OXFAM IN ACTION

INITIATIVE TO IMPROVE MATERNAL HEALTH WITH SOCIAL DETERMINANTS APPROACH

Findings from Endline Evaluation, July 2015

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CONTEXT

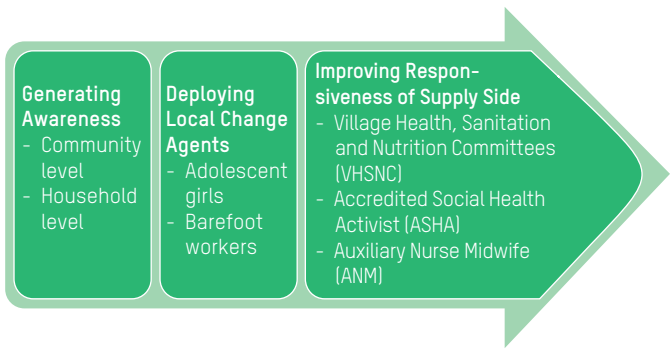
For over 60 years Oxfam has been in India, supporting civil society organisations across the length and breadth of the country. Oxfam India's (OINs) vision is to 'help create an equal, just and sustainable society by empowering the underprivileged'. Within the category of 'Essential Services', OIN strives to enable universal access to affordable health, especially to marginalised social groups.[1] OIN recognizes that one of the key gaps in healthcare is maternal health.

As per the latest UNICEF statistics, the maternal mortality ratio (MMR) in India is 167 deaths per 100,000 live births. Despite numerous efforts by the Government at the national and local levels, maternal mortality remains a persistent challenge. Numerous schemes and structures such as Janani Suraksha Yojana (JSY)[2], Janani Shishu Suraksha Karyakram (JSSK)[3] and Integrated Child Development Services (ICDS)[4] have not been successful in reaching adequate numbers of Indian women. The factors for low coverage include adverse socio-economic conditions, low status of women and power relations within households and communities. These and other factors create barriers to accessing health programs and schemes of the Government. Access rates are particularly low in states where gender disparity and patriarchy are highly prevalent. States like Bihar, Jharkhand, Chhattisgarh, Odisha and Rajasthan have high MMRs and account for almost one-third of maternal deaths in India.

Within this context, OIN took a social determinants approach to improving maternal health through an initiative supported by the Global Poverty Action Fund (GPAF) of the Department for International Development (DFID). The initiative was implemented through partner Non-Governmental Organisations (NGOs) in six states, i.e. Bihar, Jharkhand, Chhattisgarh, Odisha, Maharashtra and Rajasthan.

The program, implemented during 2012-2015, sought to improve health seeking behaviour of rural communities particularly related to maternal health. The core strategies of the program can be organised in three broad pillars of execution including both supply and demand components:

FIGURE 1: THREE MAJOR PILLARS OF EXECUTION



The primary drivers of change in this initiative were local stakeholders. A brief description of some of the key activities with them can be seen below:

- **Village Health, Sanitation and Nutrition Committees (VHSNC)**[5] that were poorly functioning and ineffective were revived to allow communities to make their own health plans suited to their needs and requirements. Committee members were trained in processes of allocation, expenditure and given important responsibilities such as monitoring the Village Health and Nutrition Days (VHNDs).[6]

1 The other 'Essential Service' focuses on education. https://www.oxfamindia.org/programdetails/100/Essential-Services

2 A safe motherhood intervention under National Rural Health Mission implemented with the objective of reducing maternal and neonatal mortality through the promotion of institutional delivery. http://nrhm.gov.in/nrhm-components/rmnch-a/maternal-health/janani-suraksha-yojana/background.html

3 A scheme intended to motivate women to opt for institutional delivery by offering them benefits. http://nrhm.gov.in/janani-shishu-suraksha-karyakram.html

4 A welfare programme of the Government of India that provides food, preschool education and primary healthcare for children under 6 and their mothers.

5 Local bodies under National Rural Health Mission formed to take collective actions on issues related to health and its social determinants at the village level. VHSNCs are intended to have at least 15 members including health workers and general community members with strong participation from all sub-groups and social categories. http://www.nrhm.gov.in/communitisation/village-health-sanitation-nutrition-committee.html

6 VHNDs are monthly platforms that allow villagers to interact freely with health personnel to obtain basic services and information. They are to be held at village Anganwadi Centres. http://nrhm.gov.in/communitisation/village-health-nutrition-day.html

- **Adolescent girls** (especially those entering the reproductive age) were targeted and trained on different aspects of hygiene, sanitation and maternal health. These efforts resulted not only in personal growth and development but also created agents of change within households.
- **Barefoot Auditors** are voluntary workers who help generate awareness and ensure accountability from supply side actors. These local residents are trained in the use of community based monitoring (CBM) tools.
- **ASHA workers**[7] were mobilized by the program to ensure that VHND were conducted as mandated by government policy. The ASHA workers would go to each household to inform pregnant and lactating mothers about the time and venue of the VHND.

7 ASHAs are one of the key components of NRHM. They are trained female community activists selected from villages and trained to work as an interface between the community and public health system. http://nrhm.gov.in/communitisation/asha/about-asha.html

ENDLINE EVALUATION

In order to measure the progress in outcome achievement and to understand the nuanced details that affected success, an endline evaluation study was conducted in 2015. The objectives of the evaluation were to:

- Measure tangible milestones achieved and the reasons for achievement in the program
- Assess which intervention strategies worked well and the reasons thereof
- Document the best practices, learnings and challenges faced by the program

The study achieved these objectives through a pre-post test analysis comparing key indicators against a baseline study conducted at the beginning of the program. Data was collected through a mix-methods approach using both quantitative and qualitative methods which can be seen in the following table:

TABLE 1: DATA COLLECTION METHODS AND DATA SOURCES

	Method	Data Source
Quantitative	Household Level Survey	- Pregnant women - Mothers of children ≤ 2 years
Qualitative	Focus Group Discussion (FGD)	- Pregnant Women - Mothers of children ≤ 2 years - Husbands - Mothers-in-law
	In-depth interviews	- Auxiliary Nurse Midwife (ANM) - Anganwadi Workers (AWW) - Village Health Sanitation and Nutrition Committee - Accredited Social Health Activist (ASHA) - Barefoot Auditor - Block Medical Officer/Chief Medical Officer - Child Development Project Officer/District Project Officer - Lady Supervisor - Medical officer in-charge

SAMPLE COVERAGE

Primary data was collected in selected villages across all six program states. A total sample size of 1,437 quantitative surveys was spread across all locations. The following table shows the state-wise breakup of quantitative data collection.

TABLE 2: QUANTITATIVE DATA COLLECTION COVERAGE

State	Number of Pregnant Women Interviewed	Number of Mothers Interviewed	Total Sample Size
Bihar	17	220	237
Chhattisgarh	21	216	235
Jharkhand	25	217	242
Maharashtra	20	224	244
Odisha	24	216	239
Rajasthan	25	215	240
Total	132	1308	1437

Qualitative data was also distributed across the six states. Coverage was as follows:

TABLE 3: QUALITATIVE DATA COLLECTION COVERAGE

Method	Coverage
Mother FGD	2 per state
Mother-in-law FGD	1 per state
Husband FGD	1 per state
ANM, ASHA, AWW Interview	1 each per state
Barefoot Auditors	2 per state
VHSNC FGD	2 per state
Child Development Project Officer	2 total
Block Medical Officer	2 total
Medical Officer in-charge	4 total
Lady Supervisor	3 total

MAIN FINDINGS OF STUDY

DEMOGRAPHIC PROFILE OF RESPONDENTS

The target population is comprised of heavily marginalised sections and largely belongs to Scheduled Tribe/ Scheduled Caste, and Muslim communities. Around 50% of the respondents lived in kaccha houses and 71% reported as poor. Only 18% of the households have access to piped water, while the majority (62%) rely on hand pumps to draw water. Only 10% of respondents reported having functional toilets.

Other relevant social indicators were low as well. 34% were illiterate and only 2% had completed higher secondary education. The average age of marriage was 18.1 years and the average age of first pregnancy was 20.

There is variation among the states across all indicators. For example, age at marriage was significantly lower in Rajasthan, i.e. 14.9 years than in Maharashtra, i.e. 20.1. Availability of toilets was much lower in Chhattisgarh, i.e. 8% than in Rajasthan, i.e. 19%.

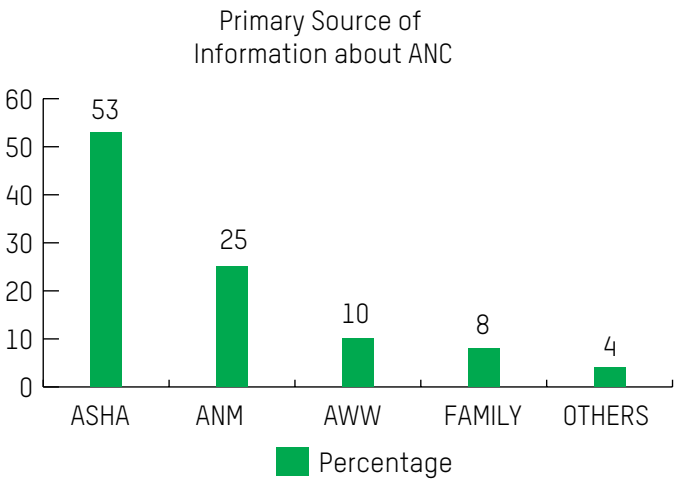
Overall it was found that the demographic profile of respondents in the endline study was quite similar to those covered during the baseline.

PROGRAM ACTIVITIES AND OUTCOMES

ANTENATAL CARE (ANC)

At the time of endline, 80% women had undergone three or more ANC consultations which was a 20% increase from the baseline situation. This success can be attributed to the program's focus on holding Village Health and Nutrition Days (VHNDs) regularly and with good attendance by women. Other efforts included enhanced functioning of community institutions such as Village Health, Sanitation and Nutrition Committees (VHSNCs). Increased awareness of ANCs was also strongly boosted by ASHAs and ANMs. These workers were cited as the primary sources of information regarding antenatal care as depicted in the diagram:

FIGURE 2: SOURCES OF INFORMATION ABOUT ANC



At the time of endline, 80% women reported receiving counselling from ANM/ASHAs, which is dramatic increase from baseline figures of 37%. Some states witnessed tremendous augmentations, i.e. Bihar from 16% to 63% and Chhattisgarh from 28% to 96%. Similarly, 68% reported to having been informed of their anaemic statuses, a significant increase from 34% during baseline.

NUTRITION

The proportion of women who received iron rich/iron fortified foods was relatively high in most states during the baseline study, so the scope for increase was not as great. Nonetheless, an improvement was observed for this indicator as well. During the baseline study, 74% of women said they received iron rich/iron fortified foods, and this figure increased to 81% during the endline study. While high levels of women reported receiving such foods, only around one-fifth consumes them alone as most still share with other family members.

Receipt and consumption of at least 100 Iron Folic Acid (IFA) tablets also increased across most states from the baseline to endline studies. Receipt rose from 31% to 54% and consumption rose from 27% to 38%.

SAFE DELIVERY

An increase of 17% in the proportion of women able to recognize at least two signs related to danger of pregnancy and at least two complications during and after child birth was observed from baseline to endline. In terms of behaviour, home delivery decreased and institutional delivery increased. Overall percentage of delivery in public and private hospitals increased from 67.3% at baseline to 74.5% at endline. Increases were most significant in Maharashtra, Odisha and Rajasthan. The program stakeholders including frontline functionaries, Barefoot Auditors and community level platforms (such as VHND) have played significant roles in this behaviour change.

NISHI KULLU AN ANM FROM THE STATE OF ODISHA SAID SHE NOTICED REMARKABLE CHANGES IN THE ATTITUDES AND BEHAVIORS AROUND INSTITUTIONAL DELIVERY. IN THE PAST, MOTHER-IN-LAWS WOULD MAKE DECISIONS AND MANY BIRTHS WOULD HAPPEN AT HOME. BUT THANKS TO REPEATED AWARENESS CAMPAIGNS, ALL FAMILY MEMBERS, INCLUDING MOTHERS, FATHERS AND MOTHER-IN-LAWS WERE CONVINCED THAT INSTITUTIONAL DELIVERY IS THE BEST OPTION FOR MOTHER AND BABY.

One key outcome of the program was an increase in awareness about the Janani Suraksha Yojana (JSY)—a safe motherhood intervention (under National Rural Health Mission - NRHM) that promotes institutional delivery by providing monetary benefits after delivery in Government health institutions. Awareness has significantly increased across all program states. However, the proportion of women who benefited under the scheme gives a very different story. In two states the proportion increased, in one it stayed about the same, and three states experienced significant declines. Overall there was a 2% decline.

TABLE 4: AWARENESS AND ACCESS TO JSY SCHEME

Indicator	Bihar	Chhattisgarh	Jharkhand	Maharashtra	Odisha	Rajasthan	Total
Change in proportion of women with awareness of JSY scheme from baseline to endline	+37%	+32%	+13.4	+24	+27%	+5%	+23%
Change in proportion of women who benefitted from JSY scheme from baseline to endline	-11	-7	-27	+27	+6%	+1%	-2%

IN ONE VILLAGE OF JHARKHAND, 66 WOMEN HAVE NOT RECEIVED THE JSY BENEFITS TO WHICH THEY WERE ENTITLED. THE ASHA WORKER, MANJU DEVI HAS BEEN WORKING TIRELESSLY TO CHANGE THIS. AT THE TIME OF THE ENDLINE STUDY SHE HAD BEEN WRITING TO AUTHORITIES REGULARLY FOR THREE MONTHS. BECAUSE OF HER EFFORTS, FOUR LOCAL WOMEN RECEIVED THEIR CHEQUES. ACCORDING TO HER "NOW WE ARE AWARE OF OUR RIGHTS, AND ALL OF US WOMEN WILL GO AND DEMAND OUR RIGHTS FROM THE GOVERNMENT AUTHORITIES".

-HAZARIBAGH, JHARKHAND

Many women in Bihar, Jharkhand and Chhattisgarh reported not receiving benefits of after opting for institutional delivery. This served as a discouraging factor resulting in low JSY availing rates.

KNOWLEDGE ABOUT LEGAL AGE OF MARRIAGE

Only 63% of respondents in the baseline study knew that the legal age of marriage is 18 years for girls and 21 years for boys. Through efforts of adolescent girls, Barefoot Auditors and VHSNCs, awareness was raised on this issue. By the endline study 88% knew the correct legal age of marriage.

There was also a huge decline in the proportion of men and women married before the legal age. The proportion for women came down to 21% from 65% and while for men it came down to 18% from 94%. In some cases this can be attributed to higher awareness and in others to direct intervention. Multiple cases were reported in Bihar and Jharkhand wherein girls below the age of 18 reported to Barefoot Auditors or village animators that they were getting married. Consequently, groups of young girls, Barefoot Auditors and members of the VHSNCs then visited parents and persuaded them not to have their daughter married so early.

AWARENESS ON SAFE ABORTION

Abortion was found to be a taboo subject during both baseline and endline studies. However, the program was successful in increasing awareness about the availability of safe abortions in public health facilities. Only 15% of women were aware during baseline, but the percentage increased to 53% by endline.

AWARENESS OF METHODS OF CONTRACEPTION

An important increase was also achieved in the proportion of eligible couples with knowledge of terminal methods of contraception (i.e. male and female sterilization) and temporary methods of contraception including male and female condoms, oral contraceptive pills, emergency contraceptive pills, intra uterine devices (IUD) and injectable contraceptives. Increases in awareness are shown in the following table:

FIGURE 3: AWARENESS ON CONTRACEPTION

Indicator	Baseline	Endline	Change
Eligible couples with knowledge of temporary contraception (in %)	69%	91%	↑ 22%
Women with knowledge of at least 2 terminal methods of family planning	43%	67%	↑ 24%
Women with knowledge of at least 3 temporary methods of family planning	45%	74%	↑ 29%

CONCLUSIONS AND RECOMMENDATIONS

- The program identified components of nutrition, safe delivery and family planning as critical to reducing MMR in India and mobilized communities to raise awareness, demand and access existing public programs and schemes.
- VHNDs were instrumental in improving indicators related to improved nutrition, antenatal care and anaemia.
- Awareness and demand were raised regarding JSY benefits. However, bottlenecks in Bihar, Chhattisgarh and Jharkhand led to non-payment in many cases. This breakdown in supply has contributed to a decline in deliveries in public health facilities. Advocacy with state level officials is needed to reverse this negative trend.
- The program harnessed the strength of adolescent girls in villages and used a life-cycle approach to educate young people on issues such as early marriage and family planning.
- Services related to institutional delivery and family planning were already available, but awareness and communication amongst young women were low. The program was able to reduce these barriers. However, more work is still required in this domain.
- Although awareness was raised about all methods of family planning, limiting methods (particularly female sterilization) are still the predominant choice in most areas. The need for spacing methods should be reinforced and their use encouraged.
- The program reconstituted village based institutions and introduced a new cadre of Barefoot Auditors. However, the sustainability of these efforts is not clear. Most notably, volunteer workers cannot be sustained without financial support.

This learning note is prepared based on a endline evaluation of project 'Initiative to Improve Maternal Health with Social Determinants Approach' for wider sharing. This study was conducted by a team of 'NR Management Consultant Pvt. Ltd.' during April 2015 to July 2015. This project was supported by the Global Poverty Action Fund (GPAF) of the Department for International Development (DFID) to Oxfam India. We would like to thank Anjali Bhardwaj, Deepak L Xavier, Jitendra Kumar Rath, Pallavi Gupta, Pratiush Prakash, Preeti Bohidar, Sanjay Suman and Sanjeeta Gawri for their inputs given during the process of endline evaluation.

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