Family Health Campaign: Accountability for Change (Sajhedar Project)

Report of Findings from Research

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Executive Summary

High rates of maternal morbidity and mortality is a continuing health problem in India. The low status of women, witnessed by low levels of literacy among women, early marriage and pregnancy as well low coverage of health services have been seen as important causes behind this phenomenon. The government of India has been announcing special programmes for improving maternal health for over fifteen years (the first being the Child Survival and Safe Motherhood Programme 1992 – 93), but it is only since the Janani Suraksha Yojana was started as part of the National Rural Health Mission has there been a concerted effort to improve health services and increase institutional deliveries. Over the last five years there has been a remarkable increase in institutional deliveries but there are questions about the quality of the services available at the institutions. Similarly questions have been raised about the availability of emergency obstetric care services. In the State of Madhya Pradesh, with Maternal Mortality of 269 (as opposed to 212 for India), the situation is quite acute. Even though surveys show that the proportion of deliveries occurring at a health institution has increased over the past eight years, the situation of the health facilities has not improved. In fact data shows that between 2008 and 2012, the shortfall in terms of human resources as well as infrastructure has actually worsened.

Maternal Mortality has been recognized as a human rights issue by the Human Rights Council of the United Nations, through a series of resolutions since 2009. The Human Rights Based Approach recognizes accountability as one of its integral components to maternal mortality and morbidity reduction. It lays down various aspects of accountability. Importantly, it recognizes the aspect of social participation in monitoring as well as review. The NRHM in India envisaged a vigorous process of social accountability through a process of communitisation which includes decentralised community based monitoring and planning (CBMP), management of untied funds, formation and strengthening of community institutions like the Village Health and Sanitation Committees (VHSCs), the Rogi Kalyan Samiti (RKS), and CBMP committees. This process showed positive results in the conditions of health centres, increased utilisation of services by the community, and provided space for community negotiation through spaces for feedback.

However, it could be noted that the accountability process practiced through the framework of CBMP, has not addressed the issues of social discrimination, structural barriers and unequal power relationships. While the NRHM has been improving the quality and range of health services available to the poor in systematic manner across different states, health outcomes are not solely the result of the status of health services. Health outcomes of women, adolescents and children are to a great extent dependant on community norms and practices and the status of women in society. In order to change existing social norms it is necessary to work with men within a framework of gender equality, since they are not only in a better position and have more power to influence such change, but their participation in such changes is also essential.

This project tested an intervention which incorporates the dual accountability concept- (i) men being sensitised and empowered as responsible and gender-sensitive partners would be accountable to the spousal and maternal needs of their partners and (ii) would equally engage with the health providers to elicit accountability and responsiveness for better maternal health services in favour of their partners. The intervention was implemented in two districts of Madhya Pradesh – Sidhi, with a predominantly tribal population, and Morena. 15 Villages in Sidhi and 14 in Morena were selected for the intervention. A rigorous research methodology was followed, using the realist evaluation framework, to whether and how the intervention worked.

Key findings:

The intervention has shown a real time outcome of change in men's behaviour towards their spouses on the one hand and their interface with the health providers along with or on behalf of their spouses has shown positive results. Even with the constraint of time, some changes have been seen and there have been learnings as well:

1. The collective leadership of gender sensitised animators and members of the groups mobilised by them and their ongoing discussions in the village attended by many others provided a space for discussions in the villages. This was supplemented by the health care campaigns and reinforced through street plays and public display of social and public health charters. In an encouraging and positively reinforcing and challenging atmosphere, it appears possible to elicit responsible leadership and partnership from men for social change which includes their personal perspectives, attitudes and behaviours.
2. In both the areas, the intervention had led to the creation of a space for discussions related to equity and power related aspects. Men's attitudes towards gender, sexuality and masculinity have moved from mostly 'traditional' to 'equitable'. Issues like men's participation in family responsibilities, maternal and child health, and relationship with one's spouse have come out in the open and started to be discussed.
3. Action has been taken by men's groups to stop marriages before the legal age, celebrate birth of the girl child, and support education for adolescent girls. The proportion of marriages taking place after legal age, and proportion of adolescent girls enrolled in school have both increased in the project period. In a patriarchal society like Morena this has been a very big impact of the programme, for these are the kind of issues which would have been never discussed earlier in public.
4. A comparative look at both the both the districts shows that the exposure of men to the intervention and the consequent dialogue between men and their wives on various issues of family health and responsibility was less in Morena compared to Sidhi. The fact that in Morena there is more caste – class and patriarchal domination could account for the slower progress with respect to more sensitive action from men's side.
5. The role of men in taking responsibility for reproductive health and parenting has undergone a change. Men are more aware of pregnancy related issues and are also taking on a greater role

in helping women in the pre- and post-partum period, as well as child rearing. The use of spacing contraception has increased, and one also sees a trend to delay birth of the first child.

6. Organized action and dialogue by group members with service providers and local governance functionaries has increased. The responsiveness of the health providers at the village level has changed from resistance to collaboration and this is evident from the proper conduct of the VHND, as well as improved and respectful behaviour of the health care providers towards women. The supervision by group members has resulted in improved service provision – organizing of VHNDs, mid day meals, malaria control programs and so on.
7. Utilization of maternal health services to some extent has improved, for instance, the proportion of women receiving three ANCs has increased. In Sidhi however, there is a reluctance to go for institutional deliveries and the proportion of home deliveries has actually increased in the intervention period. To some extent this has to do with accessibility and quality of maternal health services, but a more systematic investigation into this phenomenon is required. As of now home deliveries receive no PNC and this need to be corrected as well.
8. Despite almost ten years of NRHM being rolled out, the dismal state of health services especially in Sidhi is worth noting. Even with community monitoring, except for shifting the PHC from a rented building on an inaccessible hillock to its own building in a village, there has not been a substantial improvement in the PHC which does not have either electricity or water supply. This shows the limits to civil society's democratic efforts in moving lethargic and unwilling machinery. For optimal results, along with the motivated community for participation in improving social relationships and services, a fairly functional and responsive health care system is essential.
9. The momentum gathered through the process of community mobilisation has also translated into larger action at the district and state levels. Local groups have forged alliances with others at the state level, under the banner of a state-wide 'Maternal Health Rights Campaign' (MHRC) to draw attention to the issue of poor maternal health services.

Challenges and Limitations:

1. The availability of time for intensifying the process in a three year cycle was about two years and was found to be less. It is towards the end of the second year that the leaders started intervening at the PHC and the district levels, a process which continues.
2. The geographic terrain and accessibility due to the lack of public transport and the distances of villages from health facilities posed a great challenge in Sidhi.
3. The animators and group members faced initially stiff and later on nuanced resistance from members of the household, primarily elderly women and elders in the village for their changing behaviour towards their spouses evident from the strange remarks they hear while accompanying their wives to the VHND.

Conclusions:

Reduction of maternal mortality and infant mortality, the key indicators of health status, are contingent upon the changes on social power relationships along with the better accessibility to health care services. The changed social power relationships can be instrumental both in facilitating better access for women to health services as well as improving the quality of the services itself. This intervention has shown that by working with men to become agents of change, transformation is possible at the personal level, family level, community level and health system level as well. However, along with a motivated community, it is essential that the health system be strengthened considerably. What is also evident in a remote area like Sidhi is that even with participation of the community, there is an implicit rejection of institutional deliveries owing to various factors. This suggests that there is a need to devise new ways of providing maternal health services to women in such areas, taking into account local practices and anxieties with the formal health system.

List of Abbreviations

AHS- Annual Health Survey

ANC- Antenatal Check–Up

ANM- Auxiliary Nurse and Midwives

ASHA- Accredited Social Health Activists

AWW- Anganwadi Worker

CBMP- Community Based Monitoring and Planning

CHC- Community Health Centre

CHSJ- Centre for Health and Social Justice

CSO- Civil Society Organisation

DDT- Dichlorodiphenyltrichloroethane

DLHS- District Level Household and Facility Survey

GEM- Gender Equitable Men

JSY- Janani Suraksha Yojana

MDG- Millennium Development Goal

MHRC – Maternal Health Rights Campaign

MMR- Maternal Mortality Ratio

MPW- Multi Purpose Worker

NFHS- National Family Health Survey

NRHM- National Rural Health Mission

PDS- Public Distribution System

PFI- Population Foundation of India

PHC- Primary Health Centre

PHED- Public Health Engineering Department

PNC- Post Natal Care

PRA- Participatory Rural Appraisal

PRI- Panchayati Raj Institution

RKS- Rogi Kalyan Samiti

SHC- Sub Health Centre

TBA- Trained Birth Attendant

VHSC- Village Health and Sanitation Committee

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I. Introduction

High rates of maternal morbidity and mortality is a continuing health problem in India. As a single country, India contributes the largest numbers to the global annual count of maternal deaths, and as a region South Asia is just behind Sub – Saharan Africa in terms of maternal death rates. The low status of women, witnessed by low levels of literacy among women, early marriage and pregnancy as well low coverage of health services have been seen as important causes behind this phenomenon. The government of India has been announcing special programmes for improving maternal health for over fifteen years (the first being the Child Survival and Safe Motherhood Programme 1992 – 93), but it is only since the Janani Suraksha Yojana was started as part of the National Rural Health Mission has there been a concerted effort to improve health services and increase institutional deliveries. This has been partly due to the effort to meet Millennium Development Goal 5 which calls for reduction in maternal mortality. Over the last five years there has been a remarkable increase in institutional deliveries but there are questions about the quality of the services available at the institutions. Similarly questions have been raised about the availability of emergency obstetric care services.

Maternal Health, Human Rights and Accountability

Maternal Mortality has been recognized as a human rights issue by the Human Rights Council of the United Nations, through a series of resolutions since 2009. The Council has expressed concern for the unacceptably high rates of maternal morbidity and mortality and acknowledged that this is a human rights issue, calling upon governments to redouble existing efforts and to incorporate human rights based approaches (HRBA) in policies and programmes, to eliminate preventable maternal morbidity and mortality. (HRC 2009, para 4). In 2012, based on several studies, the Office of the High Commissioner of Human Rights released a concise 'technical guidance' document to assist policy makers in improving maternal health. This document provided guidance on devising, implementing and monitoring policies and programs to reduce maternal mortality and morbidity. It also stressed on fostering accountability in accordance with human rights.

The Human Rights Based Approach recognizes accountability as one of its integral components to maternal mortality and morbidity reduction. It lays down various aspects of accountability. Importantly, it recognizes the aspect of social participation in monitoring as well as review:

"[...] accountability is central to every stage of a human rights-based approach. It requires not just transparency but meaningful participation by affected populations and civil society groups. Effective accountability also requires individuals, families and groups, including women from vulnerable or marginalized populations, to be aware of their entitlements with regard to sexual and reproductive health and are empowered to make claims grounded in them."

NRHM envisaged a vigorous process of social accountability through a process of communitisation which includes decentralised community based monitoring and planning (CBMP), management of untied funds, formation and strengthening of community institutions like the Village Health and Sanitation Committees (VHSCs), the Rogi Kalyan Samiti (RKS), and CBMP committees. The role of Accredited Social Health Activists (ASHA) as interface between community and health care providers was also envisaged to make health services responsive, effective and accountable. The nine state pilot project initiated by Government of India in 2007 standardised a process of community enquiry which evolved a evidenced based community feedback on the availability of, accessibility to and the utilisation of NRHM services. This process of accountability referred to as "Community Based Monitoring and Planning (CBMP)" showed positive results in the conditions of health centres, increased utilisation of services by the community, and provided space for community negotiation through spaces for feedback. (Parija E., Singh S., Das A., Sharma S. 2010; CHSJ/PFI 2008; Shukla A., Saha S., and Jadhav N. 2013)

However, it could be noted that the social accountability process practiced in large scale through the framework of CBMP, has not addressed the issues of social discrimination, structural barriers and unequal power relationships. This is evident in the maternal health services which are also part of general health services in health centres, but lack utilisation due to the barriers in accessibility defined not only by physical norms and standards but also by social norms and vulnerability. Such concerns have also been shared by Dalit communities and Muslim communities. (CHSJ, interview with KSSK, Raisen district and Pradeepan, Betul, Madhya Pradesh, India).

Women's social status: an important determinant of maternal health

While the NRHM has been improving the quality and range of health services available to the poor in systematic manner across different states, health outcomes are not solely the result of the status of health services. Health outcomes of women, adolescents and children are to a great extent dependant on community norms and practices and the status of women in society. Women are often faced with adverse life circumstances like early marriage, repeated pregnancies, poor nutrition due to community norms that emerge out of a deep divide in society which creates different rules for men and women. Dietary practices for girl children and community norms around early marriage and pregnancy not only affect pregnancy and neonatal health outcomes but also affect the overall health of women. In states like Kerala, Tamil Nadu and even Himachal Pradesh the gender divide is lower and women's status is better, the status of women's health including maternal health is better. However in states like Madhya Pradesh, Rajasthan, UP or Bihar the reverse is true. In these states overall improvement in health status of women, adolescent girls and children will require a reciprocal change in social norms which will ensure women receive their fairer share of life's opportunities even at the simple level like food, health care, education, workload etc. In order to change existing social norms it is necessary to work with men within a framework of gender equality, since they are not only in a better position and

have more power to influence such change, but their participation in such changes is also essential.

Table 1: Indicators of women's status - MP

Indicator	*India*	*MP*
Literacy –Female (%) (2001)	54.03	50.03
Literacy gap (M-F)*	21.61	27.06
Life expectancy at birth (female) 2005	63.9	59.3
IMR 2008	53	70
MMR (2004 - 06)	254	335
Sex Ratio (F:1000M)	933	919
Unmet need for contraception (2005 -06)	13.2	11.8
Couple Protection Rate (2005 -06)	54.1	52.8
Total fertility rate (2005)	2.6	3.3
Anemia (2005 -06)	55.3	57.6
Children fully immunized (12 – 23 mo)	43.5	40.3

*(Literacy Gap is the difference between male and female literacy)

Accountability as related to maternal health services, located in the larger context of gender based roles and responsibilities within a patriarchal society thus demands responsiveness and accountability from the power wielders, i.e., men as spouse, sibling or sons within families. In a weakly regulated public health sector, maternal health also is contingent upon the delivery of maternal health care from the health care system which itself is not responsive to the needs and demands of pregnant and lactating women. Hence, the concept of "engendered accountability" emerges which incorporates the dual accountability concept- (i) men being sensitised and empowered as responsible and gender-sensitive partners would be accountable to the spousal and maternal needs of their partners and (ii) would equally engage with the health providers to elicit accountability and responsiveness for better maternal health services in favour of their partners.

II. Context of Maternal Health Services in Madhya Pradesh

Madhya Pradesh, located in the central part of the country, has some of the worst indicators vis a vis maternal health. The Maternal Mortality Ratio (MMR) of MP is 269 as against the national average of 212, (Registrar general- Census or Government of India, SRS Bulletins 2007) and the sex ratio in the state is 930 (as compared to 940 for the country). (M/O Health and F.W., GOI: RHS Bulletin 2012). As per the NFHS III (2005-06), 65 percent of deliveries in MP occurred at home. Over the years, however, there has been a drastic decrease in this number. As per the

Annual Health Survey 2012, the proportion of home deliveries has dropped to 14 percent.[1] However, this decline has not been uniform across the state. For instance, during the DLHS 3 (2007-08), while the proportion of women delivering in institutions in the state as a whole was X% in districts such as Sidhi, Dindori, Mandla and Barwani, less than 30% of women delivered in institutions. Moreover, even though the proportion of women delivering in institutions has risen, the situation of the health facilities has not improved. A comparison of the RHS bulletin of 2008 and 2012 shows that the shortfall in terms of human resources as well as infrastructure has actually worsened over the years.

This project was located in two districts of Madhya Pradesh – Sidhi and Morena – that signify two very different socio-economic-cultural and political contexts of the communities. In Sidhi, a district located on the north-eastern boundary of Madhya Pradesh, the villages for the project are predominantly tribal areas and various tribes such as Gonds, Agaria along with other communities belonging to the scheduled caste and backward. In the district 48.9percent of the households are below poverty line, which is much higher than the national average (30.6percent) and a little higher than that of state (42.3percent). (IIPS 2010, District Level Household and Facility Survey (DLHS-3) 2007-08: India). Although tribal, the population is exposed to the outside social norms and practices due to regular migration in search of work. Among the tribes in Sidhi, the relationships between women and men and the idea of masculinity are very different. Though patriarch exists but the patriarchal values are not that strong as compare to the other part of Madhya Pradesh. The sex ratio here is 952 which is higher than Morena and MP as well. Moreover, unlike Morena, both women and men take part in economic activities. May be this is one of the reasons for less gender based discrimination against women. In Sidhi, families are mostly nuclear. It is very common in Sidhi that young people prefer not to stay with parents after their marriage.

Like any other tribe of India, the tribal people of Sidhi also are under intense land pressure. Migration into tribal lands has increased and these tribal people have lost title to their lands in many ways – lease, forfeiture from debts, or bribery of land registry officials. Due to this many tribal members have become landless labourers. Government policies on forest reserves have affected tribal peoples profoundly. Government efforts to reserve forests have precipitated armed (if futile) resistance on the part of the tribal peoples involved. Intensive exploitation of forests has often meant allowing outsiders to cut large areas of trees (while the original tribal inhabitants

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[1] The National Family Health Survey (NFHS) is a national level household survey to gather information on fertility, family planning, infant and child mortality, reproductive health, child health, nutrition of women and children, and the quality of health and family welfare services. The latest round conducted in 2005-06 (NFHS-3) samples represented more than 99 percent of India's population living in all 29 states. The NFHS reports present health indicators disaggregated by urban and rural areas.

The District Level Household and Facility Survey (DLHS) is one of the largest ever demographic and health surveys carried out in India, with a sample size of about seven lakh households covering all the districts of the country. It is designed to provide estimates on maternal and child health, family planning and other reproductive health services. In addition, it also provides information related to the programs of NRHM.

were restricted from cutting), and ultimately replacing mixed forests capable of sustaining tribal life with single-product plantations.

There are 23 primary health centres (PHCs), 145 sub health centres (SHCs) and 6 community health centres (CHCs) in the district (CMHO, District Sidhi- MP 2012). Most of the SHCs are located in the remote areas and are operated from rented premises. The road and other infrastructure to the district or within the district form a greater challenge for health care service delivery. Also, the medical facilities are inadequate and Auxiliary Nurse and Midwives (ANMs) and Multi Purpose Workers (MPWs) seldom stay in villages due to non-availability of residential facilities. The story of Karavahi PHC provides an insight into the functioning of an average health centre in this district (see box 1)

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

The public health system in the district suffers from severe deficiencies in terms of infrastructure. The Karavahi PHC catering to 22 viallges (including 14 villages of the intervention) is located in Karavahi village and was housed in a Panchayat Bhavan, till a year ago. It does not electricity connection and lanterns/ petromax lamps are used during the night during deliveries. 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 staff includes two ANMs, two attendants and one pharmacist, with no doctor. Due to the absence of doctors at the health facility, home delivery is a prevalent practice in many of the households or people prefer to go to the district hospital at Sidhi (45 kms). Sub-centres are located in Chaufal, Mata, Barmani, Khirkhori and Amha. The CHC, the referral for PHC is located is located at Semaniah, 20 kms further away from the district place Sidhi. For some villages it is about 55 kms to reach CHC and they will have to pass through the district place. Hence, the people generally go to the district hospital or to private practitioners. The free medicines scheme which is launched by the government is practically useless as there is neither a doctor to prescribe medicines nor a pharmacist to dispense the medicines.

In Morena on the other hand, villages selected for the project primarily are mainstream villages with its historically known caste – class and patriarchal domination. Morena is part of the crime prone Chambal region –famous for its particular brand of masculinity- including moral standards, *izzat*, valour and a very domestic role/*purdah* for women and the idea that 'real men' don't hurt but protect women. Morena have a long been associated with tales of female infanticide, today with increasing number of ultrasound clinics which at times provide a safe haven for illegal foetal sex determination, these silent landmarks stand witness to the growing practice of female foeticide. Here, feudal practices dominate and display of guns is a sign of valor. The child sex ratio (0-6) is abysmally low and it has declined in 2011 census (819 from 825 in 2001 census). The general caste people are dominant in Morena and they are mostly hindu. In Morena, dowry related crime, reported rape cases and child marriage are very high. .

With respect to Maternal health, there are some distinct differences between Sidhi and Morena. In general, comparing the indicators of mortality, one finds that Sidhi is worse off than Morena. Both maternal mortality and especially infant mortality are higher in Sidhi than in Morena. The utilization of maternal health services is also low in Sidhi. The proportion of women registered for ANC as per the AHS 2011-12 was only 51percent as compared to 64 percent in Morena. Another stark difference in the two states is in their utilization of health institutions for delivery. In Morena, 90 percent of deliveries take place in institutions, while in Sidhi, only 55 percent deliveries are institutional.

Some of the health indicators of Madhya Pradesh and the districts of Sidhi and Morena are as follows

Table 2: Maternal Health Indicators for MP and districts of Sidhi and Morena

MATERNAL HEALTH OUTCOMES	MP	Sidhi	Morena
Maternal Mortality Ratio	310	336	311
Infant Mortality	67	72	48
ANTE NATAL CARE			
Currently Married Pregnant Women aged 15-49 registered for ANC (%)	66.5	51.1	64.1
Mothers who received any antenatal check-up (%)	88.6	68.8	68.9
DELIVERY CARE			
Institutional Delivery (%)	76.1	54.9	89.7
Delivery at Home (%)	23.5	44.8	10
CONTRACEPTION USED			
Male Sterilization	1	1.8	0.2
Any contraceptive method used	61.2	45.9	56.4
Average month of pregnancy at the time of abortion	3.1	3.1	3.6

Source: Annual Health Survey 2011-12

III. Intervention Programme Theory and Processes

In the light of the scenario above, it was considered important to address issue of maternal health rights and was conceptualised within the frame of social accountability. The approach was to address the social determinants that affect the reproductive and maternal health (such as early marriage, early and frequent pregnancies, and family planning) by highlighting men as equal and responsible partners, parents and also as members of the society. Improving the quality of health service delivery through community based accountability mechanisms was another focus.

Sajhedar[2] programme intervention was conceptualised by bringing together two streams, viz. health care systems and service providers on one hand and community needs and expectations on the other, through the mechanism of community monitoring. It drew upon men playing active roles in establishing alternative social norms through personal change and calling for public action for change around issues that affect health.

The overall ***goal*** was to bring about positive changes in the lives of women in rural communities of MP by improving maternal health services. 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 senstitivity and accountability towards gender based discrimination, and to establish a cyclical system of monitoring and planning on maternal health services at the community level.

Programme Theory

The accountability intervention was developed on the basis of a hypothesis that combined two elements to simultaneously develop a sense of accountability among men as responsible fathers and partners and then ask for accountability from the health system for the appropriate health care services for women and children. The approach included addressing the social determinants that affect maternal health (early marriage, early and frequent pregnancies etc.) by mobilizing and reinforcing men's accountability as responsible partners and parents within the family and society conceptualised as social accountability who in turn were expected to improve public health services and the behavior of the service providers to rural women conceptualised as public accountability. The detailed programme theory is explained in figure 1.

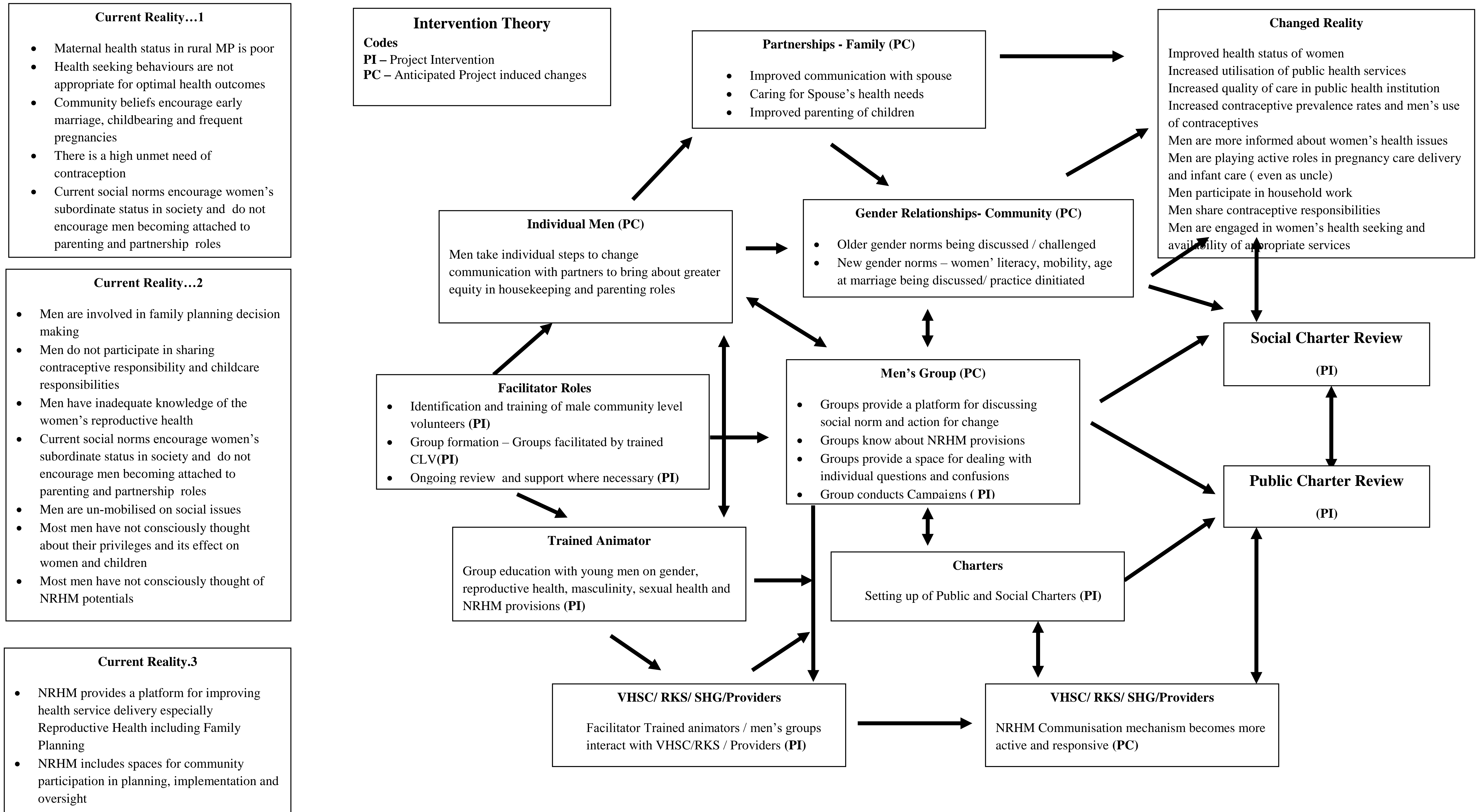
IV. Methodology

Site and Actors in the Intervention

In each district, fifteen villages forming a geographical unit were purposively selected as the intervention unit. In Sidhi, these villages come under five SHC areas fourteen coming under the jurisdiction of one PHC (Karavahi) and one village under Banjari PHC. In Morena, intervention was possible only in fourteen of the villages as one did not allow show any interest in implementing the intervention. The villages come under 5 SHC areas, six under PHC Dimni, four under PHC Jauha, and five under PHC Dikhatpura.

[2]The word *Sajhedar* means 'partner' and is related to *sajhedari* meaning partnership. The accountability intervention programme was named *sajhedar* with an understanding of the spousal relationship of mutual accountability as partnership and the collective partnership of the community with the public health system.

Figure 1- Programme Theory



The field work in each intervention unit was coordinated by partner organisations, having previous experience in working on community monitoring. At the village level the principal process facilitation was done by community level animator who acted as a bridge between the community and the health care system. Through the animator, community level men's groups in the age range of 20-35 were formed and were provided with orientation and exposure to gender, reproductive health and NRHM entitlements. The work of the animators and village level groups was supported and supervised by two facilitators who were community mobilisers or young development professionals with experience/ exposure to gender, health and community mobilisation issues. Each implementing organisation was also supported by a mentor, whose role was to provide technical and training support to the organisation, especially for its community level work.

A cyclical system of monitoring and planning at the community level was established. There was a focus on increasing leadership and initiatives among men's groups to address and engage with panchayat, VHSC, RKS around health related entitlements. The changes at the community level became sustaining and lead to other changes, both by engaging in monitoring at the local level and engaging with the policy at higher levels. The process of social accountability and public included a combination of various approaches of community mobilisation, capacity building, setting up community charters on maternal health and the processes of community enquiry. (See Box 2).

Intervention Methods

- *Organising 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 or 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, 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 Health 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 (Table 3).

Table 3: Community charters

Social Health Charter	Service delivery related – Public Health Charter
Increase in age at marriage	Increase in Ante Natal Care
Reduction on early pregnancy	Increase in Post Natal Care
Increase in spacing between children	Increase in safe deliveries and referrals
Increase female ratio at birth	Increase use of spacing methods
Improved communication between couples	Increase in overall use of male methods
Reduced domestic violence	Increase in knowledge of QoC of FP methods
	Increase in complete immunisation

- *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 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.

The setting up of these two mutually reinforcing 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.

Research Methods

The intervention included extensive documentation in addition to baseline and endline surveys. A 'realist' evaluation[3] methodology was utilised to identify the key lessons learnt (Sridharan, Sanjeev and Nakaima 2011; Das A. 2013). The following are the sources of data for this paper:

[3]Realist evaluation is an emerging methodology which allows for the understanding of not only whether a programme worked, but how the programme worked. It depends on the articulation of a programme theory or a set of hypotheses which explain how the programme is expected to work in a specific context. Realist evaluation understands the context of a complex social intervention to be active and dynamic and human engagement with programme interventions volitional rather than inexorable. Realist evaluation attempts to understand the specificities of the different interactions that take place as a result of the intervention and their results.

1. *Quantitative baseline and endline surveys:* In order to assess change over a period of time, baseline and endline surveys were conducted in the intervention area. The sample size was as follows:

Table 4: Sample size for the baseline and endline surveys

	Sidhi		**Morena**	
	Men	**Women**	**Men**	**Women**
Baseline	120	114	123	119
Endline	169	125	219	127

   The profile of respondents was largely between 18-40 years and married. In Sidhi, 60-70 percent were tribal. (Table 5 and 6) The survey enquired about socio-economic profile of the respondents, maternal health seeking, behavior of men as care givers to their wives during pregnancy and post-delivery, use of contraception, men's participation in household chores, men's 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. Analysis focused on changes in various indicators, over the period of intervention. Both these surveys were undertaken by independent investigators external to the project who were given training and methodological inputs.
2. *Participatory Rural Appraisal (PRA):* Two PRA exercises were conducted – one in August 2012 and another in October 2013. The purpose of the PRA exercise was to understand the needs of health care from a community perspective; to involve community in demanding for services provided under NRHM; to look at social determinants of women's health with the participation of the community; and to build understanding on social accountability in the community. (Score cards of both PRA exercises are attached as annexure 2.)
3. *Two Qualitative studies* to understand the overall impact of the community intervention on public health services, the diffusion effect of community mobilisation on various stakeholders, to understand challenges to intervention, and to provide critical insights from the community as well as stakeholders on the accountability approach adopted by the intervention. It was done as an interim review in July 2013 and again a final review in May 2014 by two independent and external reviewers.
4. *Ongoing documentation of stories of change:* The research methodology sought to understand not just what changes had occurred between the baseline and endline surveys, but also how the changes were occurring, and if there was a trend therein. To achieve this, an MIS was maintained where a rigorous documentation of stories of change was carried out periodically. Between July 2012 and May 2014, 62 stories of change were documented, 52 from Sidhi and 10 from Morena. These stories provided a picture of how the intervention was operating at a micro-level, and identifying the processes involved in bringing about change.

V. Trends of Change- From Personal to Public

In this section, we look at the various domains where patterns of change have been seen that can be attributed to the *sajhedar* intervention. Various sources of data have been drawn upon, including the baseline and endline quantitative surveys, results of two participatory rural appraisal (PRA) exercises and a qualitative enquiry into the impact of the intervention. The changes observed through quantitative data have been substantiated with stories of change that were collected in the district over the intervention period. 62 stories of changes were collected in all, around various themes ranging from changes in personal relationships, greater care for wives during pregnancy, taking responsibility in parenting, demanding better health services, holding providers accountable, changes in relationships with public functionaries, and development of leadership among the groups. (Table 7)

We begin by describing the individual changes that men themselves have undergone and the extension of this to gender-related social issues in the community. We then discuss the changes that have occurred in men's knowledge and contribution to pregnancy and child care, followed by their interaction with and demand for accountability from the health system, and finally, the impact that this has had on women's maternal health.

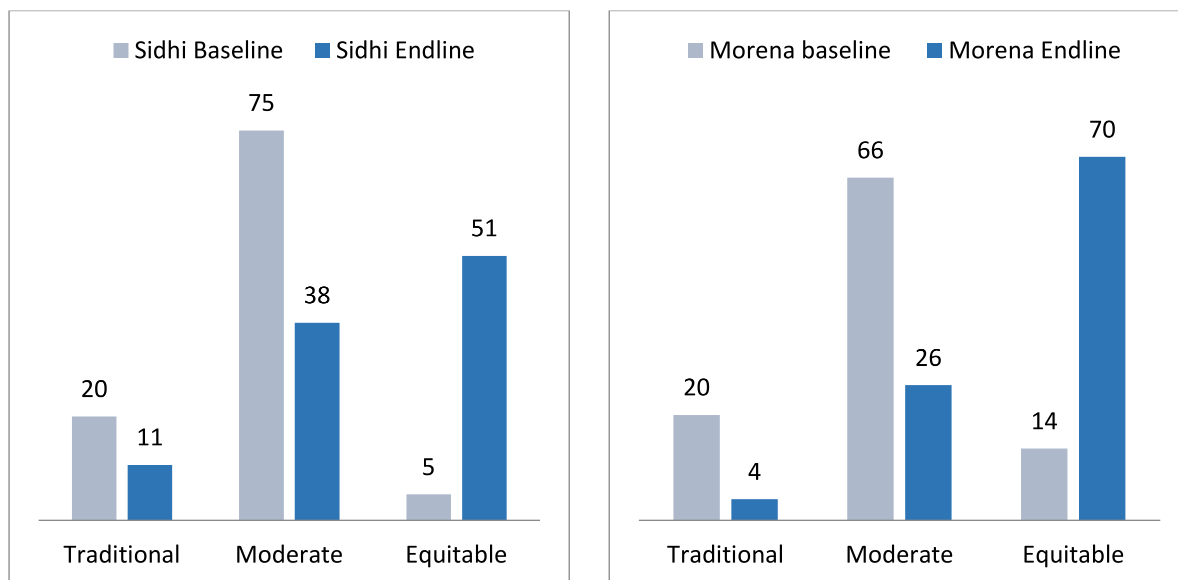
Personal transformation

The core input of the intervention has been towards young men, to change how they think about gender, masculinity and the relationships between men and women in society. Evidence indicates a change in men's own personal attitudes and perceptions about men and women's roles in the household and society, women's right to autonomy, sexuality, masculinity and violence. A 39 point scale was used to measure these perceptions and attitudes, and a significant change from baseline to endline was seen in this regard.[4] While only 5 percent of men in Sidhi and 14 percent of men in Morena were rated as 'equitable' in the baseline survey, 51 percent and 70 percent received the same rating in the endline survey respectively. (Table 8, Graph 1) Further, men's knowledge about laws related to violence against women, child marriage, sex selection and abortion increased between the baseline and endline surveys. (Table 9)

While only 5 percent of men in Sidhi and 14 percent of men in Morena were rated as 'equitable' in the baseline survey, 51 percent and 70 percent received the same rating in the endline survey respectively.

[4] 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 30 right answers were put in the category of very good knowledge or high gender sensitive. The respondents who had given 20 to 29 right answers were put in the category of good gender sensitive, who had given 11-19 right answers were put in the category of satisfactory and who had given less than 10 right answers were put under the category of unsatisfactory.

Graph 1: Perceptions of Men on Gender Masculinity and Sexuality



Along with knowledge, perceptions and attitudes, there has also been a reported change in behavior of men. For instance, self-reported incidents of intimate partner violence (physical, verbal, sexual and control of mobility) have decreased between the baseline and endline surveys. Men's participation in household work too has increased. More than a third of men (38-40%) reported in the endline survey that they had, for the first time, begun contributing to household activities such as washing, cleaning, cooking and serving food. Another 33-43% reported that they had begun contributing more than before to these chores. With regard to chores outside the house such as taking care of animals, fetching water, buying groceries and clothes for the family, 53-63% of men reported that they were already participating in these chores before, but their contribution had increased after the intervention. Less than 20% of men reported no change in their behaviour. (Table 10 a and b)

> ***More than a third of men (38-40%) reported in the endline survey that they had, for the first time, begun contributing to household activities such as washing, cleaning, cooking and serving food.***

Discussions with women also substantiate this change in the attitude and behaviour of their husbands and they attribute it to the *Sajhedar* programme. Several stories of change were recounted which indicate not just how men's perceptions about women's roles have changed, but also how this has translated into behavioural changes. The changes in behaviour range from as greater contribution to household chores, to better communication between spouses.

> *"......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)***

> *"Earlier my husband never used to help me even in our farm activities. Now after being part of the 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)***

During discussions with women in Morena it was revealed that men have become more sensitive and receptive to their needs. They said that though the men may not do household work on their own, but when asked, they definitely help. This change has been mostly restricted to the younger men who are part of the Sajhedar group.

It is interesting to note certain differences in the two districts in terms of their change with respect to personal transformation. Consistently, one sees that the attitudes of men (as indicated by their GEM scores) in the baseline and endline surveys were better for Morena. The change too has been greater in this district as compared to Sidhi. Similarly, with respect to behaviour, a much greater proportion of men in Morena have said that they have begun taking part in household tasks as compared to men in Sidhi. However, observations on the field show that in reality, the uptake of the 'social accountability' component of the intervention was not as good in Morena as in Sidhi. This can be explained by the fact that in Morena the social context is that of mixed communities marked with greater disparity of power and resources. The domination of the dominant communities and the historical violence attributed to the area signifies the deeply entrenched caste-class-patriarchal structures. The arena of social accountability has greater resistance where the personal politics of changing one's own attitudes are challenged and the same is resisted citing tradition and culture. In contrast, the message has found greater receptivity in Sidhi owing to the seemingly homogenous character both in social cohesiveness and backwardness.

Balancing unequal power relationships through personal and collective leadership

One of the most significant outcomes of this project has been the creation of spaces for discussion, and building solidarity. The important process that has been facilitated as the hub of social change, is that of community mobilisation resulting in the formation of men's group as agents of change. Various inputs and project activities have been woven together to strengthen this community mobilisation for greater social and public accountability in a concurrent manner. With the repeated, personalised and reinforcing critical inputs a strong leadership emerged in 15 animators in Sidhi and 14 in Morena. Some of them have commanded respect being personal role models

With the repeated, personalised and reinforcing critical inputs a strong leadership emerged in 15 animators in Sidhi and 14 in Morena. Some of them have commanded respect being personal role models of change. In Sidhi, out of 199 members of the groups, 69 have emerged as core members and in Morena, out of 205 members, 98 have emerged as core members.

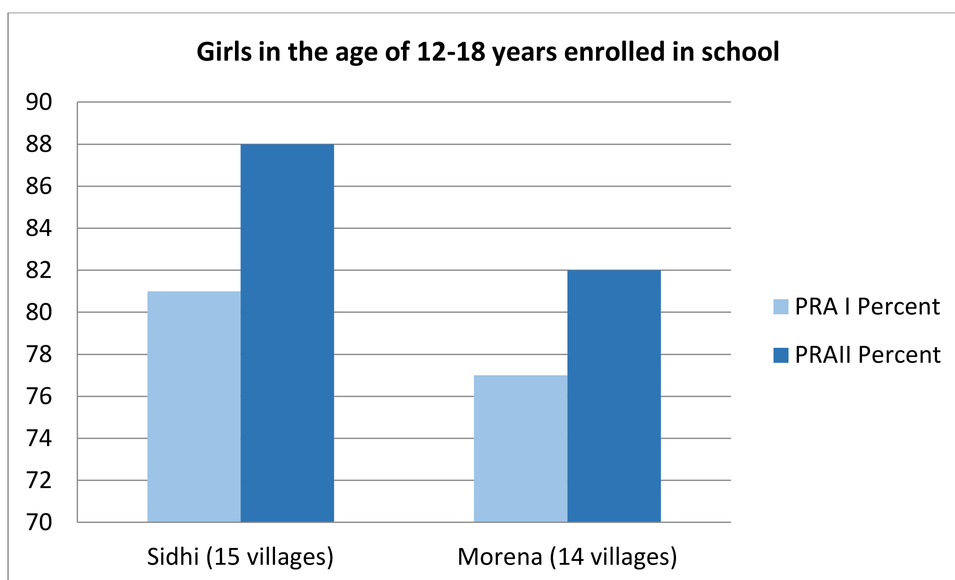
of change. In Sidhi, out of 199 members of the groups, 69 have emerged as core members and in Morena, out of 205 members, 98 have emerged as core members. Through the group processes, these men have leveraged the demand for accountability for maternal health services, proper conduct of the VHND, improved and respectful behaviour from the health care providers towards women, rapid response to telephonic calls during emergencies and the like.

The animators as a collective are critical human resources for the facilitation of change and the community groups, a conscientised critical group within these community groups serve as important and potentially very critical change makers in sustaining the accountability processes along with animators. The active membership is a potential critical resource for the present and future processes of change in community and in the health related system in the respective districts. One could project it to be a critical human resource group for further community mobilisation for advocacy, if adequate resources and inputs are made available.

Continuum of accountability from the personal to the public domain: Organising and collective action around gender issues

The animators and other conscientised men have held discussions in the community about social issues such as men's responsible participation in family responsibilities, early marriage, dowry, dropout of girl children, domestic violence, and son preference which have become matters of public discussions. The impact of this is seen to some extent in the changed indicators; for instance, the dropout rate of girls 12-18 years of age has reduced between the first and second PRA. While only 81percent of girls in this age group in Sidhi and 77 percent in Morena were enrolled in school during the first PRA (August 2012), this proportion increased to 88 percent in Sidhi and 82 percent in Morena in the second PRA (October 2013) (Table 11, Graph 2).

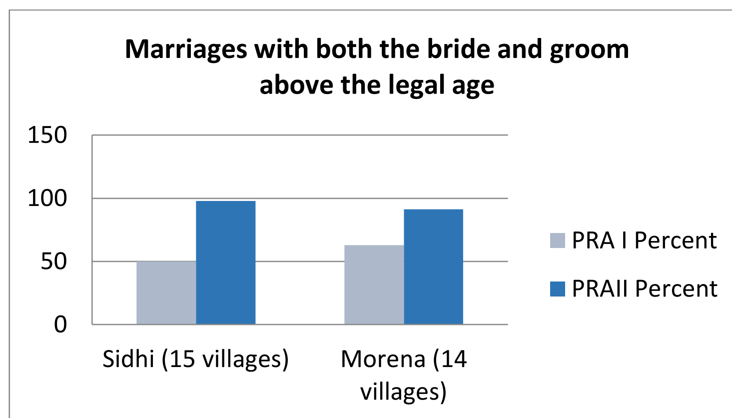
Graph 2: Girls Education in Sidhi and Morena – Changes between PRA I and II



Men's role in challenging the practice of early marriage, as well as others such as dowry and son preference has also been documented. In Sidhi, the proportion of marriages with both the bride and groom above the legal age increased from 50 percent in PRA I (August 2012) to 96 percent in PRA II (October 2013) (Table 12, Graph 3). Similarly in Morena, where only 63% of marriages occurred after the legal age in PRA I, this proportion increased to 91% in PRA II. Along with men dialoging with parents of young girls, initiatives by men to counter son preference, by celebrating the birth of girl children have been seen. These stories and changes clearly indicate the power that individual change coupled with the support of a collective, has, in bringing about social transformation.

A comparison of baseline and endline surveys clearly shows that men are now more informed about women's health issues and are also becoming more aware about their roles as a responsible parent and

Graph 3: Age at Marriage in Sidhi and Morena – Changes between PRA I and II



Violence against women as an issue, however, was not acknowledged as much by the community and instances of groups taking action to stop violence have been minimally reported. One such case in Morena was reported where a group member intervened in the domestic violence being meted out to his sister in law by his brother and parents. Although he was not able to reach out to the woman herself, nor take the matter to law enforcement authorities, he expressed his disapproval to his family and protested by refusing to contribute to household expenses. The recognition of violence within the family and the voicing of disapproval against such behavior is a small but significant step forward. It will take time and more inputs, for this to translate into more systematic action.

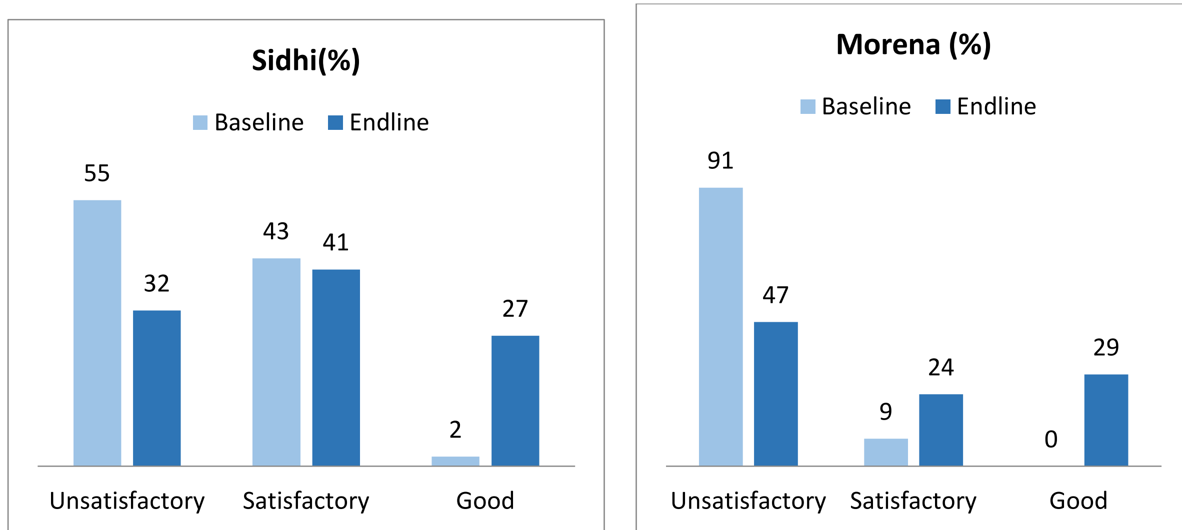
These stories and changes clearly indicate the power that individual change coupled with the support of a collective, has, in bringing about social transformation.

Responsible partners in parenting

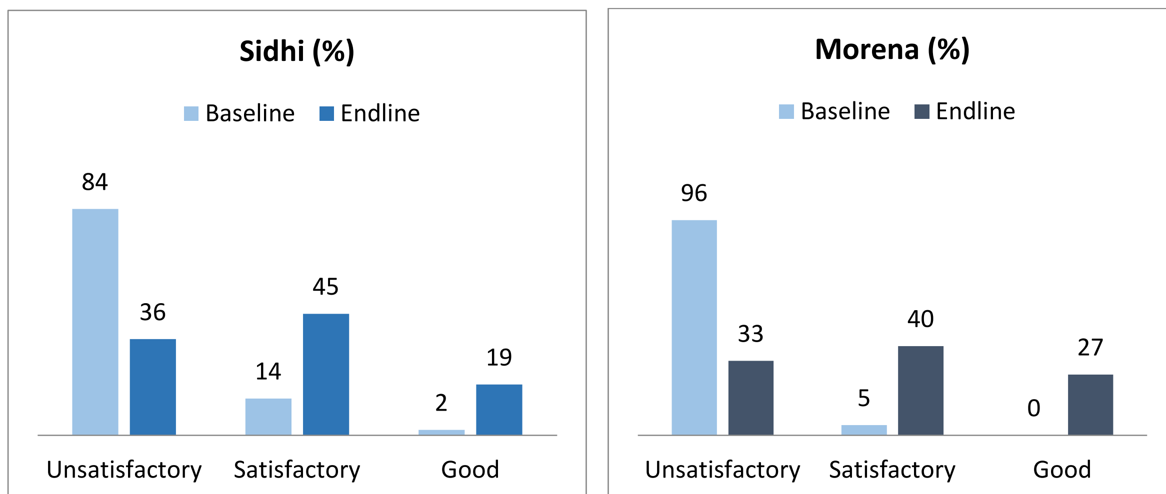
Through the inputs on maternal health and gender sensitization to men, data reveals the increased willingness of men to share the burden of housework and child rearing responsibilities. While in the baseline survey 55 percent of men in Sidhi and 91 percent in

Morena were scored 'unsatisfactory' with regard to their involvement in women's pregnancy (such as taking responsibilities for household tasks and caring for older children), this proportion reduced to 32 percent and 47 percent respectively in the endline (Table 13, Graph 4 and 5). Similarly, with reference to involvement in post-delivery tasks (such as child rearing, immunisation, allowing women to rest) the proportion reduced from 84 percent in Sidhi and 96 percent in Morena to 36 and 33 percent respectively in the endline.

Graph 4: Involvement of husband in women's pregnancy care

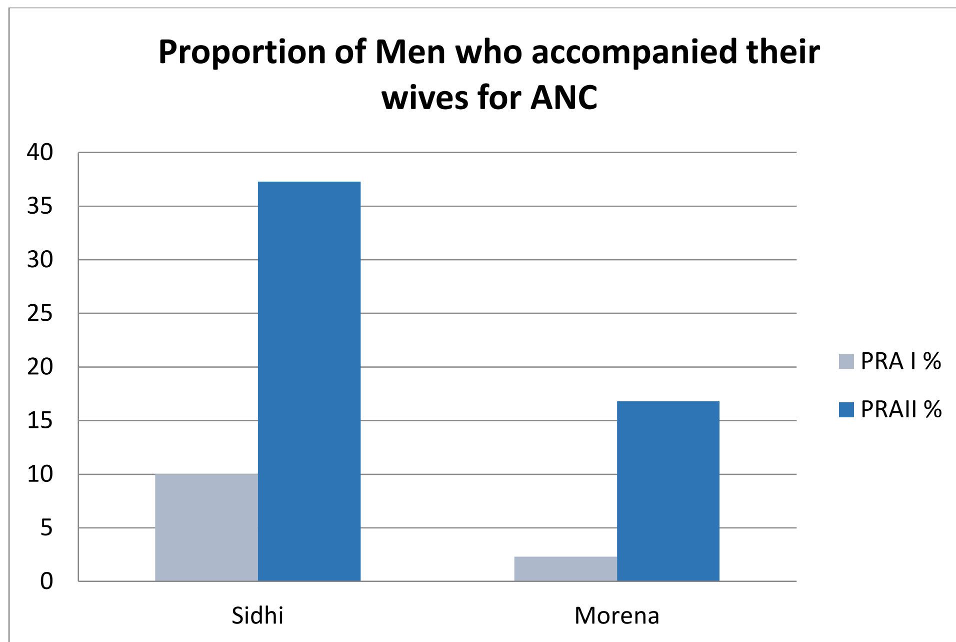


Graph 5: Involvement of husband in women's post delivery care



PRA exercise reveals that the proportion of men who have begun accompanying their wives for ANC visits has increased from 10 percent to 37 percent in Sidhi and 2 to 17 percent in Morena (Table 14, Graph 6).

Graph6: Men who accompanied their wives for ANC – Changes between PRA I and II



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 responsibility to ensure that they receive this. (See box 3)

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."(CHSJ, Stories of Change)*

Along with change in men's knowledge and behaviour, information has also trickled down to women. For instance, one animator's wife recounts:

> *"....women too have started going to the meetings at times...now we know that the supplementary feed we received from the AWW is only meant for us and not for the children...earlier women used to cook it all and serve it to the entire family on any one day."* ***(Animator's wife, Village Mata, Sidhi)***

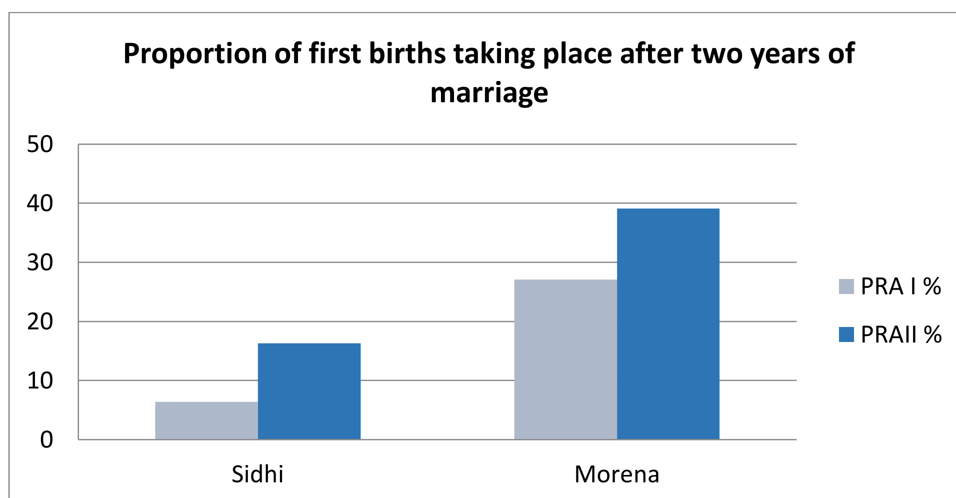
Further, the knowledge and recognition of signs of emergency too has improved between the baseline and endline (Table 15). A greater proportion of men are now able to identify signs of emergency in the pregnancy period (such as convulsions, swollen abdomen, per vaginal bleeding, swollen feet etc), at the time of delivery (such as breaking water bag, bleeding, incomplete delivery of placenta) and in the post delivery period (such as bleeding from the uterus, high fever, burning urination etc). This is critical as the recognition of these signs can lead to early help seeking, thereby averting a complication and even death. The following story, illustrates this:

> *RS, a 24 year old woman was 7 months pregnant with her second child. At around 4:30 am, suddenly she started bleeding heavily. Recognising the situation as an emergency, her father-in-law who was part of the Sajhedar group contacted the other members of the group to discuss what can be done. After some discussion the group decided that since this was an emergency, RS should be taken directly to the district hospital. They called the 108 ambulance which arrived within one hour. The village ASHA and one experienced woman from village accompanied RS to the hospital. Due to the prompt action, RS's life was saved, however, her child died in the womb.*

Men's use of contraceptives

The PRA exercise showed that the proportion of couples having a child after two years of marriage had increased in the project area from 6 percent to 16 percent in Sidhi and 27 to 39 percent in Morena (Table 17, Graph 7). In Sidhi, the use of spacing methods (Condom) has increased from 4 percent in the baseline survey to 9 percent in the endline (Table 16). This increase has been marginal, perhaps because of the short and irregular supply of condoms from the Karawahi PHC which is hardly functional. ASHAs have reported that there is a demand for condoms, but they are not always able to provide them. In Morena on the other hand, because of a better functioning health system, and perhaps the availability of spacing methods, the use of condoms has increased from 12 percent to 32 percent.

Graph 7: Delayed birth of first child – Changes between PRA I and II



Field experience also suggests that there is much more awareness among men with respect to the need for small families and they acknowledged their responsibility, although most of them when asked whether they would prefer to get themselves sterilised replied in the negative. In Morena, except in Bhatari village, where the animator has made up his mind to get himself sterilised none of the other men indicated if they were going to get themselves sterilised in the near future. In Sidhi one could see greater interest from men towards vasectomy and men felt that it was not only women's responsibility to do family planning. But it remains to be seen whether this is actually translating into positive action from men in this realm.

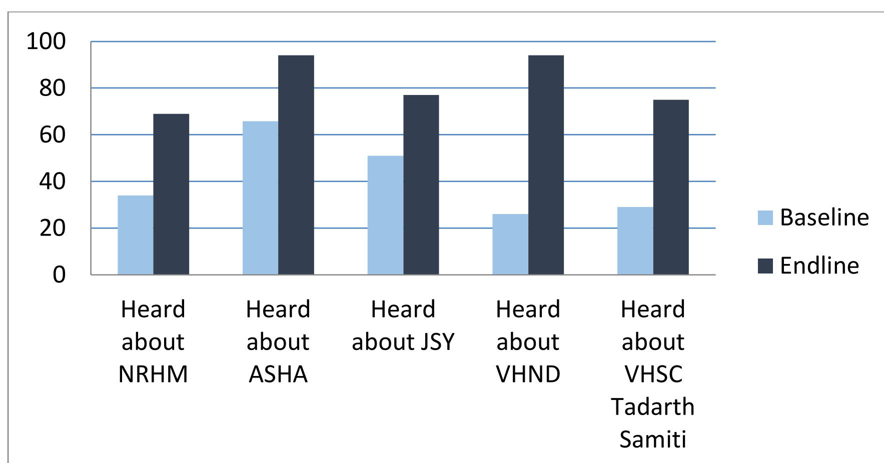
Partly, this problem could be attributed to the excessive focus of health providers on women for meeting their sterilisation targets. Discussions with health providers reveal that because a very small proportion of men prefer to get permanently sterilized, they tend to focus on women. As a result, even though men have started to think about vasectomy as a possible method of contraception, there is no interest from the system in helping them get access to the services. It appears that this trend is similar in both the project areas.

Interface with the health system: Demanding accountability to women's health services

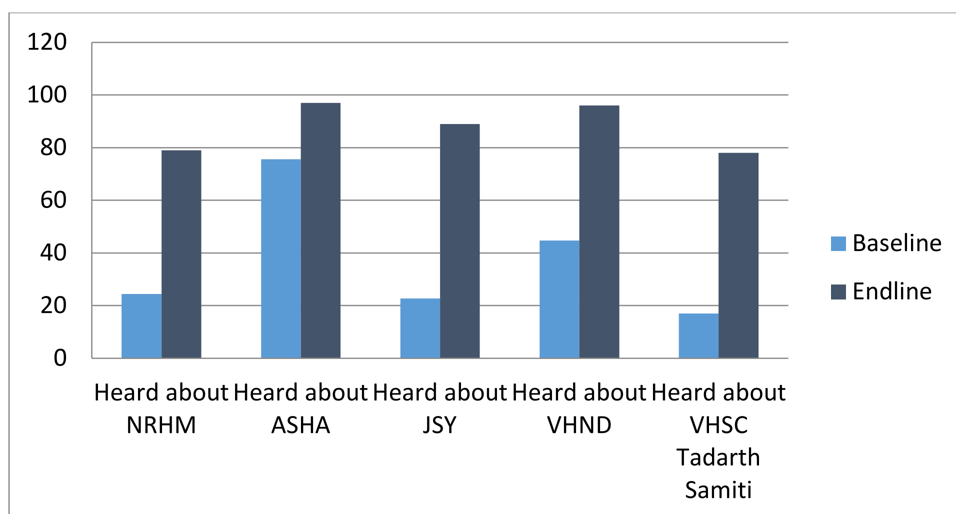
Various sources of data indicate that there is definitely an increase in knowledge about maternal health related schemes as well as interaction between the men's groups and the formal village level structures associated with health e.g. ASHA, VHSC, Panchayat, Anganwadi workers, etc. This was not the situation earlier.

The data show that there is an increased participation in the structures of local health governance in both Sidhi and Morena. Overall, participation in VHSCs increased from 11 percent in the baseline survey to 49 percent in the endline, while the participation in Gram Sabha meetings increased from 42 percent in the baseline survey to 68 percent in the endline survey. These are essentially village level governance bodies and the participation of men in them to raise issues related to women's well-being is indeed a positive sign.

Graph 8: Men's awareness on NRHM entitlements - Sidhi



Graph 9: Men's awareness on NRHM entitlements - Morena



Along with this the demand of accountability from public functionaries too has increased. For instance, in Sidhi while 37 percent of men in the baseline survey indicated that they do not go to anyone when a problem with public services is encountered, only 14 percent reported this in the endline survey. In Morena, this proportion reduced from 56 percent to 26 percent. (Table 19) This suggests that the recognition of persons who can be held accountable has increased, as has the motivation and courage to seek such accountability from them. As a result of this, the groups which have been facilitated under the project have developed a strong relationship with the service providers and they have also been able to gain confidence of the village.

The intervention has resulted in the formation of a collective, giving rise to leadership in the community, which is gender sensitive and is able to utilise its power to the benefit of women's health needs.

The impact of this engagement with structures of public accountability is seen in the improved quality of public health services available. VHNDs happen regularly on the designated days in most of the villages and women along with children have started availing them. Greater awareness about VHNDs has resulted in better service delivery. Stories from the field suggest that earlier, only immunisation used to be provided at the VHND, however, after pressure from the groups, blood pressure equipment, a table for examination, urine test kit, stethoscope etc. have been provided and all services are being given. Moreover, groups have also been able to influence how funds can be utilised to the benefit of the community, rather than as per 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 waste bins, a small fibre table, drinking water utensils and containers for storing medicines with that money." ***(Animator, Village Amha, Sidhi)***

"... earlier the mid day meal programme was not running properly in the village....they didn't follow any menu schedule, cooked what was easy and not what was nutritious and didn't followed a time schedule...we had a talk with the SHG and said that this is not right and they would have to be regular and make nutritious food....now situation has changed because we have started paying more attention...though there has been some opposition to our efforts but now they understand.

We didn't even not know about the existence of health standing committees and the untied fund grants they used to get...the AWW never used to come to this centre...now we have started to take more interest and because of that situation has changed on this aspect too...Now the untied fund is used for ensuring cleanliness in the village as also providing facilities in the health centre and for any emergency case. Of course, more needs to be done." ***(Animator and group members, Bhatari Village, Morena)***

Apart from health, awareness seems to be growing with respect to other services such as school, mid-day meal programme, public distribution system (PDS) and anganwadis. When there is a deficiency in the 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)***

In another example, members of the men's group in Sidhi 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.

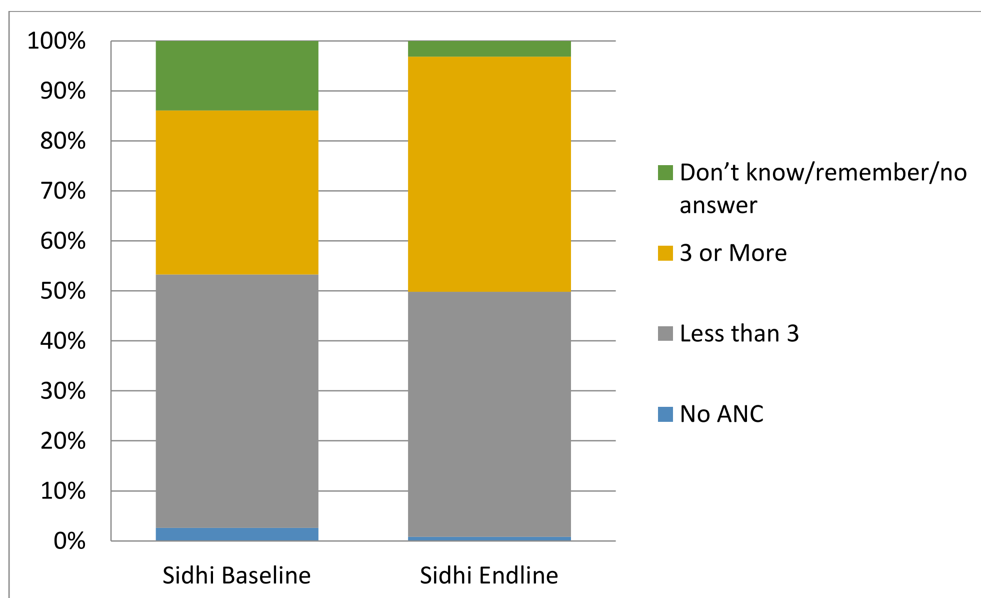
It is critical to note the momentum created by sensitised, aware, responsible men demanding health rights through the processes of campaigns and continuous meeting with the service providers. The interaction of individual animators perceived as being backed by the collective of men in the village, with the health and governance bodies, has ensured speedy response from the system. However, important as this increased engagement with public functionaries

is, it is also worth keeping in mind that it has been individuals from these institutions who have been activated, not necessarily the institutions themselves. This needs to be looked at in the context of the existing situation of local governance bodies. In MP for instance, the situation of PRIs is dismal. As a result, the VHSNC too is not an active body. What the groups have been able to do is to increase engagement with individuals in the VHSNC such as the ASHA or the Sarpanch. But the functioning of the VHSNC per se has not improved – the committees still do not meet regularly, the composition is unclear, they do not make village level plans. It is worth noting that the power of a small group of men in a selected location is limited – what they have done so far is influence whichever providers (closest to them) who they can – whether or not they will be able to influence larger structures of governance in the future remains to be seen, and can perhaps be built upon in future interventions too.

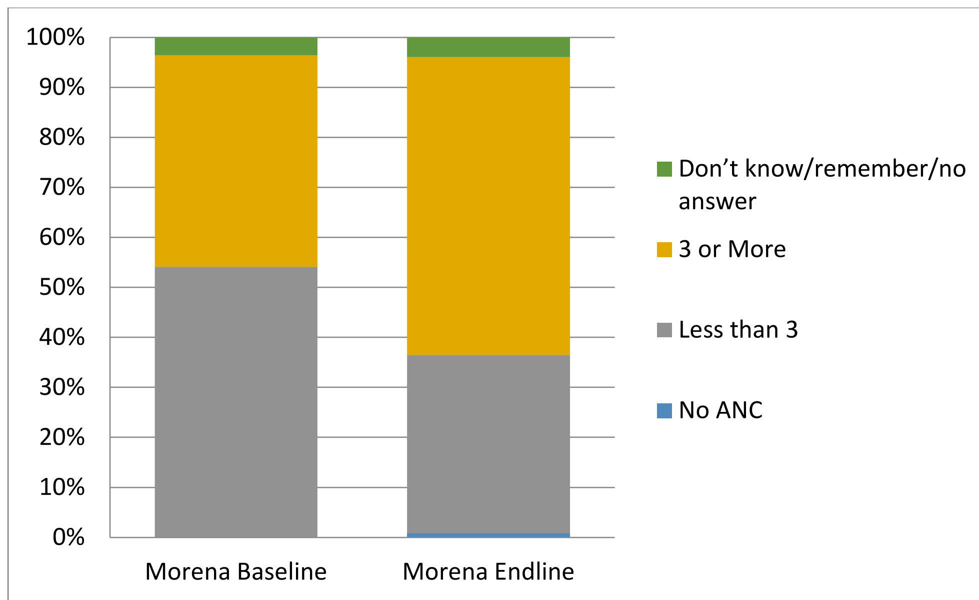
Utilisation of public health services for maternal health care

The *Sajhedar* intervention, through its focus on increasing men's participation in maternal health care and community mobilisation, has resulted in a diffusion effect, and the beginnings of impact can be seen in the demand for maternal health services and their utilisation. A greater proportion of women in the endline survey 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 (Table 20, Graph 10, 11).

Graph 10: Number of ANCs received by women - Sidhi



Graph 11: Number of ANCs received by women - Morena



Due to community mobilisation, the quality of VHNDs has also improved. There are positive stories of VHSNCs beginning to play a proactive role in this regard:

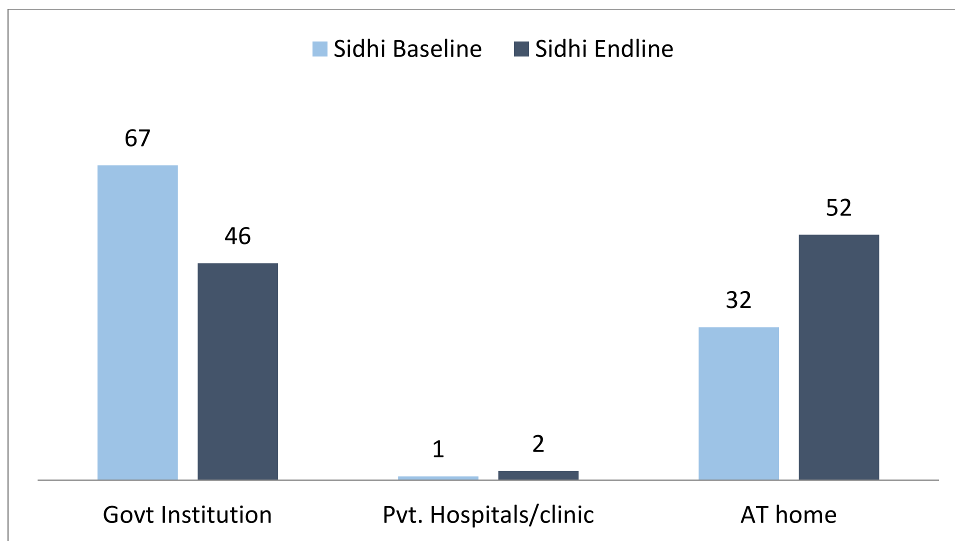
> *"….VHND is organised better in recent times...earlier only vaccination was administered but now blood test and all other tests are all done regularly....now the VHSC has become active and started to take more interest in the issues related to health and hygiene...the untied funds have also been used 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)***

Village groups have also been able to support the ANMs in organising 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 village groups have provided her support in this regard.

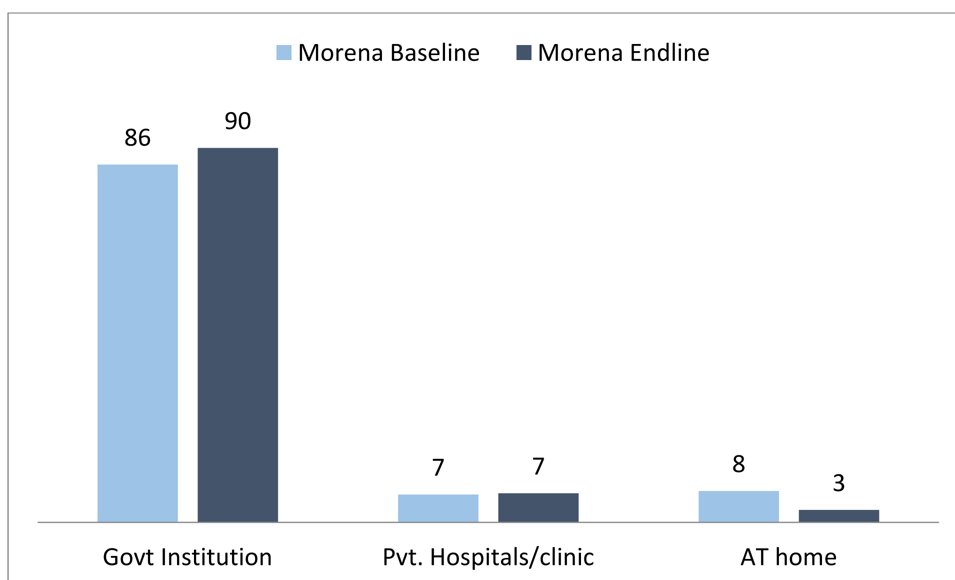
Qualitative enquiry found that there was some awareness among the women about post natal care (PNC) as well. It was reported that earlier, after delivery, the woman was usually confined to her house for a period of 10 days or so. Knowledge about post-delivery immunisation was very low. Unless the ASHA or ANM directly intervened, the woman would not go to the AWC or sub-centre. But now the situation has changed and women come on their own to the VHND.

It is worth noting here the differences in utilization of maternal health services between Morena and Sidhi. In Morena, the situation of health facilities is better and utilization of services even in the baseline was high; this has increased in the endline survey (Table 22, Graph 13). Women reported that 50% of deliveries occurred in the district hospital and an additional 34 percent in PHCs. The utilization of government ambulances which was 24 percent in the baseline survey has increased to 65 percent. This is perhaps because the villages are located close to the main road and are easily accessible. But even though a large number of deliveries take place in the institution, it is worth noting that only 7 percent were attended by a doctor. The rest were attended by a nurse or ANM.

Graph 12: Place of delivery as reported by women - Sidhi



Graph 13: Place of delivery as reported by women - Morena



The situation in Sidhi is very different from this. The utilization of some services such as ANC and use of ambulances has increased in Sidhi, but the proportion of home deliveries has

increased (Table 22, Graph 12). This could be attributed to the malfunctioning of the PHC and other compounding factors. What is interesting however is that with an increase in home deliveries, the community has made an effort to make these safer. This is evidenced by the fact that the proportion of home deliveries attended by a Dai has increased between the baseline and endline survey (Table 21). However, the PNC for home deliveries remains neglected by the health system. Community action and pressure by the men's groups has simultaneously resulted in improvement of the PHC as well. The PHC has moved from the rented building on the hillock to an own building close to the village and some appointments of nurses and pharmacist has taken place. This indicates one of the major gains that have been made as part of the intervention.

VI. Accountability from Local to State level: The Maternal Health Rights Campaign

Having been made aware of the issue of maternal health and health rights, and prompted by the weak state of maternal health services, the Sajhedar groups allied with other civil society organizations working in Madhya Pradesh, and a coalition was initiated. The attempt was to generate a collective effort for the community's interface with the health care system in MP, through the community based monitoring (CBM) approach. CHSJ along with other CSOs endorsed the critical issue of maternal health rights and agreed to address this issue collectively through the alliance which led to the Maternal Health Rights Campaign (MHRC). The collaborative advocacy through MHRC focused on empowering the community to reclaim the public health system, make the health system more responsive and accountable, and ensure quality and accessibility of maternal health services.

Preparatory phase

The process of linking local monitoring and engagement with the health system, to a state wide campaign required building alliances as well as capacity of the Sajhedar groups and other CSOs. The idea was to collect statewide data on maternal health services using CBM tools, which would form the evidence base for the campaign. To begin with, a state level workshop was held on maternal health at Bhopal in February 2013, wherein the procedures of how to undertake CBM process to assess the situation of health services related to maternal health across the 20 districts in which the CSOs were working, were discussed. Issues for community monitoring were identified which included Janani Suraksha Yojna (JSY), Janani Shishu Suraksha Karyakram (JSSK), health services available at the Village Health and Nutrition Day(VHND), condition of Rogi Kalyan Samiti (RKS) and service delivery in health institutions. To take the community monitoring process further a plan of action was drafted and the organizations were divided into three regions for the purpose of data collection, viz. Revanchal, Chambal and Bhopal to actualize the process in the respective regions.

Community enquiry

The process of community enquiry followed participatory methodology. To begin with, tools for community monitoring process were formulated[5]. The survey formats were developed in pictorial formats to make it easier to fill and understand. A two-day training was organized for investigators of three regions during April-May, 2013, which aimed to build perspective on maternal health rights among the investigators and familiarise them with the tools. The process of community enquiry was carried out during May to September 2013 during which investigators collected data from 102 villages across 13 districts of MP with participation of the community. The districts and villages were selected purposively depending on the work areas of various organisations. The community enquiry process focused on district wise data collection on village level maternal health services facilitated by group discussions on services by ANM, maternal health services and child immunization and interviews with women on JSY, JSSK, ANC services.

The information sheets (*Jaankari Prapatra*), focusing on health services available at the village level were filled in 112 villages through group discussions with people. Community feedback on VHND was gathered through observations and check list interviews with ANMs. These were filled by interviewing 92 respondents and 224 women were interviewed for JSSK and 212 women were interviewed for JSY. Extensive discussions were held through regular meetings with the communities and information on preparation of progress reports reflecting the colour code of green, yellow and red (good, average, bad respectively) was also provided to them and their feedback was sought. Based on this, report cards were prepared for each district.

The report card for Sidhi district, where respondents from 15 villages were interviewed suggested gaps in the maternal health services. Interviews with 56 women (lactating women), only 29% reported having undergone post natal checkups and counseling. 21 women out of 56 said that no full body examination was done during pregnancy and for 36 women no laboratory tests of urine, blood etc. were conducted during pregnancy. All 56 women said that they had paid Rs 150-500 as informal charges during delivery. Out of 56 women 33 women had to pay for transport from their home to the hospital, and 46 women expended money to reach home after delivery and did not get free ambulance service. Though 52 women reported receiving JSY cheques, however said there were problems in getting the cheques encashed.. Amongst 65 pregnant women interviewed 58% had undergone complete checkups. Women from four villages of Amaha, Karehi, Sarenthi and Odesa reported that all the deliveries were home based and not a single delivery was conducted in the institutional health facility. Interviews, group discussions and observations highlighted that the PHC at Karavhai in Sidhi was located on the hill and only normal deliveries were conducted there under the supervision of a staff of 5 persons including 2 nurses.

In other districts as well, a pattern was seen, in that immunization services were the only ones which were provided consistently. Quality of ANC care and receipt of entitlements under

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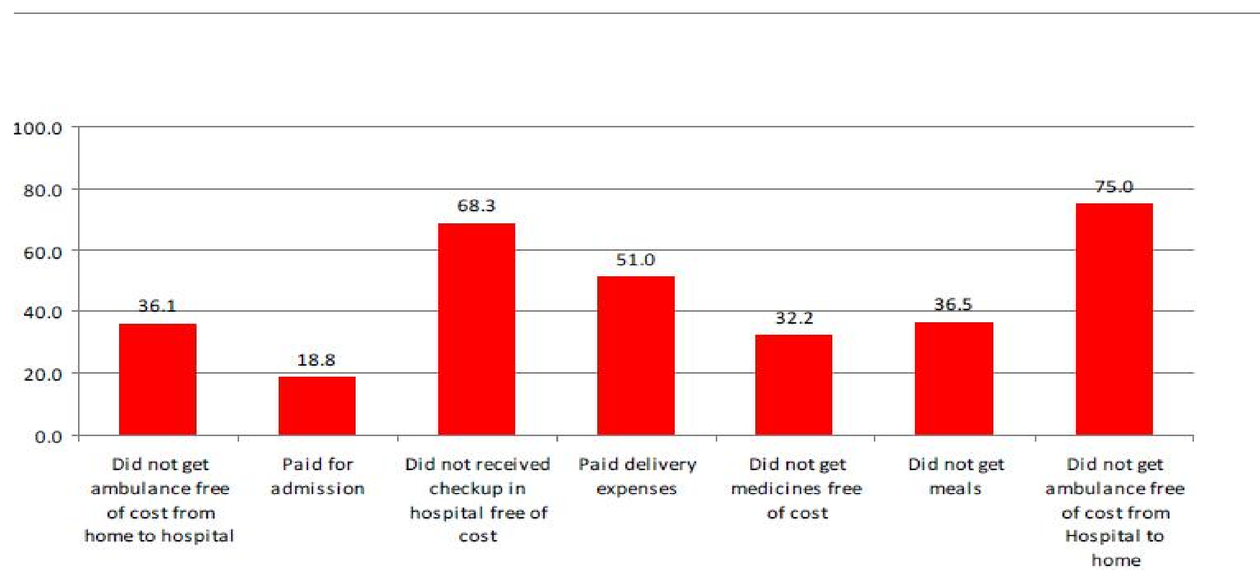
[5] These included interview guides for group discussions with women and exit interviews with patients at CHC, PHC and doctors, checklist for observations, interviews and survey formats for interviewing pregnant and lactating women

JSSK fared the worst. (See Annexure 3 for the complete report card for rest of the MP districts)

The feedback from the community outlined gaps in services such as JSY and JSSK, the quality of services, the informal payments women had to make and the quality of the services offered at the VHND. Observations, interviews in 92 villages on the status of services being provided under VHND and interviews with 112 pregnant women on antenatal care services revealed 46% of places did not have blood testing kits, 82% centers JSY revealed that 14% women did not receive any cheque, 19% of those women who received the cheques reported that they paid money to get it.

Graph 14: Services under JSSK



The feedback from women on the JSSK services delineated that 36% women had to spend money for commuting to the hospital from their homes, while 75% bore expenses for travelling from hospitals to their homes. Similarly, 19% women had to pay for hospital admissions, 69% reported not receiving free check-up in hospital, 51% had to give money as donation to hospital staff at the time of delivery, 32% did not receive medicines and 37% reported not receiving food during hospital stay.

The data collected from across districts compiled and anlaysed district wise, formed the basis for preparation of state level report card. The findings suggested that services provided under JSY and JSSK were focused primarily on the monetary benefits. The quality component was lacking and the services like weight and height measurement, regular blood pressure recordings, blood, urine and abdominal examination etc. were not being adequately provided. The women had to pay informal fees for services that were guaranteed free such as ambulance services for transport, medicinal support during hospital stay and food. The provision of ANC services was also graded as poor in most of the districts. It was reported that although the ANM was visiting the villages, but her services were limited to immunization. (See annexure 3 for the entire report card)

The report cards were shared amongst CSOs and discussed in detail at a two day state level data sharing and advocacy planning meeting in Bhopal in October 2013. The analysis of the findings and reports cards were used to identify and plan further advocacy campaigns and devise action plans. It was agreed upon to disseminate these findings with different stakeholders at various levels including community people, public representatives and health functionaries and media persons.

Community and district level public health dialogues:

The reports of the village surveys using CBM were shared with the community which further formed the basis for interface of the community with the health providers at the community level as well as in the districts. During this process, further testimonials and evidences were collected on the negligence and denial of health services.

Public health dialogues were held in nine districts including Betul, Raisen, Chindwada, Morena, Sidhi, Anuppur, Shahdol, Satna and Bhind and the media played a critical role in providing adequate news coverage to the issue. The major issues which were highlighted across the districts included a complete lack of ANC- PNC checkups at the village level in tribal districts like Anuppur, non-implementation of JSY and JSSK programme in the villages, lack of ambulance facilities for pregnant women during delivery, lack of female doctors to conduct delivery at health facilities, demand of informal charges to conduct deliveries and for ambulance services besides other gaps.

State level public health dialogue:

The bottom up pressure was supplemented by sharing the findings of health report cards from villages and districts with health officials in the state level hearing in which over 150 stakeholders from diverse fields participated in February, 2014. People reported their difficult experiences in accessing health services and lack of accountability from the health system. Documented case studies of 42 women with grievances about the absence and poor quality of maternal health services reflecting thematically issues of maternal deaths (4) infant and child deaths (6), gaps in implementation of JSY and out of expenditure including corruption, payment of informal charges (8) and discrimination faced by marginalised women in accessing health services(10) and services at Anganwadis (15) respectively along with selected six oral testimonies were also presented in the state level dialogue. While sharing their experiences in the district and state level public health hearing, women highlighted that discrimination in health was one of the major problems which hindered proper delivery of health services and amongst the socially excluded groups, Dalit and tribal women were the most excluded and the discrimination became life threatening while going through the process of motherhood.

A maternal health charter endorsed by all the people from 13 districts was also submitted to the health authorities along with the case-studies and report cards on the maternal health situation across the state. The state health dialogue was attended by the deputy managing

director of NRHM from the government of Madhya Pradesh and other officials along with civil society dignitaries.

Outcomes after Districts- State Level hearing

The process with the combined effect of evidence based community monitoring processes and people's sustained bottom-up pressure has elicited a positive response in health governance.

- The government ordered an immediate enquiry on the documented cases of negligence and denial through an office order, which was communicated to the maternal health rights campaign (MHRC). Local level health officials contacted the local organizations in the alliance for clarifications on cases and oral testimonies.
- NRHM authorities have assured to set up grievance redressal mechanisms besides it is seeking support from the alliance of CSOs in MP, as community feedback for better governance in health.
- The authorities of NRHM invited the core team of MHRC to discuss about the issues highlighted in the state dialogue and invited recommendations to improve the quality of maternal health services.
- The experience has encouraged the MHRC campaign to make way forward for further cycles of CBM to make health system more accountable.
- Media has been carrying follow up on the case stories also. After the dialogue, meetings have been held with state NRHM directorate and talks about maternal death tracking and fact finding have begun as a follow up process

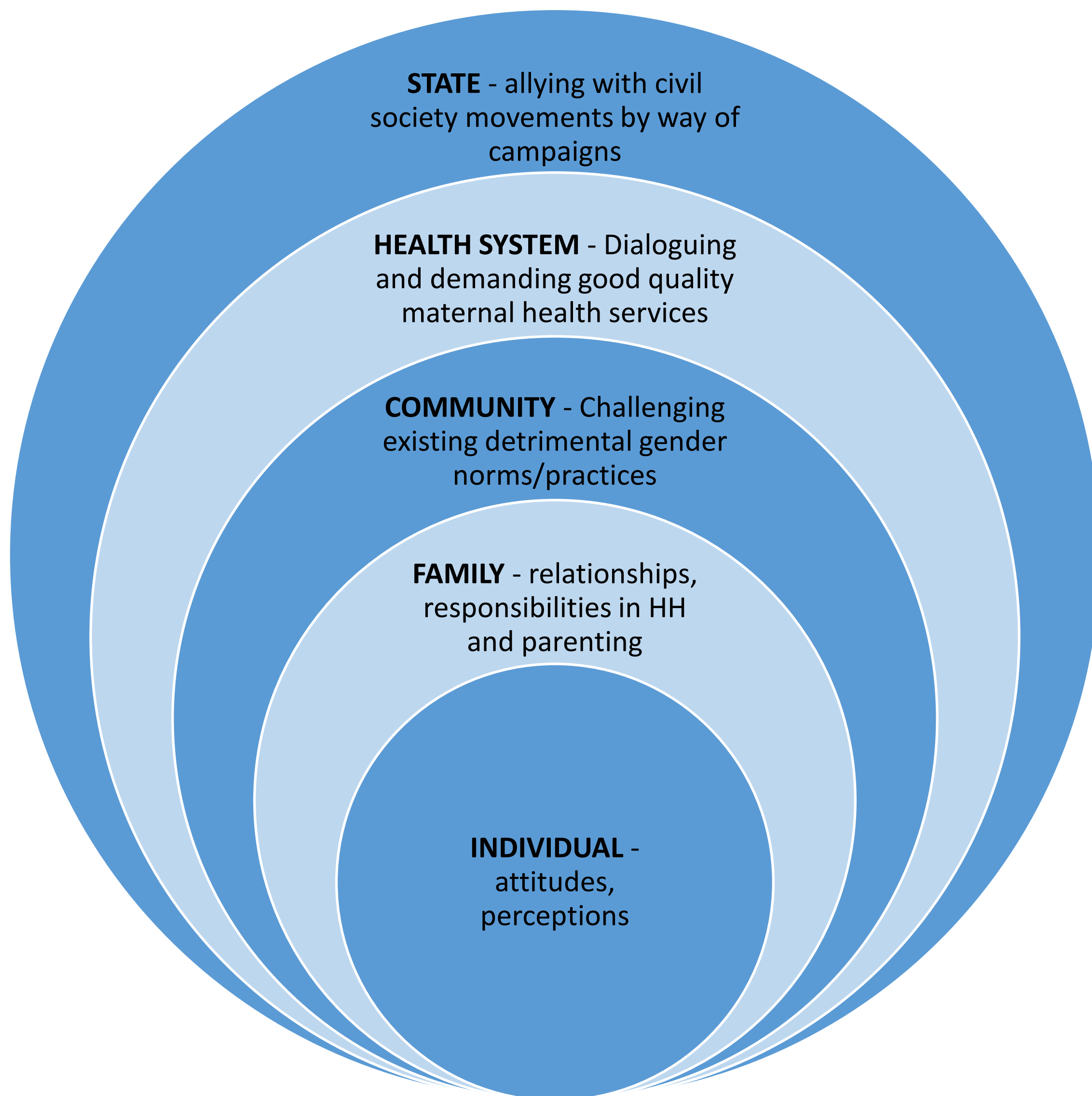
VII. Discussion/Learnings

The methodological intervention in the dual concept of accountability with men as the key actors has shown a real time outcome of change in men's behaviour towards their spouses on the one hand and their interface with the health providers along with or on behalf of their spouses has shown positive results. Even with the constraint of time, changes have been seen in various domains and there have been challenges as well.

The core intervention of sensitizing men to issues of gender and their responsibilities, as well as systematically organizing them to demand services from the health system has had an effect in different spheres and at different levels. In the domain of social accountability, we see that changes have occurred at the personal level (such as changes in attitudes, changes in behaviour, greater participation in household chores etc) and men have taken this public to affect changes at the community level (such as opposition to child marriage, valuing birth of a girl child, girl's education and so on). In the domain of public accountability, once again,

changes at various levels are observed. There is greater individual awareness about entitlements vis a vis maternal health, greater interaction with health care providers and monitoring health services on the one hand, and larger level advocacy at the district and state level with other allies from the state. Some of these gains were unanticipated when this project was conceptualized, and they reflect the ripple effect that this model of engaging men as agents of change can have.

Figure 3: Impact of the Intervention in various spheres



These gains have not been without resistance from the community. The animators and group members faced initially 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 and changes are beginning to be seen.

While this intervention focussed on the individual man as an agent of change, it is quite evident that this alone is not enough. Sensitized, mobilized groups must deal with a health system and policy that seems to be resistant to change beyond a certain point. This learning is evident from the failure to transform a malfunctioning PHC despite the best of intensive efforts to change things. Except for shifting the PHC from a rented building on an inaccessible hillock to its own building in a village, there has not been a substantial improvement in the PHC which neither has electricity nor water supply. It shows the limits to civil society's democratic efforts in moving lethargic and unwilling machinery. For optimal results, along with the motivated community for participation in improving social relationships and services, a fairly functional and responsive health care system is essential.

However, it is also evident that empowered communities make choices based on their own assessment of the health system's capacities. An interesting observation from Sidhi, was that although communities were beginning to get organized, demanding that ASHAs and ANMs perform their duties, pushing for better quality of VHNDs etc, there was a decline in use of the public health facilities for delivery. While the utilization of ANC, quality of VHNDs and relationship with health functionaries improved, there was a definite reluctance to deliver in institutions and as a result, the proportion of home deliveries actually increased in the project period. Despite all the monitoring, post natal care to these home deliveries was absent. This phenomenon needs to be explored further, as it suggests a conscious rejection of the institutional delivery model, by the community, and the failure of the system to provide any services in such a situation.

VIII. Conclusions

Reduction of maternal mortality and infant mortality, the key indicators of health status, are contingent upon the changes on social power relationships along with the better accessibility to health care services. The changed social power relationships can be instrumental both in facilitating better access for women to health services as well as improving the quality of the services itself. Changing unequal power relationships between men and women in general and the spouses in particular focussing on men's accountability both in their personal spaces and public services would lead to better results in women accessing health services.

This intervention has shown that by working with men to become agents of change, transformation is possible at the personal level, family level, community level and health system level as well. However, along with a motivated community, it is essential that the health system be strengthened considerably. Concerted monitoring and raising concerns with local, district and state authorities is required to ensure that entitlements which have been promised in government schemes are delivered.

What is also evident in a remote area like Sidhi is that even with participation of the community, there is an implicit rejection of institutional deliveries owing to various factors.

This suggests that there is a need to re-look at existing policy solutions, and devise new ways of providing maternal health services to women in such areas, taking into account local practices and anxieties with the formal health system. Existing health seeking practices need to be built on and local health care providers supported in order to ensure that even if deliveries happen in the home, they are supported sufficiently.

Annexure 1: Tables

Table 5: Socio-demographic profile of male respondents

Age of Male respondents				
	Baseline		**Endline**	
	Sidhi	**Morena**	**Sidhi**	**Morena**
Below 21 years	2 (1.7%)	10 (8.1%)	9 (5.3%)	19 (8.7%)
21-25 years	38 (31.7%)	49 (40%)	35 (20.7%)	75 (34.2%)
26-30 years	46 (38.3%)	31 (25.2%)	52 (30.8%)	65 (30%)
31-35 years	34 (28.3%)	30 (24.4%)	50 (29.6%)	48 (22%)
36-40 years	0	3 (2.4%)	19 (11.2%)	12 (5.5%)
41 years and above	0	0	4 (2.4%)	0
Total	120	123	169	219
Marital status of the male respondents*				
Status of marriage	**Sidhi**	**Morena**	**Sidhi**	**Morena**
Married	109 (90.8)	111 (90.2)	153 (90.5)	164 (74.9)
Not married	11 (9.2)	12 (9.8)	15 (4.5)	70 (25.1)
Total (N)	120	123	169	219
Religion and caste wise distribution of respondents**				
	Sidhi	**Morena**	**Sidhi**	**Morena**
Hindu	119 (99.6%)	119 (96.75)	167 (98.8%)	207 (94.5%)
Muslim	1 (0.83)	4 (3.25%)	1 (0.6%)	12 (5.5%)
Total (N)	**120**	**123**	**169**	**219**
SC	7 (5.83%)	23 (18.7%)	16 (9.5%)	17 (7.8)
OBC	7 (5.83%)	41 (33.3%)	11 (6.5%)	115 (52.5%)
ST	101 (84.2%)	1 (0.81%)	140 (82.8%)	0
General	5 (4.16%)	58 (47.1%)	2 (1.2%)	87 (39.7%)
Minority	0	0		
Total (N)	**120**	**123**	**169**	**219**
*** One Respondent in Sidhi is divorced** ****One Respondent in Sidhi did not disclose his religion**				

Table 6: Sociodemographic Profile of Female Respondents

Age of Female respondents				
	Baseline		**Endline**	
	Sidhi	**Morena**	**Sidhi**	**Morena**
Below 18 years	0	1 (.8%)	0	0

18-20 years	13(11.4%)	15 (12.6%)	12 (9.6%)	16 (12.6%)
21-25 years	50(43.9%)	60 (50.4%)	58(46.4%)	67 (52.8%)
26-30 years	24 (21.1%)	36 (30.3%)	41(32.8%)	37 (29.1%)
31-35 years	21 (18.4%)	6 (5%)	12 (9.6%)	6 (4.7%)
36-40 years	5 (4.4%)	1 (.8%)	2 (1.6%)	1 (.8%)
41 years and above	1 (.9%)	0	0	0
Total	114	119	125	127
Religion and caste wise distribution of respondents				
Hindu	110 (97.3%)	113 (94.5%)	121 (96.8%)	118 (92.9%)
Muslim	3 (2.65%)	6 (5%)	4 (3.2%)	8 (6.3%)
Total (N)	**113**	**119**	**125**	**126***
SC	6 (5.26%)	22 (18.5%)	16 (12.8)	8 (6.3)
OBC	25 (21.9%)	43 (36.13)	17 (13.6)	79 (62.2)
ST	77 (67.54%)	0	75 (60)	0
General	4 (3.50%)	54 (45.37%)	17 (13.6)	39 (30.7)
Minority	2 (1.75%)	0	0	0
Total (N)	**114**	**119**	**125**	**126***
**One respondent did not mention a religion or caste*				

Table 7: Stories of change – Themes

Theme of story	Sidhi	Morena
Greater contribution to household	2	4
Care during pregnancy and parenting	16	8
Challenging social norms, women's education, early marriage, domestic violence, sex preference of children, women's mobility, dowry	16	9
Demanding better health services	21	0
Infant Mortality	2	0
Leadership development and working of the collective	4	1
Improved interface with public functionaries	5	0
Community monitoring	9	0
Addressing other social issues	3	1
Accountability of health care providers	8	0
Networking with women's groups	2	1
Family planning and use of contraception	2	
Total number of stories*	**52**	**10**

**Total number of stories do not add up as one story may have multiple themes*

Table 8: Perceptions related to gender, masculinity, sexuality and violence

Perceptions related to gender, masculinity and sexuality - Score

Scores	Baseline		Total	Endline		
	Sidhi	Morena		Sidhi	Morena	Total
Good	6 (5%)	17 (13.8%)	23 (9.5)	86 (50.9%)	153 (69.9%)	239 (61.6%)
Satisfactory	90 (75.0%)	81 (65.9%)	171 (70.4)	65 (38.5%)	57 (26%)	122 (31.4%)
Unsatisfactory	24 (20.0%)	25 (20.3%)	49 (20.2)	18 (10.7%)	9 (4.1%)	27 (7%)
Total	120	123	243	169 (100%)	219 (100%)	388 (100%)

Table 9: Men's knowledge about different laws

Men's knowledge about different laws						
	Baseline			**Endline**		
Knowledge about laws (% of men who answered illegal)	**Sidhi (N=120)**	**Morena (N=123)**	**Total (N=243)**	**Sidhi (N=169)**	**Morena (N=218)**	**Total (N=388)**
16 year old girl should not get married	9 (7.5%)	36 (29.3%)	45 (18.5%)	100 (59.2%)	157 (71.7%)	257 (66.2%)
Taking and giving dowry during wedding is not right	8 (6.7)	22 (17.9)	30 (12.3)	62 (36.7%)	119 (54.3%)	181 (46.6%)
A woman can get abortion done within two months of gestation period	15 (12.5)	10 (8.1)	25 (10.3)	6 (3.6%)	14 (6.4%)	20 (5.2%)
Sex determination of foetus is not right	9 (7.5%)	34 (27.6%)	43 (17.7%)	51 (30.2%)	116 (53%)	167 (43%)
Man cannot beat any female members of their house	4 (3.3%)	13 (10.6%)	17 (7.0%)	55 (32.5%)	104 (47.5%)	159 (41.0%)

(Percentages indicate proportion of men who were aware of whether the acts are legal or not)

Table 10 (a): Husband's involvement in household chores

Participation of men in domestic chores - Sidhi	**Didn't do before, do now**	**Do more than before**	**Do as much as before**	**Do less than before**	**No answer**
Involvement of men in the household for washing clothes	47 (27.8%)	76 (45%)	36 (21.3%)	9 (5.3%)	1 (0.6%)
Involvement of men in the	43 (25.	81	39 (23.1%)	5 (3%)	1 (0.6%)

household for cleaning	4%)	(47.9%)			
Involvement of men in the household for cooking	55 (32.5%)	68 (40.2%)	33 (19.5%)	11 (6.5%)	2 (1.2%)
Involvement of men in the household for washing dishes	55 (32.5%)	61 (36.1) %	33 (19.5%)	18 (10.7%)	2 (1.2%)
Involvement of men in the household for serving food	54 (32%)	62 (36.7%)	33 (19.5%)	16 (9.5%)	4 (2.4%)
Involvement of men in the household for taking care of animals	29 (17.2%)	96 (56.8%)	40 (23.7%)	3 (1.8%)	1 (0.6%)
Involvement of men in the household for fetching water	27 (16%)	97 (57.4%)	41 (24.3%)	3 (1.8%)	1 (0.6%)
Involvement of men in the household for buying veggies and groceries	24 (14.2%)	91 (53.8%)	50 (29.6%)	3 (1.8%)	1(0.6%)
Involvement of men in the household for buying clothes for family	21 (12.4%)	99 (58.6%)	41 (24.3%)	4(2.4%)	3 (1.8%)

N=169

Table 10 (b):

	Participation of men in domestic chores (Morena)	**Didn't do before, do now**	**Do more than before**	**Do as much as before**	**Do less than before**	**No answer**
1	Involvement of men in the household for washing clothes	101 (46%)	71 (32%)	42 (19%)	5 (2%)	0 (0)
2	Involvement of men in the household for cleaning	92 (42%)	86 (39%)	36 (16%)	5 (2%)	0 (0)
2	Involvement of men in the household for cooking	98 (45%)	69 (32%)	42 (19%)	10 (5%)	0 (0)
3	Involvement of men in the household for washing dishes	96 (44%)	69 (32%)	44 (20%)	10 (5%)	0(0)
4	Involvement of men in the household for serving food	95 (43%)	76 (35%)	40 (18%)	8(4%)	0(0)
5	Involvement of men in the household for taking care of animals	40 (18%)	152 (69%)	23 (11%)	4 (2%)	0(0)
6	Involvement of men in the household for fetching water	45 (21%)	140 (64%)	31 (14%)	3 (1%)	0(0)
7	Involvement of men in the household for buying veggies and groceries	57 (26%)	116 (53%)	42 (19%)	4 (2%)	0(0)

8	Involvement of men in the household for buying clothes for family	55 (25%)	112 (51%)	43 (20%)	8 (4%)	1 (0.5)

Table 11: Education of Girls

	PRA I			PRA II		
	Achieved Score	Total Score	Percent	Achieved Score	Total Score	Percent
Sidhi (15 villages)	906	1119	81	1182	1346	88
Morena (14 villages)	545	711	77	774	948	82

*Table indicates number of girls between 12-18 years enrolled in school

Table 12: Age at marriage

	PRA I			PRA II		
	Achieved Score	Total Score	Percent	Achieved Score	Total Score	Percent
Sidhi (15 villages)	172	343	50	241	246	98
Morena (14 villages)	331	526	62.9	186	204	91.2

*Table indicates number of marriages that took place in the previous year in which groom and bride were above the legal age.

Table 13: Husband's involvement during pregnancy and post delivery care

Involvement of husband during women's pregnancy and post delivery care*						
Pre-pregnancy care by husband	Baseline		Total	Endline		
	Sidhi	Morena		Sidhi	Morena	Total
Good 16+	1 (2 %)	0	1 (1%)	16 (27%)	15 (29%)	23 (28%)
Satisfactory 11-15	22 (43%)	4 (9%)	26 (27%)	24 (40.7%)	12 (23.5%)	36 (32.7%)
Unsatisfactory 1-10	28 (55%)	40 (91%)	68 (72%)	19 (32.2%)	24 (47.1%)	43 (39.1%)
Total	51	44	95	59	51	110
Post-delivery care by Husband						
Good 16+	1 (2%)	0 (0%)	1 (1.1%)	10 (18.9%)	13 (27%)	23 (22.8%)
Satisfactory 11-15	7 (13.7%)	2 (4.5%)	9 (9.5%)	24 (45.3%)	19 (39.6%)	43 (42.6%)

Unsatisfactory 1-10	43 (84.3%)	42 (95.5%)	85 (89.5%)	19 (35.8%)	16 (33.3%)	35 (34.7%)
Total	51	44	95	53	48	101

N= Men who have children less than two years

Table 14: Men's participation in maternal health care - ANC

	PRA I			PRAII		
Men who accompanied their wives for ANC	Achieved	Total	%	Achieved	Total	%
Sidhi	137	1376	10.0	389	1044	37.3
Morena	17	748	2.3	183	1092	16.8

Table 15: Knowledge of signs of emergency among men respondents

Knowledge of signs of emergency among men respondents						
	Baseline			**Endline**		
Sign of emergency	**Sidhi (N=120)**	**Morena (N=123)**	**Total (N=243)**	**Sidhi (N=169)**	**Morena (N=219)**	**Total (N=388)**
During pregnancy						
Vomiting	44 (36.6%)	42 (34.1%)	86 (35.4%)	48 (28.4%)	47 (21.5%)	95 (24.5%)
Nausea and convulsions	35 (29.2%)	25 (20.3%)	61 (25.1%)	76 (45%)	80 (36.5%)	156 (40.2%)
Swollen abdomen	41 (34.2%)	22 (17.9%)	63 (26%)	53 (31.4%)	61 (27.9%)	114 (29.4%)
Bleeding	64 (53.3%)	41 (33.3%)	105 (43.2%)	101 (59.8%)	151 (69%)	252 (64.9%)
Swollenness of feet	65 (54.1%)	32 (26%)	97 (40%)	74 (43.8)	76 (34.7)	150 (38.7%)
Dizziness	64 (53.3%)	31 (25.2%)	95 (39%)	-	-	-
Labour Pain	30 (25%)	35 (20.3%)	56 (23%)	34 (20.1%)	39 (17.8%)	73 (18.8%)
Don't know	35 (29.2)	37 (30.1)	72 (29.6)	28 (16.6%)	45 (20.5%)	73 (18.8%)
At the time of delivery						
Breaking water bag	34 (28.3%)	29 (23.6%)	63 (26%)	69 (40. %)	101 (46.1%)	170 (43.8%)
Bleeding	60 (50%)	22 (17.9%)	82 (33.7%)	78 (46.2%)	125 (57.1%)	203 (52.3%)
Labour pain lasting for more than a day	61 (50.8%)	25 (20.3%)	86 (35.4%)	69 (40.8%)	69 (31.5%)	138 (35.6%)
Entire placenta does	72 (60%)	15 (12.3%)	87 (36%)	70 (41.4%)	80	152

not come out after delivery					(36.5%)	(39.2%)
Don't know	38 (31.7%)	51 (42.5%)	89 (36.6%)	32 (18.9%)	48 (21.9%)	80 (20.6%)
Post delivery						
Blood flowing from the uterus	40 (33.3%)	13 (10.5%)	53 (22%)	64 (37.9%)	88 (40.2%)	152 (39.2%)
High fever	69 (57.5%)	38 (31%)	107 (44%)	79 (46.7)	101 (46.1%)	180 (46.4%)
Pain in the hands and feet	46 (38.3%)	25 (20.3%)	71 (29.2%)	54 (32)	43 (19.6%)	97 (25%)
Continuous bleeding	81 (67.5%)	50 (40.6%)	131 (34%)	102 (60.4)	134 (62.2%)	236 (60.8%)
Burning while urinating	68 (56.6%)	16 (13%)	84 (34.5%)	56(33.1)	47 (21.5%)	103 (26.5%)
Don't know	34 (28.3)	54 (43.9)	88 (36.2)	25 (14.8)	46 (21%)	71 (18.3%)

Table 16: Contraception use among male respondents

Type of contraception used currently among MALE Respondents						
Baseline				**Endline**		
		District			**District**	
	Number of Men (N=220)	**Sidhi (N=109)**	**Morena (N=111)**	**Number of men (N=317)**	**Sidhi (N=153)**	**Morena (N=164)**
Female Sterilization	43 (19.5%)	25 (22.9%)	18 (16.2%)	106 (33.4%)	48 (31.4%)	58 (35.4%)
Male sterilization	13 (5.9%)	13 (11.9%)	0	12 (3.8%)	12 (7.8%)	0
Contraceptive pills	2 (0.9%)	0	2 (1.8%)	8 (2.5%)	4 (2.6%)	4 (2.4%)
Condom	17 (7.7%)	4 (3.7%)	13 (11.7%)	65 (20.5%)	15 (9.8%)	52 (33.5%)
Natural methods	16 (7.3%)	0	16 (14.4%)	9 (2.8%)	6 (3.9%)	3 (1.8%)
Herbs and desi dawa	1 (0.5%)	0	1 (0.9%)	0	0	0
Not using		57(52.3%)	68 (61.3%)			
Total	**85 (38.6%)**	**42 (38.5%)**	**43 (38.7%)**	**200 (63%)**	**83 (54.2%)**	**117 (71.3%)**

*Table only contains men who are married.

Table 17: Delayed birth of first child

	PRA I	PRAII

Spacing between marriage and birth of first child	Achieved	Total	%	Achieved	Total	%
Sidhi	26	409	6.4	73	447	16.3
Morena	32	118	27.1	34	87	39.1

Numbers denote children who were born at least 2 years after marriage

Table 18: Awareness regarding NRHM

Awareness regarding NRHM						
	Baseline			**Endline**		
Awareness	**Sidhi (N=120)**	**Morena (N=123)**	**Total (N=243)**	**Sidhi (N=169)**	**Morena (N=219)**	**Total (N=388)**
Heard about NRHM	41 (34%)	30 (24.4%)	71 (29.2%)	117 (69%)	172 (79%)	289 (74.5%)
Heard about ASHA	79 (65.8%)	93 (75.6%)	172 (70.7%)	158 (94%)	212 (97%)	370 (95.4%)
Heard about JSY	61 (51%)	28 (22.7%)	89 (36.6%)	131 (77%)	195 (89%)	326 (84%)
Hard about JSSK	NA	NA		93 (55%)	139 (64%)	232 (59.8%)
Heard about VHND	31 (26%)	55 (44.7%)	86 (35.4%)	159 (94%)	211 (96%)	270 (69.6%)
Heard about Rogi Kalyan Samiti	17 (14%)	14 (11.4%)	31 (12.8%)	NA	NA	NA
Heard about Janani Express	47 (39%)	91 (74%)	138 (57%)	NA	NA	NA
Heard about VHSC Tadarth Samiti	35 (29.1%)	21 (17%)	56 (23%)	127 (75%)	170 (78%)	297 (76.5%)
Participated in VHSC meeting in the last six months	21 (17.5%)	5 (4%)	26 (10.7%)	94 (56%)	94 (43%)	188 (48.5%)
Participated in Gram Sabha Meeting	72 (60%)	31 (25.2%)	103 (42.4%)	120 (71%)	143 (65%)	263 (67.8%)

Table 19: Persons contacted for solving problems

Persons contacted for solving problems								
	Baseline				**Endline**			
	Sidhi	**%**	**Morena**	**%**	**Sidhi**	**%**	**Morena**	**%**

Sarpanch	53	44.2	38	30.9	115	68.0	124	56.6
Upsarpanch	7	5.8	6	4.9	44	26.0	33	15.1
Ward panch/member	18	15.0	8	6.5	37	21.9	16	7.3
Panchayat Secretary	28	23.3	18	14.6	57	33.7	90	41.1
ANM	3	2.5	0	0.0	20	11.8	51	23.3
AWW	6	5.0	4	3.3	21	12.4	66	30.1
ASHA	3	2.5	3	2.4	32	18.9	63	28.8
Members of the female SHG/ women's groups	3	2.5	1	0.8	12	7.1	20	9.1
animator	-	-	-	-	32	18.9	82	37.4
no problem	17	14.2	2	1.6	15	8.9	21	9.6
went to no one	44	36.7	69	56.1	24	14.2	57	26.0
Teacher/ men's group/ZP representative	2	1.7	2	1.6	2	1.2	2	0.9
No answer	2	1.7	0	0.0	0	0.0	2	0.9
Total	120	100.0	123	100.0	169	100.0	219	100.0

Table 20: Antental Care received by women

	Sidhi		**Morena**	
	Baseline	**Endline**	**Baseline**	**Endline**
No of ANCs received				
None	3 (2.63%)	1(0.8%)	0	1(0.8%)
1	11 (9.64%)	9(7.2%)	10 (8.4%)	1(0.8%)
2	47 (41.2%)	52(41.6%)	59(49.5%)	44(34.6%)
3	35(31%)	50(40%)	27 (22.7%)	42(33.1%)
4+	2 (1.75%)	9(7.2%)	19 (16%)	33(26%)
Don't Remember	2 (1.75%)	0	0	0
Don't Know	10(8.8%)	1(0.8%)	3 (2.52%)	2(.8%)
No answer	4 (3.5%)	3(2.4%)	1 (0.84%)	8(3.2%)
Total	**114**	**125**	**119**	**127**
Timing of First ANC				
No ANC	6 (5.26%)	6 (4.8%)	0	3(2.4%)
<4	30 (26.3%)	41(32.8%)	46 (38.6%)	35(27.6%)
4-5	44 (38.6%)	49(39.2%)	57 (48%)	40(31.5%)
6-7	17 (15%)	22(17.6%)	11 (9.24%)	32(25.2%)
8+	6 (5.26%)	5(4%)	2 (1.7%)	10(7.9%)
Don't know	3 (2.6%)	0	1 (0.84%)	
Missing	8 (7%)	2(1.6%)	2 (1.7%)	7(5.5%)
Total	**114**	**125**	**119**	**127**

N= women who delivered in the past one year

Table 21: Delivery assistance among women who delivered at home

Delivery assistance among women delivered at Home – Sidhi		
	Base(N=37)	**End(N=65)**
Dai	13 (35.5%)	42 (64.6%)
No one	1 (2.7%)	3 (4.6%)
Mother in law	10 (27%)	0
ASHA	1 (2.7%)	0
Self	7 (19%)	0
Mother	1 (2.7%)	0
Grandmother in law	0	0
Sister/Sister in law	8 (21.6%)	0
Relative/friend	0	16 (24.6%)
Other	0	8 (12.3%)

N= women who delivered in the past one year.

Table 22: Place of delivery of women

Place of delivery as reported by women				
Place of delivery	**Sidhi**		**Morena**	
	Baseline	**Endline**	**Baseline**	**Endline**
Institutional Delivery	**67%**	**46%**	**86%**	**90%**
District Hospital	*10 (8.8%)*	*8(6%)*	*44 (37%)*	*64(50)*
CHC	*6 (5.26%)*	*12(10)*	*27 (23%)*	*8(6)*
PHC	*54 (47.4%)*	*25(20)*	*31(26%)*	*43(34)*
Sub-centre	*6 (5.26%)*	*12(10)*	*0*	*0*
Private Clinic/Hospital/ayush	**1 (1)**	**2(2)**	**8 (6.72%)**	**9(7)**
At home	**37 (32)**	**65(52)**	**8 (6.72%)**	**2(2)**
On the way/tractor	*0*	*1(1)*	*1 (0.84%)*	*1(1)*
Total	**114**	**125**	**119**	**127**

N= Women who delivered in the past one year

Annexure 2: PRA I and II Score Cards of Sidhi and Morena

Score card of 15 villages of District Sidhi						
	PRA I (August 2012)			PRA II (October 2013)		
Topic	Red* N=15	Yellow* N=15	Green* N=15	Red* N=15	Yellow* N=15	Green* N=15
Food and nutrition						
Availability of food and nutrition for children at anganwadi	14	1	0	10	5	0
Availability of food and nutrition for pregnant women and lactating mother at Anganwadi	14	1	0	8	6	1
Availability of food and nutrition for adolescent girl	14	1	0	9	6	0
Availability of food for children at school				7	7	1
Availability of food at ration shop	15	0	0	12	3	
Drinking water and hygiene						
Number of wells (Scores are given on the basis of well with platforms, no garbage dumping around the well, no one takes bath around the well and no one washes clothes around the well)	14	1	0	7	8	0
Number of hand pumps (scores are given on the basis of proper drainage around the hand pumps, no stagnation of water, no cattle feeding, no one washes the clothes)	7	7	1	1	10	4
Fetching water by men (for households, for animal and for drinking)	15	0	0	10	5	0
Toilet Facility						
Number of houses with toilet (Toilet with water facility and cleanliness maintained)	15	0	0	15	0	0
Toilets in public institutions (Toilet with water facility and cleanliness maintained)	6	5	4	5	4	6
Education						
Number of school going boys (6-12 years)	0	0	15	0	0	15
Number of school going girls (6-12 years)	0	0	15	0	0	15
Number of school going boys (12 -18 years)	0	2	13	0	5	10
Number of school going girls (12 -18 years)	0	7	8	0	3	12
Maternal Health						
Total 3 ANCs received by pregnant women	7	5	3	1	5	9
Accompany of ASHA during the delivery of pregnant women	7	4	4	4	6	5
Feeding colostrums to new born				4	4	7
Involvement of husband/men in ANC care	15	0	0	14	0	1
Child Immunization						
Full vaccination coverage	3	6	6		1	14
Marriage (Number of wedding)						
Number of wedding happened at the right and legal age among boys and girls (for girls 18+	11	3	1	0	0	15

years and for boys 21+ years of age)						
Taken and offered dowry at the wedding *	NA			NA		
Single women						
Total number of single women(widow, divorcee, abandoned women, separated, never married women)	0	1	14	0	0	15
Gap between children						
The first child was born how many months after the wedding and the gap between first and second child	15	0	0	15	0	0
• Red = Poor (the villages scored less than 60 percent) • Yellow = Average (The villages scored 60-80 percent) • Green =Good (The villages scored more than 80 percent)						
Score card of 15 villages of District Morena						
Topic	Red* N=15	Yellow* N=15	Green* N=15	Red* N=15	Yellow* N=15	Green* N=15
Food and nutrition						
Availability of food and nutrition for children at anganwadi	11	4	0	3	12	0
Availability of food and nutrition for pregnant women and lactating mother at anganwadi	14	1	0	6	9	0
Availability of food at ration shop**	8	5	2	9	6	0
Drinking water and hygiene						
Number of wells (Scores are given on the basis of well with platforms, no garbage dumping around the well, no one takes bath around the well and no one washes clothes around the well)	NA					
Number of hand pumps (scores are given on the basis of proper drainage around the hand pumps, no stagnation of water, no cattle feeding, no one washes the clothes)	7	5	3	4	7	4
Fetching water by men (for households, for animal and for drinking)	7	5	3	Info not available		
Toilet Facility						
Number of houses with toilet (Toilet with water facility and cleanliness maintained)	10	2	3	12	1	2
Community toilet (Toilet with water facility and cleanliness maintained)	10	2	3	10	4	1
Education						
Number of school going boys (6-12 years)	1	0	14	0	0	15
Number of school going girls (6-12 years)	1	0	14	0	1	14
Number of school going boys (12 -18 years)	3	1	11	2	2	12
Number of school going girls (12 -18 years)	3	1	11	2	3	10
Maternal Health						
Total 3 ANCs received by pregnant women	1	2	12	8	1	14
Accompany of ASHA during the delivery of pregnant women #				4	3	8
Involvement of husband/men in ANC care	15	0	0	15	0	0
Child Immunization						
Full vaccination coverage	13	1	1			13(2 NA due

						to non availability of children below 1 yr)
Marriage						
Number of wedding happened at the right and legal age among boys and girls (for girls 18+ years and for boys 21+ years of age)	5	6	4	0	5	10
Taken and offered dowry at the wedding	12	3	0	15	0	0
Single women						
Total number of single women(widow, divorcee, abandoned women, separated, never married women)* *In Mahadev ka pura, there is no single women in the village	2	8	4	8	4	3
Space between children						
The first child was born how many months after the wedding and the gap between first and second child	14	1	0	11	3	1
• Red = Poor (the villages scored less than 60 percent), Yellow = Average (The villages scored 60-80 percent), Green = Good (The villages scored more than 80 percent)						

Annexure 3: District wise report card of Maternal Health Services in other Districts of MP

Name of Health services	JSY benefits	JSSK- transport & Facility based services	ANC services	ANM Village visits	Maternal & Child Immunisation
Anuppur					
Ashoknagar					
Bhind					
Bhopal					
Chhindwara					
Hoshangabad					
Sagar					
Satna					
Sehore					
Shahdol					
Sheopuri					
Vidisha					

Red = Poor

Yellow = Average

Green = Good