondents in Ballia, over 70% in Buxar and over 87% in Sararam said that they had attended them.

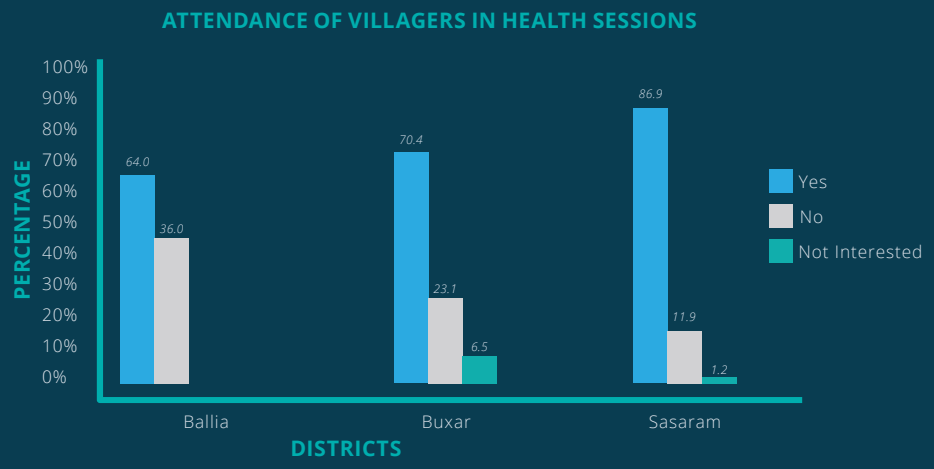


Figure 5.3: Attendance in health sessions

Source: Household Survey, June 2017. N=306
Note: Percentages may not add up to 100 due to rounding.

Household respondents were also asked to share their opinion regarding the information provided by the CHF. As shown in the table below, most of the respondents found the information to be good or excellent.

Table 5.4: Household respondents' opinion on information provided by the CHFs

Opinion on given information given by CHF	DISTRICT					
	Ballia (N=96)		Buxar (N=100)		Sasaram (N=84)	
	N	%	N	%	N	%
Excellent	60	62.5	36	36.0	15	17.9
Good	28	29.2	54	54.0	66	78.6
Poor/ could not understand the information	5	5.2	8	8.0	3	3.6
Information was good but not practical	3	3.1	2	2.0	0	0.0

Source: Household Survey, June 2017

Villagers testified to the utility of the health sessions, saying that they receive helpful information about hygiene, loan opportunities, nutrition, gardening and education for their children. They wanted the CHF to conduct more meetin. Some villagers would encourage and motivate other households in the village to attend the meeting as they felt that the meetings were beneficial.

A few women were initially not allowed by their family members to venture out of the house to attend the meeting. The CHF persistently requested their family members and then they allowed the women to attend the meetings. The women and villagers were touched by the keen interest and effort that the CHF took to give information during the meetings.

In order to assess the level of knowledge about hygiene and cleanliness, household respondents were asked regarding when they thought hands should be washed. From the responses summarized in the table below, it can be seen that majority of the respondents know that handwashing is important before handling food and water and after handling objects that could be germ contaminated.

Table 5.5: Knowledge of household respondents regarding hand washing

When you wash your hand	DISTRICT					
	BALLIA (N=114)		BUXAR (N=104)		SASARAM (N=84)	
	N	%	N	%	N	%
Before preparing meals	96	84.2	98	90.7	77	91.7
Before eating food and after using toilet	96	84.2	98	90.7	77	91.7
Before giving medicine	79	69.3	44	40.7	47	56.0
Before feeding food to the children	80	70.2	52	48.1	43	51.2
Before filling drinking water vessels	75	65.8	31	28.7	37	44.0
After cleaning animal dung and bird droppings around and inside the house	89	78.1	56	51.9	42	50.0
After working with mud and fertilizers in the field	89	78.1	51	47.2	38	45.2
Don't know	0	0.0	2	1.9	1	1.2
All of the above	92	80.7	28	25.9	45	53.6

Source: Household Survey, June 2017

Respondents were also asked regarding what should be done when one has diarrhoea. Their responses shown in the table indicate that the majority knew that it was important to take ORS when having diarrhoea.

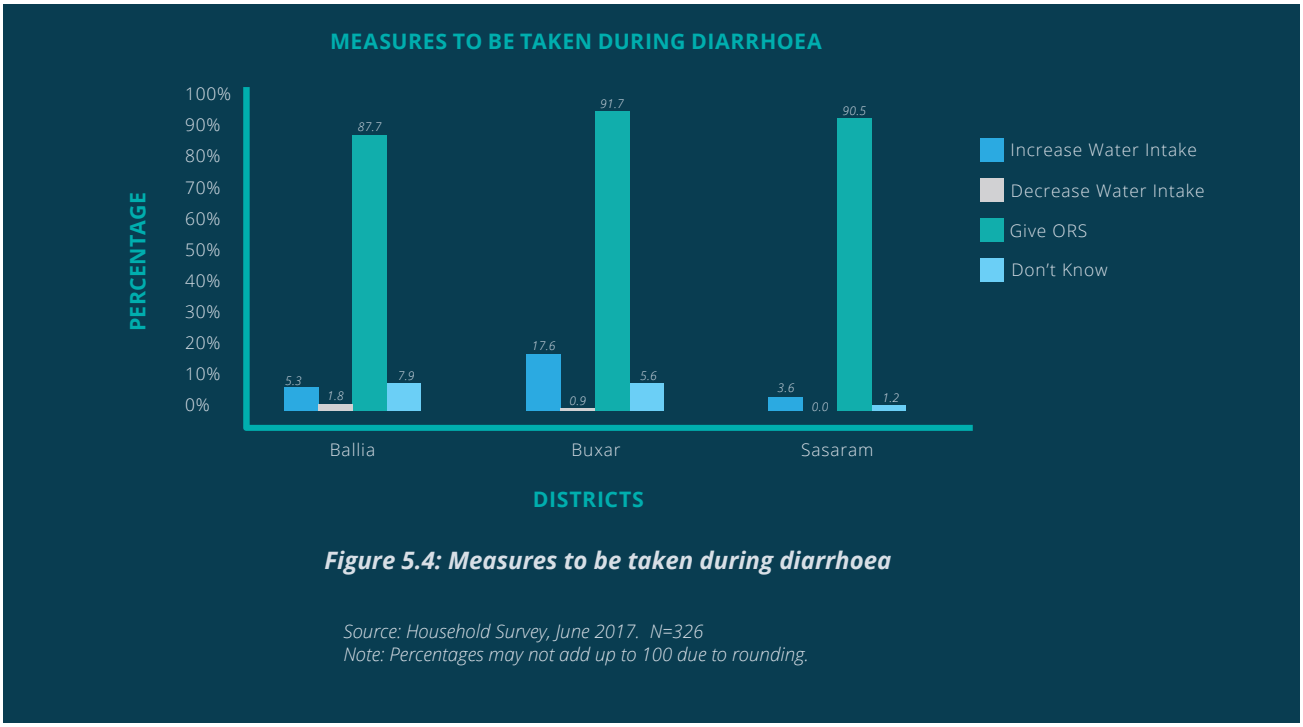


Figure 5.4: Measures to be taken during diarrhoea

Source: Household Survey, June 2017. N=326
Note: Percentages may not add up to 100 due to rounding.

MENSTRUAL HYGIENE

Another important aspect that the CHF imparts knowledge is on menstrual hygiene. In order to understand the menstrual hygiene practices of the women and their knowledge on the subject, women respondents were asked a few questions on the topic. Traditionally, women in rural areas use cloth during menstruation. Sanitary napkins are not commonly used due to issues of availability and costs. Generally there is also lack of awareness regarding why a sanitary napkin is better than cloth for menstrual health and hygiene.

Women were asked about what they use during their menstruation. Responses indicated that both dry cloth and sanitary napkins are used by the women, with sanitary napkins being used by more women compared to dry cloth in Buxar and Sasaram. Use of dry cloth is more prevalent in Ballia, with 77% of respondents using it.

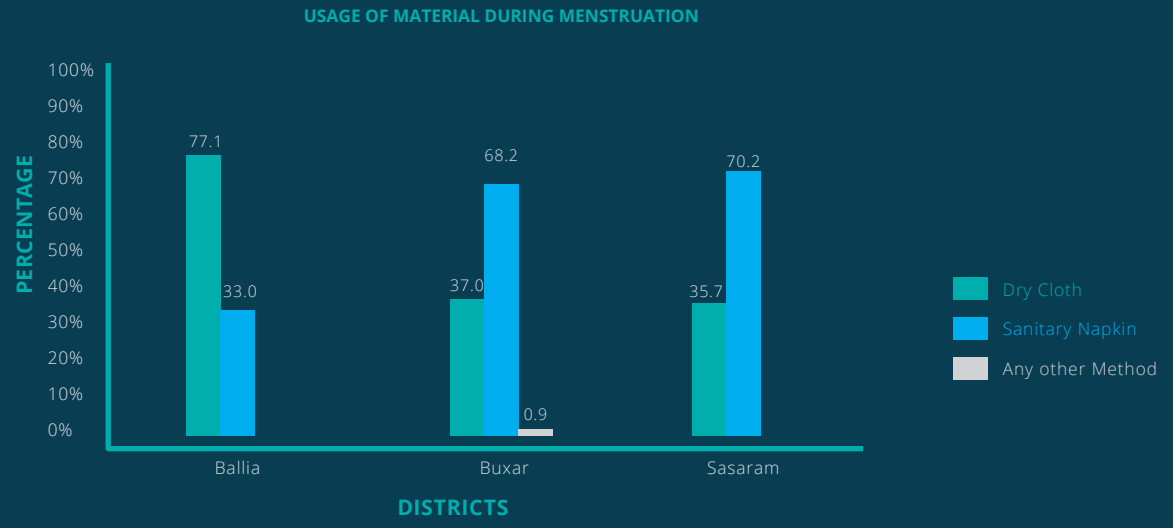


Figure 5.5: Use of material during menstruation

Source: Household Survey, June 2017. N=326
Note: Percentages may not add up to 100 due to rounding.

Women were also asked how often they changed the cloth or the sanitary napkin during heavy flow. As shown in the table below, majority of the respondents shared that they changed 1-2 times.

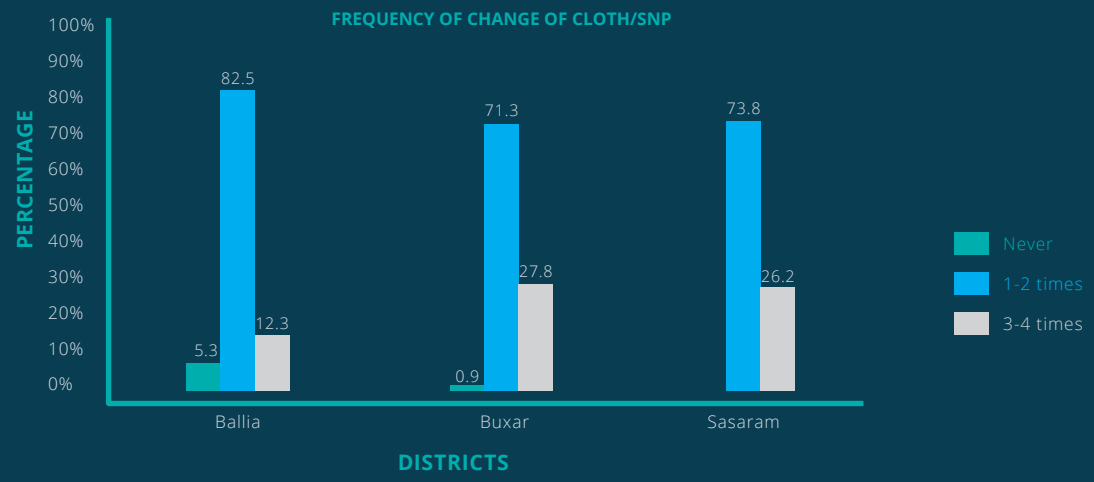


Figure 5.6: Frequency of change of cloth or sanitary napkin during heavy menstrual flow

Source: Household Survey, June 2017. N=326
Note: Percentages may not add up to 100 due to rounding.

Women who used dry cloth were also asked how many times they reused the cloth. Many women indicated that they used the cloth 2-3 times in Ballia and 4-5 times in Buxar and Sasaram. Women were also asked how they washed the used cloth. Those who reused the cloth, said that they washed it using mainly soap and hot water and dried it either outside in the sun or inside the home.

> She (CHF) told adolescent girls about using pads. She said that pad should be used, cloth shouldn't be used. Even if someone is using cloth then they should first wash it properly with surf or soap. Then it can be used. Now we use pads.
>
> - Community Member

Women were asked about how they dispose the sanitary napkins. Their responses are shown in the table below. Majority of the women threw the napkins in open bushes or in dustbins or in pits.

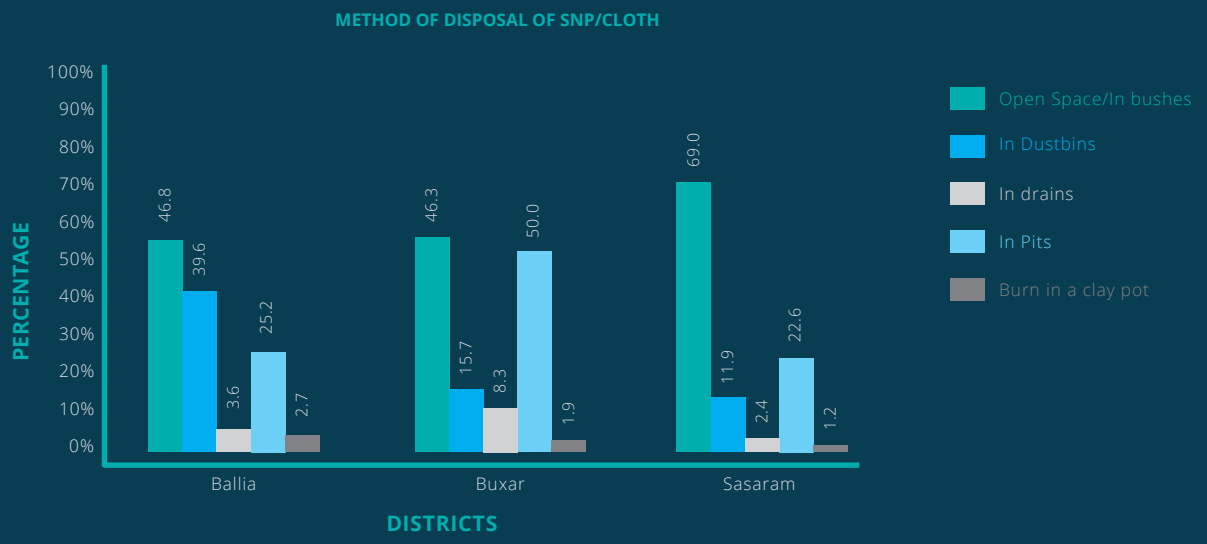


Figure 5.7: Method of disposal of sanitary napkins or cloth

Source: Household Survey, June 2017. N=326
Note: Percentages may not add up to 100 due to rounding.

Women in the villages were very appreciative of the work that the CHF does related to the sale of sanitary napkin pads. Many women said that before the CHF began her work, most women were using dry cloth instead of sanitary napkins. When the CHF warned the women of the village about the infections that come from the use of these cloths and the adverse impact on their health, they began to use sanitary napkins readily. The women also mentioned how the CHF taught them about the disposal of sanitary napkins and how that was very helpful. Earlier, the women would get sanitary napkins from the market but after the availability of MESA napkins from the CHF, the usage of sanitary napkins has become easier for the women in the village community. Women mentioned how the ease of getting sanitary napkin from the CHF was a big relief for them.

> If we use cloth during periods, it may cause infection. Hence, whether it is a woman or a girl, she should use pads.
>
> - Community Member

BEHAVIORAL CHANGE

Household respondents were asked about what advice given by the CHF was being followed by them.
The table below shows their responses. Respondents seemed to wash hands, follow healthy diets, use sanitary napkins and practice kitchen gardening more commonly from the advice given by the CHFs.

Table 5.6: Advice of CHF followed by household respondents

Which advice given by CHF was followed by you?	DISTRICT					
	BALLIA (N=109)		BUXAR (N=107)		SASARAM (N=84)	
	N	%	N	%	N	%
Hand wash	99	90.8	99	92.5	80	95.2
Using toilets	78	71.6	89	83.2	74	88.1
Intake of food advised	40	35.1	27	25.0	57	67.9
Delivery at the Govt. Hospital	24	21.1	40	37.0	22	26.2
Home Treatment	6	5.30	14	13.0	20	23.8
SNP	25	22.9	66	61.7	54	64.3
Soak-pit	2	1.8	12	11.2	1	1.2
Kitchen Garden	85	78.0	60	56.1	28	33.3
Giving immunization to children	12	11.0	17	15.9	18	21.4
Reporting illness to PHC	4	3.7	11	10.4	2	2.4
None of the above	5	4.6	0	0.0	0	0.0

Source: Household Survey, June 2017

Respondents were also asked if they saw any change by following the CHF's advice, and their responses can be seen in the figure below. Many respondents felt that there was improvement in their family's health as a result of following the CHF's advice. Many also reported better hygiene among family members and in the home. However, a few respondents in all the three districts felt that there was no difference.

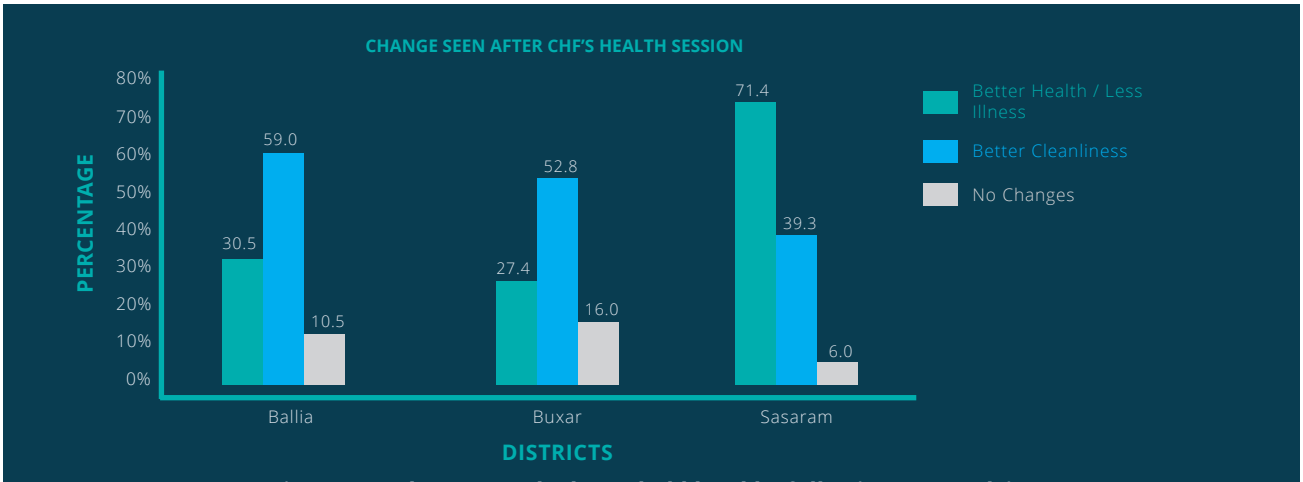


Figure 5.8: Changes at the household level by following CHF's advice

Source: Household Survey, June 2017. N=326

HEALTH SAVINGS GROUPS

In addition to imparting health education, CHFs also facilitate the formation of health savings groups in the villages. The goal of the group is to make small savings every month, just like a Self Help Group, but microloans are made by the group to a member only to meet health related expenses.

Household members were asked if they were part of the health saving group in their village. Around 63% of households in Ballia, 55% in Buxar and 66% in Sasaram were part of the group. Those households that had not joined the health savings group were asked the reason for not joining.

From those who responded, 16 respondents in Buxar and Sasaram were not aware of the health savings group. Eleven respondents in Ballia and five in Sasaram felt that the health expenses they incurred were not much while nine in Sasaram felt that it would reduce their disposable income and hence didn't feel the need to join it.

UTILIZATION OF HEALTHCARE

Household respondents were asked if anyone in the household had been hospitalized in the past year. Their responses are shown in the table below.

Table 5.7: Number of hospitalizations in one year

In past one year, has any family member been admitted to the hospital?	DISTRICT					
	BALLIA (N=114)		BUXAR (N=108)		SASARAM (N=84)	
	N	%	N	%	N	%
Yes	10	8.8	39	36.1	27	32.1
No	104	91.2	69	63.9	57	67.9

Source: Household Survey, June 2017

Over 30% of the respondents from Buxar and Sasaram and 9% in Ballia, had admitted a family member to the hospital. The reasons for hospitalization were - accident, appendix, blood pressure, cancer, delivery, typhoid, tuberculosis, etc. Few respondents whose family member had passed away in the past one year indicated that the family member had been seeking treatment from the private practitioner or the government hospital or the village PHC.

Respondents were also asked who they preferred to first approach when they first fell ill. The local practitioner is the most preferred followed by the government hospital and the CHF.

Table 5.8: First contact person for illness

Whom do you approach when you fall ill?	DISTRICT					
	BALLIA (N=114)		BUXAR (N=108)		SASARAM (N=84)	
	N	%	N	%	N	%
CHF	8	7.0	18	16.7	2	2.4
ASHA	2	1.8	2	1.9	1	1.2
ANM	3	2.6	1	0.9	0	0.0
Govt. Hospital	24	21.1	47	43.5	4	4.8
Local practitioner	77	67.5	40	37.0	77	91.6

Source: Household Survey, June 2017

FIRST AID AND HEALTHCARE

The CHFs have helped their communities in the times of a medical emergency. CHFs have also spread indigenous knowledge and low cost home remedies that people can take advantage of. For example, the CHF encourages the villagers to use aloe vera. Some CHFs knew about these home remedies but they have only put this knowledge to practice after receiving the training. The CHFs encourages people to boil water for drinking purposes.

There have also been instances where the CHF has nursed people during fever or post childbirth to good health or has accompanied them to visit the doctor to ensure good treatment. Through first aid, the CHF has saved many lives; she has tied bandages to stop the poison of snake or a scorpion bite from spreading through the body and then taken them to the nearest health center. There were also cases in the village where people had taken poison to commit suicide and the CHF had given first aid. Apart from these, medical emergencies such as accidents and injuries were also first treated by the CHF before a doctor's help could be availed. Villagers mentioned that they would usually reach out to the CHF immediately as the first person for guidance on any medical emergencies.

> She talks to everyone and helps us always in all situations. In case of some financial compulsions she is always there. She also visits our place and keeps reminding us about good things."
>
> - Community Member

> Our health has improved a lot. Earlier we used to eat anything, even the stale food from the previous night. Though the food was stinking and tasted bitter, we used to eat it thinking that how can we throw food. But that used to make us fall sick later. Now that didi has told us to eat fresh food only, we never do such things.
>
> - Community Member

DRINKING WATER AND ITS PURIFICATION

Another important area that the CHF tries to address is the importance of purification of drinking water, since this can prevent a host of illnesses. As can be seen in the table below, over 65% of households in Sasaram use private taps for drinking water, while in Ballia and Buxar, over 60% of respondents used hand pumps.

Table 5.9: Sources of drinking water

Sources of drinking water	DISTRICT					
	BALLIA (N=114)		BUXAR (N=108)		SASARAM (N=84)	
	N	%	N	%	N	%
Community Well	1	0.9	2	1.9	1	1.2
Private Tap	43	37.3	40	37.0	55	65.5
Community or Government Tap	3	2.6	8	7.4	19	22.6
Handpump	70	61.4	67	62.0	6	7.1
Other	5	4.4	0	0.0	7	8.3

Source: Household Survey, June 2017

Methods of water purification included boiling the water and straining the water with cloth. However, many respondents also reported not using any purification methods for tap water.

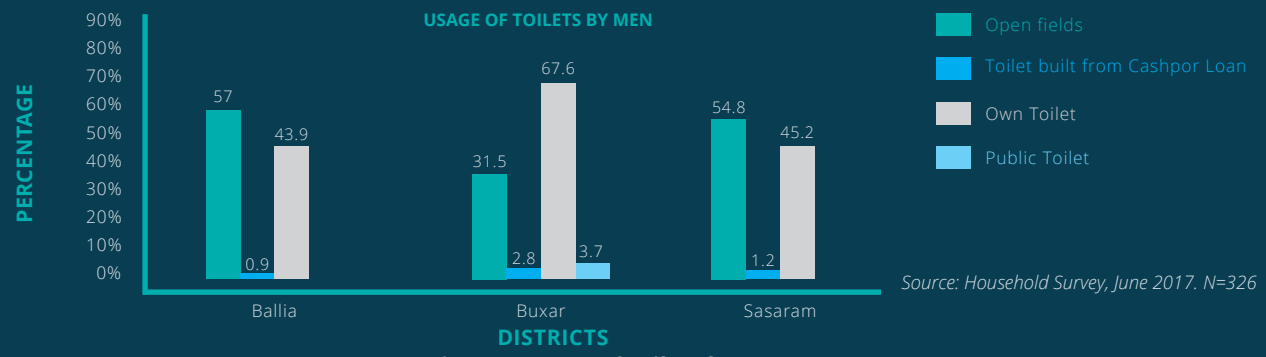
Table 5.10: Method of water purification used

Method of water purification used	DISTRICT					
	BALLIA (N=114)		BUXAR (N=108)		SASARAM (N=84)	
	N	%	N	%	N	%
Cloth	21	18.4	0	0.0	4	4.8
Boiling	18	15.8	25	23.1	6	7.1
Bleaching	1	0.9	1	0.9	0	0.0
Chlorination	0	0.0	0	0.0	0	0.0
Alum	18	15.8	2	1.9	0	0.0
Water filter	0	0.0	0	0.0	0	0.0
Other Sources	5	4.4	18	16.7	1	1.2
No Purification Method	73	64.0	70	64.8	77	91.7

Source: Household Survey, June 2017

USE OF TOILETS

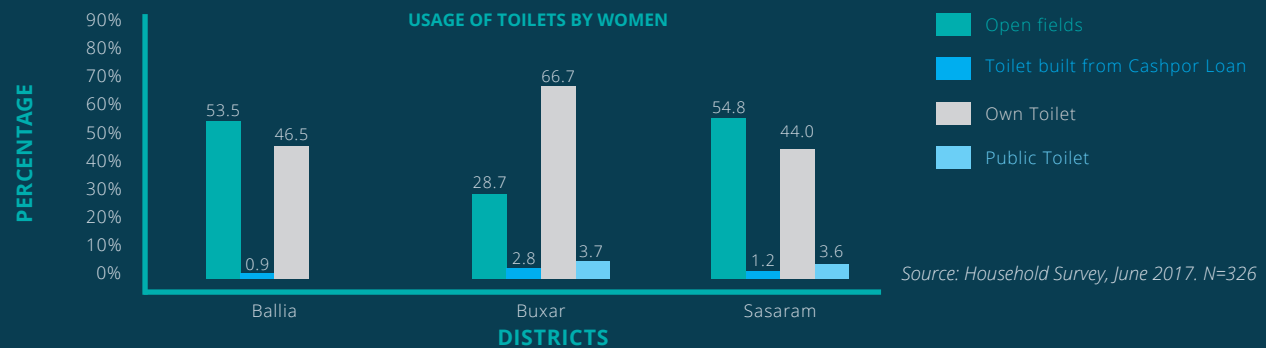
CHFs encourage community members to use toilets for better hygiene and preventive healthcare. In order to assess status of use of toilets, household respondents were asked where the men, women and small children of their households went for defecation. Their responses are shown in the tables below. Men reported going to open fields for defecation or use toilets constructed through their own funds in all 3 districts.



Source: Household Survey, June 2017. N=326

Figure 5.9: Use of toilets by men

In Buxar, almost 70% of the women and children use toilets, mostly built from their own funds, some built from CASHPOR loans or public toilets. In Ballia and Sasaram too, almost 50% of the women and children were using toilets from their own funds or CASHPOR loans or public toilets.



Source: Household Survey, June 2017. N=326

Figure 5.10: Use of toilets by women

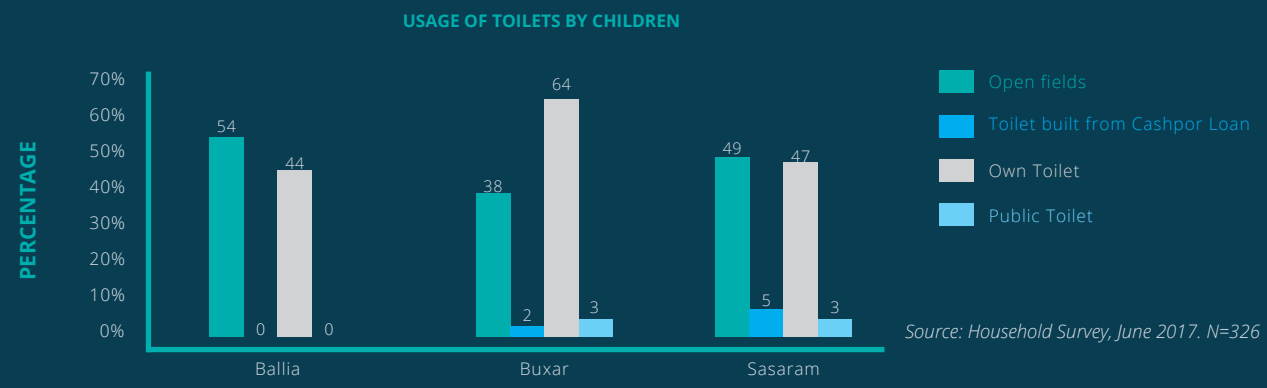


Figure 5.11: Use of toilets by children

MICROFINANCE LOANS

The CHF also facilitates the distribution of microfinance loans through CASHPOR microcredit for WATSAN loans . The CHF begins by talking about the importance of clean water and toilets for better sanitation. She makes the community aware of the perils of open defecation and health risks due to unclean water. The CHF also proposes the option of low cost WATSAN loans available through CASHPOR microcredit. Some community members shared that they had obtained loans from CASHPOR for building toilets. However, some of them expressed their keenness to get loans for other purposes of livelihood rather than just for toilet or hand pump construction - they felt that the loans should be more versatile for more people to take them such as higher or lower amounts or loans as per needs

A clear impact of WATSAN loans made available by CASHPOR and the building of WATSAN infrastructure in the village community cannot be deduced as the village community members take loans from government schemes or other sources apart from CASHPOR loans. However, it is to be kept in mind that the CHF has done the major work of creating awareness and encouraging members to build toilets and get water hand pumps installed. Some of the community members have built toilets and hand-pumps from their owns expenses and others have availed the building of WATSAN infrastructure through other sources such as government schemes like the Swachh Bharat Abhiyan or state government subsidies. The availability of construction of free toilets through the Swachh Bharat Abhiyan that has currently taken a great impetus has led to many people constructing toilets through this or other government schemes as they are free or at a subsidized cost. Thus, through the encouragement and support of CHF, some WATSAN infrastructure has been built in which CASHPOR loans have been used completely or partly in some cases. Community members suggested that larger loan amounts and smaller interest rates spread out over a longer period of time by CASHPOR Microcredit would benefit them greatly.

OTHER SOCIAL CHANGES

In addition to improving health awareness, some CHFs have become social change agents in their villages. CHFs have tried to create awareness on other issues such as domestic violence and school education. Some women also felt that the CHF was a role model for them, since she had managed to overcome social and cultural barriers by stepping outside the house and doing work.

As highlighted in the sections above, CHFs assist community members in a number of ways. They provide health counseling by informing communities about the importance of washing hands, using sanitary napkins, receiving vaccinations, seeking out prenatal care at hospitals, consuming iron tablets, differentiating pure and impure water, maintaining a nutritious diet, going on walks, growing kitchen gardens, and keeping kitchen spaces clean, to name a few examples. They provide infrastructure support by exposing community members to loans for toilet installations, soak pits, drains, marriages, and small businesses, and by teaching people how to read and write. They foster communal spirit by encouraging the formation of health savings groups, going door to door to generate communal turnout at CHF trainings, and even teaching the importance of respecting others, all of which they are able to do because they speak the same language. They are a visible and convenient source of health or first aid guidance for minor illnesses such as colds and fevers, for which CHFs' advise home remedies. Several community members gave examples of the CHFs being their first of point of contact for medical advice before going to the hospital, of the CHFs taking them or their family members to the hospital and staying with them, or of CHFs waking up at all hours of the night to attend to illnesses.

5.4 DIFFERENCE BETWEEN ASHA WORKER AND CHF AS PERCEIVED BY COMMUNITY MEMBERS

The village community view the CHF in a much more positive light than the ASHA worker. They noted that the ASHA worker would visit and give information only to the people who were sick or pregnant women but the CHF visits all the households and gives them health information. Although the ASHA worker gets a regular income from her salary, people complained that she would ask for money from the households that she assisted in institutional delivery unlike the CHF who would accompany the woman and never ask for any remuneration. Villagers felt that the ASHA worker had less work as compared to the CHF as she assisted the village on multiple parameters for healthcare.

5.5 RECOMMENDATION AND EXPECTATIONS OF THE COMMUNITY MEMBERS

Suggestions for improvement of the programme from the community members included:

- ***Setting up of a factory producing SNP pads to provide employment opportunities.***
- ***Installing RO water filtration facility.***
- ***Health center along with dispensary should be set up in each village.***
- ***A good doctor should visit the CASHPOR centre every month, so that patients don't have to travel far for treatment***
- ***CASHPOR could make arrangements for mosquito repellants to be sprinkled in the area.***
- ***Setting up of quality schools in the village.***
- ***Employment should be generated in the village by setting up small scale industries or small enterprises such as packaging spices.***
- ***Basic infrastructure such as toilets, drainage system, roads and transport facility should be made available.***
- ***BP and Sugar screening machines should be kept at the center which the CHF can monitor.***
- ***CASHPOR services that have been shut in some villages should be resumed again.***
- ***CHF can help children who are not getting admitted into the anganwadi centers and look after their nutrition.***

CHAPTER SIX

REVIEW OF THE PROGRAMME'S THEORY OF CHANGE AND REALISTIC EVALUATION

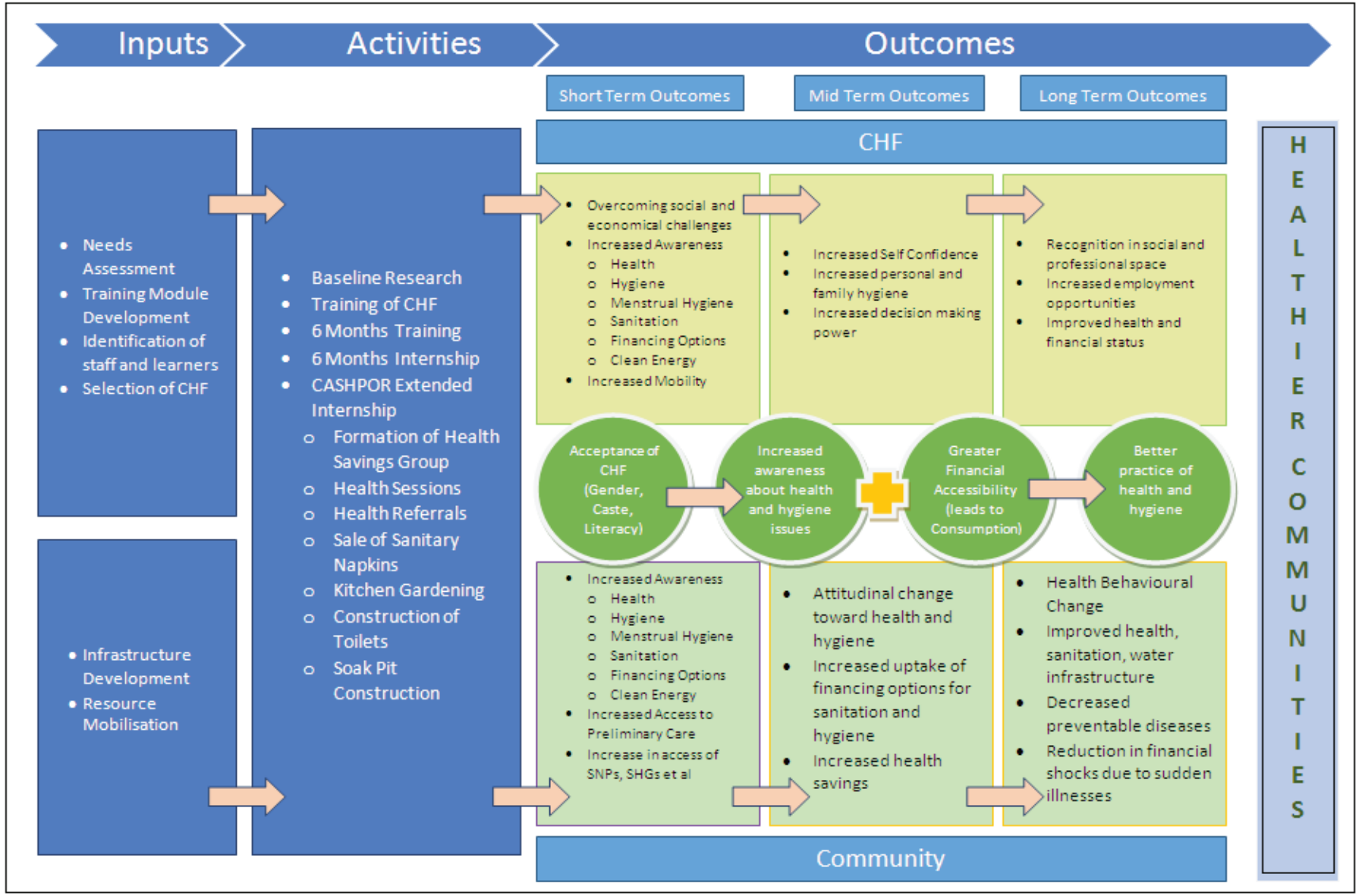
One of the main objectives of the study as put forth by Healing Fields Foundation and CASHPOR was to review and clarify the theory of change based on the evaluation findings. Another important objective was to gain knowledge of the challenges and context-specific factors that influence the effectiveness of the programme and put forth recommendations with a road map for the future.

The long term outcome to be achieved by Healing Fields Foundation and CASHPOR is to bring about a self-sustained livelihood for the CHF in the village and a larger transformation in each of the village communities in which the CHF is working.

The logic model for the CHF programme was developed from the literature reviewed and interactions with HFF and CASHPOR and is described below. As seen above, the pathways of change for the HFF-CASHPOR programme map the desirable changes at 2 levels:

- Changes in the CHF as a result of having participated in the training programme.
- Changes in the village communities resulting from the work of the CHF in the communities.

FIGURE 6.1 LOGIC MODEL FOR THE CHF PROGRAMME



Assumptions-
Each of the interventions towards the pathway of change has some assumptions underlying the thought-process of the programme model:

- Women who become CHFs are the best facilitators for health awareness and prevention and will be accepted as change agents in the community as they belong to the community.
- Availability of microfinance loans for hand pumps and toilets will be well-received by the community and lead to better health and sanitation infrastructure (once there is increased knowledge)
- SNP packs available at a low cost will be well received by the women in the menstrual age and they will be open to change the old method of using cloths through encouragement and knowledge from the CHF. This will improve women's menstrual health.
- Health awareness sessions by the CHF will lead to increased knowledge in health which in turn will lead to a change in attitude and behaviour and thereby lead to better preventive care, health and hygiene in communities and create a demand and access to available health care services.
- Demonstration of kitchen garden and soak pit will be readily implemented by the community.

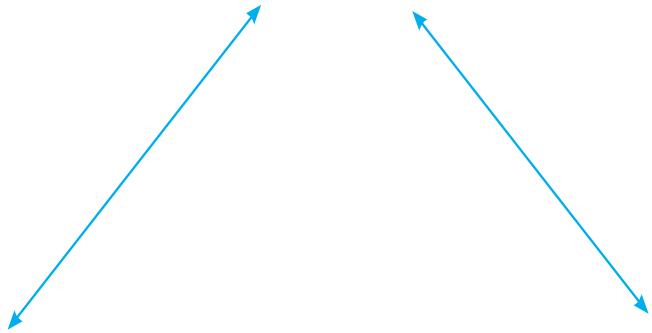
The programme model poses that an increase in knowledge of preventive healthcare and availability of financing options will lead to increase in consumption of healthcare commodities (sanitary napkins, toilets, drinking water purifier, etc) that will lead to healthier practices and ultimately healthier communities. The incentives earned from the consumption of commodities will help the CHF to have a sustainable livelihood.

This programme model needs to be assessed using a realistic evaluation framework as shown below. The framework of realistic evaluation helps to better shed light on the context specific challenges that the women who have trained to become a CHF have faced through their work.

INTERVENTION

MECHANISM

1. CHOICE OF MESSAGE / MEDIUM / COMMUNICATION
2. CHOICE OF FACULTATION



CONTEXT		OUTCOMES
SYSTEM CONTEXT	What are the supply side of factors in delivery of services?	Does availibility of loan lead to a better infrastructure?
SOCIAL CONTEXT	Caste barriers / Status of women?	Can the CHF help transient the Caste barrier / women status in village?
CULTURAL CONTEXT	Cutural barriers Demand side factors	Have the cultural practices of open defecation changed through the educational sessions of CHFs?

Figure 6.2: REALISTIC EVALUATION FRAMEWORK

Through the framework of a realistic evaluation, the context of the CHF programme is also assessed. In a realist evaluation the question 'Does this programme work?' is not asked. Instead what it asks is 'What works for whom in what circumstances and in what respects, and how?'.

The following four pointers explain the essence of a realistic evaluation:

- **PROGRAMMES AS THEORIES**

The intervention method of HFF to achieve its long term mission is through the dissemination of information among women in the village and support the action of CHFs as well as changes in health practices in the community through appropriate financing mechanisms. This along with basic preventive healthcare infrastructure increases the health outcomes in the village. The implicit programme theory is partly what is known as the KAP – knowledge, attitudes and practices. Once we give knowledge/information to people, this would influence their attitudes to the desired change which in turn would lead to a change of practices- promoting healthy practices like use of toilets, and reducing unhealthy practices like open defecation. In addition in the theory of change that defines this intervention, the loans for the community overcome financial barriers to adoption of healthy practices, through their investment in commodities linked to these practices. The incentives to the CHFs promote activities leading to a consumption of health commodities which are linked to the healthy practices.

- **PROGRAMMES ARE EMBEDDED**

It is important to realise that the work of the CHF and of Healing Fields Foundation is embedded in social systems. The rural communities in these three districts of UP are steeped into the problems of patriarchy, low income, cultural constructions of sanitation and poor accessibility for health. Hence, within the framework of realistic evaluation, a systems context, a social context and cultural context are present for better clarity on its functioning in the real world.

- **PROGRAMMES ARE ACTIVE**

While it is undeniable that the CHF are working towards better healthcare for the community, the success of the program also depends on the members of the village community. The dissemination of information by the CHF or that of microfinance loans is also dependent the resources of the villages and the acceptance of knowledge by the village community. The village community is an active stakeholder in the success of the program. Hence, the inter-pretations of the participants of the program is critical and important in the success of the program despite best intentionality among the program implementers.

- **PROGRAMMES ARE OPEN SYSTEMS**

As programs function in active and open systems, they are open to externalities. The work of the CHF may be impacted by personal challenges or that the community may not be very forthcoming due to political turmoils.

The following figure describes the systems, social and cultural contexts in which the CHF programme is embedded.

SYSTEMS

Lack basic healthcare practice communication, access to clean water, toilets, proper drainage, water for toilets, clean energy source, menstrual hygiene and reproductive health, preventive measures to health shocks or health insurance. Easy accessibility to healthcare institutions, means of waste disposal (used sanitary napkins).

SOCIAL

Gender in itself is a challenge.

Being a woman is a challenge.

Men are uncomfortable to see a woman

- As a professional
- Having a voice agency
- Having knowledge
- Participating in decision-making
- Rising to power positions

PATRIARCHY

Applying for loans, Decision-making (Toilet construction, clean energy and water)	Males will take decisions
Institutional delivery Visit to PHC	Dependence on males for mobility outside the house
Buying sanitary Napkins	Males have control over finances

CASTE

Women of higher caste don't accept taking advice from the lower caste, especially health advice as a result of years of oppression. Women of higher caste will refrain from giving advice to lower caste women or being in contact with them. In many villages, lower caste people are not allowed to use water from the common village resources. To receive knowledge or any services from lower caste is considered disrespectful by the upper caste.

CULTURAL

Is the community ready to listen to health communication messages from a woman and put them into practice?

Is the community open to investment in the various loans, suggestions of the CHF of kitchen garden, use of sanitary napkins, etc?

Does the availability of loans for toilets lead to change in practice of open defecation?

Are the health communication sessions by the CHF effective to change the cultural practices?

Women in villages are not allowed to use self-driven mode of transportation

Women always have to be accompanied by a male member for any movement within or outside the village. Girls are not allowed to ride bicycles.

Based on the findings summarized in Chapters 4 and 5, the Theory of Change of the programme can be reviewed using the realistic evaluation framework and examining the contextual factors presented above.

THE FINDINGS INDICATE THAT WITH REGARDS TO THE CHANGES IN THE CHF, MOST OF THE SHORT-TERM, MID-TERM AND LONG-TERM OUTCOMES ARE ACHIEVED :

- CHFs are being able to overcome social and financial barriers in order to complete the training programme
- CHFs have increased mobility and health knowledge
- CHFs are becoming confident
- CHFs play an active role in decision-making at the household and community level
- CHFs and their families follow better hygiene and healthcare practices
- CHFS gain recognition in professional and social space
- CHFs have increased financial status

HOWEVER, TWO OUTCOMES THAT COULD NOT BE ASCERTAINED THROUGH THIS STUDY WERE :

- **Increased sustainable employment opportunities for the CHF:** Most of the CHFs had been associated with the programme for 3 to 5 years. Their individual income has increased from before the programme to after joining the programme due to the stipend provided by the programme, commission on sale of sanitary napkins and incentives from facilitation of CASHPOR loans. However, after completion of the extended internship period, the CHFs have not been able to earn enough through the sale of sanitary napkins and the incentives from the CASHPOR loans since the number of napkins sold and loans facilitated are not large in number. As a result, many CHFs, have not been able to continue their work on a regular basis.
- **Improved health status of the CHF:** Since the programme had ended and many CHFs are now only occasionally engaged in sale of sanitary napkins or facilitation of loans, the health status of the CHF is not tracked by programme as such; but most of them do report improved health and hygiene practices at personal and family level as a result of having participated in the programme.

IN TERMS OF CHANGES IN THE COMMUNITY :

- Community members had awareness of basic health and hygiene practices
- Community members had access to preliminary healthcare through the CHF
- Community members said that they had made changes in their hygiene practices such as hand-washing, paying attention to their diets, using sanitary napkins. Improved health infrastructure such as toilets and hand pumps were also seen in many households. Use of toilets by some community members was also observed.

THERE ARE A FEW CONTEXTUAL FACTORS THAT NEED TO BE HIGHLIGHTED TO EXPLAIN WHY CERTAIN OUTCOMES MAY TAKE LONGER TO ACHIEVE :

ACCEPTANCE OF THE CHF AS A CHANGE AGENT

The CHFs are women from low income households and not highly literate; these factors along with their gender has posed challenges in their acceptance as knowledge disseminators and agents of change by the community, where some of them were also viewed with suspicion by community members. Many CHFs shared that they had overcome their initial barriers and are now respected in the community after having associated with the programme for 3 to 7 years. However, with them not being able to continue their work on a regular basis, the CHFs and the community have started questioning their role as an agent of change in the long run.

Some of the sampled CHFs belonged to Other Backward Classes and other or general class, that are generally considered to be better off than Scheduled Caste and Scheduled Tribes in terms of socioeconomic status. These CHFs from Other Backward Classes and other class could have gained easier acceptance into the community, as opposed to their Scheduled Caste counterparts.

Another factor to be taken into consideration is that the CHFs largely work with women who have marginal decision making powers and no financial independence due to the patriarchal system. These women are mostly dependent on men for day to day decisions. As a result, the men need to accept the CHF (as an agent of change) and her advice in order that women in the households are able to make behaviour changes.

BEHAVIOURAL CHANGE TOWARDS HEALTH AND HYGIENE

An assumption made by the programme model is that increased knowledge of good health and hygiene practices and availability of financing will lead to behaviour change in terms of utilization of toilets, drinking water purifiers and sanitary napkins. However, it takes time and continuous social messaging and marketing by the CHF to impact the negative traditional practices of health and hygiene. The CHFs from the three districts that were part of this study, have been associated with the programme for 3 to 7 years. Many of them have been able to create awareness and subsequent attitude and behavior change in some community members as a result of having worked for so many years.

Another factor impacting behavior change outcomes is the size and location of the village; larger villages and those located closer to urban centres, with better infrastructure facilities, may find adoption of behavioral changes easier than smaller and more remote villages.

CHAPTER SEVEN

CONCLUSION

7.1 CONCLUSION

The evaluation of the CHF programme has revealed a number of positives. The programme is striving to promote better health and hygiene practices in rural parts of Uttar Pradesh, where the access to healthcare is poor due to which even the preventable and easily curable illnesses tend to turn fatal.

The programme trains rural, marginalized women as Community Health Facilitators in preventive healthcare, hygiene, nutrition, menstrual health and first aid, so that they in turn impart this knowledge in their communities, and thereby become agents of change. The evaluation has revealed that the CHFs overcome a number of social, financial, mobility and other challenges and undergo a transformation process, making them more aware, confident and empowered within their families and their communities.

The programme also envisions change in the health and hygiene practices of communities, through the transfer of knowledge from the CHF during health awareness sessions. The evaluation revealed that communities had started gaining awareness of health and hygiene practices and have started making behaviour changes such a handwashing, use of sanitary napkins, making dietary changes to incorporate nutritious foods. However, the study also revealed that though there was access to financing options facilitated by the CHF for construction of toilets and purchase of water purifiers, the communities have had a lukewarm response to avail these loans, due to financial constraints (funds available were still not enough) and lasting resistance to change socially accepted practices such as open defecation.

The study has also delved into the programme's theory of change and looked at the social, cultural and systems contexts that would affect the outcomes of the programme. It was seen that acceptance of the CHF who is a low income, Scheduled Caste, not very well educated woman as a change agent remains a challenge. Once the CHF gains acceptance, the change from knowledge to attitude to behavior in terms of preventive healthcare and hygiene practices and use of health infrastructure such as toilets and water purifiers would still take time due to the social and cultural context in rural India.

In conclusion, the study found that creation of livelihood opportunities for the CHF and behaviour change in communities are long term outcomes that would take time to achieve. Though HFF and CASHPOR microcredit has set up a pilot sanitary napkin production unit as a livelihood activity significant future focus is required on exploring product baskets for health entrepreneurs and/or in creating partnerships with government institutions to ensure continuity in the CHF's work.

7.2 RECOMMENDATIONS

TISS suggests the following recommendations after consideration of various contextual factors that affect the outcomes of the CHF programme.

1. Sustain the CHF for transition from individual empowerment to community empowerment

The work of the CHF needs to be sustained over a longer period of time. While the entire experience is transformative for her but it takes a longer time for the transition from individual empowerment to community empowerment. Too quick a withdrawal of the external push may lead to sub-optimal results.

2. Clear Prioritization of Functions

It is suggested that the CHFs work on at least five focussed interventions over a three-year period. These could be:

- Care in pregnancy
- Addressing malnutrition
- Eliminating open defecation
- Follow up with patients with chronic communicable illness - TB, leprosy and HIV
- Follow up with households to address risk factors of chronic non-communicable illness- mainly tobacco, alcohol, hypertension and diabetes care

These priorities are chosen based on where one could expect government support since it is synchronous with government policy - but also where government intervention is currently insufficient. For example - The focus on child immunization is already adequate and hence a CHF may have limited value addition. But in the other suggested areas, though they are part of sub-center functions, without the CHF support, they would not happen on-scale.

3. Refresher Training and Continuous on-ground Monitoring and Support

Training is a continuous ongoing process. It is not only about the skills that it provides but also a sense of solidarity and confidence amongst women working for change in a very patriarchal milieu. Constant skill upgradation and support also builds motivation. For such a continued training, monitoring and support programme, a force of one supervisor per 20 to 40 CHFs is recommended.

4. Travel Allowance For Training And Field Visits To CHFs

The internship amount given to the CHFs is also invested in commuting for the health awareness sessions. Due to non-availability of funds, the CHFs travel on foot even for long distances. Travel to distant places with no monetary reimbursement has also been one of the reasons for them to drop-out from the CHF Programme. Therefore, travel allowance support must be provided to the CHFs during the training time as well as for outreach and organising health awareness sessions.

5. Maintain Database

Healing Fields and CASHPOR should maintain computerised data for all of its components especially for the primary data collected from the field such as training modules, pre and post training scores, surveys conducted by each CHF in their villages. The CHF should also monitor all the specific cases as mentioned in point 2 and track the usage of WATSAN facilities in her village for CASHPOR Microcredit. This will track specific components of health behaviour change and impact on the village community through measurable outcomes.

6. Use Of Technology

If an investment in technology is possible, the CHF can be provided with tablets. These tablets can be used for the dual purpose of monitoring of important indicators by the CHF and refresher-training courses for the CHF or reference materials for the CHF and community during health awareness sessions. Closed user groups can also be created so that the CHFs can connect with each other and share their experiences.

7. Integrating In The National Rural Health Mission

The work of the CHF cannot be sustained only by market incentives of sanitary napkins or microfinance loans. HFF and CASHPOR microcredit needs to decide if the CHF will work for their villages on a full time basis like the ASHA worker or part time with other livelihood engagements. If part time, the CHF can scale back the work to a few hours per week with a target number of households. She would be working more or less as a volunteer, who would get some incentives based on sale of sanitary napkins and facilitation of loans.

If on the other hand, CHFs are engaged completely as a dedicated health professional for better healthcare in their villages, then in the longer run they should become the **nodal or coordinating person in Village Health Sanitation and Nutrition Committee** (VHSNC) of the National Rural Health Mission (NRHM). The VHSNC are at a larger habitation level and not per village but people working for healthcare can be a part of the committee. The CHF needs to continue her independent work on sanitation and health where she is not duplicating the work of the NRHM. The VHSNC in National Rural Health Mission is at the grassroot level but it struggles to be visible or functional. By bringing in the ASHA, ANM, anganwadi worker, women panchayat leaders and women coordinators of self help group into the VHSNC one can revitalize an otherwise moribund institution. This work requires liasoning efforts from HFF and CASHPOR microcredit with the local governments.

8. CHF As A Social Auditor

If the CHFs have expanded their work as per the suggestion in number 7 above and have begun to track the health status of the village; they could flag any premature deaths in the village or hospitals to relevant health authorities. These can take a form of social audit in healthcare and can reinforce the importance of preventive healthcare and the work of the CHF.

A few preventive health indicators that may be tracked include:

- ***Blood typing and antibody screening for prenatal patients***
- ***HIV screen for prenatal patients***
- ***Bacteraemia screen for prenatal patients***
- ***Immunizable conditions***

- ***Low birth weight rate***
- ***Adolescent immunisations***
- ***Anaemia screening for pregnant women***
- ***Cervical gonorrhoea screening for pregnant women***
- ***Hepatitis B screen for pregnant women***
- ***Hepatitis B documentation in record at time of delivery***
- ***Hepatitis B immunisation for high- risk groups***
- ***Influenza vaccination for high-risk groups***
- ***Pneumococcal vaccination for high-risk groups***
- ***Vaccination for Japanese encephalitis***
- ***Causes of infant death such as sepsis, asphyxia, LBW, pneumonia, diarrhoea, fever, measles***
- ***Causes of maternal death such as abortion, obstructed/prolonged labour, hypertension/fits, bleeding, high fever***

This data is available from the Primary Health Center or sub center near the villages. CHF can follow up this data and report to VHSNC. Specific cases that can be helped by the skills and knowledge of the CHF such as anemia (advising on nutrition) can then be followed up by the CHF. This will improve the health facilities in the village and will also help in improving the health conditions of the community.

9. Establish Sanitary Napkin Units in CHF Villages In A Cluster

Sanitary Napkin Production Units are important to establish in CHF villages and can be developed as women led entrepreneurship model. Since the demand of SNP is huge, it is most likely to work. With initial funding for 5 years the production unit can go on becoming self sustaining unit. During this time HFF can establish linkages with government as well as public and private sector enterprises to support these units.

Cashpor is providing sanitary napkins to CHFs with an incentive to them at same cost as HFF since the main objective is to cover maximum women and adolescent girls with health and hygiene by increasing the availability of the product to them; this in turn would also enable the CHFs to earn more.

10. Increase The Loan Coverage With A Larger Amount of Money And Lower Interest Rate

CASHPOR microcredit should increase the amount of loan sanctioned for toilets and hand pumps with a lower interest to make it more affordable to the villagers.

11. Establish Linkages With Private And Public Companies That Are Engaged in Corporate Social Responsibility

HFF needs to engage with other public or private sector enterprises for funds to reduce the loss in the production of sanitary napkins and also increase the outreach of these napkins to more geographical areas. With the help of CASHPOR microcredit that has already began to sell low-cost sanitary napkin, both partners may begin a joint venture for better geographical outreach.

12. Human Resources For Public And Private Engagement

In order to deliver the above initiatives, there is a pressing need of one or two human resource who can dedicatedly work on exploring partnerships and make HFF and CASHPOR microcredit work more visible to the government, private and public stakeholders.

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Since its inception, the TISS has relentlessly responded to changes in social realities through development and application of knowledge, applying the heart and mind. Professors, academicians and researchers at TISS, invest in core research, which in turn powers the wheels of change. TISS also initiates field action for demonstration of models of best practice for scale up and replication regionally and nationally.

The National CSR Hub at TISS was established in 2010 at the behest of the Department of Public Enterprises (DPE) under Ministry of Heavy Industries & Public Enterprises. The Hub is a think tank and facilitation knowledge partner that commits itself to impact driven implementation of Corporate Social Responsibility activities of companies.

Initiatives under National CSR Hub are an attempt to create sustainable development models by converging best practices undertaken by businesses, NGOs and other community organisations. The Hub emphasizes on cultivating an environment for learning and problem solving, by substantially expanding the access to opportunities for the marginalized communities of our society.

The thrust of the Hub's activities is on capacity building, research, sustainability, empowering communities, developing inclusive socio-economic growth, environment protection, promotion of green and energy efficient technologies, development of backward regions and upliftment of marginalised communities.

Towards this end, the Hub also undertakes a number of research studies, such as needs assessments, impact assessments, monitoring and evaluation for programmes, guided by TISS faculty. The Hub believes that action research is imperative to data-driven planning, implementation and decision-making and endeavors to help corporates, NGOs and practitioners to create impactful programmes by undertaking such research.

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