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Engendered Accountability for Responsive Health Governance

Intervention with *Adivasi* Men in Madhya Pradesh
for Accountability in Maternal Health

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A B S T R A C T

Community driven accountability processes are increasingly being seen as key factors to improve the delivery of public services. Much of the discussion on maternal health rights and accountability has been highlighting the role of women as principle agents and rights holders and the health service providers as duty bearers. Men's reproductive responsibility as partners and fathers, and for addressing patriarchal norms that jeopardise women's health has not been included in such accountability interventions. This paper explores the concept of "engendered accountability", a process that simultaneously transforms gender relations at the family and community level as well as the dynamics of community interface with the health care system through the active and gendered participation of men as responsible husbands in demanding quality maternal health services.

Centre for Health and Social Justice (CHSJ), a non-profit organisation working on health policy research, formulated and used the conceptual framework of engendered accountability for increasing access to maternal health services in 15 villages of Sidhi district (Madhya Pradesh). Young men between the age of 20 and 35 were sensitized as responsible and concerned partners and parents as well as responsible citizens to demand maternal health entitlements. Taking responsibility for changes in personal behaviours, they collectively negotiated with the local health service providers for improved maternal health services. Within the context of the National Rural Health Mission (NRHM), which provides space for the communitisation of health services, the strategy and tools of community based monitoring (CBM) were used to negotiate with providers and to ensure accountability of the health system. Quantitative and qualitative methodologies were used to measure the change in men's relationship with their spouses and their negotiation with health providers impacting women's health both at the beginning and end of the two year process.

The results of the intervention show changed gender relationships among spouses, collective action taken by men's groups to seek accountability from the health system, and an improvement in maternal health services. The collective initiative of gender sensitised men conducting discussions and community campaigns on gender on one hand, and demanding accountability from public services on the other, provides an alternative model for addressing gender and development at the community level. The synergy of these two strands of consciousness, offers an effective approach to work on maternal health rights.

Keywords: Responsive governance, social accountability, gender, power, maternal health, community participation

Key Messages:

- While organizing communities to demand health rights and hold the health system accountable is certainly desirable, addressing the communities' own responsibility to put an end to gender discriminatory social practices that jeopardize women's health is equally important.
- The idea of 'engendered accountability' proposed by this project synergises men's increased understanding of gender and involvement in the family with a sense of entitlement to public health services offers an effective approach to work on maternal health rights. This approach allows for improvements in access and quality of maternal health services and at the same time addresses social conditions that jeopardize maternal health.
- Engaging men as responsible and concerned partners and parents as well as responsible citizens allows them to reconfigure their roles in their personal lives as well as in the public domain. The consciousness of their new roles not only leads to changes in individual and community behaviours but allows them to constructively engage with the health system demanding for better services.
- Accountability led improvements in health systems are possible within a policy framework which acknowledges the claims of the marginalised. Interaction of collectives of the gender-sensitized men with the health care providers has prompted responsiveness from the health providers at different levels, more effective change being seen at the village level. At the village level resistance has given way to collaboration and this is evident from the proper conduct of the Village Health and Nutrition Day (VHND), as well as improved and respectful behaviour of the health care providers towards women and also promptness in delivering maternal health services.

Acknowledgements:

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I. INTRODUCTION

Public health governance is influenced by multiple socio-political factors that interface with the societal structures and the health care system at different levels ranging from the local to the global contexts. (Dodgson et al. 2002, WHO 2011) Accountability has been proposed as a key factor in improving health system performance and for good governance in health. (Brinkerhoff 2004, Clearly et al. 2013, WHO CSDH 2008) Maternal health services provide an example of such an intersection between social factors (like caste, class, gender) and accountability of the health care system, both of which are critical in determining women's access to and quality of maternal health services. (Dasgupta 2011) This paper explores the concept of engendered accountability, a process that simultaneously transforms gender relations at the family and community level as well as the dynamics of community interface with the health care system through the active and gendered participation of men as responsible husbands in demanding quality maternal health services. The paper first describes the methodology of intervention and the research, within an overall framework of accountability, with a specific reference to the Implementation Framework of National Rural Health Mission. (NRHM, Government of India 2005) We then describe the changes that were observed using both qualitative and quantitative data. We conclude with the key learnings and the limitations within which these can be interpreted.

Governance and Social Accountability in Health:

Governance is a complex as well as a contextual construct and is related to the three dimensions of authority, decision making and accountability. (Institute of Governance) Health governance is described as the actions and means adopted by a society to organise itself in the promotion and protection of the health of its population. (Dodgson et al 2002) Responsiveness is explained both in relation to dignity and respect experienced by the client/patient as well as delivery of timely services with quality. (WHO 2000) Further responsive governance relates both to a public system which responds to the compact arrived at in the policy framework of State as the duty bearer as well as to the active and participatory citizenship which demands accountability.(AMHI/ OSF 2011, Gaventa and Valderrama 1999) These three concepts are intricately linked to each other and are increasingly recognised as key factors for improving health outcomes.

Social accountability, generally understood as

answerability, is closely knit with responsive governance and focuses on the centrality of active citizenship to demand accountability. (Dasgupta 2011, Qadeer 2011) It is located within complex and unequal societal power relationships. Health systems are embedded in the socio—economic milieu of any given society and reflect the social inequalities and prejudices of that society.(Qadeer 2011) Active citizenship requires three essential components namely participation, a focus on good governance and the presence of a rights based development framework.(Clarke and Missingham 2009) Social accountability brings them together through citizens' negotiation with the health system for responsive, respectful and quality services. (WHO 2000)

Active citizenship is central to the processes of responsive governance and social accountability. It has been endorsed through the citizen-centric social accountability processes adopted within the larger policy framework of accountability of the National Rural Health Mission (NRHM) in India. (IIPS 2007-08, CHSJ and PFI 2009)

Policy Context-Accountability and Health Governance in India: NRHM envisaged a vigorous process of social accountability through 'communitization' which included decentralized community based monitoring and planning (CBMP), formation and strengthening of community institutions like the Village Health and Sanitation Committees (VHSCs), and the Rogi Kalyan Samiti (RKS), and management of untied funds by these committees. The Accredited Social Health Activist or ASHA was seen as an interface between the community and health system to make health services responsive, effective and accountable. A nine state pilot project on CBMP was initiated by Government of India in 2007 which developed an evidence based community feedback mechanism on the availability, accessibility and utilisation of NRHM services. This process showed positive results in terms of improvement in the conditions of health centres, increased utilisation of services by the community, through community negotiation with providers. (CHSJ and PFI 2009, Parija et al. 2010, Shukla et al. 2014a)

India has the largest number of maternal deaths in the world. Despite the commitment to reducing maternal mortality as part of Millennium Development Goal5 (MDG-5) through a number of schemes¹, reduction of

¹ Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram

maternal and neo-natal and infant mortality, especially in the so-called NRHM high focus states² has remained a challenge. While the CBMP processes and tools have addressed the service delivery components and have led to some improvements (Shukla et al. 2014a, 2014b), there is a need to address the contributing factors such as early marriage, early and repeated pregnancy that lie beyond the influence of the health care system. These are related social discrimination and unequal gender power relationships within intimate relationships, within the family and within the community. The inferior social status of women, and lack of access to resources and to decision making are rooted in how men and women are socialized into specific gender roles. To address and reverse these requires men's commitment and participation to challenge stereotypical gender norms within families and at the community level. Recognising the limitations of a 'health systems only' approach, the need to create an 'enabling environment' through the shared responsibility and participation of men, has been highlighted in various declarations and conventions. (UNFPA 2004)

We propose the concept of 'engendered accountability' as an approach where there are concomitant efforts to engage with men to transform their perspectives and behaviours shaped by dominant patriarchal social norms, and to facilitate leadership among such men to organize their community for demanding better maternal health services. On a practical plane this approach allows for improvements in access and quality of maternal health services to synergise with improvements in social conditions that jeopardize maternal health. This synergy is built on a common understanding of power, privilege and responsibility which includes both gender power relations on the one hand and state citizen relations on the other.

Context of Maternal Health Services in Madhya Pradesh:

The indicators for maternal and child health in Madhya Pradesh (MP) are poorer than the average for the country. The Maternal Mortality Ratio (MMR) of MP is 230 as against the national average of 178. (Registrar General, 2013)

Sidhi is a district located on the north-eastern boundary of MP and is populated mostly by Adivasis, scheduled castes and backward class communities. Nearly half (48.9 percent) of the households live below poverty line, which is much higher than the national (30.6percent) and state (42.3percent) averages. (DLHS 3 2007-08)³ It is a backward district and the road and other infrastructure to the district or within the district form a greater challenge for health care

service delivery. Key maternal and child indicators fare poorly compared to the state averages with Infant Mortality Rate(IMR) being 72 per 1000 live birth (state average 67) and institutional delivery rate being 54.9 (state average 76.1). Female IMR of 89 is one half times more than male IMR of 56 indicating strong gender differences. (AHS 2011) There are 23 primary health centres (PHCs), 145 sub health centres (SHCs) and six community health centres (CHCs) in the district. (CMO 2012) Most of the SHCs are located in remote areas and are operated from rented premises. Many Auxiliary Nurse Midwives (ANMs) and Multi Purpose Workers (MPWs) seldom stay in villages due to non-availability of residential facilities compromising access. The story of Karavahi PHC provides an insight into the functioning of an average health centre in this district at the time of beginning the project. (See Box 1)

Box 1: The Condition of Health Services in Karavahi PHC in Sidhi, MP

The Karavahi PHC catering to 22 villages (including 14 villages of the intervention) is located in Karavahi village and was housed in a Panchayat Bhavan. Due to its remote location the people did not feel safe in going there at night nor did the nurse stay in the premises as there was no electricity or water supply. The PHC had no electricity connection and lanterns/ petromax lamps were used during the night during deliveries. Due to the absence of doctors at the health facility, the utilization of the PHC was minimal and home deliveries were a norm. Occasionally when deliveries did occur in the PHC, they were conducted by the nurse with the assistance of a local birth attendant. In the absence of tap water and a bathroom the women were discharged within a few hours after the delivery. The PHC did not have a good reputation among the people of the villages. It has been alleged that hundreds of birth certificates were not issued because the poor patients were not able to shell out the bribes which was asked for by the staff posted here. The free medicines scheme which was launched by the government is practically useless at the PHC as there is neither a doctor to prescribe medicines nor a pharmacist to dispense the medicines. Owing to the poor quality of services at the PHC, people preferred to go to the district hospital 45 kilometres away, or to private practitioners.

(JSSK) and many state based programmes such as Mamata (Orissa), Muthulakshmi Scheme (TamilNadu) etc.

² Ten states in North and Central India with poorer health indicators

³ The District Level Household and Facility Survey (DLHS) is a national household level demographic and health survey covering all the districts of the country.

II. METHODOLOGY

Site and Actors in the Intervention

The intervention was undertaken in fifteen villages during the period June 2011 to May 2014, of which the first year was for the preparatory processes. The villages are remote, the farthest being 60 km from the district headquarters. The terrain in this region is hostile and access by public transport extremely difficult. Fourteen were under one PHC (Karavahi) and one village under another (Banjari). It was implemented in partnership with the local civil society organisation Gram Sudhar Samiti (GSS)⁴. It included village level 'animators' who were identified in consultation with the community to act as a bridge with the health care system. The animators were trained on gender, reproductive health, NRHM entitlements and leadership and were expected to act as role models in the community. They also organized community level men's groups (in the age range of 20-35 years) and these groups were provided with orientation on the same issues. They were supported by two facilitators who were senior staff of GSS and a mentor.

The process of social accountability included a combination of community mobilisation, capacity building, setting up community charters on maternal health, the processes of community enquiry and dialogue and a cyclical system of monitoring and planning was established. (See Box 2). There was also focus on increasing engagement with gram panchayat, VHSC, RKS around health related entitlements.

Research Methods

The intervention adopted a modified realist approach (Pawson and Tilley 2004, Sridharan and Nakaima 2010, Das 2013) including the development of a programme theory and testing it throughout the intervention with both quantitative and qualitative methods which included the following. :

- **Quantitative baseline and endline surveys:** In order to assess change over a period of time, two surveys were conducted at baseline and endline. The first survey included women who had delivered in the last one year in these 15 villages with a total of 114 women at baseline and 125 women at endline. The second survey included men who had been part of the intervention and included 120 men (intended group members) at baseline and 169 men at the endline. The profile of participants is

provided in Table 1. The men's survey enquired about their attitudes and perceptions related to gender, sexuality, masculinity and violence, their knowledge regarding health rights and entitlements and their interaction with existing local governance structures. The women's survey looked at maternal health seeking behaviors, men's participation as care givers to their wives during pregnancy and post-delivery, use of contraception, men's participation in household chores and so on. Data collection was done by trained independent investigators.

- **Participatory Rural Appraisal (PRA):** Two rounds of PRA exercises were conducted to develop a shared understanding with the community about gendered maternal health status of the community focusing on social determinants. The first PRA was followed by a process of establishing the social and public health charters.
- **Qualitative investigation:** A mid-term assessment was conducted in July 2013 to understand the influence of the intervention on public health services, and to provide insights on the accountability approach adopted by the intervention. A similar exercise was repeated in May 2014. Both these were conducted by external reviewers.
- **Ongoing documentation of stories of challenges and change:** In order to understand the process of change, stories were documented throughout the intervention period. Ninety six stories of change were collected, covering themes such as demanding accountability from health care providers, challenging social norms, women's education, intervening in early marriage, men's participation in caring during pregnancy and parenting, sharing of household chores, collective action for improvement of services, improved interface with public functionaries, and networking with women's collectives and so on.
- **Adopting a modified realist evaluation approach-** A modified realist approach was adopted for this intervention which comprised the development of a program theory at the outset and the periodic examination of progress to understand whether the assumptions of context and mechanism were indeed leading to the anticipated outcomes. The embedding of two rounds of PRA and qualitative investigations along with quarterly review meetings allowed the project team to review the programme theory on an ongoing basis.

⁴ GSS has its main office at Satna and has a field office in Sidhi. The organisation has been working for over twenty years with the tribal communities in the area. They have undertaken various community development interventions like watershed development and micro-credit programmes with community participation.

Table1: Socio-demographic profile of respondents

Age	Women		MEN	
	Baseline	Endline	Baseline	Endline
Below 21 years	13(11%)	12 (9.6%)	2 (1.7%)	9 (5.3%)
21-25 years	50(44%)	58 (46%)	38 (31.7%)	35 (20.7%)
26-30 years	24 (21%)	41 (32.8%)	46 (38.3%)	52 (30.8%)
31-35 years	21 (18.4%)	12 (10%)	34 (28.3)	50 (29.6%)
36-40 years	5 (4.4%)	2 (2%)	0	19 (11.2%)
41 years and above	1 (.9%)	0	0	4 (2.4%)
Total	114	125	120	169
Marital status				
Married	114 (100%)	125 (100%)	109(90.8%)	153 (90.5%)
Not married	0	0	11(9.1%)	16(9.4%)
Total (N)	114	125	120	169
Religion distribution of respondents*				
Hindu	110 (97.3%)	121 (96.8%)	119 (99.2%)	167 (98.8%)
Muslim	3 (2.65%)	4 (3.2%)	1 (0.8%)	1 (0.6%)
Total (N)	113	125	120	168
Caste distribution of respondents*				
SC	6 (5.26%)	16 (12.8%)	7 (5.83%)	16 (9.5%)
OBC	25 (21.9%)	17 (13.6%)	7 (5.83%)	11 (6.5%)
ST	77 (67.54%)	75 (60%)	101 (84.2%)	140 (82.8%)
General	5 (3.50%)	17 (13.6%)	5 (4.16%)	2 (1.2%)
Total (N)	113	125	120	169

*One respondent did not mention a religion or caste

Programme Theory:

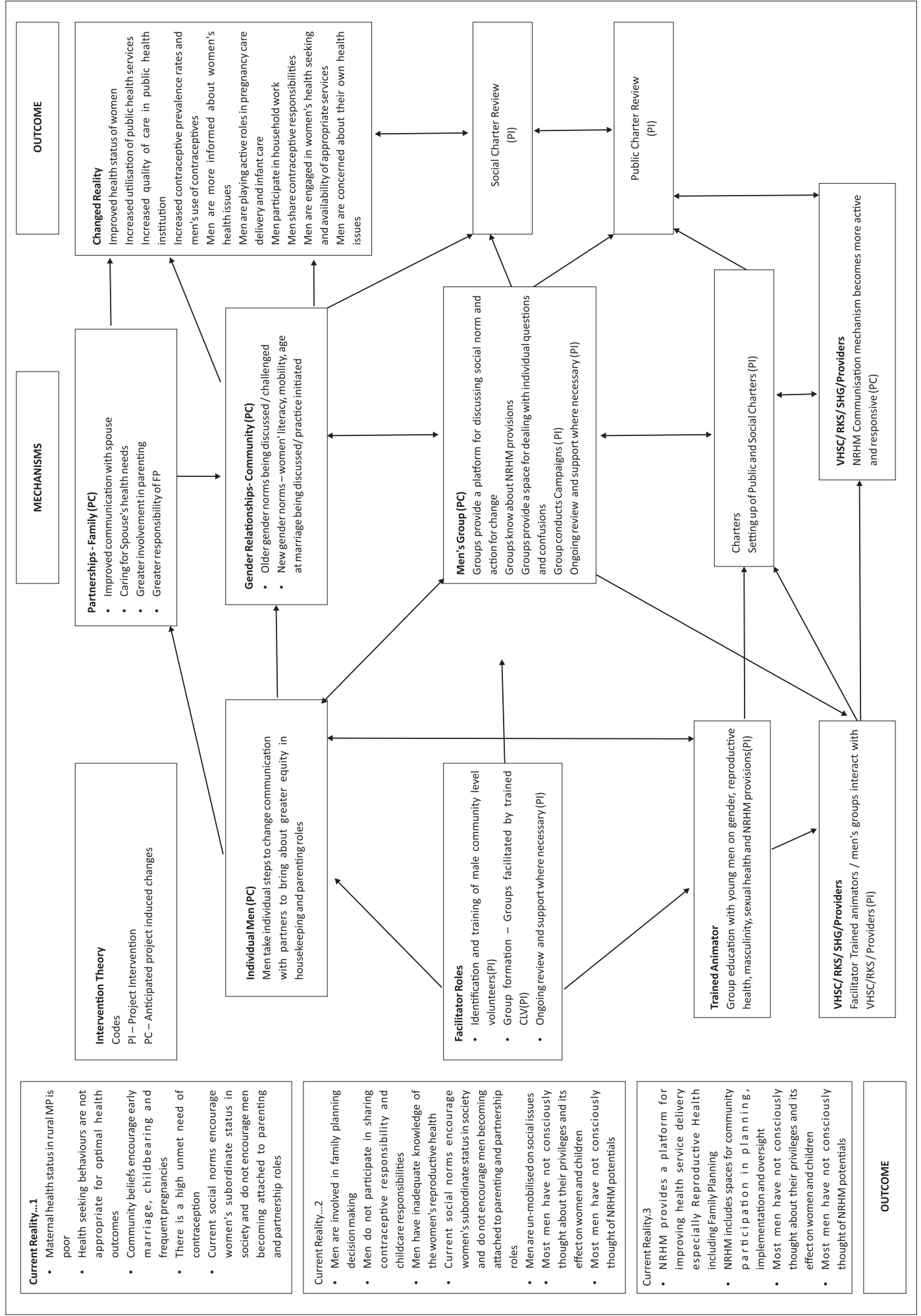
Within the context of NRHM entitlements the 'Sajhedar'⁵ project utilised a two pronged approach as its operational mechanism. The first component was to engage young married men, and facilitating an understanding of gender discrimination and patriarchy to bring about changes in their roles as responsible partners and parents. Using the same gendered understanding they were also organised and encouraged to take public action to challenge gendered social norms that affect reproductive and maternal health (such as early marriage, son preference, early and frequent pregnancies, and so on). The second approach was to establish community based accountability mechanisms with the aim of improving the quality of maternal health service delivery. The objectives of this intervention were to increase knowledge of maternal health entitlements in the men's groups, to increase men's leadership towards maternal health rights, to enhance men's sensitivity and accountability towards gender based discrimination, and to establish a cyclical system of monitoring and planning on maternal health services at the community level. It was hypothesized that this combined approach would lead greater awareness and importance of maternal health, men taking more responsibility in family planning and child care leading to establishment of alternate social norms, and greater

utilisation of improved services. (See Figure 1)

The young married men were organized into groups at the village level and were trained on gender, power and patriarchy, and how it impacts maternal health. The group was a space for the men to reflect on their lives and relationships, and peer support to try new behaviours. This would lead to improved communication with spouse, greater responsibility in family planning, participation in household chores and child care. During intervention care was taken to emphasise the privileges that men enjoyed and their responsibility to promote gender equality. Through these groups, men were also encouraged to organise campaigns and take public action against gender discriminatory practices such as child marriage, violence, dowry and so on. The group members were provided with information about maternal and reproductive health, the opportunities for community participation under NRHM, as well as their entitlements in government schemes. They were trained in simple data collection methods and gathered information on these issues and interacted with local governance bodies such as the Panchayat Raj Institution (PRI), Village Health Sanitation & Nutrition Committee (VHSNC), and also health care providers to highlight the gaps that they saw in the system. The groups also articulated the changes they wished to see, not just from the health system, but also from the community in the form of a social charter and a public charter which were prominently displayed and reviewed periodically. (Box2) The setting up of these two mutually reinforcing

⁵ The word Sajhedar means 'partner'. The intervention was named Sajhedar to indicate partnership both in spousal relationships and community relationship with the public health system.

Figure 1: CONCEPTUAL FRAMEWORK – Theory of Change



charters and the regular monitoring of these both at the community level and at the level of health service delivery constituted a bilateral accountability process where health systems have to be accountable to community and the men in the community are also accountable to the community for better health outcomes of women.

Box 2: Community Charters on Social norms and Public Health

Social Charter	Public Health Charter
Increase in age at marriage	Increase access to Ante Natal Care, Post natal care, delivery care and family planning services
Reduction of early pregnancy	Improved quality of antenatal, post natal and delivery care
Increase in spacing between children	Safe Deliveries at institution as well as home
Balanced sex ratio at birth	Availability and accessibility to a range of contraceptive methods, especially male methods
Improved communication between couples	Availability and access to complete immunisation
Reduced domestic violence	Availability of well functioning VHND and PHC
Availability of safe drinking water and sanitation facilities	

Intervention Methods

- **Organizing and capacity building of men's groups** - Men in the community were mobilised into men's groups and these groups were facilitated by trained animators (one animator for each village) to orient and train them on gender related health issues and NRHM entitlements. These groups included members from the families of VHSC and local Panchayats so that there is a bridge with formal committees.
- **Setting up Community level Charters in association with village level structures** - The village level men's groups developed relationships with the ASHA, AnganWadi Worker(AWW), VHSCs and Panchayats, and together called for the establishment of two charters. The charters were in the nature of a commitment of the community and the VHSC

towards women and their health. One of them drew upon NRHM commitments called the Public Health Charter and the other focused on men's increased understanding of social issues affecting health of women and children called the Social Health Charter. The Social Charter included a list of socially desirable attributes at the family and community level that were developed by the village level Men's groups as a result of training and mobilisation around gender equality and family health (Box 2).

- **Community Campaigns** - The men's group in association with the ASHA, AWW, and village level Animator conducted community level information campaigns calling for the community to adopt practices which promote the Social and Public Health Charter.
- **Community enquiry, report cards and public sharing** - Every six months the village level men's group supported and facilitated the VHSC to conduct a community enquiry to ascertain the performance of the health system and the community around the public health and social health. The community enquiry is the process of conducting an assessment to understand to what extent the village is able to fulfill the commitments of the charter. This assessment was done using participatory methods and the enquiry results were publicly shared through a Community Score Card having two parts for the two sets of charters.

Ethical Considerations:

This intervention research was undertaken in partnership with an established local civil society organization Gram Sudhar Samiti (GSS). The selection of villages was done in consultation with the leadership and team of GSS, both of whom had local credibility. The villages were consulted and animators⁶ were nominated by the community in open community meetings held every village. The risks of demanding accountability from the health providers and the potential backlash was discussed with them. To mitigate such risks the local health providers (ASHA, ANM, male health worker) were also included in the capacity building modules. Confidence building measures were also undertaken with health providers. Women participated in all community level activities and discussions. Informed consent was taken for all base-line and end-line surveys and for the qualitative interviews. The overall ethical protocol was shared and finalized with the Project Advisory Group.

⁶ Animator - A young man with leadership skills

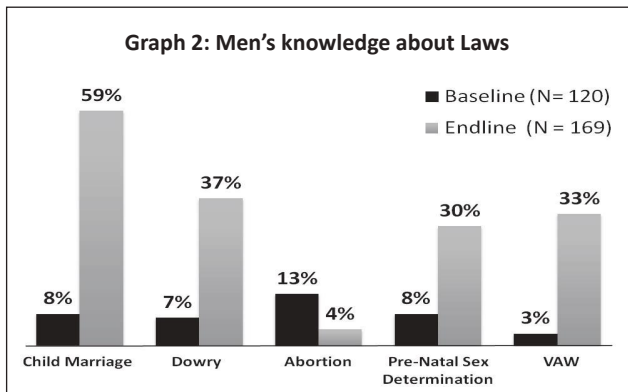
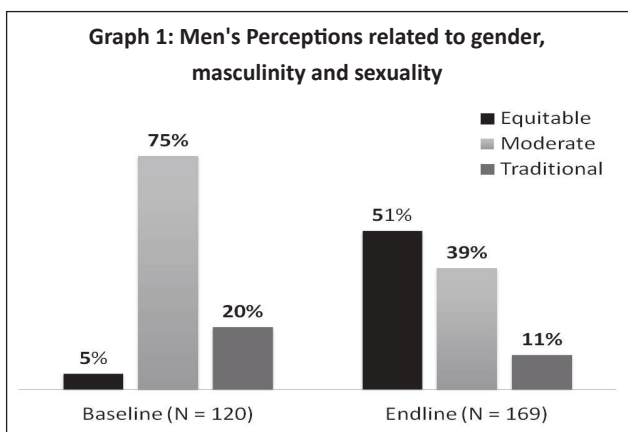
III. FINDINGS

Trends of Change- From Personal to Public

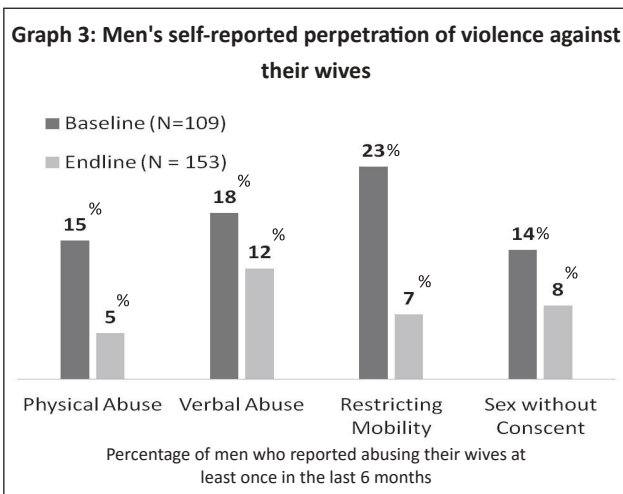
The project was based on a set of interlinked hypotheses. This section examines whether these assumptions have held true drawing upon data from the different sources mentioned earlier.

1. Personal transformation of beliefs and attitudes

The core input of the intervention was aimed at young men, to change how they think and act related to gender, masculinity and the relationships between men and women. A 39 point scale was used to measure these perceptions and attitudes, and the change from baseline to endline is quite evident.⁷ Five percent of men were rated as 'equitable' at baseline while, 51 percent received the same rating at the end. (Graph 1) Men's knowledge about laws related to violence, child marriage, sex selection and abortion increased in this period. (Graph 2) Changes in self-reported behaviors of men are also noteworthy with self-reported incidents of intimate partner violence (physical, verbal, sexual and control of mobility) decreasing between the two surveys. (Graph 3)



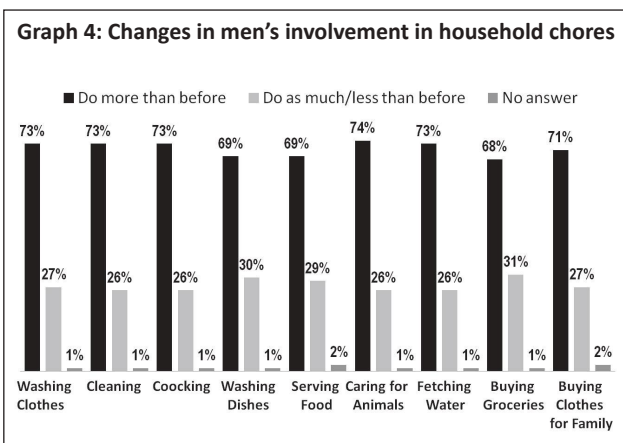
⁷ A modified version of the Gender Equitable Men (GEM) scale was used which consists of 39 statements on attitudes related to gender, masculinity and sexuality and each statement had the responses agree and disagree. The responses were scored 1 and 0 depending on whether the response was gender sensitive or not. Out of these 39 statements those who had given more than 20 gender equitable answers were put in the category of "gender equitable". The respondents who had given 11-19 right answers were put in the category of "moderate" and who had given less than 10 right answers were put under the category of traditional".



N=Married men

2. Affecting gender power differentials at the household level:

i. **Men's participation in household work:** Men's participation in household work increased with many more men participating in household activities such as washing, cleaning, cooking and serving food on a more regular basis. (Graph 4)



N=169; only measured in endline survey

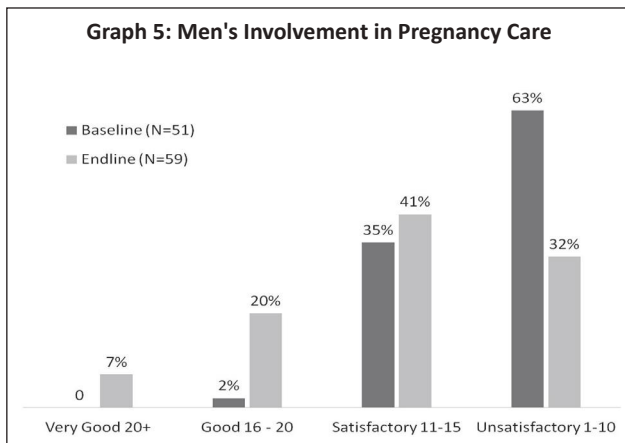
Discussions with women and several other stakeholders substantiate that these changes are a result of the perspectives received due to intervention and participation in the peer group processes which were the key inputs of the Sajhedar intervention.

"Earlier my husband never used to help me even in our farm activities. Now after being part of Sajhedar, he seems to have understood the importance of sharing the workload and now we both do all work – be it inside the house or outside". (Animator's wife, Sidhi Interviews with Stakeholders 2014)

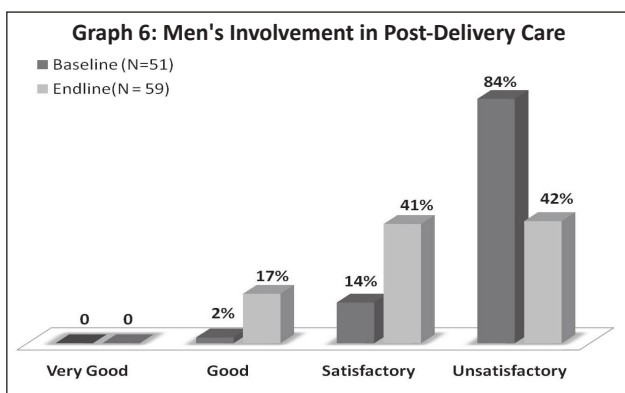
The animator was expected to be a role model inspiring his group members through personal example and the evidence shows strong leadership emerged in all 15 animators.

“.....I can now ask my husband to help me with household tasks for if he does not help me then he cannot tell the other men to be supportive...my in-laws wonder what has happened to their son and whether he’s not ashamed doing household chores... communication between us has improved and our relation has got strengthened.” (Animator’s wife, Village Bhangohar- Sidhi; Interviews with Stakeholders 2014)

ii. **Responsible partners in parenting:** The project had assumed that the the group would provide a powerful vehicle of reflection and change for the members. A comparison of baseline and endline data shows that group members who had children less than two years old are now more informed about women’s health issues and are also more aware about their roles as a responsible parent and spouse. The baseline shows 63 percent of men being ‘unsatisfactory’ with regard to their involvement in women’s pregnancy, but at endline this reduced to 32 percent (Graph 5).



N= Men who had children in two years preceding the survey



N= Men who had children in two years preceding the survey

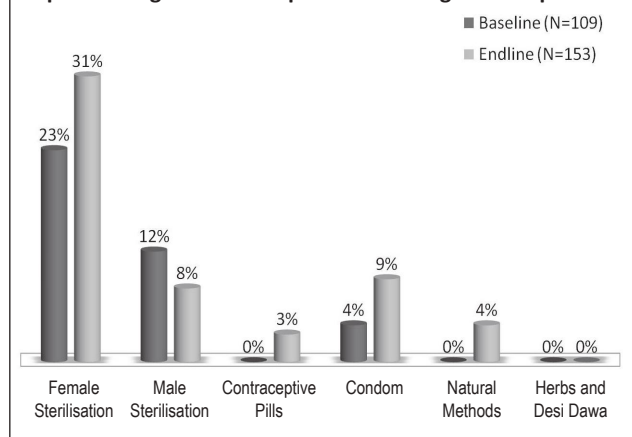
Similar changes were observed in men’s involvement in post-delivery care and child care related activities. (Graph 6) Further, testimonies of men illustrate how there is now an increased understanding of the care that women require in the period of pregnancy and beyond, and men’s spousal responsibility. (See Box 3)

iii. **Greater responsibility in family planning:** The overall use of contraceptives by men increased considerably between baseline and endline surveys. The use of condoms increased from 4 percent to 9 percent (Graph 7).

Box 3: Story of Personal Change

[The] animator from Chhawari village has undergone a big personal change. Some years ago, he was a regular village boy, loitering around and playing cards. He got married and soon after the marriage, his wife got pregnant with their first child. During this time, he did nothing to assist her in household chores, nor did he pay attention to her health. In the 7th month, she fell ill and later delivered at the PHC. It was a normal delivery, but the baby was born dead. Sometime after this, he joined the Sajhedar group. In another one and a half years, his wife was pregnant once again. This time, having been a part of the group, he was better prepared to assist his wife. He helped her with household chores, such as cleaning, fetching wood, cooking, washing clothes. He gained knowledge about maternal and child health, and accompanied her for health visits, ensured she got good nutrition, got her iron tablets. He was convinced that unless he, as a decision maker, takes an interest in his wife’s health, things will not change much. Eventually his wife had a normal delivery and the child was healthy. Even after the birth of the child, he continues to play the role of a father, such as taking the child for immunisation. Testimonies of men illustrate how there is now an increased understanding of the care that women require in the period of pregnancy and beyond, and men’s spousal responsibility.

Graph 7: Change in Contraception use among male respondents



N = Married men

This increase has to be seen in the context of the irregular supply of condoms. ASHAs reported that there is a demand for condoms which they are not always able to fulfill. Earlier men hesitated to come to ASHAs for condoms and the ASHA herself was uncomfortable. But later, the animators began dialoguing with the ASHA and helped facilitate condom distribution among men. While interaction with men suggests that they are interested in vasectomy and they believe that family planning is not only women’s responsibility, the data shows otherwise.

3. Affecting power relationships at the societal level

A concern for gender power, male privilege and accountability were central to the changes anticipated as a result of the intervention. The men's groups held many discussions in the community about social issues such as men's responsible participation in the family, early marriage, dowry, drop-out of girl children from school, domestic violence, and son preference. At the community level, changes in social norms are evidenced in increased enrollment of girls in schools (Table 2).

Group members successfully dialogued with parents of young girls to stop their early marriages while encouraging them to educate girls further. The proportion of marriages with both the bride and groom above the legal age increased from 50 percent in PRA I to 98 percent in PRA II (Table 2). There were initiatives by men across 15 villages to counter son preference, by celebrating the birth of girl children in the community. These stories indicate that changed individuals also came together as a collective for bringing about social transformation.

4. Negotiating change with the health system

An increased interest in the wellbeing of the family and an awareness of health entitlements underpins the concept of 'engendered accountability'. A comparison of baseline and endline survey data shows that there is an increase in awareness of entitlements under NRHM, Janani Suraksha Yojna (JSY), Janani Shishu Suraksha Karyakram (JSSK), VHND and the role of ASHAs among male respondents (Table 3). A significant change seen is in the leadership shown by young men in the villages in interacting with the health care system, taking up women's health issues and demanding accountability for women's and particularly maternal health services. Consequently, an increased participation in the structures of local health governance was observed; for example, participation in VHSCs increased from 17 percent in the baseline to 56 percent in two years and participation in Gram Sabha meetings increased from 60 percent to 71 percent during the same period. (Table 3)

The change of relationships at the community level has resulted in a more collaborative action from that

which previously had a tinge of hostility and suspicion. Animators and men's groups used the methodology of community monitoring (using pictorial tools) to assess availability and quality of services at the village and PHC level and held a series of negotiation meetings using this information, in each village. They were able to negotiate as well as collaborate with service providers to benefit services. Animators supported the ANMs and ASHAs in organising VHNDs and ensuring participation of more women and children at

Table 3: Awareness of NRHM mechanisms and utilization

Table 3: Awareness of NRHM mechanisms and utilization		
Awareness regarding NRHM*		
	Baseline (N=120)	Endline (N=169)
Heard about NRHM	41 (34%)	117 (69%)
Heard about ASHA	79 (65.8%)	158 (94%)
Heard about JSY	61 (51%)	131 (77%)
Hard about JSSK	NA	93 (55%)
Heard about VHND	31 (26%)	159 (94%)
Heard about Rogi Kalyan Samiti	17 (14%)	NA
Heard about Janani Express	47 (39%)	NA
Heard about VHSC Tadarth Samiti	35 (29.1%)	127 (75%)
Participated in VHSC meeting in the last six months	21 (17.5%)	94 (56%)
Participated in Gram Sabha Meeting	72 (60%)	120 (71%)
Persons contacted for solving problems		
Sarpanch	53(44.2%)	115(68%)
Upsarpanch	7(5.8%)	44(26%)
Ward panch/member	18(15%)	37(21.9%)
Panchayat Secretary	28(23.3%)	57(33.7%)
ANM	3(2.5%)	20(11.8%)
AWW	6(5%)	21(12.4%)
ASHA	3(2.5%)	32(18.9%)
Members of the female SHG/ women's groups	3(2.5%)	12(7.1%)
Animator	–	38(22.5%)
no problem	17(14.2%)	15(8.9%)
went to no one	44(26.7%)	24(14.2%)
Teacher/ men's group/ ZP representative	2(1.7%)	2(1.2%)
No answer	2(1.7%)	0
*Multiple Responses		

Table 2: Changes in gender-related norms at the societal level

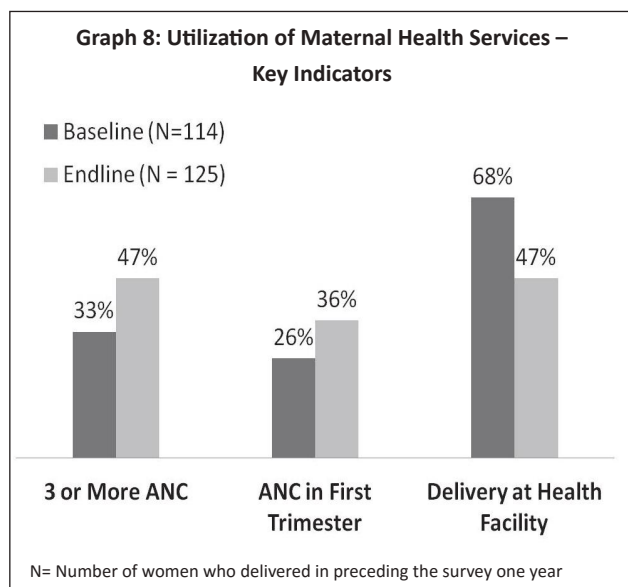
	PRA I			PRA II		
	Number of girls between 12-18yrs enrolled in school	Number of girls between 12-18yrs eligible for school	Percent enrollment of girls in school	Number of girls between 12-18yrs enrolled in school	Number of girls between 12-18yrs eligible for school	Percent enrollment of girls in school
Girl's education	906	1119	81%	1182	1346	88%
Age at Marriage	Total number of marriages above legal age	Total number of marriages in the village	Percent of marriages above legal age	Total number of marriages above legal age	Total number of marriages in the village	Percent of marriages above legal age
	172	343	50%	241	246	98%

the VHNDs. For instance, often times the ANM does not have any one to accompany or assist her during emergency situations, especially at night and there have been many instances when the men from the groups have provided her assistance. Besides, the regular participation of men in their respective VHNDs and a demand for properly conducting the VHND, better maternal health services, improved and respectful behaviour from the health care providers towards women has impacted the quality of the VHNDs. Overall, they were able to articulate and negotiate with health care providers even at the PHC level for better health services.

5. Responsiveness of the health system:

The goal of continuous negotiation of men’s groups with health care providers at the village level, and the health system at the PHC and district level, was to bring about a systemic change and improved availability of services at the village level. We see a qualitative difference in the responsiveness of the system to negotiations for services at the village level vis-a-vis the effort required for changes at the systemic level.

i. Improved services at the village level: The Sajhedar intervention was expected to change social norms through a combination of individual and collective motivations and actions. Qualitative enquiry indicates a number of changes in the attitude towards and utilisation of services. The negotiations have led to an increased availability and improved quality of maternal health services. VHNDs are now being conducted regularly on the designated days in most of the villages and their utilization has increased. The survey among women who delivered in the last one year shows that a greater proportion of women received three or more ANC visits than in the baseline (increased from 33 percent to 47 percent), and the proportion of women receiving first ANC within the first trimester has also increased (Graph 8).



The community reports that the quality of VHNDs has also improved. Pressure from the community groups has led to an expansion of services offered (from mere immunization to the availability of blood pressure equipment, a table for patient examination, urine test kit, stethoscope and so on) and also an improvement in the attitude of local health providers towards women which has contributed to greater utilisation of services by the community.

“...VHND is organized better in recent times...earlier only vaccination was administered but now blood test and all other tests are all done regularly...now the VHSNC has become active and started to take more interest in the issues related to health and hygiene...the untied funds have also been used to buy certain equipments as also to provide better services to the citizens...even the ANM comes on other days to follow up on vaccination cases in case there are some problems and she interacts more with the group and the community on how best to tackle health related issues.” (Animator and group members, Village Amha, Sidhi; Interviews with Stakeholders 2014)

The groups have also been able to influence how untied funds can be utilized to benefit the community, rather than by arbitrary orders from the health department.

“There was an order from the Health Department that with the available funds under the untied head, mike sets be purchased for the purpose of communicating about VHND...when the ASHAs informed the Sajhedar group, they said that instead of wasting that money on the equipment it could be used for something more beneficial to the community. They also volunteered to go around the village informing people about the VHND and exhorting them to come and avail the services. In Amha village the ASHA bought dust bins for waste disposal, a small (plastic) table, utensils for drinking water and containers for storing medicines with that money.” (Animator, Village Amha, Sidhi; Interviews with Stakeholders 2014)

The villagers had earlier experienced apathy from the district health service system officials even during emergencies. They are now able to summon emergency medical response from the health provider through telephonic calls during emergencies. In two of the cases, the animators were able to call for JSSK ambulance at midnight and save the life of the women in labour as she could reach the district hospital. This was a very surprising change, as was expressed by the group members given the traditional response of health care providers to adivasis in those villages. (FGD with animators during midline review).

Central to accountability is a consciousness of being a citizen with rights and entitlements. The entitlement consciousness and demand for accountability by the community has continued to elicit responsiveness for other public services as well. The demand for adequate mid-day meal programme, proper functioning of public distribution system (PDS) and anganwadis has

increased. When there is a deficiency in basic services being provided, in many cases the community has taken proactive steps to address the problems.

“...during the summer months 5 hand pumps of the village had failed and the village was facing a serious crisis with respect to water...animator spoke with the Public Health Engineering Department (PHED) engineer but there was no positive response...subsequently he contacted the toll free number of the department at Bhopal... immediate response and within a day team arrived and repaired all the five hand pumps and also put bleaching powder to disinfect them....since then people within the village who were not earlier supportive of the group have now extended their support and trust.” (Animator, Village Mata, Sidhi; Interviews with Stakeholders 2014)

In another example, members of the men's group supervised the spraying of DDT for malaria control in a remote village, 36 km away from the district headquarters. In the past, DDT spraying was done very quickly and sometimes the pesticide was also diluted. Supervision by the men ensured that this did not happen, and DDT spraying went on for two days as opposed to only 3 hours that it used to take before.

ii. Affecting systemic change: While community level changes were achieved rather at a quicker pace during the programme intervention, effective transformative changes in the system per se - functioning of the Karavahi PHC in this instance - took much more concerted effort, time and different strategies. Despite continuously generating data on the poor conditions of the PHC and making representations at the district level with repeated evidence, the functioning of the PHC did not improve much. This is amply evident in the delivery data which showed that at the time of the endline survey (March 2014), there had been a decrease in the institutional deliveries even though ANC utilization had improved (Graph 8). Women's reluctance to go the PHC for delivery was a combination of the poor quality of services resulting from the dysfunctionality of the PHC, as well as non-availability of JSY scheme.⁸ Previously women were at least accessing the PHC for the JSY incentive. Once there was a problem in obtaining the incentive, going to the institution for delivery was rendered absolutely useless for women, and this explains the drop in numbers. The revival of the Karavahi PHC and ironing out issues related to JSY payment required a much more concerted effort which took place after the endline study, during the extended phase of the intervention, i.e. during April 2014 - March 2015.

⁸ The mode of payment of JSY money was changed from cash payment to cheque payment which required a bank account. The entire region of the PHC does not have a bank. Over 300 JSY cheques from this area expired as the banks refused to open 'nil' balance deposit account for women even after repeated visits to the far away banks (Chief General Manager RBI 2007), and the three months validity period of the cheques expired even before the bank accounts could be opened. After this experience women from this region stopped going for institutional delivery.

During this time, the animators had been linked to a state level campaign known as the Maternal Health Rights Campaign (MHRC). Animators' participation in the MHRC simultaneously exerted collective pressure on the health system, especially at the state level for improving services available at the Karavahi PHC. The synergy of strategies led to significant transformative changes in the PHC (See Box 4).

Box 4: Changes in Karavahi PHC

The dismal condition of the PHC was highlighted during a participatory rural appraisal exercise conducted through the project. This triggered community discussions about the state of the PHC and the need to initiate action to improve its services. The animators began to dialogue with local health care providers about various entitlements, including the utilization of untied funds. At first, they did not receive any answers from the system, but their persistence sent a strong message to the staff that the community wanted account of the funds which were sanctioned for the development of the PHC. 3 rounds of community inquiry were carried out at the PHC, and findings were shared with local functionaries through public dialogue at the district level. The Chief Medical Health Officer (CMHO) cited lack of resources and staff for the poor functioning of the PHC, but the animators persisted and continued to put pressure on the authorities to get the PHC functioning. The gaps in functioning of the PHC were shared routinely with the media which also took an interest in reporting them. A post card campaign was initiated through which 750 postcards were sent to the Chief Minister stating the important correctional measures to be taken for PHC. This created greater pressure on the system to improve the PHC. Consistent advocacy was carried out by the community members with local governance bodies such as the *Gram Panchayat* as well as with elected representatives. The members seized the opportunity of state legislative elections and made representation to the contesting candidates and presented them a people's manifesto with a demand to revive the Karavahi PHC. Lobbying with a local legislator (Member of Parliament) resulted in electricity and clean water being provided to the PHC within a month.

Through the sustained and intense advocacy carried out by the community, significant changes have been seen in the PHC. The location of the PHC has been moved from an inaccessible location (Panchayat Bhavan) to a more accessible place. The infrastructure has improved considerably; the building is in a better condition, there is electricity and water supply too. In terms of supplies, all essential medicines are now available in the PHC. The attendance of ANM and nurses is more regular and deliveries are being carried out routinely. The OPD of the PHC has increased and this shows that people are utilizing its services. The village of Karavahi was recently chosen as a 'model village' under the local area development plan of the legislator.

The PHC has now been moved from the rented building on the hillock to its own premises closer to the village, it has received electricity and water supply and the utilization has also increased. During the time period between July 2014 and January 2015, 57% of deliveries took place in institutions as compared to 36% deliveries that took place between July 2013 to June 2014. The revival of the PHC by the mobilised community of men indicates that for accountability interventions to succeed against such seemingly static public systems, it is important to capture the opportune moments of greater receptivity such as elections for the process of accountability to yield results.

IV. DISCUSSION

Most interventions aimed at reducing maternal and infant mortality focus on improving accessibility to health care services including emergency obstetric care. Community driven accountability processes are increasingly being seen as key factors to improve the delivery of public services. Much of the discussion on maternal health rights and accountability has been highlighting the role of women as principle agents and rights holders and the health service providers as duty bearers. (Afrin et al 2013, Das and Dasgupta 2013). Men's reproductive responsibility as partners and fathers, and for addressing patriarchal norms that jeopardise women's health has not been included in such accountability interventions. This intervention successfully develops the model of 'engendered accountability' drawing upon a context where the NRHM provided opportunities to implement community driven accountability strategies and CHSJ's past experience on working with men on gender issues (Das and Singh 2014, Das et. al. 2012) to integrate men's involvement to address gender discrimination as well as demand health rights. Even though the overall time frame of the intervention was short, the enabling policy context, with guidelines for community driven accountability processes and some resources for decentralised planning, allowed the intervention to obtain sufficient successes for the community to continue their accountability initiatives even after the project period was over.

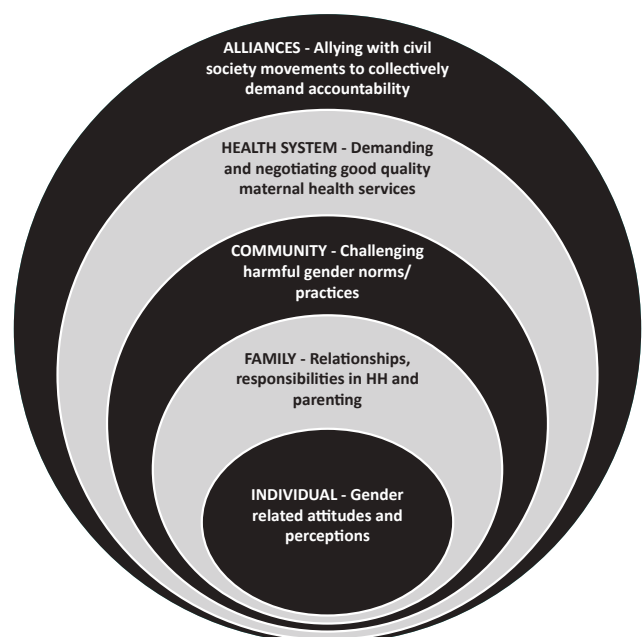
The evidence shows that core intervention of sensitizing men in groups to issues of gender and their responsibilities in the family and community, as well as systematically organizing them to demand services from the health system has probably been the most successful component of the project. The collective initiative of gender sensitised men conducting discussions and community campaigns on gender and demanding accountability from public services provides an alternative model for addressing gender and development at the community level. The men's peer group emerged as an important vehicle for fostering

greater individual awareness and change as well as demanding accountability from public systems.

The group also provided a safe environment for exercising greater agency and autonomy for the community members as evidenced by greater interaction with health care providers and monitoring health services at the local level. They also undertook higher level advocacy at the district and state level with other allies from the state. The NRHM mandated provisions for encouraging decentralisation and involving communities in accountability processes allowed for the project to interact with providers and also enabled greater responsiveness from the health providers. The overall attitude of constructive engagement where the men's groups also chalked a role for themselves to facilitate service delivery at the village level changed a potentially adversarial relationship to one of collaboration and this has been testified by women, men and the providers themselves.

This project was based on a set of interlinked assumptions. The first assumption was that changes in men's concept of social power relationships within a framework of gender equality and citizenship at the personal and public level can become a powerful motivation for change in men's behaviours at the household level, towards their spouses and their children and their aspiration for them. This aspiration can in turn become a powerful motivation for public collective action at the community level when there is a peer group who have also been supportive partners in this journey of individual change. Collective action aimed at public services which are informed with an entitlement framework finds expression in accountability or demand for better services. The results show that these mechanisms can emerge, at least during the duration of a short project.

Figure 2: Impact of the Intervention in various spheres



However, these gains are not without any resistance from the community. The animators and group members initially faced stiff and subsequently nuanced resistance from members of the household, primarily elderly women and elders in the village for their changing behaviour towards their spouses. But these were slowly overcome.

While the enabling policy context allowed empowered communities to negotiate with the health system and achieve some successes, the overwhelming bureaucracies of public services also makes them resistant to change beyond a certain point. There were a few occasions when this was evident during the project. The failure to get JSY cheques encashed, in a context where JSY was a flagship scheme of the government was a case in point. Despite continuous representations during the project the Karavahi PHC continued to conduct deliveries with kerosene lamps for illumination and without any water supply. For accountability interventions to succeed against such seemingly static public systems, some receptivity and small changes in the health care system is essential.

Challenges and Limitations: The intervention was undertaken in a remote area among Advasi or tribal communities, which indicates a high level of isolation and marginalisation. The remoteness and hilly forested terrain with poor connectivity and large distances between houses and villages and of the villages from health facilities posed a great challenge to the outreach processes. The survival struggles lead to men seasonally migrating for work and posed a challenge to continuity of interventions.

The overall time available for field intervention in this three year project was about two years. It was too short to achieve the change in social norms that were anticipated. It was only towards the end of the second year that accountability process started gaining momentum and the leaders started intervening with greater purpose at the PHC and the district levels. One of the more dramatic results, the transformation of the Karavahi PHC took place during the extended period beyond the initially stipulated time-frame.

The information from qualitative and quantitative data suggests that community actions facilitated through the intervention played a key role in bringing about many of the health system changes, as the actual implementation of NRHM was almost absent in these tribal villages. However, as the intervention was undertaken during the NRHM consolidation phase (2012-15) the research acknowledges that the larger policy framework and actual improvements planned through the routine implementation process might too have contributed to the actual changes in the villages achieved through this intervention.

V. CONCLUSION

This limited intervention in an *Adivasi* area in a difficult terrain offers valuable insights for improving maternal health services in difficult areas and among marginalised communities. The idea of 'engendered accountability' proposed by this project synergises men's increased understanding of gender and involvement in the family with a sense of entitlement to public health services offers an effective approach to work on maternal health rights. While organizing communities to demand health rights and hold the health system accountable is certainly desirable, addressing the communities own responsibility to put an end to gender discriminatory social practices that jeopardize women's health is equally important. Engaging men as responsible and concerned partners and parents as well as responsible citizens allows them to reconfigure their roles in their personal lives as well as in the public domain. The consciousness of their new roles not only leads to changes in individual and community behaviours but allows them to constructively engage with the health system demanding for better services. Accountability led improvements in health systems are possible within a policy framework which acknowledges the claims of the marginalised. These changes in turn keep the spirit of community engagement alive. It is this spirit of constructive engagement despite odds and reversals which can lead to the construction of a 'citizenship' assertion which is at the core of rights based development of marginalised communities, who otherwise need to depend on the largesse of benevolent bureaucracies or client – patron relationships based political patronages or mercies.

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
CBM	Community Based Monitoring
CBMP	Community Based Monitoring & Planning
CHC	Community Health Centre
CMHO	Chief Medical Health Officer
GSS	Gram Sudhar Samiti
IMR	Infant Mortality Rate
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojna
MDG	Millennium Development goals
MHRC	Maternal Health Rights Campaign
MIS	Management Information System
MMR	Maternal Mortality Ratio
MP	Madhya Pradesh
MPW	Multi Purpose Worker
NRHM	National Rural Health Mission
OPD	Out Patient Department
PDS	Public Distribution System
PHC	Primary Health Centre
PHED	Public Health Engineering Department
PRA	Participatory Rural Appraisal
PRI	Panchayati Raj Institutions
RKS	Rogi Kalyan Samiti
SHC	Sub Health Centre
VHND	Village Health & Nutrition Day
VHSC	Village Health & Sanitation Committee
VHSNC	Village Health Sanitation & Nutrition Committee

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