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## Economic Strengthening and Health

### Trickle Up's Approach with Ultra-Poor Women in India

AUTHORS

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## **About SEEP**

The SEEP Network is a nonprofit network of over 130 international organizations that believe in the power of enterprise to reduce global poverty. SEEP members connect in a global learning community to increase their impact in over 170 countries, where they collectively serve over 89 million micro-entrepreneurs and their families. Through SEEP's learning initiatives, microenterprise development practitioners co-create and exchange strategies, standards, and tools for building healthy economies with a sustainable income in every household.

## **About HAMED**

SEEP's Health and Market Development Working Group (HAMED) was formed to address the challenge of health access among vulnerable populations, including HIV and AIDS-affected communities. The goal of HAMED is to connect economic strengthening development practitioners, such as microfinance and microenterprise, with public health professionals and policy makers in order to document, demonstrate, and disseminate a growing body of best practices regarding the integration of health with economic strengthening programs.

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# Executive Summary

Founded in 1979, Trickle Up supports ultra-poor women in India, Central America and West Africa to move out of poverty by enabling them to plan and execute a series of livelihood activities, become active members in their savings and credit groups, and learn skills to strengthen their livelihoods. In 2006, Trickle Up launched a graduation pilot project in West Bengal, India, with support from the CGAP/Ford Foundation Graduation initiative, to introduce several new components into our program, including health.

Given that health expenditures are second only to food expenditures among ultra-poor families, poor health represents a threat to their economic well-being, in addition to lowering their quality of life. Trickle Up established a health component with a two-pronged approach, focusing on education and awareness-raising on health care issues critical to these rural communities, and creating linkages to no- or low-cost government health care services to which they should have access.

Following the pilot project, Trickle Up rolled out a new graduation model, including the health care component, across its entire program in India, supporting 2,350 participants in fiscal year 2011. As the first cohort approaches the end of the 3-year project, Trickle Up conducted in-house research to assess the effectiveness of the health component, and to inform the refinement of the health services offered. We found that:

- Advocacy by health workers, field workers, senior partner staff and self-help groups resulted in significant progress in important indicators such as children born in government health care centers (instead of at home).
- Improved village-level government health care services and Trickle Up services resulted in improved health indicators such as mosquito net usage and vaccination of children. The relative contribution of Trickle Up's services is not clear.
- Trickle Up health workers struggled to advocate effectively with government health care facilities to provide services they are required to provide because of the health workers' relative youth and inexperience. Increasing the minimum education requirement and experience of health workers would improve their ability to advocate and increase their capacity to provide other support to participants.
- Trickle Up can most efficiently address the health needs of ultra-poor families by supplementing, rather than duplicating, the services offered by government health care workers and health facilities. Specific gaps were identified in health information and awareness, and certain diseases and health issues not covered by government health workers. Our experience highlights the importance of crafting a health component that takes into account the capacities and limitations of other actors in the community.

# Economic Strengthening for the Ultra-Poor

The ultra-poor represent a segment of the population not typically reached by economic strengthening programs, and pathways out of poverty for this population remain few and far between. Ultra-poor families are isolated from their communities, heavily reliant on sporadic wage labor, and food insecure. They are susceptible to health shocks that destabilize the household economy and health expenses for these families typically represent the second largest expense after food. Social safety net programs and other short-term supports designed for this population generally serve to stave off immediate crises without actually breaking the cycle of poverty.

Trickle Up, a livelihood development organization operating in India, West Africa and Central America, combines economic strengthening strategies with awareness-raising, training, and links to safety net programs to move ultra-poor families out of poverty. In 2006, in partnership with the CGAP-Ford Foundation Graduation Program,<sup>1</sup> Trickle Up established a pilot project in South 24 Parganas, West Bengal, India, where for the first time we systematically integrated a health component into our livelihood development program. Now a part of our core program model in Bihar, Jharkhand, Orissa, and West Bengal, India, we see the integration of preventative and curative health components into our economic strengthening initiatives as critical to addressing one of the key vulnerabilities of ultra-poor families.

## Trickle Up India's Model

Women are selected for Trickle Up's program using household-level participatory rural appraisal tools that engage the community in identifying ultra-poor families followed by two levels of verification. Because of the isolation of the ultra-poor women we select, Trickle Up's intervention starts by connecting the women to support systems including both a coach who will mentor them over the three-year project and a savings and credit group that consists of 10-15 Trickle Up ultra-poor program participants. Women in these self-help groups meet weekly, begin to save, take small loans (initially for consumption and eventually for productive activities), and serve as an additional support mechanism for one another that will prove critical to their progress. Over the next three years, the women, with help from their coaches, plan a series of livelihood activities, with the first two or three made possible by seed-capital grants to purchase productive assets. They attend trainings tailored to the

Participant Profile at Baseline *	% of total
Demographics	
Scheduled Caste	20%
Scheduled Tribe	58%
Primary Livelihood Strategy	
Wage Labor	82%
Skills and Experience	
Able to Sign Name	31%
Access Public Health Center	18%
Assets and Liabilities	
Kachha housing (mud wall, roof, and floor)	91%
Total Asset Value < Rs 2000 (~\$45)	75%
Own > 0.5 Acres	16%
Own > 1 Acre	1%
Have Savings	7%
Of those w/ Savings, Avg. (Rs)	937(~\$21)
Have Debt	49%
* Baseline data is taken from most recent baseline survey of 1,750 participants in post-pilot Ultra-Poor program.	

Baseline Food Security Survey	% of total
Always eat enough of desired foods	0%
Enough food, but not desired kinds	3%
Sometimes not enough food	74%
Often not enough food	24%

<sup>1</sup> The CGAP-Ford Foundation Graduation Program is a global project bringing together 10 microfinance and development organizations across eight countries to design, adapt, and begin scaling up a common methodology for "graduating" the ultra-poor out of extreme poverty. The Graduation Program encompasses pilot programs in Ethiopia, Ghana, Haiti, Honduras, India, Pakistan, Peru, and Yemen, with 3 of the 10 participating pilots now in their proof of concept phase along with Trickle Up. See <http://graduation.cgap.org/> for more information.

livelihood activities they will pursue, receive a stipend during the “hungry season” in the first year of the program to prevent forced migration, learn how to access government safety net programs, and take significant steps to improve their own health and hygiene and that of their families.

Our program is implemented in conjunction with local partner organizations that enable us to work effectively in remote, rural areas and whose capacity strengthening is another core goal for Trickle Up. In consultation with Trickle Up, our partners identify the best market opportunities to support livelihood growth, prioritize health issues relevant to the communities they serve, and leverage their network of government contacts to help facilitate linkages to public services.

The table below shows the three-year timeline for the delivery of the program.

<b>Timeline of Activities for Participants</b>		
<b>YEAR 1</b>	<b>YEAR 2</b>	<b>YEAR 3</b>
<ul style="list-style-type: none"> <li>• Select working areas</li> <li>• Select participants, utilizing Participatory Rural Appraisal (community mobilization and mapping and poverty wealth ranking) and a household poverty assessment</li> <li>• Mobilize self-help savings and credit groups</li> <li>• Deliver livelihood planning and training</li> <li>• Disperse seed capital grants (6 months after self-help group formation)</li> <li>• Supply consumption stipend during the hungry season before new livelihoods yield profit</li> <li>• Begin health education</li> <li>• Provide weekly one-on-one coaching</li> </ul>	<ul style="list-style-type: none"> <li>• Build autonomy of self-help groups</li> <li>• Support expansion and diversification of livelihood activities through additional planning and training (with participants beginning to expand livelihood activities through self-help group loans)</li> <li>• Continue health education</li> <li>• Deliver coaching on key social issues (e.g., family planning, child marriage, domestic abuse, legal rights) to help participants make informed choices and advocate for better treatment</li> <li>• Facilitate access to government programs that provide subsidized products/ services and wage labor</li> <li>• Continue supporting participants through weekly coaching</li> </ul>	<ul style="list-style-type: none"> <li>• Assist self-help groups in obtaining bank accounts and applying for formal credit</li> <li>• Monitor credit use to protect against over-indebtedness and support ongoing livelihood expansion</li> <li>• Continue supporting participants and families in improving their health and connecting to services</li> <li>• Continue individualized coaching, as required, to ensure successful completion of livelihood plans, with a focus on those participants facing the greatest challenges</li> </ul>

# Health in a Livelihood Development Program

Trickle Up's carefully sequenced program is designed to address the various vulnerabilities of the ultra-poor, from food security to isolation to income instability. Success is defined in the following terms. By the end of the program:

1. Participants are less vulnerable to shocks and trends, and more resilient to the hungry season;
2. Their livelihood activities are dignified, diversified, productive and sustainable;
3. They have a fair and effective means to save and access credit;
4. They have improved access to available basic social services;
5. They and their families enjoy a better quality of life, including improved food security;
6. They have made significant progress toward economic and social empowerment.

While improving the health status of the household is not an explicit indicator of success for Trickle Up, addressing health issues is critical to achieving several of these goals as health shocks are one of the principal factors that can undermine any gains our participants may achieve. Typically, ultra-poor participants and their families have poor health, lack access to affordable health care services, may not know how to prevent or treat certain illnesses and cannot afford preventive health care services. Further, they cannot afford regular, much less nutritious, food. With this in mind, Trickle Up's health component in India has two primary objectives:

- 1) *Augment human capital*: A healthy individual is capable of taking more responsibility towards livelihood generation. Good health allows the participant to be more productive, thereby increasing her earning potential. A healthier household can better support the participant and other household members in productive activities, as unhealthy household members can require large amounts of the household's time and money for care and treatment.
- 2) *Prevent depletion of productive resources/capital*: An ultra-poor family is more prone to health shocks. The lack of a comprehensive public health care system or low-cost medical insurance facilities can force households to incur health expenditures beyond their means, resulting in indebtedness or the sell-off of the household's small portfolio of assets. This risk reduces the likelihood the participant is able to engage in sustainable livelihood activities.

Of course quite apart from the economic benefits good health can offer, it is also of intrinsic value for the well-being of the individual household. Trickle Up's program endeavors to address the health challenges participants face through a combination of education and coaching, linkages to support services and economic strengthening, all of which are designed to work in concert to bring about improved health, well-being and greater economic stability. The key to all of these interventions is the support and guidance provided by the field worker and the health worker who serve as the participant's two coaches, mentoring her throughout the three-year process.

## Coaches: Mentoring the Participant to Success

Each participant is assigned two coaches, a livelihood field worker to support the development of her livelihood strategy and a health worker who facilitates discussion on health topics at self-help group meetings and focuses on improving the health and well-being of the participant's family. Trickle Up partners generally work with cohorts of 300 participants. Each cohort has five field workers dedicated to livelihood and social strengthening and two health

workers, with one coordinator to oversee the staff responsible for each cohort. All field and health workers live in or near the participants' communities. Field workers, almost exclusively men, work with approximately sixty participants each and visit them weekly. Health workers, exclusively women, each support 150 women, visiting self-help group meetings bi-weekly and individual households bi-monthly or more frequently if there is an illness or the participant is pregnant or has recently given birth.

Field workers provide much-needed support and mentoring to women and families unaccustomed to receiving help. Staff members provide “just-in-time” messages to women to reinforce training, reminding them, for example, to purchase fertilizer, vaccinate the goats or visit a government office for an application for a jobs card. This ongoing support enables participants to stay on track with their goals, particularly in the beginning of the program. The field workers also work with self-help groups, building their financial skills, fostering the group's autonomy and catalyzing the development of social capital within the groups. Health workers regularly visit participants to introduce family members to government health systems, deliver timely information about health, hygiene and nutrition, and troubleshoot during family health crises.

While field workers focus more on supporting self-help groups and livelihood activities, they also provide significant value for Trickle Up's health work. First, they steward the development of livelihood strategies that improve household food security, and they help participants increase their self-confidence as an individual and as a member of a self-help group to avail themselves of public resources and to assert themselves in their community. Also, relative to the health worker, they spend more time with the participants. This, combined with the fact that they are generally more experienced and male, better positions them to learn about certain health issues, advocate with local officials, and address topics like family planning with the husbands of participants.

## Identifying Priorities

To identify the specific needs of the participants selected for the program, Trickle Up partner organizations administer two baseline surveys to every participant. The primary household survey includes information on the household's demographics, housing, assets, debt, savings, participation in government schemes, migration and food intake. There is a separate health baseline, administered by the health workers, which includes information on access to government health schemes, mosquito net ownership and usage, history of institutional or home delivery, services availed during any earlier pregnancies, immunization details for children, and family planning methods in use.

Health workers, together with the coordinator, analyze baseline data to determine the most pressing needs for the women and their families, and tailor their trainings during self-help group meetings accordingly. Meanwhile field workers use what they learn from the baseline survey to help each woman to develop a livelihood plan (together with other household income earners, if any). In addition to considering the economic needs of the family, the field worker also must determine if there are food security issues with the family and help the woman build a suitable livelihood strategy accordingly. For food insecure families, short-cycle activities are critical at the beginning to generate income quickly and agricultural activities help the women to provide nutritious food for their families.

Finally, field and health workers are responsible for maintaining records in an information book kept in each household in which they record data related to the livelihood and health status of the family, identify topics that were discussed during the visit and note any issues that arose. These records are entered and sent to Trickle Up India monthly to enable us to assess the participant's progress, provide guidance on individual staff performance and troubleshoot issues.

# A Two-Pronged Approach to Health: Education and Linkages

Trickle Up's health intervention takes a two-pronged approach, including health education and linkages. The health education focuses on prevention strategies and the linkages entails linking families to low- or no-cost government health care services in their area.

## Education and Awareness-Raising

Based on the baseline survey, field workers and health workers tailor their education and awareness-raising efforts to identify the most critical needs in the communities they serve. They then develop strategies for working with participants at the household and self-help group level to address those needs, which most commonly include reproductive and child health, family planning, malaria prevention and personal hygiene.



Women learn about the three food groups (corresponding to the colors in the India flag) in a self-help group meeting.

## Reproductive and Child Health

Improving nutrition contributes to improved health, and this is particularly true during pregnancy. Health workers support improved nutrition by educating participants about inexpensive, nutritious foods and encouraging them to grow leafy vegetables. Health workers also inform participants about the government's safe motherhood program, Janani Suraksha Yozana (JSY), and facilitate the process of registering the participant at the nearest health center.

Once registered, the participant receives a health card, which government health workers will use to document the pre- and post-natal care checkups and immunizations of the newborn baby. Trickle Up health workers then carefully track the participant's progress through the JSY program, ensuring that participants undergo three antenatal checkups and receive free Tetanus Toxoid injections. They also ensure that participants consume free iron and folic acid tablets during pregnancy, working to build participant awareness of the importance of the tablets and providing advice on how to prevent the nausea that causes many women to stop taking the tablets.

While many participants are accustomed to delivering their children at home, health workers encourage them to deliver their child at a local health center to minimize risk to the mother and child. According to the World Health Organization and Save the Children, more than 900,000 infants die in India each year, 28% of the global total<sup>2</sup>. Most of these deaths are due to easily preventable causes like respiratory



Encouraging ultra-poor women to feed their families leafy vegetables is only feasible if they have profitable livelihoods. Hazra Bibi, above, used a grant to purchase a water pump turning her fallow field into a healthy crop for her family to eat and to sell.

2 Oestergaard MZ, Inoue M, Yoshida S, Mahanani WR, Gore FM, et al. (2011) Neonatal Mortality Levels for 193 Countries in 2009 with Trends since 1990: A Systematic Analysis of Progress, Projections, and Priorities. *PLoS Med* 8(8): e1001080. doi:10.1371/journal.pmed.1001080

infections and diarrhea, and a central part of the government's initiative to improve this statistic is to encourage women to give birth in health centers where care and close supervision are available.

Trickle Up's strategy is the same. Health workers provide information about the benefits of giving birth in an institution and also try to help remove barriers to women's access to health centers. Health workers may intervene in several ways: helping the participant prepare to talk to a mother-in-law who thinks the delivery should be at home as the family had done in the past, or making arrangements with a rickshaw driver to ensure that a participant can get to a hospital if needed. The health worker also raises awareness of government incentives (in-cash and in-kind) that promote delivery in government health care centers.

After delivery, the health worker informs the participant of the benefits of colostrum feeding and exclusive breast feeding in the first six months, and the risks of common practices such as feeding newborns honey and sweetened water, biscuits, or boiled rice. The health worker also ensures that newborns undergo immunizations and post-natal checkups as scheduled, and informs the participant of the availability of free vaccinations from the local health centers for diseases such as polio, diphtheria, tuberculosis, hepatitis B, and whooping cough.

### ***Family Planning***

Health workers raise awareness of the value of small families, and available temporary and permanent family planning options. The health workers then carry out home visits with a subset of participants-- those in childbearing years with more than two children--and encourage them to consider permanent birth control measures. If appropriate, the health worker may request the field worker to speak with the husband about the issue to answer questions and address any concerns he may have.

### ***Malaria Prevention***

There is a high prevalence of malaria in Trickle Up's areas of operation, and the risk of infection can be considerably reduced by the use of mosquito nets and cleaning of standing water in surrounding areas. The health workers raise awareness about prevention techniques and emphasize the importance of all household members using mosquito nets throughout the year.

### ***Personal Hygiene***

The health workers advise participants about the importance of following personal hygiene strategies. For example, participants are advised to use soap after defecation, wash hands before and after eating, keep children clean, take showers regularly, maintain a clean house, ensure the use of safe drinking water, and keep food clean and free of insects.

# Links to Complementary Government Services and Programs

Although the Indian government provides a multi-tiered healthcare system and offers basic healthcare resources such as medication and tests, institutional delivery, immunizations, and physician consultations in the case of disease, access to these services by ultra-poor families is extremely limited, and families often turn to rural practitioners (often called “quacks” or “magic healers”). As accessing better quality and more affordable health care can lead to better health outcomes, field workers encourage participants to visit government hospitals, instead of quacks. Families can receive better and free or reduced-cost care at government facilities, and it is particularly important that they seek out these services early in an illness, rather than wait until a situation is critical.

However, ultra-poor families often underutilize these resources due to a lack of awareness, self-confidence, and a sense of exclusion. Families may not understand that it is their right to access these services, and may even have had a bad experience being turned away from a health center in the past. To effectively link these ultra-poor families to health facilities, therefore, participants must understand their rights and how to exercise them. Also, Trickle Up partners work with women to help build their self-confidence by building connections to other members of the self-help group and increasing their mobility within the community (attending savings groups meetings, trainings, visiting the bank, etc.). Eventually women, usually together with their self-help group, learn to advocate for services at health centers and elsewhere. For greatest effect, partner agency staff members may also need to visit staff at the health center to introduce ultra-poor families, describe the project underway and encourage health center staff and leadership to allow participants and their families to access the appropriate care.

## How Linkages Work: *a closer look*

Trickle Up’s strategy to connect ultra-poor women with government health care services must address challenges on several levels. A look at our work with one partner, Human Development Centre (HDC), in South 24 Parganas, West Bengal, India, and their experience encouraging institutional birth, illustrates the effort required to bring about change in these communities.

In March 2011, Trickle Up’s program officer visited HDC to help address concerns about the low rate of births in health centers in their working area. Participants were half-way through the three-year project, but despite the health workers’ efforts they had had little luck encouraging any of the women in the program to deliver their children in government health care centers rather than at home.

Trickle Up’s Program Officer decided to focus on convincing one woman in each village of the project area to deliver in hospitals, in the hopes that a positive example would encourage other women to follow suit. Active promotion by HDC health workers and senior staff members was required to bring this about. In addition to regular instruction on the value of giving birth in a health center, health workers encouraged women to call them when they went into labor. They wrote their mobile phone numbers in chalk on the pregnant participants’ walls and made sure each family identified someone with a phone they could use.

Another barrier was a lack of transportation when women needed to get to health centers. The villages are very remote and women in labor need to travel to the health center in auto rickshaws. However the drivers were unfamiliar with the villages and concerned about finding the participants' homes, particularly at night. Field workers and health workers found at least one driver who was willing to take pregnant women in each village to the hospital and assured them that they would accompany him, day or night, to collect the women. Field workers and health workers carried a list of willing drivers with them at all times.

Drivers also complained that they weren't receiving payment from the health centers, as provided by a government program. Health workers asked the self-help group to set aside payment for transporting the woman to a health facility from their own funds, and they readily agreed. If the driver didn't receive payment from the health center, then the self-help group would cover his costs.

Meanwhile, HDC's director visited the hospital or health center chief administrator to introduce the program and advocate for the women. One of the first women to try to deliver in a government health center was accompanied by a health worker but was told that she wouldn't be registered or assigned a room until she started to deliver. When the health worker stepped away to find her some food, the woman got frightened and fled, delivering her baby on the way home. HDC's director appealed to the health center to register women upon arrival and counseled his health staff to ensure it happened. He also spoke with the hospital administrator to ensure that the staff paid the rickshaw driver immediately.

## The Power of the Self-Help Group

Self-help groups are critical to the sustainability of program success, including improved health. They not only provide a resource to save and borrow during lean periods, but they also increase participants' social capital that can be critical to them accessing local public health resources.

One self-help group in Jharkhand successfully advocated with local government authorities to establish an Integrated Child Development Service (ICDS) center in their hamlet. When the authorities came to determine where to place the center, they consulted with self-help group members and agreed with their suggested location.

Collective actions such as this reflect participants' empowerment and the support provided by their self-help groups to advocate for themselves. Because the group remains long after Trickle Up's project is complete, the sustainability of the initiatives is more likely.

Self-help groups also played a critical role. Groups discussed the pros and cons of home delivery with the health worker and talked about the superstitions and family pressures that have kept them at home during childbirth. They discussed the benefits of delivery in a health clinic or hospital. The government offers incentives to women to deliver in health centers, but most Trickle Up participants were unaware of this. The Janani Suraksha Yozana (JSY) program allows women to receive a cash payment, saris, clothing for the children, medicines, mosquito nets and payment for transportation to the health center.

Gayatri Sardar of Kalua Khali village gave birth to her first two children before the project began at home. The third, delivered during the project period, was delivered in a health center and she was the first woman in her village to do so. She describes it as a "group decision"—members of her Annapurna Self-Help Group discussed it and helped her decide. When she went into labor she called the field worker (it was nighttime so the female health worker couldn't ride with the driver to the village). She was scared but her husband traveled with her and happily she gave birth to a healthy baby. Her example was all that was required for all other women to go to a health center to give birth.

Now institutional birth is the norm, not the exception. Auto-rickshaw drivers know the villages and will come with a phone call, and regularly receive their payments at the health centers. Self-help group members accompany each other to hospital, travelling without field or health workers. The health department has seen increased demand for institutional delivery in Jeevantala, the nearest health center to Trickle Up participants, and participants and staff report that the services at the health center have improved, benefiting not only Trickle Up participants.

With this partner, HDC, at baseline only 6% of the women having children below 6 years reported that they gave birth in a health center. But since this new initiative began, 80% of children born were born in health centers. Some barriers do remain, however. Roads become impassable during the rainy season, which is what prevented the remain-

ing 20% from delivering at a health center. At HDC the local health center was cooperative and services improved—but the cooperation of health center staff has been inconsistent across Trickle Up sites, requiring staff to appeal to staff higher up in the bureaucracy. This relationship-building is ongoing.

Despite these difficulties, establishing linkages with health centers for delivery overall has been successful, and some stand-out performances exist. A Trickle Up partner in Bihar has seen institutional birth rates rise from 30% at baseline to 88% after two-and-a-half years. While a push from state government officials to improve health services has contributed to that tremendous rise, advocacy by partner staff and self-help groups and awareness-raising have also played a key role. There's reason to believe this success will be replicated elsewhere.



Some of the babies of the Annapurna self-help group who were born in government health centers

## Economic Strengthening

Trickle Up's livelihood development and self-help groups also directly benefit participant health. While the health component encourages improved nutrition through education about inexpensive, nutritious foods and encouragement to grow leafy vegetables, food security is also enhanced as a final outcome of increased income through profitable livelihood activities, and semi-subsistence endeavors such as paddy and fish cultivation provide the household with key nutrients. Profits from livelihood activities and loans from the self-help groups are often the only source of capital for investments in health care or better hygiene and nutrition practices that are promoted by the program and require financial outlays. Participants are also supported to access government food subsidy programs for the very poor and to better understand their rights.

While livelihood and self-help group development lead to better health outcomes, the health component also plays a critical role in economic strengthening. In order to develop successful livelihoods, critical areas of vulnerability must be addressed. Expenses and lost income due to poor health represent a major source of "leakage," both of profit and productive assets. One major health shock can wipe out a family's assets, so reducing the likelihood of this occurring through preventative health strategies and equipping families to be able to cope when shocks do occur are critical to sustainable success.

# Evaluation of the Health Component

While the long-term effects of the program cannot yet be assessed, preliminary analysis of midterm results and qualitative research suggest that Trickle Up health workers have positively affected behaviors associated with improved health outcomes, primarily mosquito net utilization, children born in health facilities, and family planning, showing a degree of effectiveness with both the education and linkage strategies of the program. The ultimate impact of the health workers on antenatal care and post-natal care visits is difficult to effectively report prior to program completion, as the eligibility and appropriateness of the different visits varies throughout the project.

The quantitative research was conducted with three partner agencies in Bihar, Jharkhand and West Bengal (800 participants) at the mid-point of the 3-year intervention and the qualitative with three partner agencies in West Bengal, each of which is at a different point in the implementation cycle. The evaluation showed that Trickle Up health workers are having a positive impact on participants in education and increasing links to formal health services, including some examples of benefits spilling over to non-participant families. A closer look revealed that gaps exist in the attendance and effectiveness of government health care workers (Anganwadi workers) who are charged with maternal and child health, and Trickle Up’s health workers are filling that gap. But we found that in addition to complementing the services of the Anganwadi worker, Trickle Up can improve its intervention by educating women about common diseases that are not currently addressed.

<b>Preliminary Midterm (18-month) Assessment for Health Component</b>			
	Mosquito Net Utilization	Delivery in health facility	Family Planning
No. of participants targeted	800	144	416
Baseline Utilization	476	35*	157
Actual--18 months from program start	681 (85%)	88 (61%)	272 (65%)
3- Year Target Utilization (%)	100%	70%	50%
Percent increase in participant utilization since baseline	26%	37%	28%
* Number of women who delivered children in health facilities in the 6 years prior to project start.			

The mid-term evaluation showed the following results (left).

We looked more closely at the health component with qualitative research with three partners in West Bengal (one of which had also participated in the mid-term quantitative evaluation) with 108 of a total of 900 participants through either individual interviews or as part of focus group discussions (most of whom had been in the program for two years or more). When the project began, Trickle Up found that Anganwadi workers, like many government workers assigned to remote, poor villages, were not consistently providing services across all Trickle Up’s working areas. Trickle Up’s health component was designed to complement these services, but it should be noted that recently the Indian government has emphasized improving the quality

of service provided by Anganwadi workers over the last few years and our research suggests that this is having an effect in some Trickle Up working areas, most notably West Bengal.

Results from research with partner agency Jamgoria Sevabrata (JS) show the complementary role the Trickle Up health worker played to the government health worker in increasing Trickle Up participant awareness. The Trickle Up health worker clearly played an auxiliary role in this working area, bolstering the messaging and support already provided by government health workers while also advocating for improvement. However in states other than West Bengal the government health care service is not as effective and Trickle Up’s education and linkage efforts are more vital.

Researchers recommended that JS’s health staff should continue to reinforce messages about mother and child health early in the program because most women do not remember the dates for vaccinating the children, and the Anganwa-

di workers do not visit the village so regularly that they can keep on track with vaccinations. However, well before the end of the project, as women gain experience in accessing vaccine services and self-help groups provide encouragement and support to new mothers, Trickle Up's role in this process ceases.

In addition to the effects of the program on Trickle Up participants, researchers found evidence of some spillover effects of health education and linkages in the communities. Some neighbors of participants reported that they are increasing their utilization of government health resources and non-participants are travelling with participants to the health centers after learning from the participants about the availability of free medicines. Neighbors also have adopted healthy behaviors such as storing water safely and keeping cooking areas clean after asking the participant what they discussed with the visiting health worker and seeing the participants' children's health improve over the course of the project.

Self-help groups have also undertaken a number of collective actions that have benefitted their communities. When one Trickle Up self-help group in Jharkhand began to clean the community well, other community members joined in and decided to install a drain to prevent standing water to combat malaria. Also, the advocacy efforts of partner staff can have spillover effects on others in the community. In one case in West Bengal, a partner's field officers and management talked to authorities about improving the facilities and services at public health and Integrated Child Development Centers, which resulted in the auxiliary medical nurses attending the centers more regularly.

Trickle Up will continue to monitor the effectiveness of the health program through monthly reports generated using records kept by field and health workers in the household. These records include, but are not limited to, details related to maternal and child health, birth control measures taken by eligible couples, and use of mosquito nets. This participant data is aggregated in a monthly health report. Feedback to field workers is provided by Trickle Up staff to the Coordinator, who reviews the data monthly and suggests action, as required, to bring about improvements.

# Next Steps

As a result of the mid-term survey and field research, Trickle Up has altered its health program in several ways.

## **Health Staff with Higher Qualifications**

Trickle Up's health component depends on the quality of its health workers, and both the success of the health component and the limits of that success relate to their capacity. To date, health workers typically have been women who have passed 10th Standard, and so are young and have limited experience. In terms of building participant awareness, staff evaluation of health worker performance has found that performance varies between health workers, and, at times, health issues are addressed with insufficient focus. Beyond the quality of awareness building, the relative youth and inexperience of Trickle Up's current health workers has made it more difficult for them to successfully engage the husbands of participants and lobby local governing bodies and government health workers on behalf of the participants.

We believe that graduates (12th Standard) can gain a better understanding of the local governing bodies and health care resources, and have confidence to lobby these key stakeholders. Therefore, we are increasing the academic qualification to graduate with the expectation that the health worker will be able to help the participants raise issues with the local panchayat health committees.

## **Additional Components for Health Education**

Trickle Up has introduced new components to its health program focused on diseases common in Trickle Up's working areas. Our research revealed that participants and their families face significant health challenges that are not given much attention by government health workers who are more focused on maternal and child health. Given this fact, and with the increased capacity of the new health staff, we have added information on common community diseases and health hazards such as tuberculosis, jaundice, diarrhea, malaria, typhoid and anemia, which health workers will share with participants during self-help group meetings. Because Trickle Up's target population has very high rates of migration, particularly among male members of the household, health workers will also focus on HIV/AIDS education. In addition, we have added components on health care for adolescent girls and menstrual health.

## **Greater Emphasis on Self-Help Group Education and Mobilization**

While better qualified health workers may improve government health provision, the inconsistent quality of public services and the participant perception of exclusion and neglect are major obstacles. Many facilities are overcrowded, and as one Trickle Up staff member noted, "While some [government] staff members are very helpful and nice, many don't see participants as clients, they see them as charity cases, not patients. The participants may not get treated seriously or the doctor may not explain to them what is wrong, or may say that medicines are not available, even after the participant has travelled and waited in a long line. There's no place to complain about this."

Trickle Up participants will continue to face challenges with health center staff but we have observed that self-help groups are a powerful vehicle for advocating for change. For example, in Jharkhand when take-home rations from a local mother-and-child health center were found to be of poor quality, members from one self-help group raised this issue at the health center. When they were ignored, they took their complaints to local government officials who agreed to improve the quality. Given the effectiveness of self-help groups in their own advocacy efforts, Trickle Up

will place greater emphasis on mobilizing self-help groups to advocate for improved services, particularly in the second half of the program when the women’s solidarity is stronger. Trickle Up will build the solidarity and independence of the groups, encourage collective actions or advocacy for change, and will foster exchanges between self-help groups to share examples of challenges and successes.

## Share Learning with other Trickle Up Regions

Trickle Up has programs in West Africa and Central America and we are sharing the relevant learning from our experience in India. As with other program components that are very context-specific, we are grappling with whether and how to include a health component in regions where barriers to health care differ or links to government health services are more challenging. These realities have implications for how this component is adapted for other regions and for participants outside of the ultra-poor. Trickle Up is currently studying its health component in other regions and will consult with health professionals in refining the component as needed in order to best support the ultra-poor.

# The Costs of the Health Component

The cost of the health component as it existed at the time of the mid-term evaluation is shown to the right.

The calculation (right) is approximate and includes the health worker training, participant training by health workers, health worker salary, and travel costs. Indirect costs, such as the support of Trickle Up India’s staff members, are not included in the above calculation. The total estimated cost per participant is currently \$550 for the entire three-year program, 43% of which is a grant for livelihood activities and assets.

<b>Estimated Cost of Implementation (Three-Year Program Total)</b>	
Total Cost per 300 participants (Rs)	404,391
Cost per participant (Rs)	1348
Cost per participant (US\$)	28
1 US \$ = 44 Rs	

This cost for this component is borne by Trickle Up which, as a livelihood organization, is not subsidized with funds from a lending organization. Working with the ultra-poor is more expensive than working with other strata of the poor—they often require support to build social networks, financial capital and human capital. The coaching component is perhaps one of the most important components of the program and that brings additional costs. But to support the sustainability of participant progress after the project, Trickle Up endeavors to build capacity at three levels: the participant, the self-help group, and the local partner. Social connections and human capital built through the program remain after Trickle Up exits, self-help groups function independently and have established links with local banks to access additional capital even after the project, and the partner agency remains active in the nearby area to continue to serve as a resource to participants even after the project ends.

# A Note on Other Graduation Projects

Trickle Up is one of 10 graduation projects underway in eight countries around the world. The building blocks of the graduation model are rigorous poverty targeting, savings, skills training and regular coaching, and asset transfers—carefully sequenced to promote stabilization of the household, asset building, and increased self-reliance. Trickle Up, like other graduation pilots, has adapted the model to the context in India, and built on our several decades of experience of providing livelihood support to the poorest families.

The health component varies quite widely between each of the pilot projects, though all of them try to address health needs in some way. Several pilots focus on linking participants to government services, where possible, though the availability and effectiveness of those services vary. Some pilots focus on health ‘events’ designed to bring health workers to communities on a specific date to provide check-ups and treatment, often for a particular health concern. In addition to Trickle Up, several other pilots include prevention through health and hygiene messaging. As Fonkoze expands their program beyond the pilot project, they have established a partnership with Partners in Health, which will provide prevention and treatment for ultra-poor families. As outlined in CGAP Focus Note 69<sup>3</sup>, “Bandhan is creating “health entrepreneurs”—women who take on healthcare provision as a livelihood. They will be trained in preventive and basic curative health services, and taught to deliver hygiene and family planning messages. Bandhan is confident that these women will be able to provide treatment for common illnesses while earning income from the sale of health products.”

CGAP and Ford Foundation have created a Community of Practice for graduation pilot projects and others interested in work with ultra-poor families. There is a strong online presence and regular gatherings for the Community of Practice to share learning from each of the pilot projects and into scale-up. Trickle Up will continue to monitor results from other pilot projects as they relate to health outcomes, with a particular focus on those pilots operating in our regions of focus, to determine how to further improve our health intervention.

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<sup>3</sup> Hashemi, S. and de Montesquiou, A. (2011), Reaching the Poorest: Lessons from the Graduation Model, CGAP Focus Note No. 69, Washington DC: CGAP. <http://www.cgap.org/gm/document-1.9.50739/FN69.pdf>