



Maa aur Shishu Swasthya (MASS)

Mother and Child Health Program, 2015–2018

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Final Project Report
December 2018

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Grameen Foundation

Grameen Foundation is a global nonprofit organization that helps the world's poorest people achieve their full potential by providing access to essential financial services and information on health and agriculture that can transform their lives. In 2016, Grameen Foundation and the global nonprofit [Freedom from Hunger](#) decided to join forces under the banner of Grameen Foundation. The integration of the two organizations brings together Grameen Foundation's expertise in digital innovation to end poverty and Freedom from Hunger's focus on providing the world's poorest women with self-help tools to reduce hunger and poverty. Grameen Foundation is headquartered in Washington, D.C., with offices in the U.S., Asia, Africa, and Latin America. For more information, please visit www.grameenfoundation.org or follow us on Twitter: @GrameenFdn.

RESULTS Educational Fund

RESULTS Educational Fund (a US-based nonprofit 501(c)(3)) is an advocacy organization working in the United States and around the world on projects focused on three key pillars in the fight to end poverty: 1) health, 2) education, and 3) economic opportunity. RESULTS Educational Fund performs cutting-edge research and oversight in these three areas; educates and mobilizes the public, policymakers, and the media; and supports powerful citizenship by training volunteers in public speaking, generating media, and educating their communities and elected officials on issues of poverty. In May 2016, the Microcredit Summit Campaign merged its structure and operations with those of its parent organization, RESULTS Educational Fund. For more information, please see www.results.org.

Freedom from Hunger India Trust

Established in 2012, Freedom from Hunger India Trust (FFHIT) is an independent Indian non-profit organization based in New Delhi with an office in West Bengal. The technical staff of FFHIT oversee health, nutrition, financial inclusion, vulnerable youth and savings group methodologies, and provide expert advice on learner-centered curriculum design. FFHIT's goal is to achieve nutrition and food security, reduce poverty and improve economic and social status of poor and marginalized women and their families through increased integration of financial services with other essential services such as health, nutrition and livelihood opportunities. FFHIT is also an active member of National Coalition of Food and Nutrition Security.

Aikyatan Development Society (ADS)

Aikyatan Development Society is a non-profit development organization engaged in the self-help group (SHG) movement, health care and livelihoods to support vulnerable families in the district of Burdwan in West Bengal, India. ADS's sanitation program with the state government is the largest program of ADS and it is well known for its effective linkages with the public health system and SHG strengthening programs. It was conceived in 1999 with active support of CARE India. ADS became a partner of Freedom from Hunger and Freedom from Hunger India Trust in 2014. Through this partnership, ADS has reached 2,000 SHGs (women's savings and credit groups) with health education in water, sanitation and hygiene (WASH), nutrition and anemia prevention. <http://aikyatan.org/>

Bandhan Konnagar (Bandhan)

Bandhan Konnagar is a nonprofit entity registered under the West Bengal Societies Registration Act 1961. Its main goal is to alleviate poverty and help bring about women's empowerment. It was founded in 2001 as a pro-poor organization, and now caters to more than 2 million households across 11 states. Bandhan Konnagar offers an entire suite of development programs in the areas of education, health, securing of livelihood, market linkage, skill development and financial literacy – all focused on turning the lives of the underprivileged around. In 2007, Bandhan started its health initiatives in collaboration with Freedom from Hunger and has reached out to more than 1 million households mainly with mother and child health care issues besides water and sanitation. At present, in partnership with Freedom from Hunger India Trust, Grameen Foundation, and Results Educational Fund, Bandhan Konnagar is implementing the MASS project, referred to by Bandhan as the 'Safe Motherhood Initiative through Linkages and Education (SMILE)'. <http://www.bandhan.org/>

Community of Practice for Health and Microfinance

The Community of Practice for Health and Microfinance (COPHAM) in India is an experiment born out of the MASS project to bring together stakeholders in the health and microfinance sectors to promote universal healthcare coverage. COPHAM members learn from each others' experience and create strategic partnerships to leverage their complementary strengths. Sa-Dhan, the premier national network of development financial institutions in India, now hosts the COPHAM Secretariat with the support of RESULTS Educational Fund, the ACTION Global Health Advocacy Partnership, Freedom from Hunger India Trust, and Grameen Foundation. Aikyatan Development Society (ADS) and Bandhan, whose data is presented in this report, are both active members of COPHAM. For more information, please see <http://healthandmicrofinance.org/>.

Acknowledgements

We would like to thank the staff of Aikyatan Development Society (ADS) and Bandhan Konnagar for their collaboration in the research described in this report. In particular, we would like to thank Dr. Uttam Ghosh, Trideep Roy and Subhadip Roy of Bandhan along with the Community Health Organizers and Area Coordinators at the field level where the study was conducted. From ADS, we would like to thank Sudhir Dutta, the block coordinators, and all field staff.

We would also like to thank our colleagues Dr. Soumitra Dutta, Alope Chakraborty and Saraswathi Rao of Freedom from Hunger India Trust, and Dr. DSK Rao of RESULTS Education Fund for their support of this project and review and input into this report. We would also like to thank Dr. Atanu Ghosh and his team of researchers from AG Consultancy for conducting the health diaries surveys and assisting in the analysis.

We would also like to voice our appreciation of Sa-Dhan for their collaboration in finding a sustainable solution for the community of practice and of Johnson & Johnson for supporting this program through an educational grant.

Finally, this program and this assessment would not be possible without the collaboration and participation of the women who participated in the surveys and monitoring assessments.

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Acronyms

ADS – Aikyatan Development Society

ANM – Auxiliary Nurse Midwife

AWC – Anganwadi Centre

AWW – Anganwadi Worker

BPHC – Block Primary Health Centre

CoP – Community of Practice

FFHIT – Freedom from Hunger India Trust

FGD – Focus Group Discussion

FSP – Financial Service Provider

IFA tablets – Iron and Folic Acid tablets

ICDS – Integrated Child Development Scheme

INR – Indian Rupee

MASS – Maa Aur Shishu Swasthya (Mother and Child Health)

MCH – Maternal and Child Health

MFI – Microfinance Institution

NHM – National Health Mission

PLC – Pictorial Learning Conversation

SC – Sub Centre

SDG – Sustainable Development Goal

SHG – Self-Help Group

SHPI – Self Help Promoting Institution

SS – Swasthya Sahayika

USD – United States Dollar

VHSND – Village Health Sanitation and Nutrition Day

VHSNC – Village Health Sanitation and Nutrition Committee



Overview

Maa aur Shishu Swasthya (Mother and Child Health)

Health Education

- > MASS trained 70 self-help group promoters or local partner staff members to deliver health education using Grameen Foundation's Pictorial Learning Conversation methodology.
- > 1,117 people, mainly women, have been trained to deliver health education since 2015.
- > 556,541 women participated in education since 2015 on anemia, healthy pregnancies, menstruation, acute respiratory infections and more.

Linkages with Health Providers

- > 122,356 women and girls have gained better access to health services via facilitated partnerships between local health centers and financial services providers.
- > Partnerships are designed according to the context, need and availability of interested health providers, often involving the local government to further support and sustain these community linkages.

Community of Practice

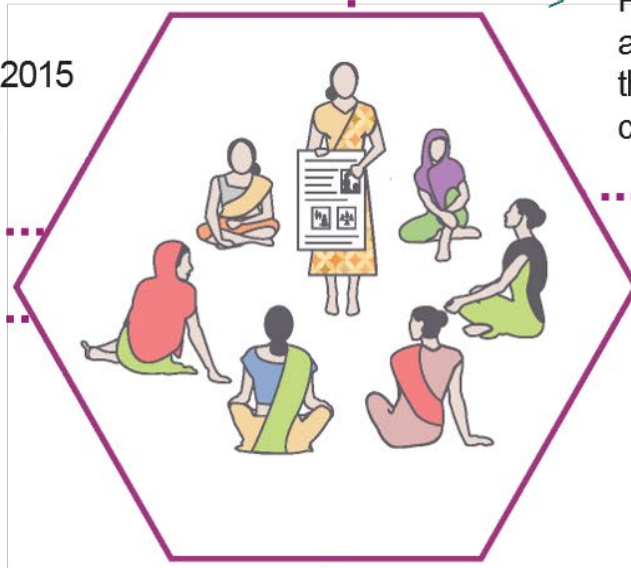
- > 51 health, microfinance and government organizations are members and contributors of the Community of Practice for Health and Microfinance (COPHAM) established by MASS.
- > Since 2015, nearly 400 people participated in 11 events to exchange ideas and experiences around the integration of health and financial services, with focus on maternal child health, health access and gender.

Self-Help and Credit Groups

- > 9 financial services provider partners across 5 states in India have reached 556,541 women and adolescent girls through this group-based network since 2015.

Health Finance

- > Replicating Grameen Foundation's Saving for Change methodology for health savings in West Africa, each SHG decides on its weekly savings amount, interest rate and other rules.
- > 15,500 women from SHGs are saving separately for health in addition to their regular SHG activities – giving them access to health loans and an annual savings payout earmarked for health expenses.
- > 1,555 SHGs have accumulated approximately INR 2 million (USD 30,000) in savings.



556,541 women, girls and their households reached with health education since 2015

122,356 women and girls linked to health care services and providers

1,555 savings groups chose to incorporate health savings into their group, providing 15,500 women and their households with access to health loans and an annual savings payout earmarked for health expenses.

INR 2 million has been collected for health savings (USD 28,032)*

51 health, microfinance and government organizations are members of the Community of Practice for Health and Microfinance (COPHAM)

* 1 USD = 71.35 INR, February 2019



Overview | Outreach

In 2015, Freedom from Hunger India Trust, Grameen Foundation¹ and RESULTS Educational Fund launched a collaborative effort called the *Maa aur Shishu Swasthya* (Mother and Child Health) program (*hereafter*: MASS). The program sought to **empower poor women through integrated health and financial services** across India, and a key component was implemented in West Bengal and Jharkhand with two key financial service partners, Aikyatan Development Society (ADS) and Bandhan Konnagar.

¹ Freedom from Hunger and Grameen Foundation merged operations in 2016. MASS originated with Freedom from Hunger.



MASS aims to improve the health of women and children in India through increased access to and use of health services.

MASS Project Objectives:

1. Improve health-seeking behavior among poor women and adolescent girls through health education messaging.
2. Increase access to health products and services among poor women and their families by offering sustainable health financing mechanisms.
3. Increase access to health products and services among poor women and their families by offering sustainable linkages with local health providers.
4. Build an active community of practice (CoP) where actors across sectors share experiences and partner to deliver integrated health and financial services to increase access to health services to women and their families.
5. Amplify awareness of the integrated health and microfinance methodology as a development strategy for achieving the SDGs through a marketing, advocacy, and communications strategy that highlights the contributions of an integrated approach toward sustainable development outcomes.

Partner Approach

As part of MASS, members of self-help groups (SHGs) served by ADS and village bank clients and community members served by Bandhan Konnagar (Bandhan Bank's development program arm) participated in an integrated package of financial services, health education sessions and linkages to local health services aiming to improve health outcomes of women and their families.

At ADS, SHGs were also encouraged to save for health expenses utilizing a health savings methodology that mimics Grameen Foundation's *Saving for Change*² methodology in addition to their regular savings and loan activities. With the health savings methodology, women first deposit savings into their general group "account" and then repeat the savings process earmarking savings specifically for health.



² *Saving for Change* is a methodology jointly developed by Freedom from Hunger, Oxfam America and Strømme Foundation for self-managed savings and lending groups integrated with simple trainings in health, business and money management. *Saving for Change* brings basic financial services to areas that are typically beyond the reach of microfinance institutions and, in doing so, creates sustainable, cohesive groups that tackle social issues facing their members and their communities.

1. Program assessments revealed visible increases between baseline and endline in SHG member health knowledge and behaviors, particularly regarding anemia and healthy pregnancy. For some midline and endline indicators, slight decreases were found, but the endline was still higher than baseline, suggesting sustained impact over time.
2. Dramatic improvements in knowledge and behavior in institutional delivery at childbirth.
3. Visible increases in knowledge of healthy menstruation practices in addition to increases in positive menstrual management behavior among adolescent girls.
4. Increase in saving for health and confidence in ability to cover future health expenses.
5. Despite insurance schemes available and the government's goal of universal health coverage (UHC), out-of-pocket expenses are still a burden. Financial service providers (FSPs) have an important role to play in helping the poor manage health expenses.
6. Successful linkages established between FSPs, local government leaders, health providers and SHG members are actively used by SHG members. A positive step has been made toward matching health service demand with supply.
7. COPHAM is uniquely positioned to bring together the siloed sectors of health and microfinance and promote the expansion of access to health products and services to underserved populations.
8. Donor support will be invaluable in helping COPHAM develop new training modules of health education, manuals for practicing integrated health and microfinance, and conducting research to build the social and financial case for the strategy.



Key Findings

Knowledge

While there were successes in the uptake of anemia and healthy pregnancy education, understanding of danger signs experienced during pregnancy that require immediate medical attention remained low. This could be addressed with adjustments in the education session design and repetition of the session.

Behavior

Anemia testing and diagnoses remain below 30% across a population that regional statistics show at least 44% of women are anemic in the ADS area and 71% in the Bandhan areas. Children are even less likely to be tested or diagnosed with anemia. Of those ever tested, there is visible alignment with those who do get diagnosed with anemia, even though it's not a 1-to-1 alignment. Further collaborations with health sector actors to address this challenge should be considered.

Gender

The MASS project did not address gender constraints as part of the overall project design, but findings around decision-making power in the project research reveal that this is a critical piece in successfully improving the health and well-being of women and children. Future iterations of MASS should address gender constraints.



Challenges



Research, Evaluation and Monitoring (REM) Methods

REM | Introduction

Under MASS, research, evaluation and monitoring (REM) activities have played a key role in helping all program stakeholders understand changes in knowledge, attitudes and practices associated with the health programming as well as to uncover how households planned for and experienced health costs.

Multiple pre- and post-test assessments managed by ADS and Bandhan staff (with oversight from Grameen Foundation research team and FFHIT) assessed outcomes related to education sessions associated with anemia, healthy pregnancy, health provider linkages, health cost management and savings, menstruation and learning games for girls. Mixed-method, frequent surveys called “Health Diaries” followed women over time to capture health costs and health seeking behaviors.



6 quantitative surveys with baseline and endline results
(some indicators with midline results)

100–250+ sample size of ADS and Bandhan
beneficiaries, using simple random sampling

10 Health Diary surveys with **45** women

1 end-of-project monitoring assessment

1 independent qualitative evaluation



Snapshot of REM Methods

Study Designs

- **Health Diaries:** Between May and December 2017, the Health Diaries or a series of frequent household surveys were administered by AG Consultancy, a research firm located in West Bengal, with approximately 45 women. The 45 women were purposefully selected so as to capture a range of experiences related to pregnancy. For this reason, pregnant women, women with young children, and mothers or mothers-in-law of pregnant women were selected to participate. Fifteen women were tracked among ADS members; 30 among Bandhan clients. The Bandhan clients were split up between Jharkhand (n=15) and West Bengal (n=15). A total of 10 surveys were conducted every 3-4 weeks to capture health events experienced by the women or others in her household, how they responded to these events with treatments, and how much these events cost the household, how they covered the costs, and the perceived burden of the costs.
- **Quantitative Surveys (pre/post tests):** The survey instruments for the client outcome studies were designed to measure changes in attitude and behaviors after receiving health education delivered via the PLCs (*Prevent Anemia for Better Health, Healthy Mothers Make Healthy Communities and Menstrual Health and Hygiene. Learning Games for Girls*). The surveys were conducted between 2016 and 2018 by ADS and Bandhan staff. The research team utilized Lot Quality Assurance Sampling (LQAS) to establish the random sampling strategy. Basic averages were compared for each question posed to ascertain the pre- and post-test averages. Sample sizes were between 100-200+ beneficiaries.
- **Monitoring Assessment:** A series of interviews with key stakeholders over the course of one week were conducted in early October 2018. Interviews were conducted with SHG members, health provider partners, ADS and Bandhan staff, Gram Panchayat (local government leaders) and the Bandhan Swasthya Sahayika (SS) workers (community health volunteers). The objective of the monitoring assessment was to capture lessons learned, successes and challenges from the key stakeholders via focus group discussions (FGDs) and individual interviews. Findings complement the health diaries, quantitative baseline and endline findings and inform future scale and replication.
- **External Qualitative Assessment:** This study was commissioned by FFHIT to assess successes of the project using external evaluators in September 2018.

Study Details

Research Collection	Baseline	Midline	Endline
Prevent Anemia for Better Health PLC pre/post test ADS	June and July 2016 n=266	September 2016 n=266	July 2018 n=266
Prevent Anemia for Better Health PLC pre/post test Bandhan	July 2016 n=228 114 from Pakur and 114 from North Parganas)	December 2016 n=228 114 from Pakur and 114 from North Parganas)	July 2018 n=95 (95 from Pakur)
Healthy Mothers Make Healthy Communities PLC pre/post test ADS	May 2017 n=266	July 2017 n=266	July 2018 n=266
Healthy Mothers Make Healthy Communities PLC pre/post test Bandhan	--	--	July 2018 n=2018 (95 from Pakur)
Menstruation Health and Hygiene PLC pre/post test ADS	August 2017 n=95 (West Bengal)	--	July 2018 n=95 (West Bengal)
Learning Games for Adolescent Girls PLC pre/post test Bandhan	May 2018 n= 266	--	September 2018 n=266 (evaluation pending)
Health Diaries Bandhan and ADS	Between May 2017 and December 2017, a total of 10 surveys were conducted every 3-4 weeks with 45 women: <ul style="list-style-type: none"> • 15 ADS Clients (West Bengal) • 15 Bandhan Clients (Jharkhand) • 15 Bandhan Clients (West Bengal) 		
Independent Evaluation Bandhan and ADS	--	--	Completed by independent consultants in November 2018 and involved a series of interviews with clients, front line health workers and providers and partners
Monitoring Assessment Bandhan and ADS	--	--	Completed by FFHIT and Grameen staff in October 2018 a series of interviews were conducted with clients, front line health workers and providers and partner staff

Timeline of Key Activities



2013–2015

ADS and Bandhan deliver *5 Steps to a Healthier Family* PLC

Development and roll-out of the Health Outcomes Performance Indicators

Listening Tour of Indian microfinance partners to explore interest in CoP

Began work on the Community of Practice for Health and Microfinance (COPHAM)

2016

ADS and Bandhan deliver *Prevent Anemia for Better Health* PLC; baseline and endline conducted

ADS launches Healthy Savings

ADS and Bandhan launch efforts to coordinate services and link women clients and their households to formal health services

First 20 members join COPHAM and 2 events held

2017

ADS delivers *Healthy Mothers Make Healthy Communities* PLC; baseline and endline conducted

Bandhan delivers education on *Acute Respiratory infections and Healthy Child*

ADS and Bandhan clients participate in Health Diaries

COPHAM membership reaches 40 and stakeholder meet convenes 31 organizations in Gandhinagar

2018

ADS delivers *Learning Games for Girls* to adolescent girls; baseline and endline conducted

Bandhan delivers menstruation education to adolescent girls; baseline and endline conducted

Final endline survey conducted with ADS and Bandhan women clients

51 COPHAM members, 5 events, and launch of volume 3 of the State of Practice report



Project Evaluation Findings

There are stark differences in socio-economic status between the two partner implementation areas, which should be noted to help interpret the client outcomes for each area.



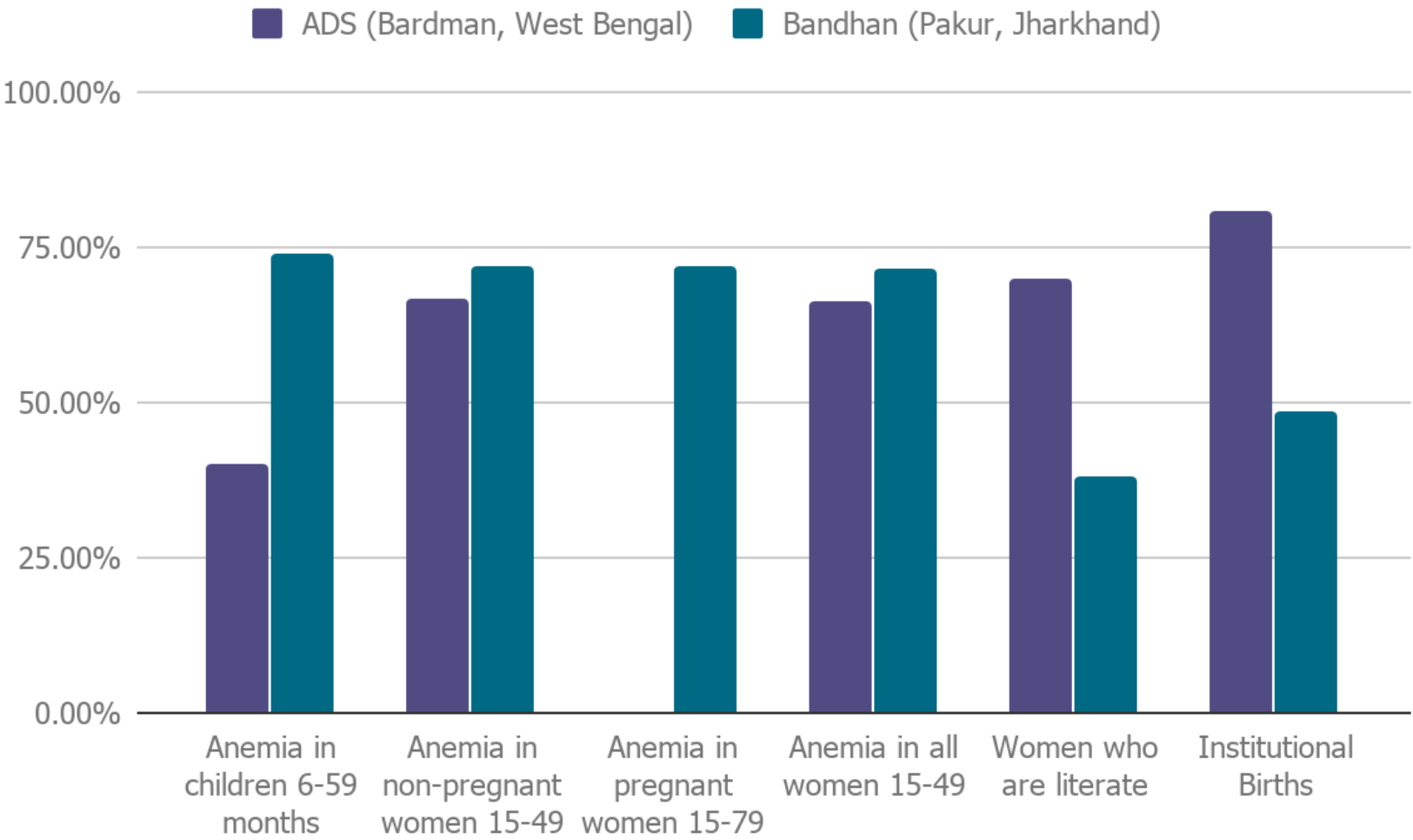
The ADS MASS Program area was in Bardhaman Burdwan, West Bengal.



The Bandhan MASS Program area was in 24 North Parganas, West Bengal, and Pakur, Jharkhand. Most evaluation results are from Pakur.



Health Outcomes for Women in West Bengal and Jharkhand, India



According to NHFS-3 data³, anemia rates among women and children are high, particularly in Jharkhand among children and all women.

Women are more literate in West Bengal.

There are a greater number of institutional births that occur in West Bengal than in Jharkhand.

³ [National Family Health Survey-4 \(NFHS-4\) 2015-2016, India. West Bengal and Jharkhand state reports.](#)

Who is a typical ADS client living in West Bengal?

- She is 37 years old
- She has been a member of her SHG for 11 years
- She has 4 or more people in her household
- She is literate
- She lives under \$4.00 per day
- She is food insecure



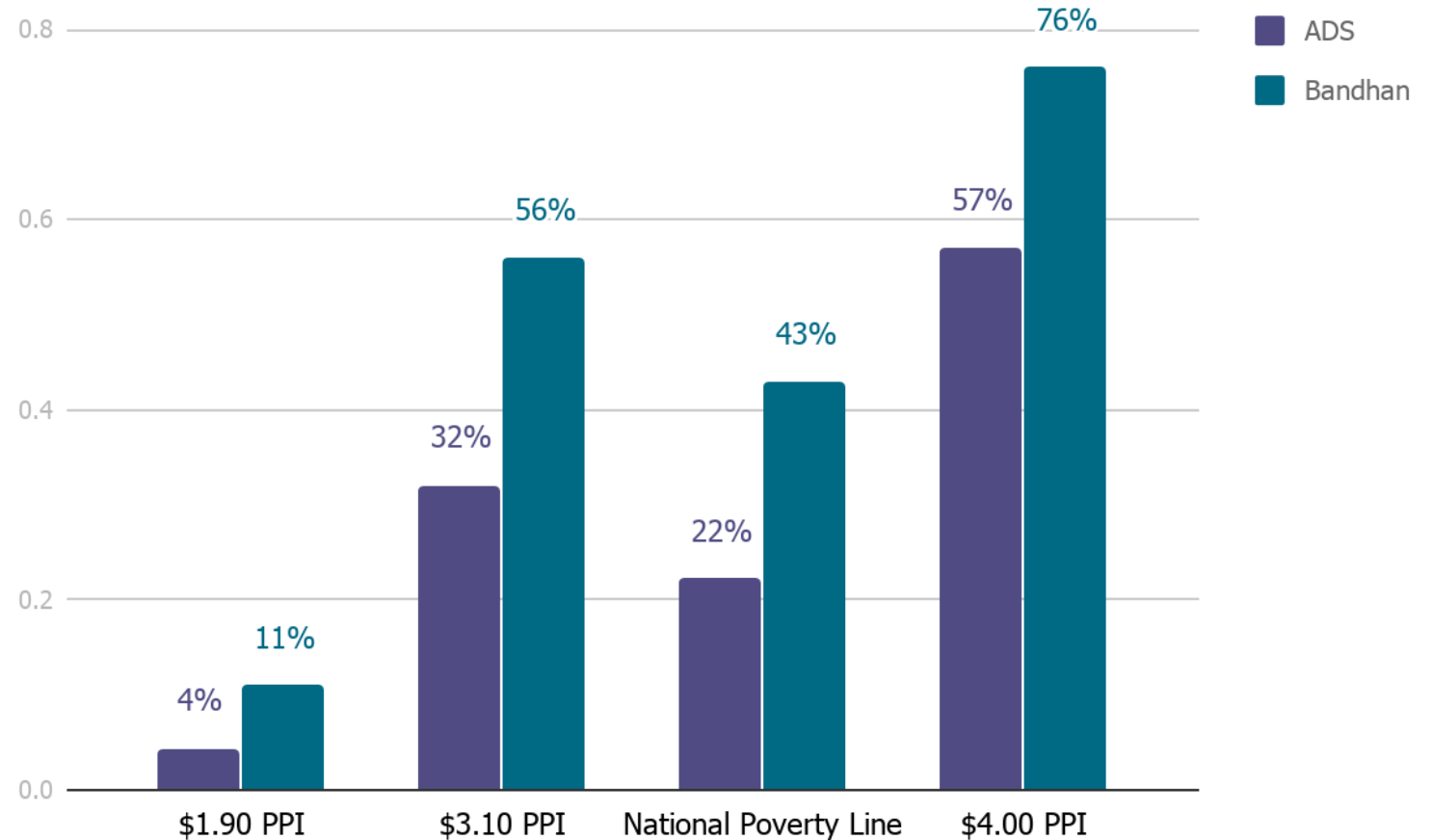
Who is a typical Bandhan client living in Jharkhand?

- She is 35 years old
- She has been a member of her SHG for 8 years
- She has 5 or more people in her household
- She is illiterate
- She lives under \$3.10 per day
- She is food insecure

Who are the women of MASS?

Poverty Profile at Endline (2018)

Women and their households are poorer in Jharkhand. Over half of Bandhan clients live under \$3.10 per day and 11% live under \$1.90 per day. This is in contrast with the majority of ADS clients, who live under \$4.00 per day.



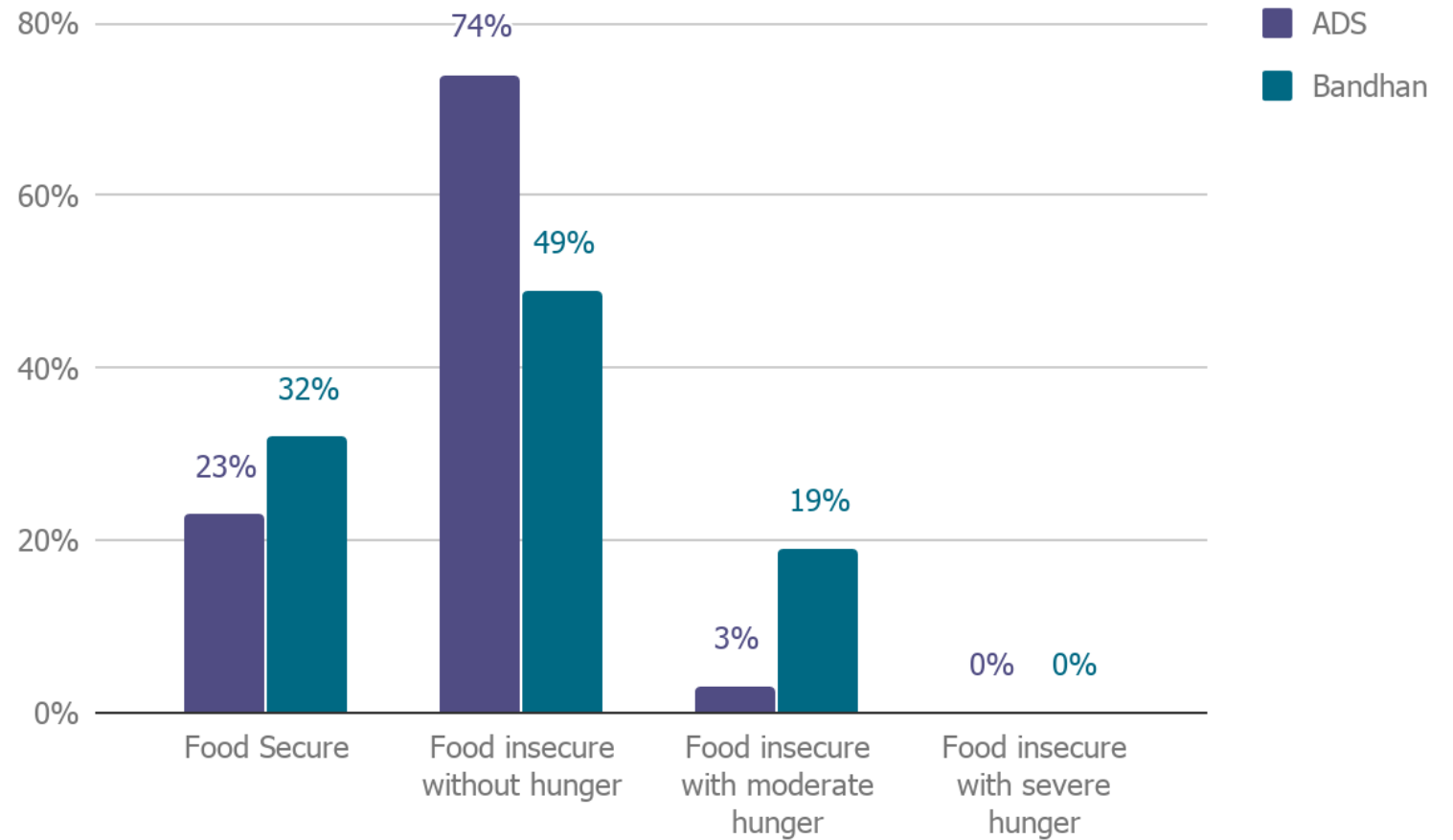
The international Poverty Line (IPL) \$1.90/day, IPL \$3.10/day, \$4.00/day and national poverty line indices were constructed using values from the India Progress out of Poverty Index (PPI). Raw values were generated based on responses, summed, and then matched with probability ranges using PPI documentation. A limitation of this research is that the sample size of the survey is very small and as a result, the results of the PPI analysis are simply suggestive of a likely poverty rate for the respondents. A defined level of confidence in the likelihood that the survey respondents live below various poverty lines would require a much larger sample size. The PPI is now known as the Poverty Probability Index and still known by its same acronym: PPI. Please visit the Poverty Probability Index website for more information:

<https://www.povertyindex.org/about-ppi>.

Food Security at Endline (2018)

To measure food security, participants were asked to choose among four statements that would best describe their household in the last 12 months: had enough to eat of the nutritious foods they wanted (food secure), had enough food but not always nutritious (food insecure without hunger), sometimes not enough food to eat and was sometimes hungry (food insecure with moderate hunger), often not enough food to eat, was often hungry (food insecure with severe hunger).

Food security tends to cluster around “Food insecure without hunger” but a relatively large group of Bandhan clients still face food insecurity with moderate hunger.



The goal of the MASS project is to improve the health of women (pregnant and lactating), children (under 2 years of age) and adolescent girls (15 to 18 years).

The evaluation findings that follow will be organized according to the three areas that the project focused on in order to increase access to health knowledge through **health education**, **health financing** and **health service linkages**.



Health Education

Health Financing

Health Service Linkages



Health Education

Objective 1: Improve health-seeking behavior among poor women and adolescent girls through health education messaging.

Indicators: Percentage increase in knowledge and behaviors before and after the delivery of the following PLCs:

- Prevent Anemia for Better Health
- Healthy Mothers Make Healthy Communities
- Menstruation Hygiene for Adolescent Girls

What do the women say about seeking and receiving health care?

“We want the mothers to be educated, so they can teach children in the proper way” – End of Project Monitoring Assessment

“If we go to this [quack], it costs less money for medical care. He does not go away.” – MASS beneficiary, Health Diaries

“My son had a health problem, and I learned of it early and he will get an operation.” – MASS beneficiary, End of Project Monitoring Assessment

“If they tell us about the government schemes, we can get advantages from them.” – MASS beneficiary, Health Diaries

“I had an institutional delivery and immediately breastfed.” – MASS beneficiary, End of Project Monitoring Assessment

“The health center does not have iron tablets so we have to go to quacks.” – MASS beneficiary, End of Project Monitoring Assessment

“We are scolded at the health center because we need medicine, and we do not get all that we need so we go to quacks to get this medicine.” – MASS beneficiary, End of Project Monitoring Assessment

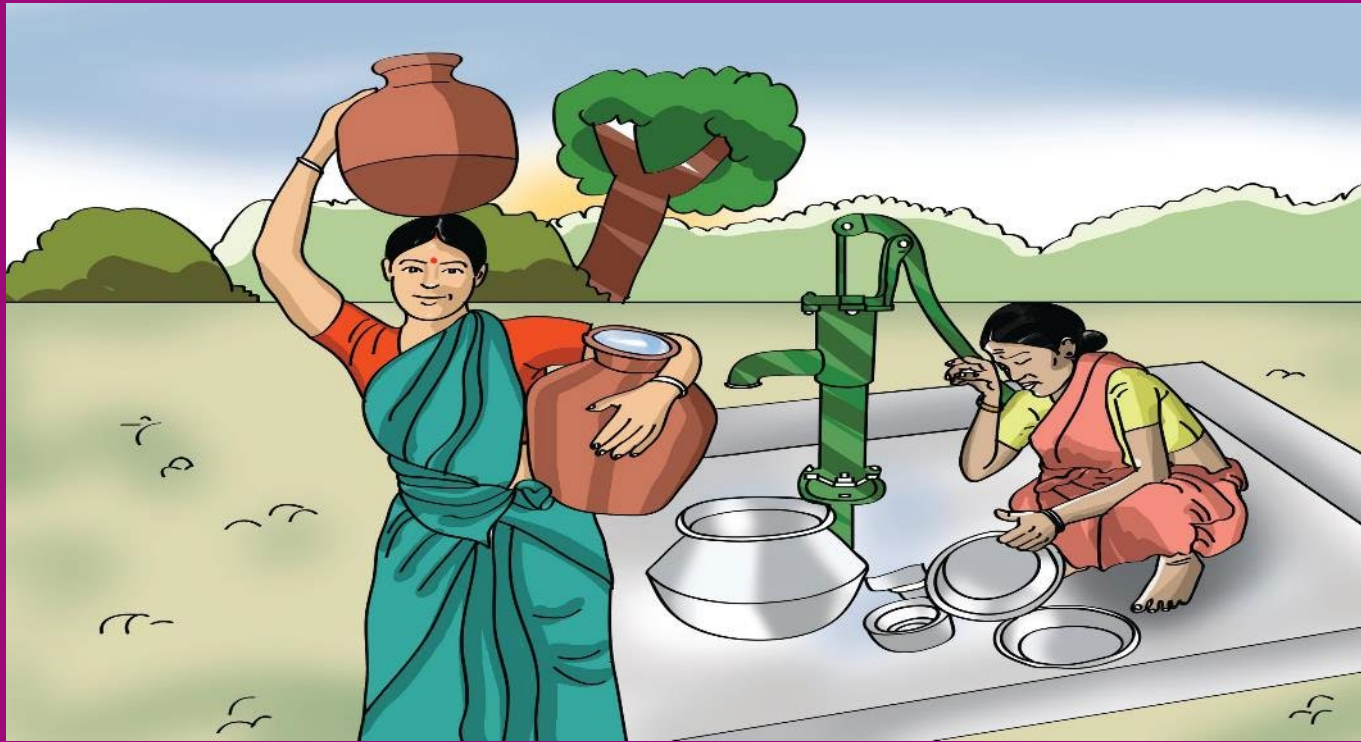
“Bandhan would report it if health workers are not doing their job.” – End of Project Monitoring Assessment

“The [quack] is near at home. Time is lost when traveling to another place, travel costs. We are well treated by the [quack].” – MASS beneficiary, Health Diaries

“My baby is 4 months old, and I’m not feeding the baby anything but breastmilk and will continue feeding her until she is 6 months old.” – MASS beneficiary, End of Project Monitoring Assessment

“Sometimes ADS accompanies us to the hospital for delivery” – MASS beneficiary, End of project Monitoring Assessment.

“We would not have known what services were available without Bandhan” – MASS beneficiary, End of Project Monitoring Assessment



Prevent Anemia for Better Health

Summary of Knowledge Change



Most anemia and hygiene knowledge indicators saw improved knowledge and attitudes at the midline, and these changes were fairly sustained at the endline assessment that occurred two years after baseline. This suggests sustained improvement over time.

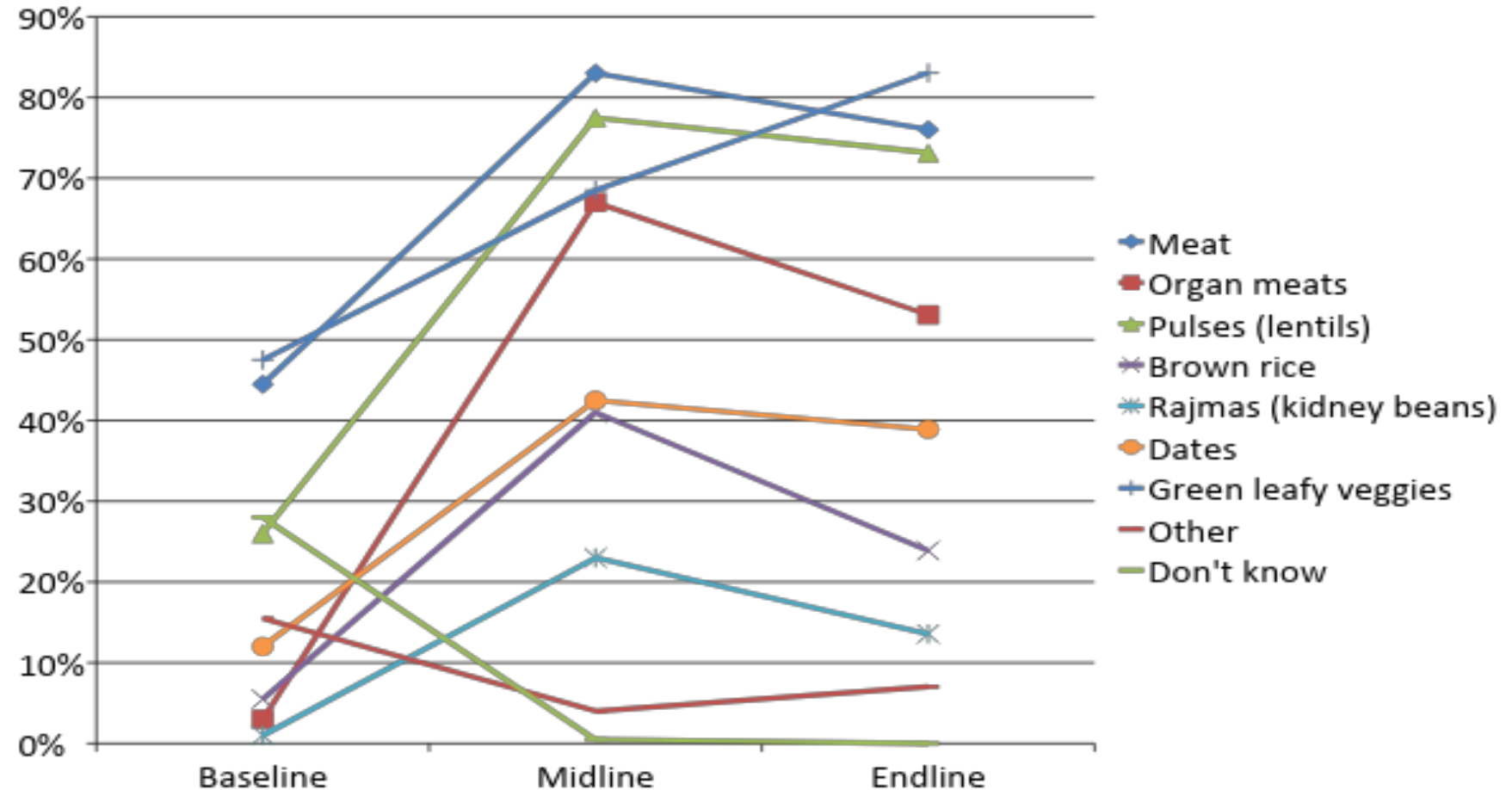
- Increases in knowledge about groups of people vulnerable to anemia occurred between baseline, midline, and endline. There was a decrease in knowledge of children being vulnerable to anemia among Bandhan clients, which should be explored.
- Cause and testing for anemia increased at midline and slightly decreased by endline, but was still much higher at baseline.
- There were decreases for some indicators in knowledge regarding signs and symptoms of anemia but increases among others. Despite some decreases, endline averages were still visibly greater than the baseline.
- Knowledge of foods high in iron have decreased since the midline but are still higher than the levels at baseline. While some foods saw larger decreases, it's important to note that the foods people most likely have access to at lower costs, are also those that had more sustained knowledge (pulses, green leafy vegetables) followed by meat and meat products.
- Slight decrease in knowledge for most treatments for severe anemia but still higher than baseline measures.
- Increases and decreases in knowledge regarding hygiene, but still higher than baseline measures.

Example: Knowledge of Iron Rich Foods⁴

Increase in knowledge of foods rich in iron at midline (2016).

Two years later (2018), while there is a slight decrease in knowledge from the midline, averages at endline are still higher than at baseline.

This knowledge change seems quite sustained, particularly among foods people most likely have access to and desire, such as knowledge of meat, green leafy vegetables, and pulses.



⁴ ADS and Bandhan results have been combined.

Prevent Anemia for Better Health: Summary of Behavior Change



Anemia testing and diagnoses remain below 30% across a population that regional statistics show at least 44% of women are anemic in the ADS area, and 71% in the Bandhan areas.⁵ Children are even less likely to be tested or diagnosed with anemia. Of those ever tested, there is visible alignment with those who do get diagnosed even though it's not a 1 to 1 alignment.

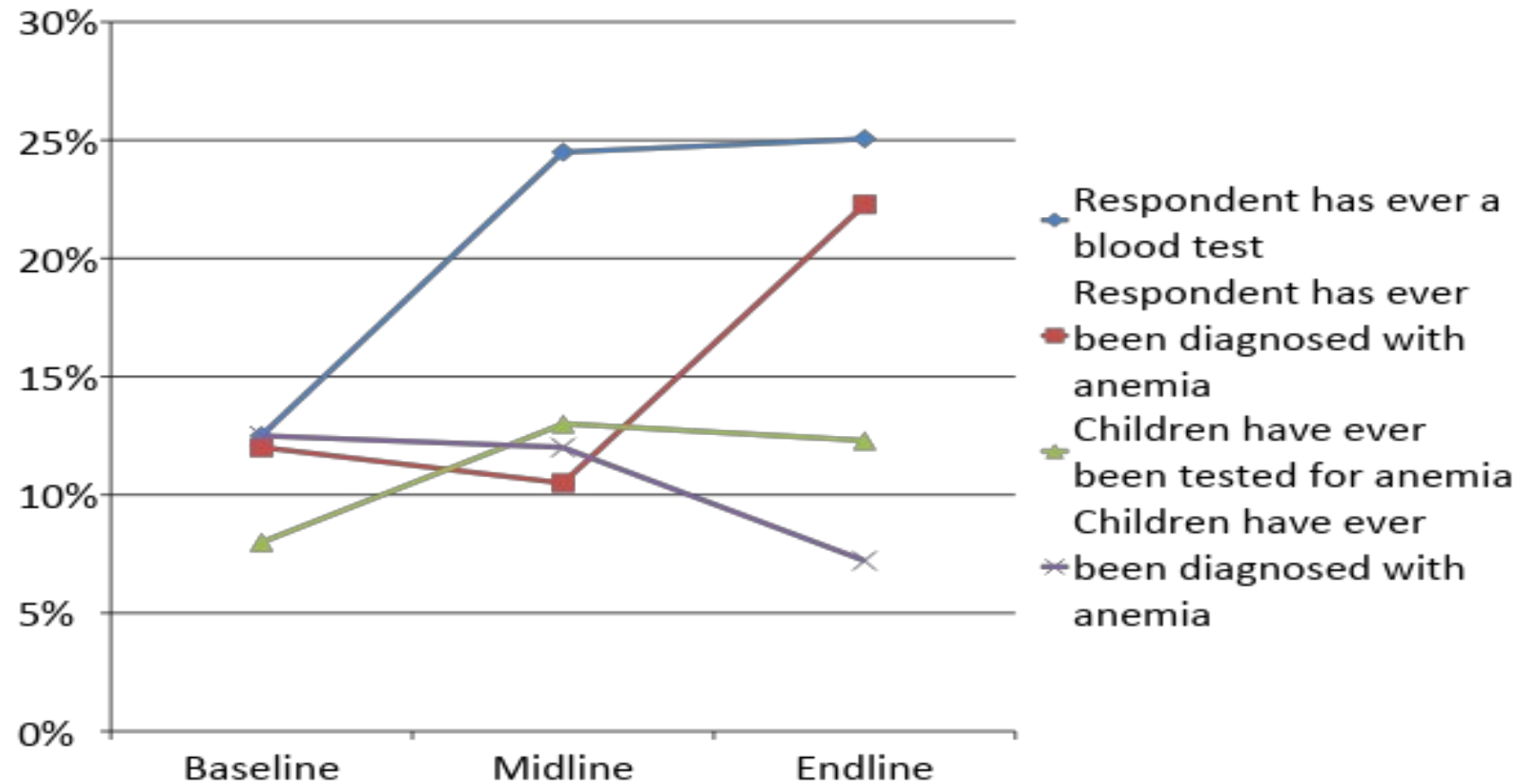
Sustained consumption of foods high in iron and vitamin C (still better than baseline measures). Most importantly, there was an increase in those who ate both iron and vitamin C in last 24 hours and while these decrease at the endline, it is also still greater than at baseline.

⁵ [National Family Health Survey-4 \(NFHS-4\) 2015-2016, India. West Bengal and Jharkhand state reports.](#)

Example: Testing for Anemia⁶

Despite important increases in knowledge that blood tests are the way for people to be diagnosed with anemia, use of these tests are still quite low, despite regional and national statistics suggesting at least half of women and children are anemic at any given time.

However, by endline, at least a quarter of women had ever been tested for anemia and almost as many were diagnosed with anemia. There was a decrease in knowledge on children being vulnerable to anemia among Bandhan clients, which should be explored.

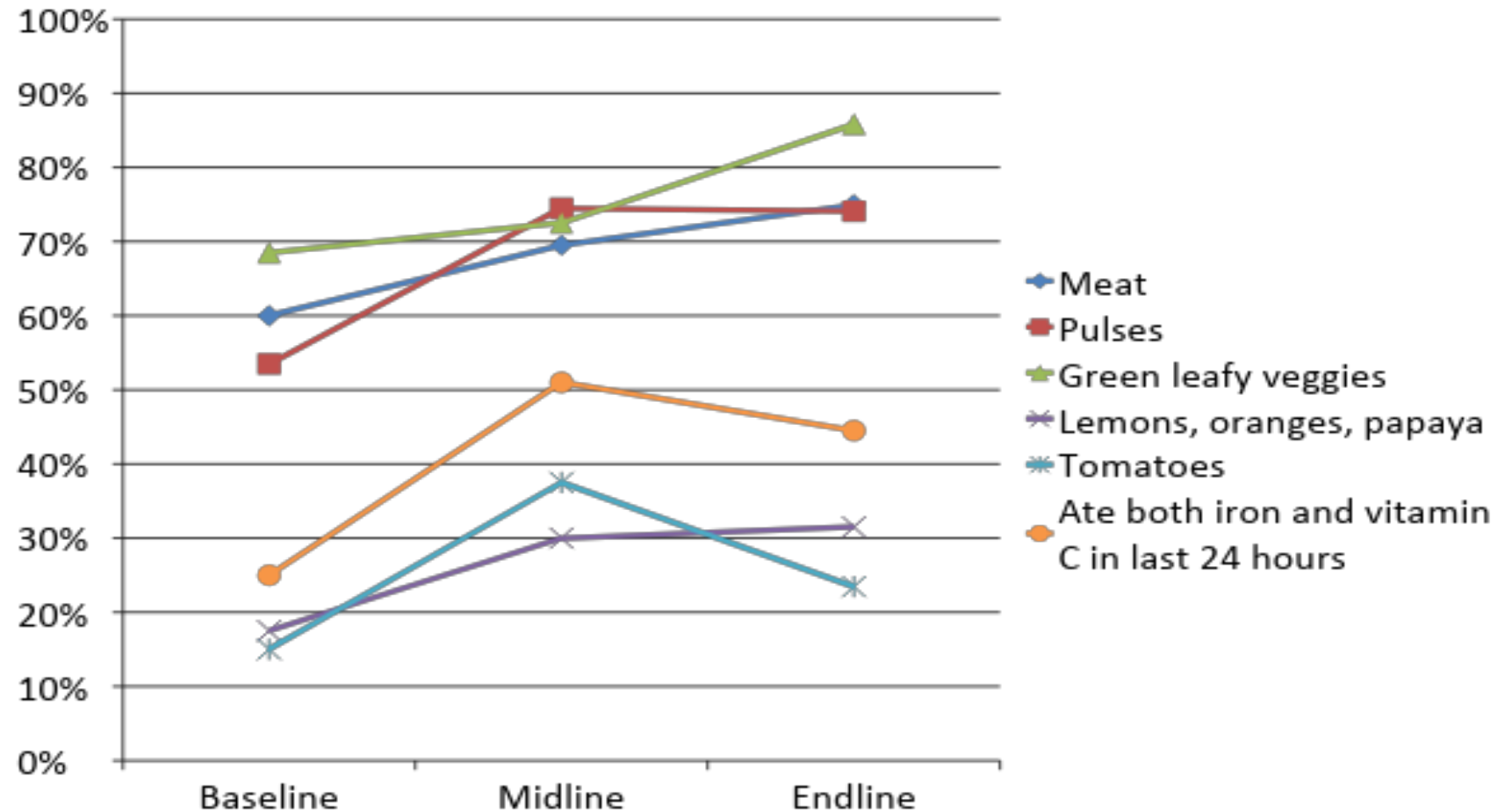


⁶ADS and Bandhan results have been combined.

Example: Consumption of Iron Rich Foods and Vitamin C⁷

The consumption of foods rich in iron and vitamin C, which the women were taught is necessary to help improve iron absorption, was improved and sustained over the life of the project, if not increased for some foods, such as leafy green vegetables.

At baseline, about a quarter of the women reported consuming both a food rich in iron and vitamin C in the prior 24 hours. At midline, this was at 50% and by the endline, this takes a slight decrease, but is still greater than at baseline.



⁷ ADS and Bandhan results have been combined.



**Healthy Mothers Make
Healthy Communities**

Summary of Results for ADS



Survey data was collected on the Healthy Mothers education at baseline, midline and endline for ADS. Most indicators saw improved knowledge and attitudes at the midline, and these changes were fairly sustained at the endline assessment that occurred 2 years after baseline.

- Increases in knowledge of pregnancy nutrition supplements (folic acid, iron and IFA⁸). Almost all know they should take IFA as a nutrition supplement while pregnant or of reproductive age. At the endline, almost all could note IFA tablets.
- Slight decrease in knowledge of danger signs during pregnancy (swelling arms/legs, vaginal bleeding, and abdominal pain) at midline, but generally equal or higher than baseline.
- Increases in knowledge of other danger signs during pregnancy (headaches, difficulty breathing, and fever).
- Slight increase in knowledge about going immediately to the health center if a pregnancy danger sign is experienced.
- Increase in those who would likely give birth in a facility while cost and having a facility nearby remain the two main constraints.
- Decrease in the number of women reporting that lack of trust of the health facility as the reason not to deliver in a health facility.

⁸ At baseline, the survey question gave the participants the option to answer iron and folic acid, and did not include an option for an IFA tablet. This was revised for the midline and endline since IFA tablets are most prescribed.

Healthy Mothers Make Healthy Communities: Summary of Results for Bandhan

Survey data for the Healthy Mothers education was only collected at endline for Bandhan.

- If we used 80% as a knowledge threshold, such that 80% of clients should know the danger signs after the education, abdominal pain, fever, difficulty breathing, headaches, and vaginal bleeding are all below this threshold. Swelling is the only danger sign that more than 80% of women could mention. But, 91% could mention at least 3 symptoms.
- Most women were able to demonstrate knowledge that folic acid was an important supplement for pregnant women and that when a pregnant woman experiences danger signs she should go immediately to the health center.
- Most women indicated a high likelihood of delivering at a health facility if they were to become pregnant, but overwhelmingly cite that cost is a primary constraint followed by the preference for home delivery.

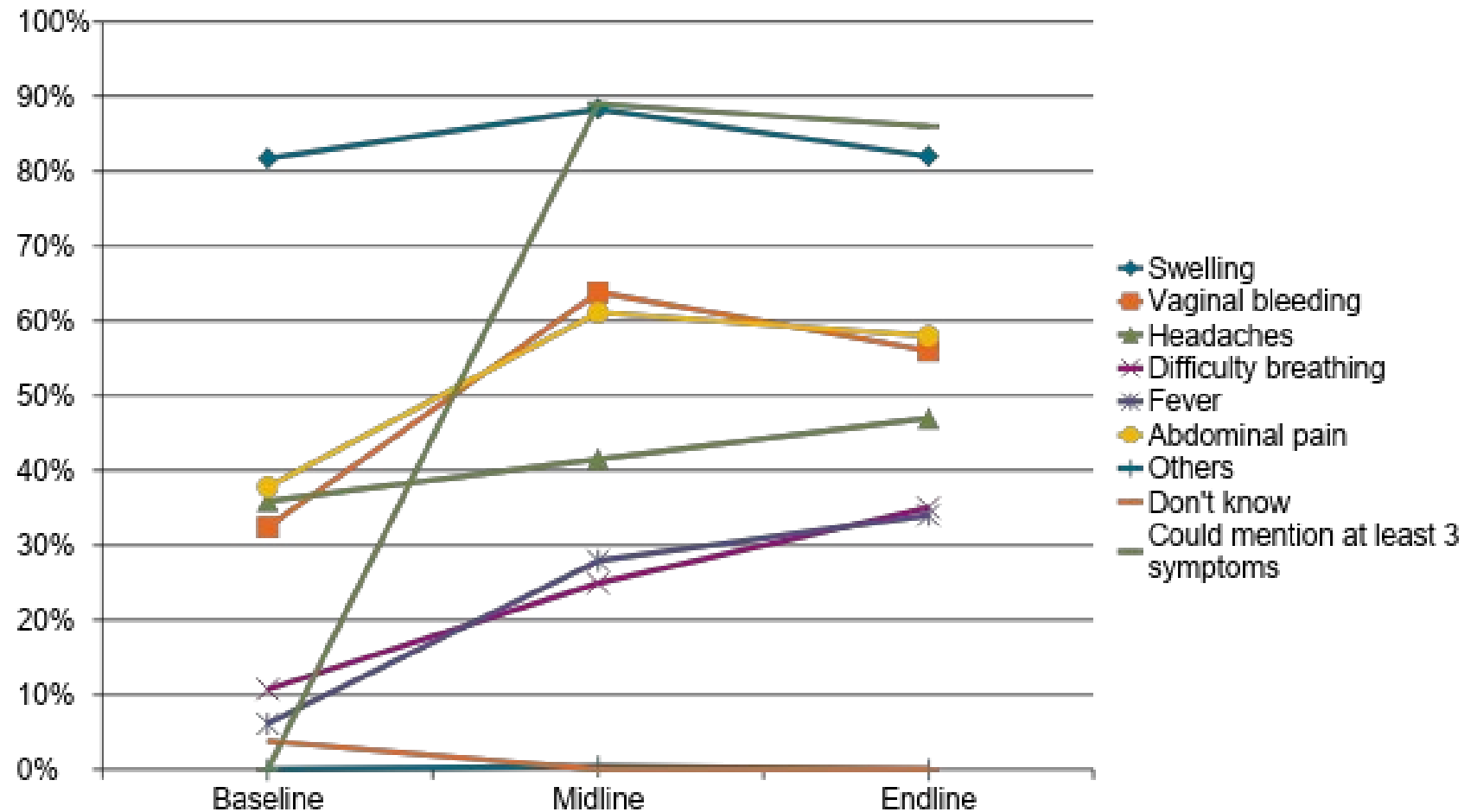


Example: Pregnancy Danger Signs at ADS

Knowledge of swelling as a danger sign was the only one that reached the 80% threshold of expected knowledge, but it was also already above 80% at baseline.

While more than 80% of participants could mention at least three danger signs by midline and again at endline, knowledge of the remaining danger signs remained below 80%.

This should be explored to determine why it is difficult to recall the danger signs. It could be that this message is not consistent with what medical providers indicate, or there is disagreement or inability to remember six different signs.



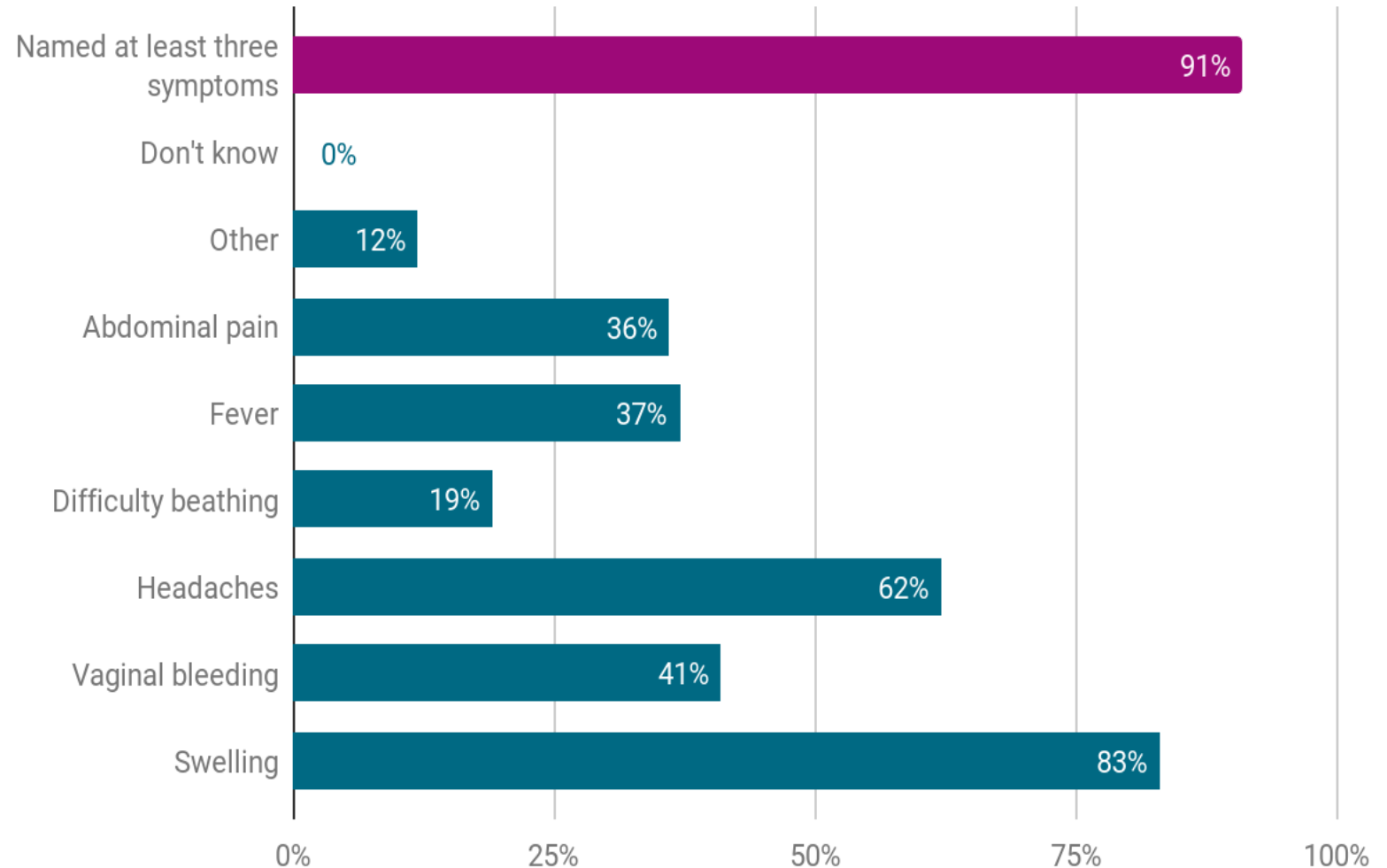
Example: Pregnancy Danger Signs at Bandhan

The question of pregnancy danger signs was only asked at the endline for Bandhan.

Like ADS, knowledge of swelling as a danger sign was the only one that reached the 80% threshold of expected knowledge, but it was also already above 80% at baseline.

While more than 90% of participants could mention at least three danger signs by midline and again at endline, knowledge of the remaining danger signs remained below 80%.

This should be explored to determine why it is difficult to recall the danger signs. It could be that this message is not consistent with what medical providers indicate, or there is disagreement or inability to remember six different signs.



An opportunity: Sexual and Reproductive Health Education in Jharkhand



Meet Guljan from a Bandhan SHG in Jharkhand. She, like other women in her village, has a large family. “I have 15 children; 5 are dead.” She took a loan from Bandhan, so she could immunize her children and invest in her bidi making business to supplement her family’s income. She has delivered all of her children at home because “there was no one to take me to the hospital.”

Guljan is one of the many women interviewed as part of the end-of-project monitoring assessment. Here is what other mothers from Bandhan had to say about their desire for sexual and reproductive health education in Jharkhand:

“We want to learn how to stop having so many children. Bandhan tells us to have 2 or 3, but how to stop? We have children every year.”

“We have had many children, but are taking birth control from Bandhan and SS — we can take proper care of children when we have less.”

“I went to deliver at the hospital — my baby is 3 months old. I have 12 children; 6 are dead, 6 are living. Nine were home delivered; three were hospital [delivered].”

“I have seven children; two are dead, three girls are alive. Two were hospital deliveries; I went for ligation.”



Menstrual Hygiene for Adolescent Girls

1. 12,000 adolescent girls participated in Bandhan's menstruation education.
2. Solid knowledge change regarding menstruation, the female reproductive system and why girls shouldn't get pregnant
3. Increased reporting of advantages of using a sanitary pad, but cost is a limiting factor
4. Increased reporting of good sanitary pad disposal behavior and personal hygiene management
5. Dramatic increase of reaching out for help at home or with medical provider for menstrual health issues



Menstruation Hygiene for Adolescent Girls: Summary of Results

Methods

Trainings were conducted by Bandhan SS workers in Pakur, Jharkhand

Baseline	Endline
N=95, August 2017	N=95, July 2018
*Branches: Joykristopur, Jikurhati, Prithivinagar, Bhabanipur, Maheshpur	
Average Age: 16	Average Age: 17

*Limitation: While the data in this study is helpful in understanding potential benefit of the menstruation education, the fact that data was not collected among the same girls at baseline and endline (except in the case of Bhabanipur), the endline data may be reflecting an overall difference in knowledge/behavior of a different cohort of girls.





Menstrual Hygiene for Adolescent Girls: Summary of Knowledge Change

Some indicators showed that knowledge was strong at baseline and even increased further by endline. These indicators included how long a menstrual cycle lasts and the average age that menstruation begins. There were dramatic increases in knowledge from baseline to endline in the:

- understanding that menstruation is normal monthly bleeding,
- identification of health symptoms during menstruation,
- identification of female reproductive parts of the body and
- identification that early pregnancy should be avoided due to health risks for mother and baby.

Menstrual Hygiene for Adolescent Girls: Summary of Behavior Change

Sanitary pad use

- At baseline, sanitary pad use increased while cloth/napkin use decreased. Reasons cited for this was because sanitary pads are easy to use and effective but cost was cited as a disadvantage by over 80% of respondents.

Hygiene management

- Dramatic increases in reports of the importance of washing hands between pad changes, frequency of pad changes and bathing regularly with soap.

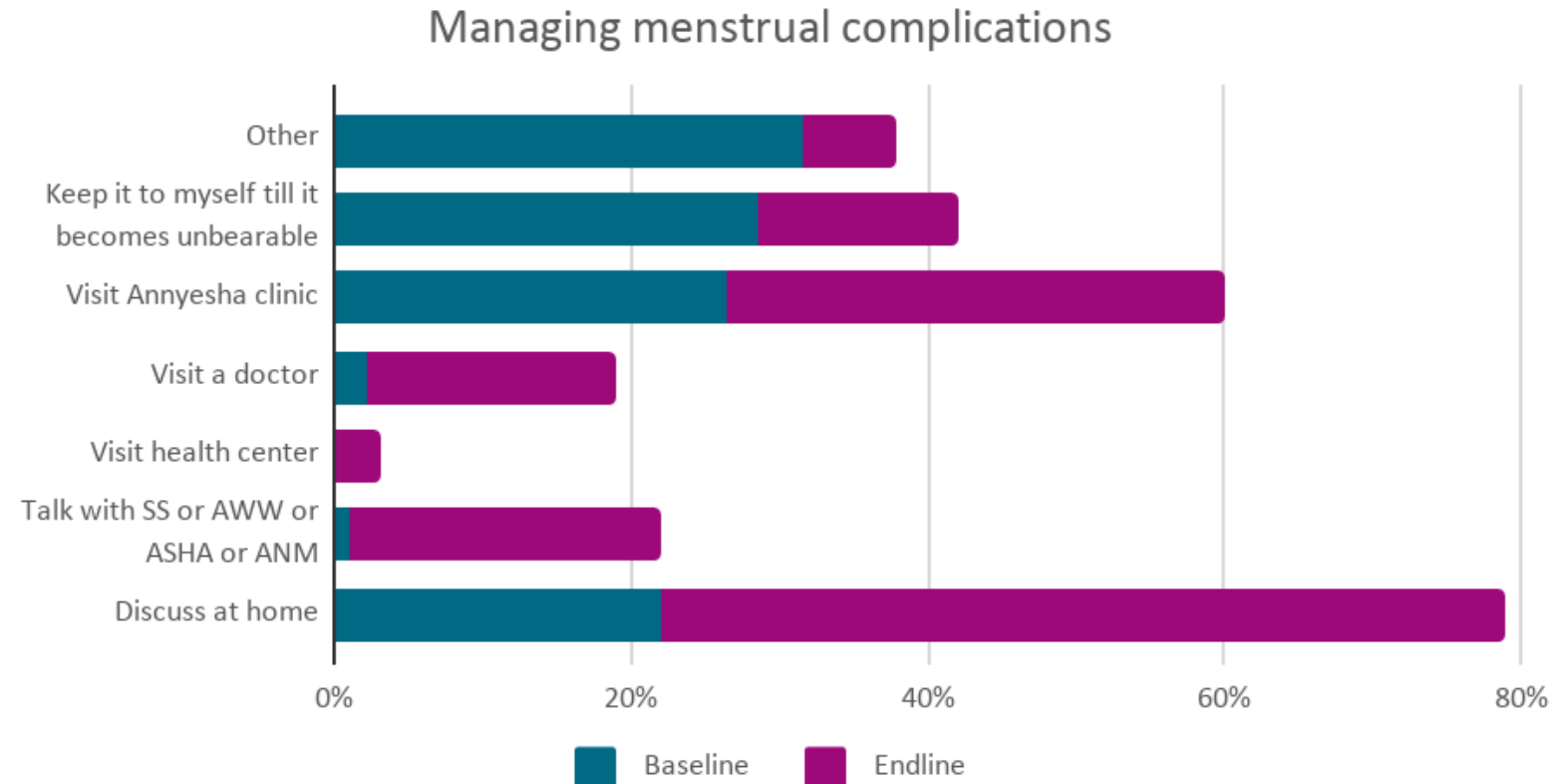


Example: Management of Abnormal Menstrual Symptoms

Of particular interest was the change in how the girls reported that they manage abnormal menstrual symptoms from baseline to endline.

At baseline, the most common answer was “other” followed by “keep it to myself until it becomes unbearable,” but by endline, the most common answer was “discuss at home” followed by “visit to Anwesha (health) Clinic.” Visiting a doctor, visiting a health center and talking with a health worker all increased as well.

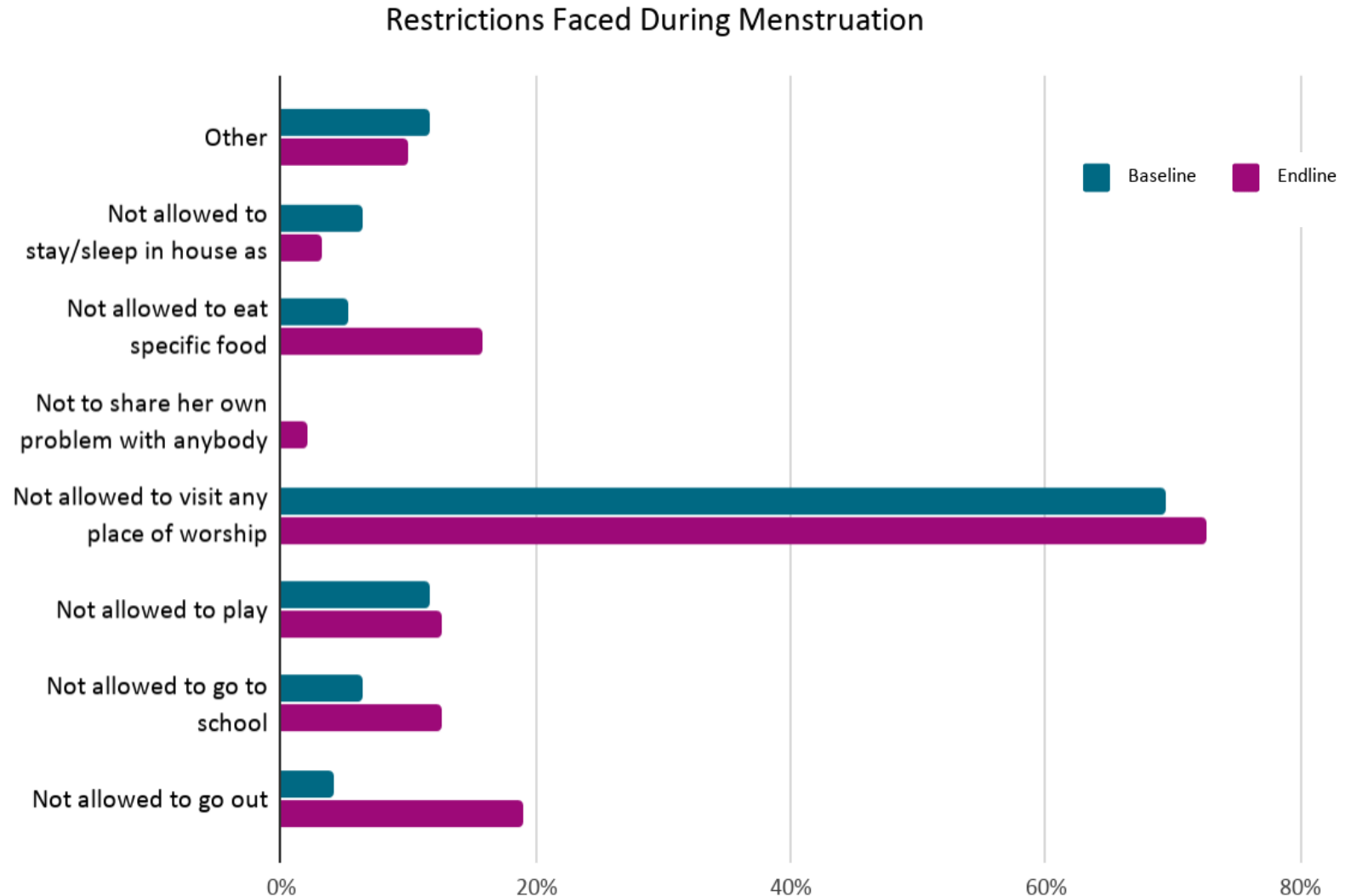
It is possible that discussing these topics out in the open with the girls increased their comfort level in seeking help at home, but also their trust in seeking health care through appropriate channels.



Example: Restrictions Faced During Menstruation

There was a 29% increase in identified restrictions faced during menstruation from baseline to endline. This result highlights the fact that changing cultural norms requires education and dialogue at the household and community level.

The fact that the restrictions showed an increase from baseline to endline may be a result of the girls becoming more aware of what restrictions they face simply through the experience of raising their awareness and reflection.



Future Considerations | Health Education

Limitations: Data was collected by ADS and Bandhan staff, and there is no counterfactual group. However, the client outcomes assessments are helpful tools in helping stakeholders understand whether the education and tools that they provide beneficiaries are resulting in improved knowledge, attitudes and behaviors.

- Given after 1-2 years, knowledge is still higher than baseline, for most indicators, but it is on a declining trajectory. This highlights importance of repeating sessions periodically to maintain improved levels of change.
- Despite more than 80% of women being capable of mentioning at least 3 danger signs for pregnancy at both ADS and Bandhan, knowledge for all signs did not meet the threshold of 80% knowledge. This is a critical message: either the session deserves repeating and/or qualitative research is needed to understand why not all danger signs can be remembered.
- More than 40% of women and children in West Bengal and 70% in Jharkhand are estimated to have anemia at any given time. While pregnant women are often treated for anemia proactively (through prescribed IFA tablets), less than a quarter of women and children have ever been tested. A deeper collaboration with local health providers should be explored to reduce anemia rates among SHG populations, such as increased testing rates or re-iterating messages that empower households to improve consumption of foods rich in iron and vitamin C.
- Cost is the main reason women are not giving birth in facilities. Bandhan and other financial institutions should consider the role they can play in helping women financially prepare for institutional birth (and associated costs).
- The monitoring assessment revealed an interest and desire for more information on Family Planning and could be considered as a follow-on topic for ADS and Bandhan to explore.
- Education conducted with Adolescent girls experienced similar improvements in knowledge and behaviors, highlighting the important role that financial service providers can play in engaging this target group.



Health Financing

Objective 2: Increase access to health products and services among poor women and their families by offering health financing mechanisms.

ADS Health Savings

At ADS, SHGs were encouraged to save for health expenses, utilizing a health savings methodology that mimics Grameen Foundation's *Saving for Change*⁹ methodology in addition to their regular savings and loan activities.

With the health savings methodology, women first deposit savings into their general group "account" and then repeat the savings process earmarking savings specifically for health.

⁹ *Saving for Change* is a methodology jointly developed by Freedom from Hunger, Oxfam America and Strømme Foundation for self-managed savings and lending groups integrated with simple trainings in health, business and money management. *Saving for Change* brings basic financial services to areas that are typically beyond the reach of microfinance institutions and, in doing so, creates sustainable, cohesive groups that tackle social issues facing their members and their communities.



What do the women say about health financing and access?

“Suppose we need money for health immediately or at night — we can just take a health loan and pay for a private doctor or travel far for care.” – ADS client, End of Project Monitoring Assessment

“Quacks treat us better than local doctors; they are close by, and we don’t have to spend money on transport. If it isn’t cured by a quack, then we spend money to travel to the health center. Sometimes, we wait for 3-4 days — sometimes 8 days. We have to take loans to go to the health center.” – ADS client, End of Project Monitoring Assessment

“We want to increase our savings from 50 rupees to 100 rupees so that we can treat bigger ailments.” – ADS client, End of Project Monitoring Assessment

“Suppose we need money for health immediately or at night — we can just take a health loan and pay for a private doctor or travel far for care.” – ADS client, End of Project Monitoring Assessment

“We like health savings best because we can take money in an emergency. After 1 year, we keep a certain amount and give back the rest. Later, we plan to increase our health savings to 100 rupees, but will keep our regular savings at 50 rupees.” – ADS client, End of Project Monitoring Assessment

“Some of us have 10 to 15 children, and it costs too much to care for our children.” – ADS client, End of Project Monitoring Assessment

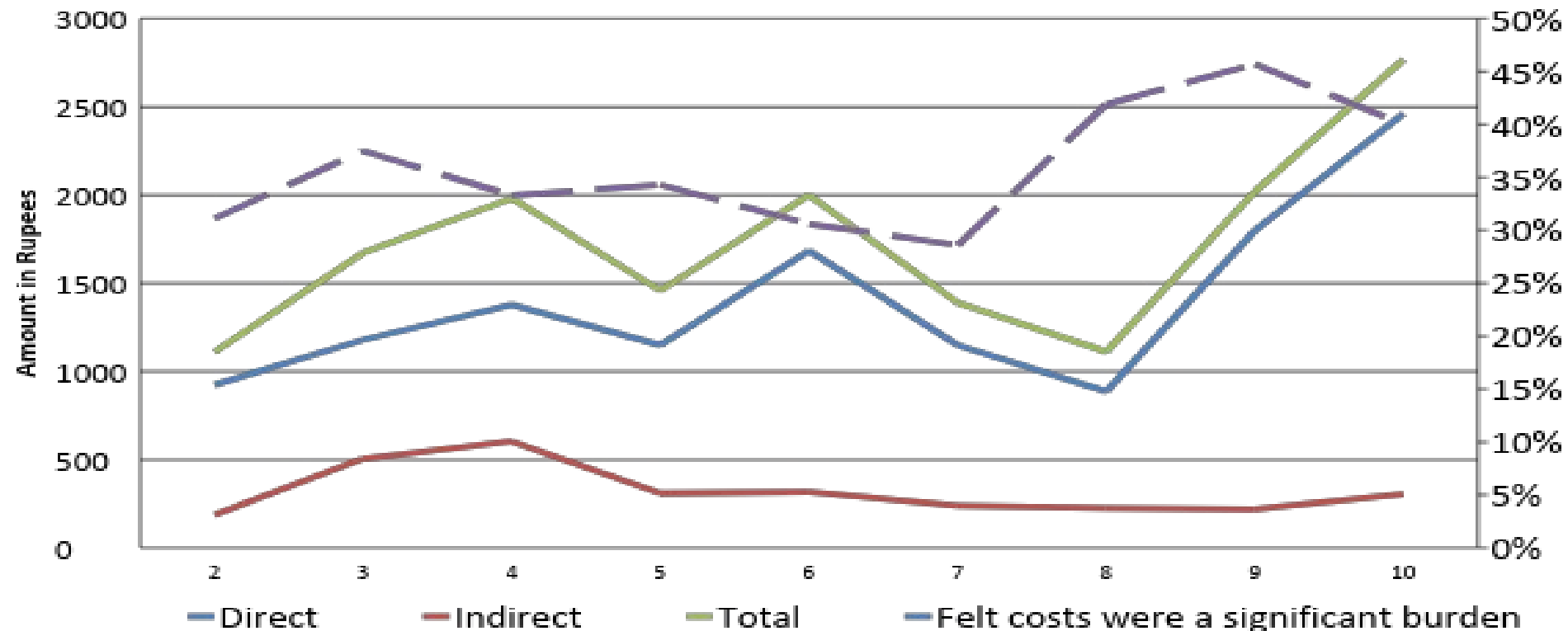
“We like health savings more than the bank because the bank is closed, and anytime of the day I can take money out.” – ADS client, End of Project Monitoring Assessment

“If I did not have a health loan, I would have had to take a high interest loan from a lender or sell my housewares.” – ADS client, End of Project Monitoring Assessment

“If there is any problem, we can get money immediately to get health check-up. We have one year to repay. Before health savings, we had to borrow from others and that was shameful, and now, we don’t have to do that so we are happy.” – ADS client, End of Project Monitoring Assessment

Total Health Costs and Cost Burden

A series of health diaries — or frequent surveyor-administered surveys — conducted with 45 clients of ADS and Bandhan revealed the extent to which health costs are seen as a burden and at what amount. The reported health costs were found to be catastrophic¹⁰ for any household living under the \$4.00 International Poverty Line, and over a third of households felt out-of-pocket health expenses were a burden. There is an important role for financial service providers to play to help low-income households manage health costs, even when government health schemes exist.

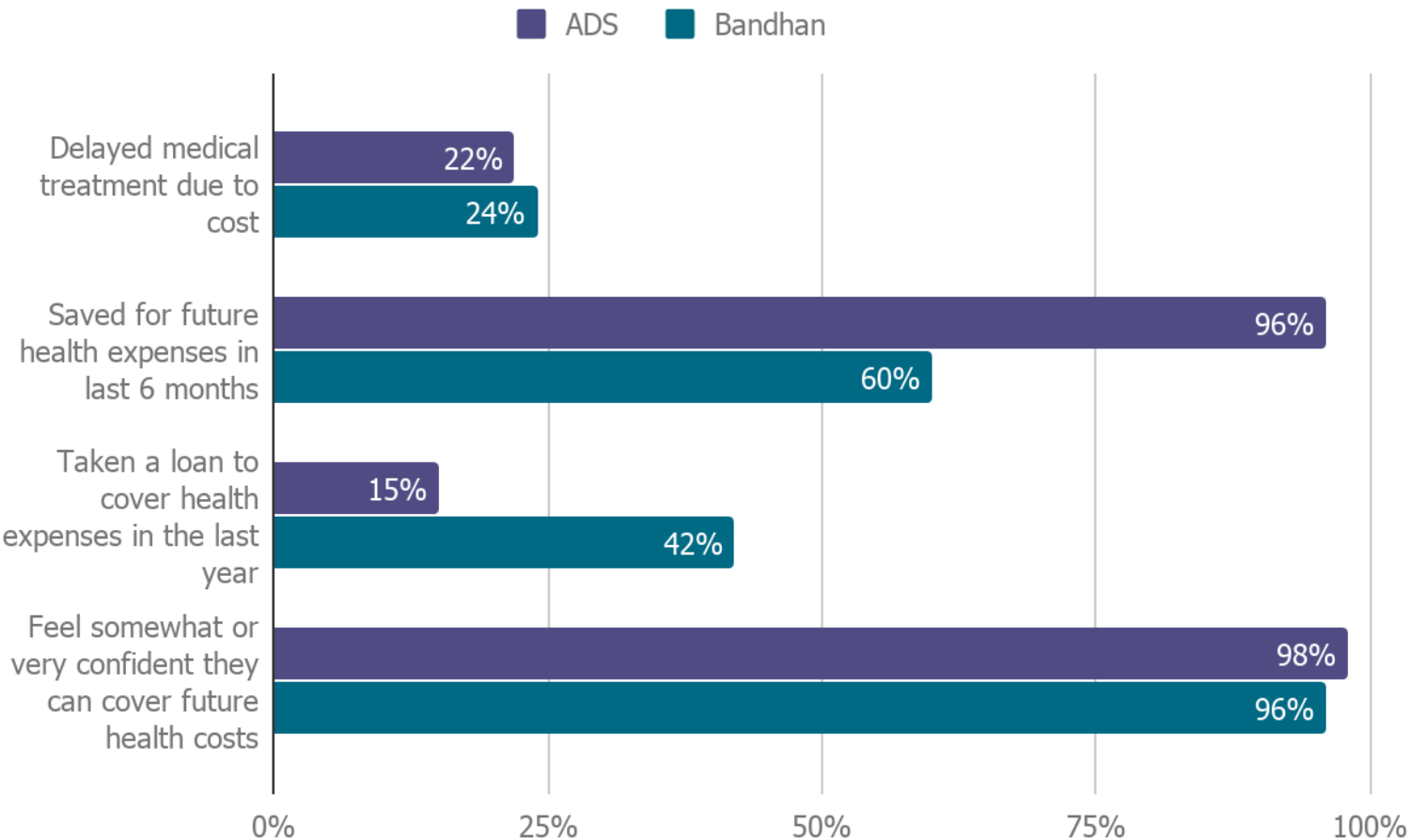


¹⁰ Catastrophic health costs are estimated to be those that exceed 10% of monthly income

Financial Attitudes and Behaviors

Using data collected in the endline survey only for both Bandhan and ADS, the data shows that less than a quarter of the women reported that they delayed medical treatment due to cost, while more than half reported that they saved for health costs in the last six months. More clients at ADS reported saving for health, but this is most likely due to most groups choosing to save for health.

Almost all of the women felt somewhat or very confident that they can cover future medical expenses.



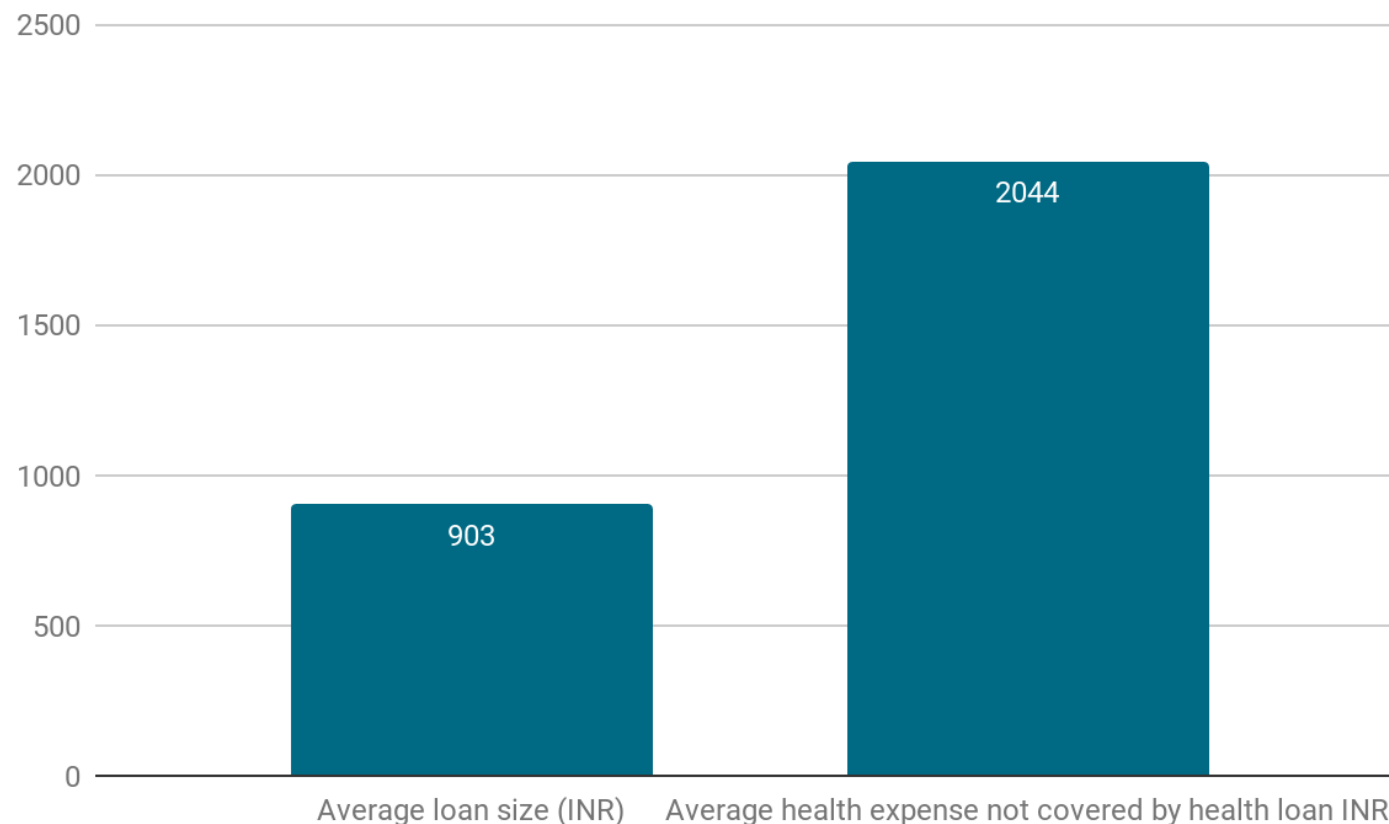
ADS Health Savings Use

All the 266 ADS clients interviewed indicated they belonged to a group that saves for health, and almost all indicated they had saved for health in the last 6 months and would recommend health savings to other SHGs.

There has been relatively little use of the health loan and groups that have distributed those health savings funds. Only 22% of the women indicated they had delayed medical treatment due to cost.

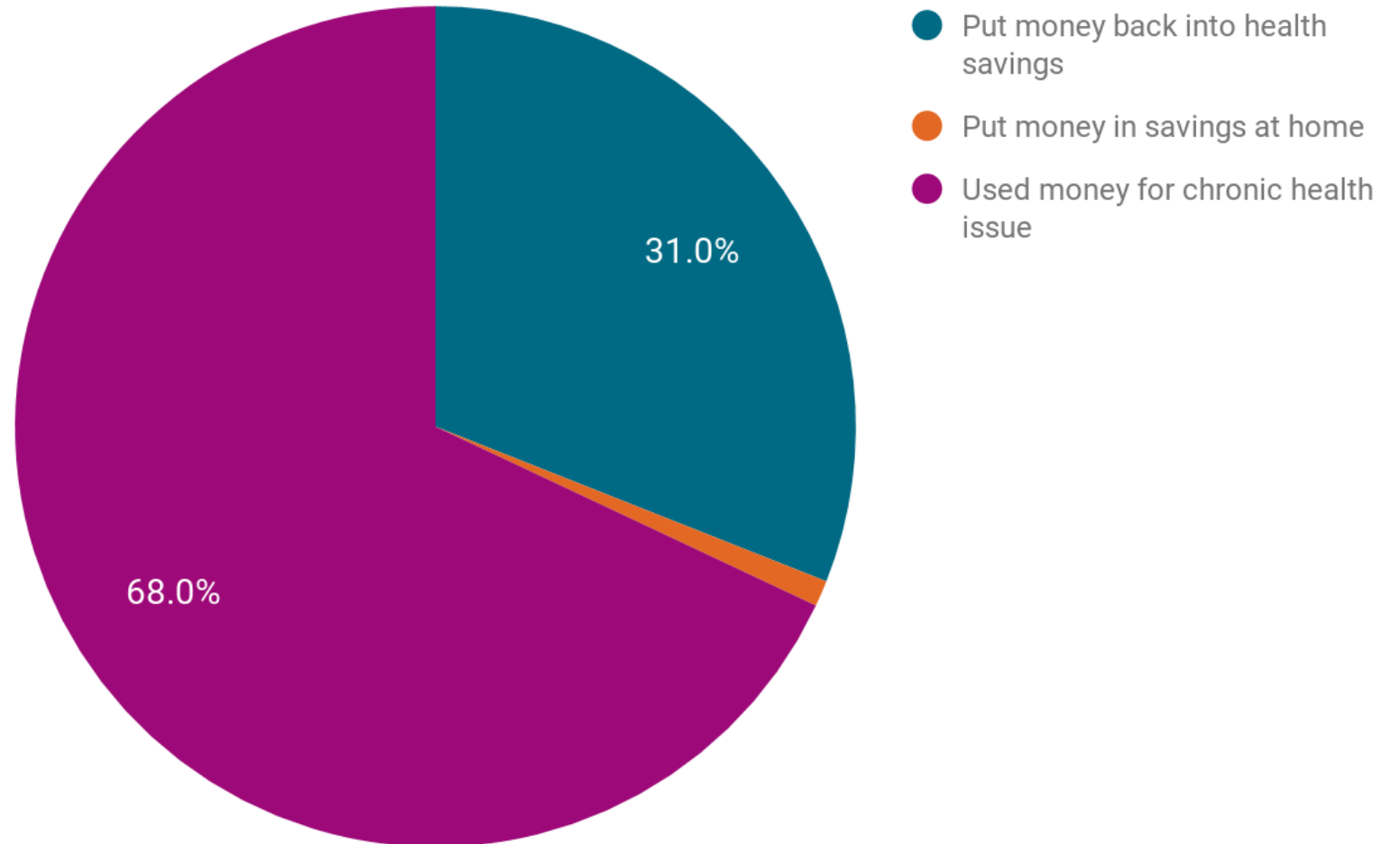
Of the 15% who said they had taken a loan, the average loan size was approximately INR 900, and the uncovered health expenses was approximately INR 2000.

54% of the women who took out a health loan said it covered the entire medical expense.



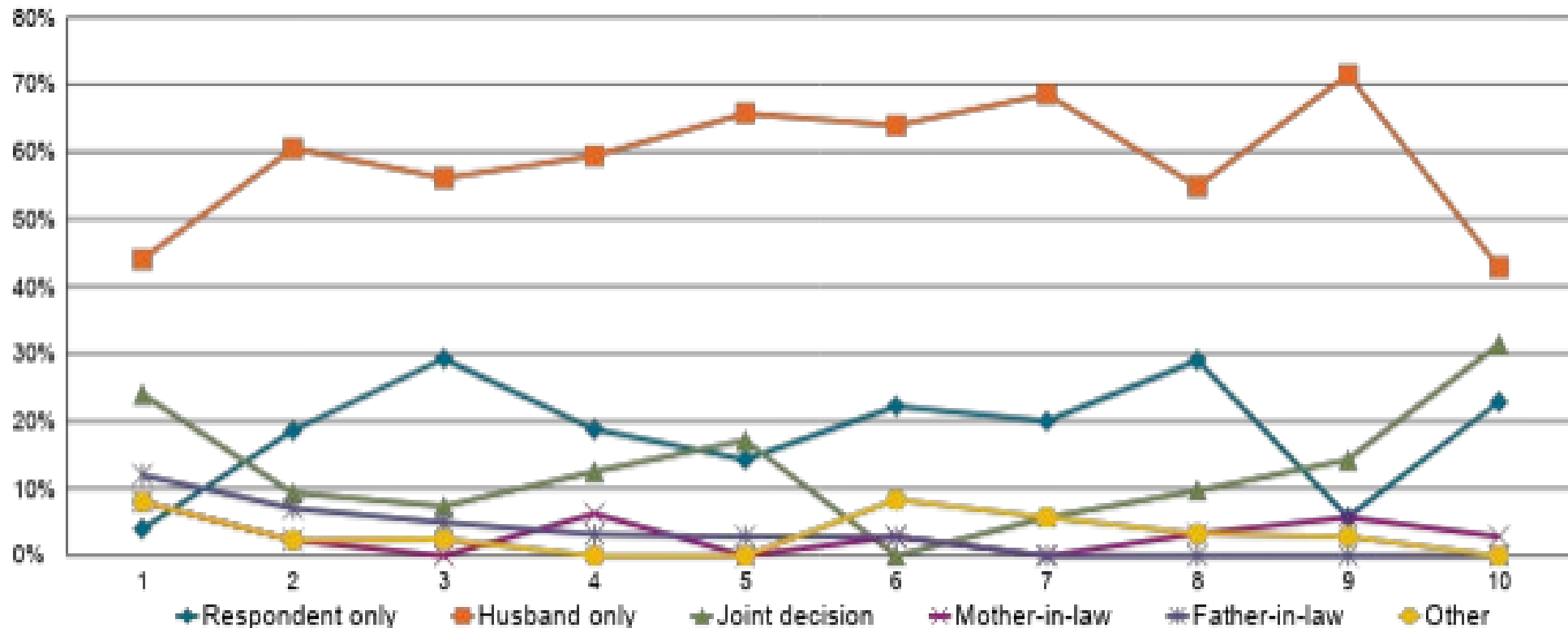
ADS Health Savings Distribution

Of the 15% who said they had distributed their health savings, most of the money was reportedly used for a chronic health issue (68%) or they put the money back into health savings box held with group.



Household Decision-making Regarding Health

Drawing on health diary data from both ADS and Bandhan, women were more likely to report that their husband actually made the decision as to how they would financially respond to an illness, despite women generally reporting that if a health event were to occur, they would make decisions or share the decision with their spouse. Low decision-making power among women regarding health expenditures has implications for the design of health financing tools.





These three women all have something in common.

Each are members of ADS SHGs who have recently taken out health loans and were interviewed during the monitoring assessment. Not only are their experiences similar, they align with other data collected in the monitoring assessment and in health diaries. They each sought care from a private doctor and required money for transportation, doctor's fees and medicine. Costs for medicine represented the highest cost incurred.

Rimpa, took a loan of INR 1,000 for her son's diarrhea. She spent INR 200 on transportation, INR 300 for doctor's fees and INR 500 for medicine.



Purniana took out a health loan of INR 1,500. She used INR 300 for doctor's fees, INR 100 for transportation and INR 500 for medicine. The balance was used for private testing and food.



Sunanta took out a INR 1,500 health loan for an ailment that she has been suffering with for the last 2 years. She spent INR 300 for doctor's fees and INR 1,000 for testing. She borrowed another INR 1,500 from her husband for medicine.

Sunanta plans to take out another health loan when she returns to the doctor in three months for more tests. Without her health loan, Sunanta says, "I would have had to take a loan with higher interest."

Future Considerations | Health Financing

- India is introducing a universal health coverage scheme. Current programs to assist low-income households with health expenses do not fully reduce the burden of out-of-pocket health expenses.
- Financial service providers have an opportunity to design products that can help assist households with out-of-pocket medical expenses.
- Health financing tools, such as health savings and loans, have to respond to the sense of urgency households feel when faced with a health expense (whether the health expense can be planned for, i.e. pregnancy, or not). Women are ashamed to ask friends and family for money to cover health expenses, despite often turning to them for help.
- While group-based health savings can reduce the need to turn to family and friends, they do not altogether keep a woman's health needs private as the group still has to agree on providing a health loan to the women, which requires her sharing the need for which the loan is being requested.
- Women are also not the ultimate decision-makers as to how the household will cover a health expense. Designing a health financing product will require designs that engage men as well, to ensure agreement between spouses of how to use and benefit from the product.



Health Provider Linkages

Objective 3: Increase access to health products and services among poor women and their families by offering sustainable linkages with local health providers.

What do the women and providers say about the linkages?

“This is a very, very poor area. Bandhan is mobilizing the community in a nice way; they are convincing village members. We used to work independently. When we learned about Bandhan, they proposed to work with us. We met and learned what they were doing. They helped us with a rubella campaign for children 9 months old to 15 years. They would survey the children, meet with SHGs to educate them and convince the guardians of vaccinations. Bandhan was able to get into many areas that we couldn’t get into.” – Dr. Hague, Pakur Block Doctor, End of Project Monitoring Assessment

“Bandhan would report it if health workers are not doing their job.” –End of Project Monitoring Assessment

“There was a deficiency regarding information from the grassroots level to the government. ADS works at this level and informs us [Gram Panchayat] and the government. We did not have that before.” – ADS client, End of Project Monitoring Assessment

“Sometimes, ADS accompanies us to the hospital for delivery.” – ADS client, End of Project Monitoring Assessment

“We get free medicines [and] proper check-ups — all paid for with our [Swasthya Sathi] card.” – ADS client, End of Project Monitoring Assessment

“I did not know how to use the sub-centers; I wasn’t aware of the services until the SS [Swastha Sahayika] went door to door.” – Bandhan client, End of Project Monitoring Assessment

“Because of us, 102 SS were able to help people do institutional deliveries, breastfeeding, link to healthcare, vaccinations, birth control and improved hygiene. We have been able to bridge the gap.” – Health Provider, End of Project Monitoring Assessment

Overview of Linkages

ADS and Bandhan were instrumental in building the capacity, awareness and connection between government health frontline workers (FLWs), who are main service providers, with SHG members. They addressed both demand and supply issues with the FLWs through advocacy on behalf of the SHG members and providing the necessary education and making use of the local self-government known as the Panchayat, particularly with regard to vaccination campaigns and institutional deliveries.

Who are involved in the linkages?

Bandhan

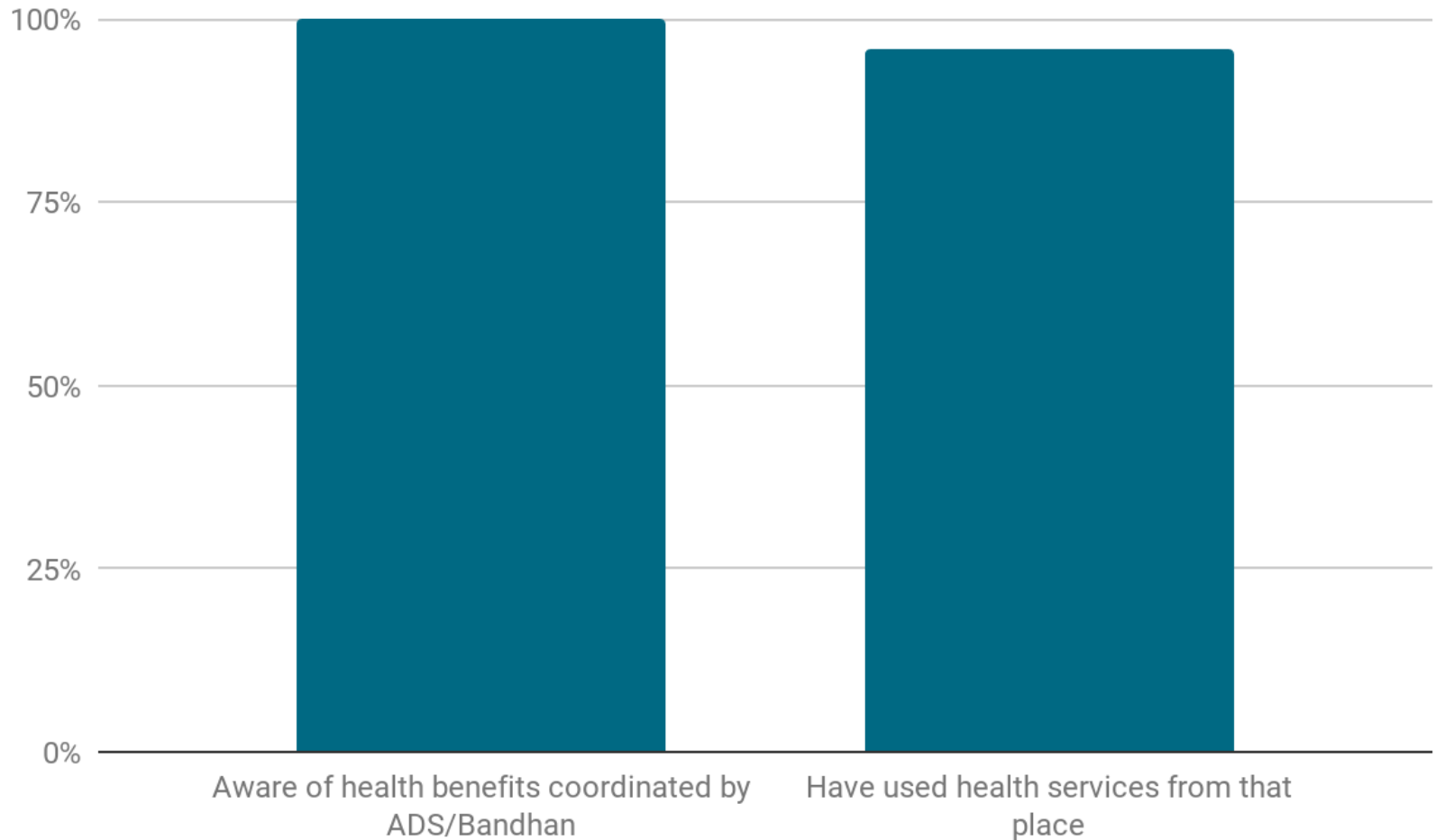
- Bandhan staff: provide household counseling, conduct health forum trainings and oversee village-level health volunteers, called Swasthya Sahayikas (SSs)
- SSs: recruited and trained by Bandhan staff, who visit the SHG door-to-door to deliver health education. The SSs also sell health products for a modest sum that are provided by Bandhan. The SS workers continue to offer their services as Bandhan exits the community.
- Auxillary Nurse Midwife
- Anganwadi workers: work at nutrition and pre-primary centers called Anganwadi Centers
- Pakur Health Department: Primary Health Center doctors

ADS

- ADS staff: provide health and health savings education to the SHGs and conduct joint home visits with local FLWs.
- Attendance at sub-health centers and health and nutrition days (VHND)
- Monthly meeting at Gram Panchayat office with Panchayat Leaders, ADS staff and FLWs
- Auxiliary Nurse Midwife
- Anganwadi workers: work at Anganwadi Center on supplementary nutrition and pre-primary education
- Accredited Social Health Activists (ASHAs): similar to SS at larger scale, run by government

Linkages with Health Services

Developing linkages between the FSP partners and local health actors was a significant part of the project. Those linkages may be paying off, since all the women from both ADS and Bandhan indicated they were aware that linkages or some sort of coordination existed between ADS/Bandhan and local health providers and that most had used services from that place in the prior year.



Bandhan Health Provider Linkage Results

In addition to client awareness and reported use of health provider linkages, Bandhan staff and local health providers collected their own data on health service utilization.

Medical providers reported dramatic increases between 2016 and 2018 in institutional delivery, immunizations, and use of general medical services.

“Before, Bandhan gave me trainings; now I can be trained by government — I know much more and I learn of things faster. This enables me to assist more. Meetings with the district leads and doctors empowers me. We need each other.” *(Bandhan Area Coordinator - End of Project Monitoring Assessment)*

Bandhan partner data collected over the life of the MASS project from health providers in Jharkhand

	2016	2018
Institutional Delivery	20%	88-90%
Immunizations	62%	90%
General services	60%	90%

Reported from Dr. Samiokul Hague, Medical Officer in Charge, and Dr. Thomas, District Immunization Officer (Pakur Block, Jharkhand)

	December 2016	September 2018
Institutional Delivery	26%	50%
Exclusive Breastfeeding (0 -6mos)	70%	95%
Immunizations	35-38%	80-82%
Pre-natal check -ups	28-30%	80%

Reported from Sutata Das, Bandhan Area Coordinator (Jharkhand). Information collected from 9,805 households

Linkages

Meet Maskura Bibi, a Bandhan SS worker. She is 32 years old and is married with four children. Her youngest child is 3 months old and her oldest is a 13-year-old daughter. She began work as a Bandhan SS in October 2015 because she “wanted to educate myself on health programs and wanted to educate others.” She took a six-day training from Bandhan staff and goes “door to door telling [pregnant mothers] to go to the hospital to deliver and even before delivery so proper precautions are able to be taken. I talk about vaccinations, how to eat good nutrition that is required, to go for blood checks [to detect anemia], and to get medicine. Every evening, I go house to house, and one time per month we call everyone to one place and we have a meeting. Sometimes, I conduct this meeting on my own.”

Maskura also sells health products purchased from Bandhan for a modest sum and uses “the profits for my own household” — the most popular item being sanitary pads. When asked about whether people are buying contraceptives, she said, “it used to be that no one was buying contraceptive pills, then it went to 10%, now it is 30%, and it is increasing. People are buying contraceptives. Men ask for condoms, but I don’t stock them.”

Maskura profits between INR 350 and 400 per month (about \$5.00). She wants much more training on health education and reports that she “wants to be an ASHA,” a government-trained and supported community health worker.

She has support from her mother-in-law and 13-year-old daughter to watch her younger children while she goes door to door working as an SS. “I want knowledge for myself and for others, so we can have a healthy village.” She also has support from her husband, who takes her to her Bandhan trainings.

Maskura reports that if she discovers a child who is not vaccinated, she will take them to the health center herself. “At first, they didn’t know what vaccination to get and when, but I educate them on the vaccination schedule. I tell pregnant women to take 2 hours of rest, to eat proper food and to take iron tablets.”



Future Considerations | Linkages

- The landscape of providers has to be understood, to identify the best entry point for collaboration. Use of [earlier guidance](#) on how to map out service provision and to identify points of entry for collaboration remains relevant.
- Linkages, to be successful, need to be developed starting with existing community structures, for example, using community-level meetings as a place for coordinating activities between financial and health service providers. ADS leveraged Saturday Panchayat meetings to develop their collaboration with local health sector actors.
- Linkages between financial service providers and health providers take time, and are difficult to measure given the cross-sectoral nature of the collaboration between service providers. Bandhan used their staff to track key indicators, related to institutional birth and immunizations, to understand use of health services among their beneficiaries.
- The development of cross-sectoral collaborations requires a long-term commitment. Staff rotate in-and-out of both financial service providers and health providers, therefore requiring periodic renewal of shared goals and planned activities.
- Public versus private? The health diary research revealed that despite linkages with public health providers (and the benefit of the lower out-of-pocket costs), private providers are still used by low-income populations due to preferences, availability of the provider and perceived quality of care. Developing linkages with both types of providers should be explored.
- Universal health coverage (UHC): As countries like India transition to UHC schemes, there will still be a role for financial service providers. UHC will not cover all costs associated with seeking treatment. Beneficiaries will need to understand how to access and use the benefits to their advantage. Bandhan and ADS both played roles in helping raise awareness and in accessing government benefits for health care among their beneficiaries.
- While not fully explored during this project, there is an emerging opportunity to explore digital payments given the growth of mobile phone ownership and digital technologies being used in the health and financial sectors in India.



Community of Practice in Health and Microfinance (COPHAM)

Objective 4: Build an active community of practice (CoP) where actors across sectors share experiences and partner to deliver integrated health and financial services to increase access to health services to women and their families.

COPHAM

Since 2010, RESULTS Educational Fund, Grameen Foundation and Freedom from Hunger India Trust have been in a strategic alliance to promote integrated health and microfinance. The Community of Practice for Health and Microfinance (COPHAM) is the realization of their community building efforts in India.

COPHAM brings together organizations in the health and microfinance sectors in India to promote universal healthcare coverage through partnership and to facilitate a learning agenda. Sa-Dhan, the premier national network of development financial institutions in India, hosts the COPHAM Secretariat.

Membership to COPHAM requires a commitment to advance health, particularly maternal and child health (MCH) and water, sanitation, and hygiene (WASH), in accordance with the guiding principles, mission, and vision of the consortium.

Vision

Ensure healthy lives and promote well-being through universal healthcare by integrating health and microfinance.

Mission

Ensure access to comprehensive, high quality healthcare and sustainable management of water and sanitation, particularly for women, adolescent girls, and children by aligning the strategies of microfinance and health sectors and catalyzing collective action.

Members

As of December 2018, COPHAM had 51 members from across India.



www.healthandmicrofinance.org

Members: Health

Meet Mukti Bosco, a member of COPHAM and

co-founder and secretary-general of Healing Fields Foundation (HFF), a health-focused NGO committed to empowering women as health change agents in their communities.

With her friend Nimish Parekh, Ms. Bosco founded HFF in 2000, soon after completing her master's in healthcare management. She has received recognition as a social entrepreneur in micro health insurance, winning an Ashoka Fellowship in 2007 and Manava Seva Dharma Samvardhani's Tenth Sadguru Gnananada National Award in 2009 ("Women Social Entrepreneur" category).

HFF's contribution to integrated health and microfinance is in working with other NGOs, the private healthcare sector and the government to improve access to basic healthcare products and services for the underprivileged. HFF provides training in health, nutrition, hygiene and common illnesses for women in rural areas, for example microfinance clients or SHG members. HFF supports these Community Health Facilitators (CHFs) to build a livelihood on their new skills, working as health change agents in their communities.

In March 2017, Ms. Bosco and the executive director of CASHPOR, one of HFF's field partners, led a webinar for COPHAM members on [Community Health Workers: A Feasible, Viable Channel for Promoting Health Workers](#). The 35 attendees actively engaged the speakers, seeking greater understanding of the model and how they might adapt for their own organizations.





Members: Microfinance

Meet John Alex, a member of COPHAM and

group head – social initiatives at Equitas Small Finance Bank, an innovative MFI from day one. Established in 2007, Equitas provides transparent and trustworthy access to financial and other relevant products and services by deploying cutting edge technology and forming partnerships and alliances.

Equitas allocates 5% of the company's profits to its Trust and healthcare tops Equitas' non-financial services provided out of their corporate social responsibility (CSR) team. Equitas provides health education, health clinics and camps, telemedicine, linkage to hospitals, health helpline, and pharmacies. They organize monthly health camps in each branch and deploy CSR staff across its network to provide non-financial support to clients.

In a July 2016 webinar, Mr. Alex and the executive director of SKDRDP, another leading microfinance institution, shared their [Lessons Learned in Building Partnerships to Reach Scale](#). Mr. Alex talked about how Equitas leverages its investment by partnering with healthcare providers and others to decrease the expenses clients spend on health services. For example, they partner with a network of more than 900 hospitals to provide affordable, quality health care—including telemedicine options—to 3.6 million people.

Learning Events: Webinars and Workshops

Over the last 3 years, COPHAM has promoted integrated health and microfinance among key stakeholders in health, microfinance, government, philanthropy and other sectors through events in-person and online.

Under RESULTS' leadership, COPHAM has organised regional and national workshops (two each) for key stakeholders in the health and microfinance sectors, and 10 COPHAM member institutions delivered five experience-sharing webinars. Through these events, COPHAM members have learned about each others' innovations and best practices and found new partners.

In September 2018, RESULTS launched [Integrated Health and Microfinance in India, Volume III: Banking on Health](#) at Sa-Dhan's National Seminar; the report highlights the innovative integrated services delivered by COPHAM members and explores how this model can support the Government of India's universal health coverage (UHC) efforts.

Workshops and Stakeholder Meets

- September 2016 | [Stakeholder Workshop on “Community of Practice for Health and Microfinance”](#)
- June 2017 | [Rajasthan Nutrition Project Leverages SHG Platform for Improved Nutrition](#)
- September 2017 | [Second Annual COPHAM Stakeholder Meet](#)
- October 2018 | [Improving Health and Nutrition Outcomes in West Bengal & Jharkhand](#)

Webinars

- June 2016 | [Community of Practice: The Journey So Far and the Next Steps](#)
- July 2016 | [Lessons Learned in Building Partnerships to Reach Scale](#)
- March 2017 | [Community Health Workers: A Feasible, Viable Channel for Promoting Health Workers](#)
- April 2017 | [Affordable and Quality Healthcare for MFI Client Families](#)
- February 2018 | [COPHAM in 2018: Let's Get Started](#)
- June 2018 | [Meaningful Health Protection “the Mutual Way”](#)
- October 2018 | [What Does Universal Health Coverage Mean for COPHAM Members?](#)

Future Considerations | Community of Practice

India is poised for a healthcare revolution.

How its citizens access and finance their healthcare is at a turning point. New and existing publicly funded social health protection schemes for the poor have a limited effect on out-of-pocket expenditure due to a range of factors, including limited awareness of entitlements that hinder the benefit of such schemes for those who need them most. This leaves an opportunity, as explained earlier in the discussions about linkages, to complement government-sponsored schemes.

With the announcement in 2018 of India's UHC scheme, Ayushman Bharat, we see a golden opportunity for COPHAM to promote integrated health and microfinance. COPHAM will convene key stakeholders in health, microfinance, government, philanthropy and other sectors for the Third National Stakeholder Meet in New Delhi to explore how this model can support UHC efforts.

Sa-Dhan, the national network of development financial institutions, now houses the COPHAM Secretariat and has committed to facilitating more players in the microfinance sector to take up health related services and products. Sa-Dhan will officially take over COPHAM as of April 2019, and with their leadership, the initiative has a chance to achieve sustainability and benefits from the legitimacy of being locally rooted and member-driven.

Challenges

- It is a difficult funding landscape for integrated health and microfinance, with long-time funders moving out of the space.
- Though COPHAM members were engaged in the process of selecting a local host for the secretariat, it was recognized that any choice would favor one of the two (health or microfinance) sectors and, thus, be a potential problem.
- Members agreed to pay a membership fee to achieve sustainability, but Sa-Dhan's membership fee for NGOs to participate is perceived as being too high.

Opportunities

- With a membership of 190, Sa-Dhan has a vast number of institutions it can influence to offer health services, and they can cross-pollinate with their other programs.
- Sa-Dhan is both well-regarded and well-connected in India, which will help them to expand COPHAM's reach and funding.
- COPHAM has an important role to demonstrate how collaborative activism across sectors can address and improve community health.



Communication and Advocacy

Objective 5: Amplify awareness of the integrated health and microfinance methodology as a development strategy for achieving the SDGs through a marketing, advocacy, and communications strategy that highlights the contributions of an integrated approach toward sustainable development outcomes.

MASS Publications

Project Evaluations

- [Prevent Anemia for Better Health: Research Brief](#)
- [Healthy Mothers Make Healthy Communities: Research Brief](#)
- Bandhan *Maa aur Shishu Swasthya* Program: Client Outcome Study
- ADS *Maa aur Shishu Swasthya* Program: Client Outcome Study
- Bandhan Adolescent Menstrual Hygiene Management: Outcome Study
- ADS Learning Games for Girls: Outcome Study (forthcoming)
- MASS Impact Evaluation Report

Research - Health Diaries Breakthroughs

- [What 'Health Diaries' tell us about managing health care and costs among women in West Bengal and Jharkhand](#)
- [What "Health Diaries" tell us about financial and medical preparation for giving birth among women in West Bengal and Jharkhand](#)
- [Decision-making power of women in microfinance and financial self-help groups in Jharkhand and West Bengal](#)

State of the Sector Reports

- [Integrated Health and Microfinance in India: Harnessing the Strengths of Two Sectors to Improve Health and Alleviate Poverty -- State of the Field of Integrated Health and Microfinance in India, 2012.](#)
- [Integrated Health and Microfinance in India, Volume II: The Way Forward](#)
- [Integrated Health and Microfinance in India, Volume III: Banking on Health](#)



Tools

- [Healthy, Wealthy, and Wise: How Microfinance Institutions Can Track the Health of Clients](#)

MASS Communications

Media Coverage

- [The Indian women eating with their families for the first time](#), Geeta Pandey. BBC News, Delhi. September 2017.
- [Mental health matters for microfinance](#). Bobbi Gray. 100 Million Ideas. October 2015.
- [New database tool can help you define and refine client outcomes](#). Bobbi Gray. 100 Million Ideas. February 2016.
- [Healthy, Wealthy & Wise: The results of integrating financial and health services](#). Gabriela Salvador and Bobbi Gray. Microfinance Barometer 2016.
- [Dear Health Diary: The True Cost of Healthcare to Low-Income Households in India](#). Sabina Rogers. UHC Coalition. October 2018.

Promotional Videos

- [Banking on Health: Changing Lives in India](#)
- [Banking on Health: Changing Lives in India training video](#)

Global Events

- **The Johnson & Johnson Changemakers' Expo**, New York, September 2017
- **Social Performance Task Force International Seminar on "Customer Centricity Challenge,"** Mallapuram (Tamil Nadu), February 2018
- **World Bank Spring Meetings CSO Innovation Fair**, Washington, DC, April 2018
- **Rotary International Ending Ultra-Poverty Summit**, Toronto, June 2018
- **RESULTS International Conference**, Washington, DC, July 2018
- **World Bank End Poverty Day**, Washington, DC, October 2018
- **Sa-Dhan National Seminar**, New Delhi, September 2018
- **2019 Women Deliver Conference** (planned), Vancouver, BC, June 2019



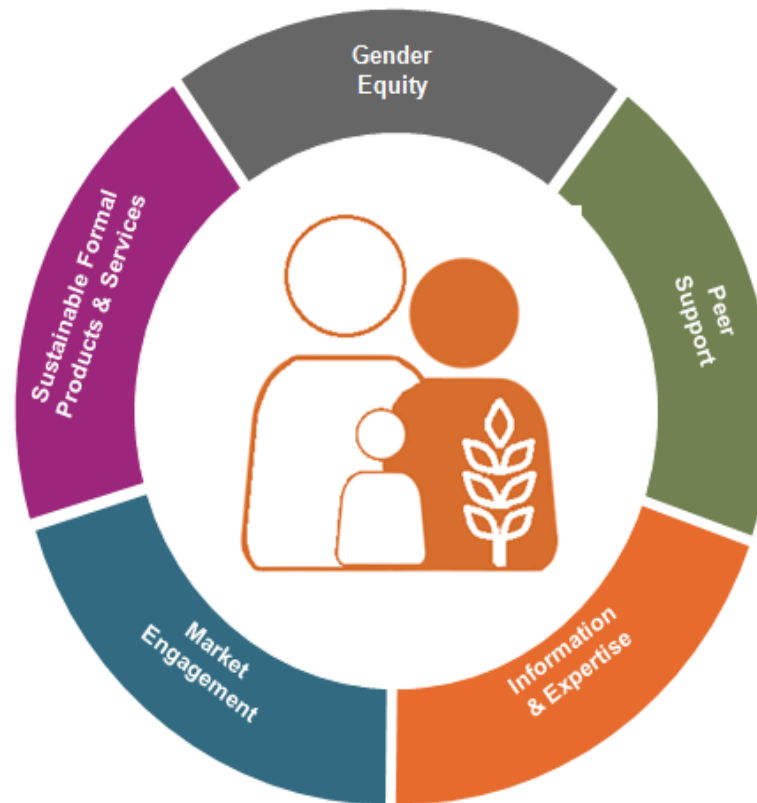
Conclusion

Empowering Ecosystems for Rural Women and Their Households

Grameen Foundation's programs and partnerships aim to strengthen five main elements of an empowering ecosystem for women described to the right. Interventions are designed to ensure that most programs address these elements and they are also used to measure beneficiary outcomes to determine the success of the interventions.

For the MASS project, the five main elements of the ecosystem can be used to highlight the interventions that were implemented:

- > **Gender Equity:** MASS did not have an intervention to directly address gender equity, Future replications of this project should address the role of men in decision-making regarding health.
- > **Peer Support:** Women's savings group, field-level workers served to support group members in accessing health financing and services.
- > **Information and Expertise:** Health education provided women with information on anemia, healthy pregnancy, menstruation, among other topics.
- > **Market Engagement:** Linkages between financial and health service providers and availability of health savings and loans (ADS-only) encouraged women to actively use local health services.
- > **Sustainable Formal Products and Services:** The formal collaboration of local health and ADS/Bandhan staff and the local leadership of COPHAM provide ongoing identification of community health needs and areas of needed collaboration.



GENDER EQUITY

Interventions and information that help transform gender norms in the household, community and marketplace

PEER SUPPORT

Women's groups and field agent networks that provide encouragement, practical support and training

INFORMATION & EXPERTISE

Knowledge and skills gained through information, tools and training that are easily accessed and understood

MARKET ENGAGEMENT

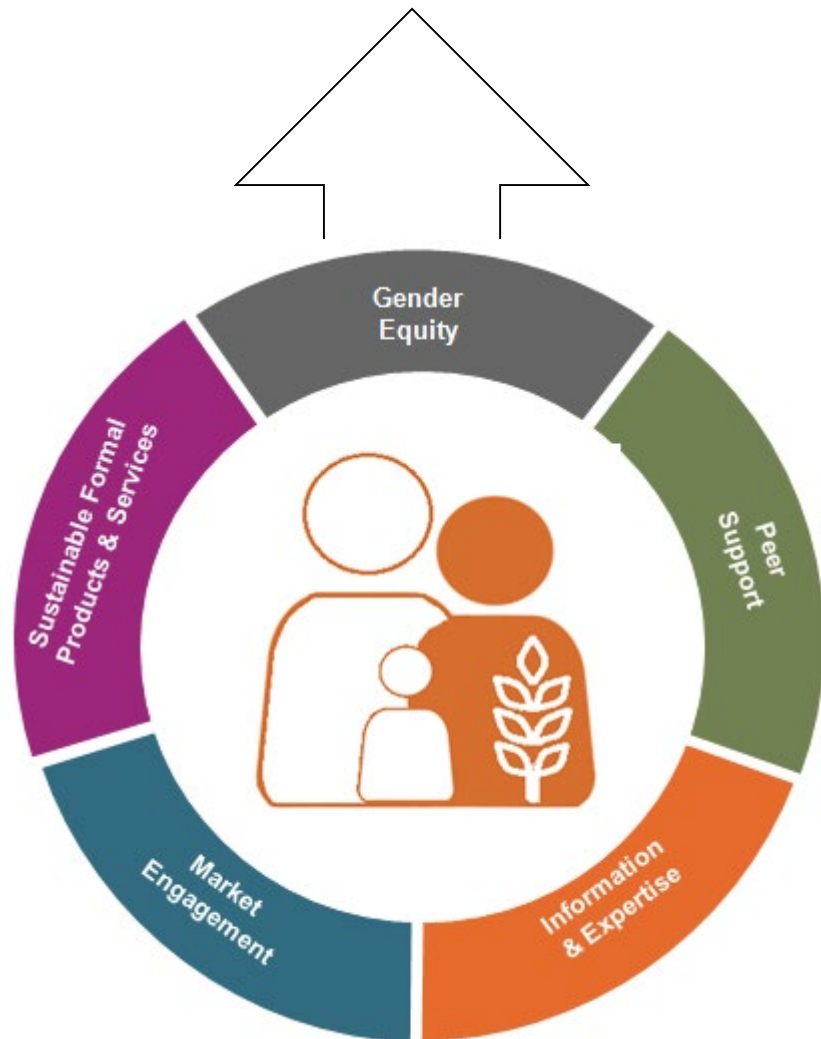
Avenues that enable poor communities to access and actively participate in the agricultural, financial and health marketplaces

SUSTAINABLE FORMAL PRODUCTS & SERVICES

Financially sustainable tools available to meet the needs of poor women, their families and communities to accelerate their climb out of poverty

Measuring Our Success

Improved the health of women and children in India through increased access to and use of health services



Using the ecosystem as a framework for evaluating the success of the MASS program in improving the health of women and children in India through increased access to and use of health services, we find the following:

Gender Equity

- No evidence of relational changes at the household level (nor were these measured since there was no strategy to improve such changes).
- Health diaries revealed women had very little decision-making power on health expenditures. This is an area to improve upon.

Peer Support

- No evidence of change among women and their group members nor between the beneficiaries and the frontline workers. This is an area to improve upon.

Information and Expertise

- Evidence of improved and sustained knowledge among many of the indicators; lack of improvement in recognition of danger signs during pregnancy requires action by both education session designers and the partners to improve the design before further replication or scaling of this session.

Market Engagement

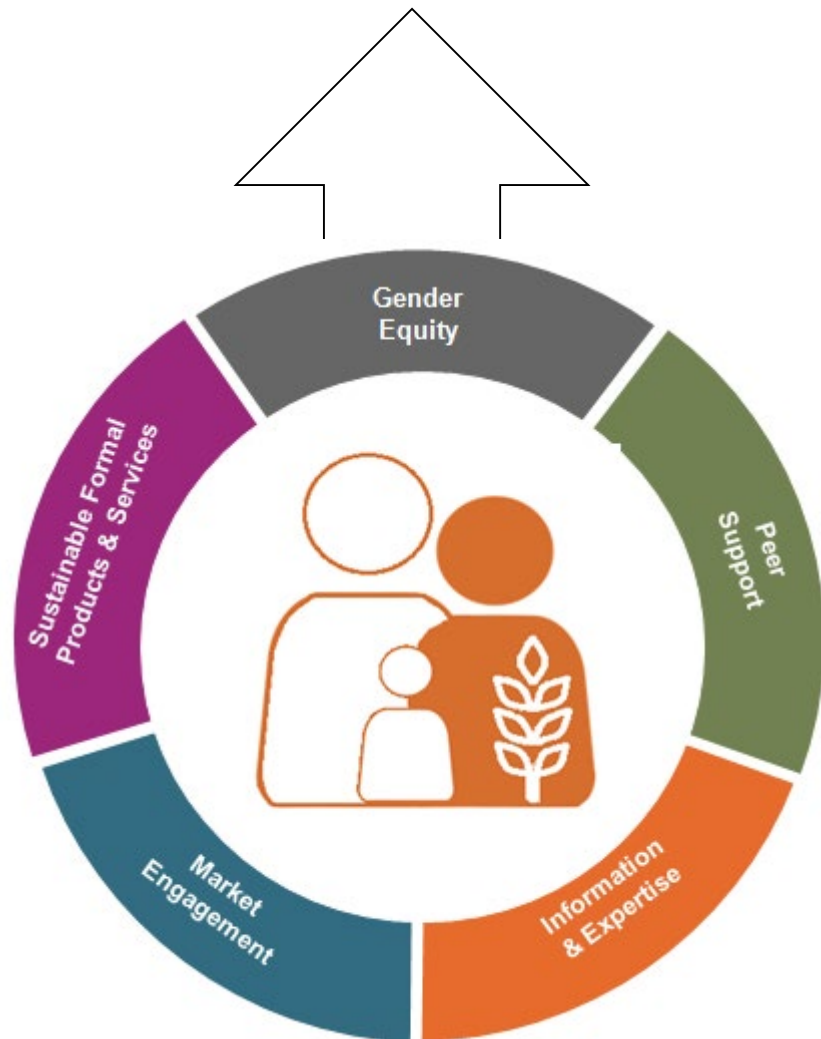
- Increased access and use of health savings and loans among ADS clients.
- Health provider and Bandhan records show increase in institutional birth, immunizations, pre-natal check-ups, and breastfeeding behaviors among the target population.

Sustainable Formal Products and Services

- The provision of health services through an existing sustainable financial services platform generates marginal costs, allowing for sustainability of the integrated financial services-health strategy for the financial service providers.

Measuring Our Success: Behavior Change

Improved the health of women and children in India through increased access to and use of health services



The overall impact MASS aimed to achieve was improved health of women and children in India through increased access to and use of health services. While the program was unable to measure health status, such as reduced morbidity or mortality, MASS was able to achieve short-term outcomes (behaviors), such as:

- Improved and sustained consumption of iron-rich foods and vitamin C which should result in reductions in anemia where food consumption is the primary cause of anemia.
- Increased use of sanitary pads among adolescent girls, which contributes to improved hygiene.
- Medical/health sector data showing increased use of health services, particularly for institutional birth, immunization and other medical services.

Supply Meets Demand

Integrating microfinance and health services provision assists in ensuring that supply of health services is met with demand from communities for their services.

Supply

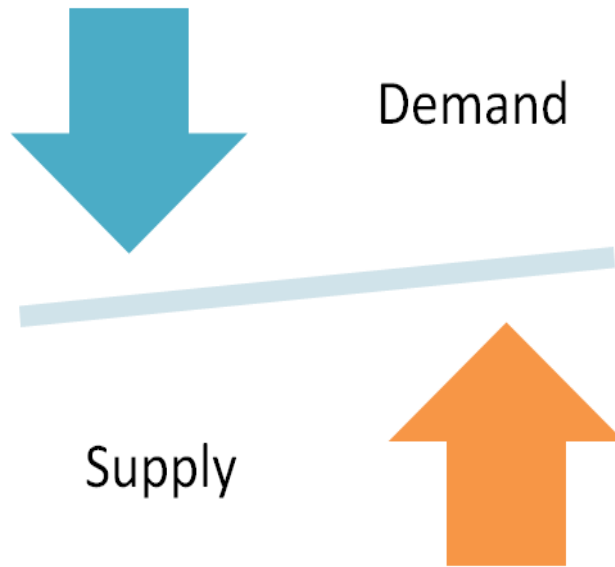
- Linkages from Financial Service Providers to Health Providers provides visibility and confidence in health services among communities.
- Financial Service Providers advocate for quality services on behalf of their clients.
- Health providers have an advocate in FSPs to ensure communities adhere to treatments and health services, such as for antenatal and postnatal care, immunizations, etc.

Demand

- Clients participate in awareness-raising campaigns, ensuring they are educated on appropriate health and treatment-seeking behaviors, and are confident in accessing services.
- Clients have access to health savings and loans to assist in covering out-of-pocket expenses.

It's a win-win-win proposition

- Clients experience better health and reduced financial stress due to tools designed to assist them in covering health expenses and confidence in their ability to take care of their families' health.
- Financial service providers have healthier clients, and therefore a healthier financial portfolio.
- Health providers effectively cover their communities with necessary medical services, meeting public and private health goals.





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