INTRODUCTION

‘Accountable and Universal Basic Health Services’ is one of the envisioned programming areas under Oxfam India’s strategy 2010-15. Oxfam India (OIN) initiated project on ‘Improving Maternal Health’, towards fulfilling its commitment to provide ‘right to life with dignity for all’.

Through this project, OIN attempts to bring long term changes in community perception regarding women’s reproductive health and enhance women’s access to essential maternal health services in six states of India.

The project aims to contribute to improving access to complete package of maternal healthcare through social determinant approach.

It intends to work at multiple levels on women’s access to intra household nutrition, healthcare awareness, demand generation for health services, empowerment of women and delayed marriage, building community capacity for planning and demanding accountability of health services with specific emphasis on women’s health services.

The project is contributing to the MDG-1 (Millennium Development Goal-1), which is focused on eradicating extreme poverty and hunger, and MDG-5, which is focused on reducing the maternal mortality. It will also leverage the government programmes on health, child development, and food security1.

KEY RESULT AREAS OF THE PROJECT

IMPACT

ENSURING UNIVERSAL ACCESS TO MATERNAL HEALTH
TO ACHIEVE MDG-5 BY THE YEAR 2015 IN SIX STATES OF INDIA

OUTCOME

IMPROVED WOMEN’S HEALTH STATUS IN THE SIX POOR STATES OF INDIA.

OUTCOME INDICATOR1

NUMBER OF WOMEN WITH INCIDENCES OF SERIOUS HEALTH PROBLEMS RELATED TO CHILD BIRTH

OUTCOME INDICATOR2

NUMBER OF WOMEN CONCEIVING AT LEAST ONE YEAR AFTER THE LEGAL AGE OF MARRIAGE

OUTPUTS

OUTPUT 1
COMMUNITY CAPACITY TO ADVOCATE FOR WOMEN’S ACCESS TO A WHOLESOME BALANCED DIET.

OUTPUT 2
WOMEN HAVE IMPROVED AND INCREASED ACCESS TO OBSTETRIC CARE INCLUDING REFERRAL SERVICES IN PROJECT INTERVENTION AREAS.

OUTPUT 3
WOMEN WITH INCREASED AWARENESS AND KNOWLEDGE ON LEGAL AGE OF MARRIAGE AND CONTRACEPTION METHODS.

OUTPUT 4
INCREASED ENGAGEMENT OF CIVIL SOCIETY ORGANISATIONS (CSOS) IN MONITORING AND PLANNING OF THE GOVERNMENT HEALTH DELIVERY SERVICES THROUGH IDENTIFICATION OF POLICY GAPS AT ALL LEVELS.
The broad objective of the study was to set up a baseline for future evaluation of the project, help create a log frame for monitoring progress on key indicators and provide strategic inputs to the project to the extent possible. Interstate and inter-community variations noted through the baseline would form an important part in contextualizing the implementation of the programme.

Some of the specific objectives of the study were to assess knowledge, behavior and practices at the household level, with focus on current level of knowledge and practices regarding maternal health, unsafe abortions, legal age of marriage, and unmet need for contraception. Aspects relating to women’s empowerment and access to food / nutrition were also covered under the baseline. Additionally, the baseline collected data on awareness about and access to National Rural Health Mission’s (NRHM) maternal health service guarantee a and incentive based schemes such as Janani Suraksha Yojana (JSY).

The baseline covered 14 districts across 6 states, viz. Rajasthan, Bihar, Jharkhand, Chhattisgarh, Odisha and Maharashtra. Selection of villages was done through PPS (probability proportionate to size) on the basis of total SC/ST population. The study included segments of SC, ST and Muslim population and others (referred to as sub-groups).

Both quantitative and qualitative research techniques were adopted to collect the data. Quantitative information was collected using structured and semi-structured questionnaire. Qualitative data was collected through focused group discussions (FGDs) and In-depth interviews (IDIs) with target population viz. women & their family members and the public health officials. The study was conducted using uniform bilingual questionnaires and guides in English and regional languages.

At the household level, 2625 mothers of children less than two years, mother in law and husband were treated as respondents. At institutional level, Auxiliary Nurse-midwife (ANM), Anganwadi Worker (AWW), Accredited Social Health Activists (ASHA), Village Health and Sanitation Committee (VHSC), Rogi Kalyan Samithi (RKS), Child Development Project Officer (CDPO) and (Block Medical Officer) BMO were covered.

All the completed questionnaires were scrutinized by the supervisors/editors on field as well as prior to data entry. Scrutinized questionnaires were coded for open-ended responses. Data entry was done using CS Pro (The Census and Survey Processing System). A tailor made cleaning programme was used to suit the requirements to arrive at the quality data. The data analysis was carried out using SPSS (Statistical Package for the Social Sciences). FGD (Focus Group Discussion) and IDI (In-depth interview) transcriptions were prepared for qualitative data and entered in to excel spreadsheet.
I. SOCIO ECONOMIC AND DEMOGRAPHIC PROFILE

Significant proportion of respondent women is young and illiterate: The average age of respondent women is 25 years across the states. More than one third (37%) of the women are illiterate and about 10% can read and write although they have never been to school. Only about 5% women have studied up to higher secondary levels or above. Proportion of illiteracy in the social groups was highest among Muslims (50%) followed by Scheduled Tribes (41%) and across the six states highest among respondents in Rajasthan (60%) and Bihar (58%).

More than half of the women are housewives: Nearly 51% women reported that they do not work (productive engagement), majority of which are from Bihar and Jharkhand. Community wise, proportion of women who do not work is highest among Muslims (84% of all Muslim women under survey). Majority of women who reported to be working are engaged in agriculture work in their own land or as agriculture laborer. Similarly, across the states, labour work emerges as the main economic activity for men from surveyed households as nearly 41% women reported that their husbands work as laborers. This proportion was relatively high in Jharkhand (65%) and Odisha (62%). Proportion of women with husband working as laborer is higher among scheduled caste (47%) and scheduled tribes (44%).

Mean average monthly household income is less than USD 66: Overall mean average monthly household income across states was INR 3900. Among the social groups, it was lowest among STs (INR 3202 per month), less than two-dollars a day.

More than half of the respondent households have BPL cards: About 56% of surveyed households across states have BPL cards. Among states, Chhattisgarh and Bihar recorded highest proportion of house holds with BPL cards (70% and 69% respectively). Across communities, highest proportion of households having BPL card is 65% among Muslims and about 54% among STs.

Good proportion of surveyed households have access to electricity and safe water sources while access to toilet facilities is extremely poor: Among all respondent households, 68% have electricity connections and about 60% have access to safe sources of drinking water (piped water and hand pumps), although quality of water and duration of electricity supply were not probed in detail.
Inter-state variation in access to electricity was very high with about 90 % HH from Maharashtra and Jharkhand reporting in affirmative while only 12 % HH from Bihar reported having electricity connection. Overwhelming proportion of the households (87%) has no toilet facility except for Maharashtra state, where 69% respondents reported having toilet facilities.

II. AWARENESS ON MATERNAL HEALTH ISSUES

Awareness regarding legal age at marriage for girls is higher than that for boys: 63 % women were aware of stipulated legal age at marriage for girls while only 46% reported correctly the legal age at marriage for boys. Among all communities, awareness level on this indicator was the lowest among STs. The qualitative data shows that awareness levels on this count were lower among mothers-in-law and men (husbands) although they do have a notion of ‘ideal age’. In terms of priority issues, women were concerned about health and infant care, while men were more concerned about mental status of the young girls and boys, adjustment issues and mutual understanding among young couple.

Awareness regarding primary health care facilities is higher than about secondary and tertiary level facilities:

Overall half of the women are aware of sub center and primary health centre although only 35 % are aware of district hospital. Awareness about primary health centre seems to be lower among the women from Rajasthan (27%) and Chhattisgarh (40%) when compared to other states. Awareness about quacks is higher among Muslim (14%) than the other social groups in the study.

Almost all women are aware of one or more symptoms of pregnancy related complications: About half of the women consider pelvic or abdominal pain as a symptom of complication. Women are also aware of complications such as swelling of hands/face (41%), persistent back pain (33%), and severe headaches/blurry vision (31%).

Awareness on delivery related complications is limited: Responses show that complications with obvious external symptoms such as premature labour, prolonged labour and excessive bleeding are more commonly known to women although degree of awareness about these symptoms vary across states and communities. Awareness about hypertension, obstructed labour, breech presentation, and convulsions was considerably low. Regular health check-ups, dietary concerns and sound mental health during pregnancy were indicated as important aspects by both men and women during the study. Awareness about post-natal checkup, consumption of IFA tablets and the TT injections during pregnancy, was very low among men.

Awareness about contraception methods is highest among Muslim women and lowest among STs: The three contraceptive methods that a majority of women are aware of include female sterilization (71%), male sterilization (48%) and oral pills (45%). The awareness level of women
Awareness regarding spontaneous abortion is high but that on induced abortion is low: More than two third of women reported to be aware of spontaneous abortions (66%) while only 28 percent were aware about induced abortion. Only 27 % women across states were aware of the time period for safe abortions (27%). Awareness about spontaneous (61%), induced abortions (21%) and time period for safe abortions (20%) is less among ST women.

Awareness regarding Janani Suraksha Yojana (JSY) is high with notable inter-state variation in awareness levels: Overall, 68 percent of women reported that they are aware of JSY scheme, with the proportion being higher in Jharkhand and Rajasthan (84% and 80% respectively) and lowest in Maharashtra (55%). Inter-community variation on this count was negligible. However, only half of the respondent women were aware about Village Health and Nutrition Day (VHND). Awareness about VHND was higher in Odisha and Jharkhand (84% each) and lower in Bihar (23%).

III. WOMEN EMPOWERMENT AND PERCEPTION ON GENDER ROLE

Women’s access to banking and ability to take household level financial decisions is limited: Nearly 17 percent women have reported to have bank accounts. Higher proportions of ST women (22%) have bank account compared to other social groups in the study. More than one third of the women (37%) reported to have the freedom to spend the money. Higher proportion of women from Maharashtra (58%) reported to be free to spend money while Odisha recorded the least percentage (23%).

Only about half of the women have liberty to visit a doctor on their own: Only 54% of women expressed to have the liberty to visit a doctor when needed. Odisha had a higher proportion of women (70%) who reportedly had this liberty compared to other states. SC and ST women were better placed at 57% on this count.

Gender bias predominate perceptions regarding roles and responsibilities: About half of the women expressed that household work is the sole responsibility of women across the states and also three-fifth of the women expressed the view that men should take the final decision in home affairs except in Rajasthan. About 14 percent of the respondents feel that only husbands can decide when to have a child. Also, majority (85%) of the respondents felt the need for reservation for women, this proportion being higher in Maharashtra (94%). More than 80% felt that both men and women should have equal opportunities at work place. Maharashtra had a higher proportion of women (96%) supporting this idea.
CONCLUSION

► **Strengthening strategies of information dissemination and behaviour change communication:** There is a need to educate the couples and pregnant women about the importance of ANC (Ante Natal Care) package, proper care during and post pregnancy, breast-feeding and newborn care. Barriers to educate pregnant women and household decision-makers about the complete ANC package and proper care during pregnancy and newborn also need attention. The IEC activities need to be strengthened for this purpose. Also, efforts have to be made to educate families and girls about the legal age at marriage.

► **Greater understanding of factors that motivate families to opt for institutional deliveries is required:** Understand the factors that contribute to the shift towards institutional delivery and preference for government health facilities and work towards increasing institutional deliveries in the project districts.

► **Enhancing access to services and improving outreach:** It is necessary to enhance the reach of postnatal services in the programme districts. This can be done by improving postnatal visits by health care providers, ASHAs and AWWs and by extending health services through special measures such as mobile health clinics, health camps etc. A need for strengthening the food supplementation programmes for pregnant women and nursing mothers was also noted.

► **Strengthening accountability of public health institutions through community empowerment:** There is a need to strengthen Public health institutions and make them accountable by empowering community for monitoring of the services and increasing awareness on the health services/entitlements provided by the government at various levels of the public health system.

The baseline data indicates a number of shortcomings in public health services and challenges women face in realizing their reproductive health rights. It also highlights the importance of bringing changes in perception at the level of family and community that influence women’s decision-making regarding their reproductive intentions.
### Baseline Data on Key MCH Indicators:

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<thead>
<tr>
<th>Indicator</th>
<th>Overall Baseline Data</th>
<th>Notable Observations</th>
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<tbody>
<tr>
<td>Average age at marriage</td>
<td>17.8 years (mean)</td>
<td>75% respondent women married at 15-19 yrs. Early marriage more prominent in Bihar and Jharkhand.</td>
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<tr>
<td>Pregnancy registration</td>
<td>100%</td>
<td>Angan Wadi Worker (AWW) most preferred personnel for registration of pregnancy followed by ANM and ASHA.</td>
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<td>Ante Natal Care (ANC)</td>
<td>60% had 3 ANCs</td>
<td>Bihar and Rajasthan had lower records of ANCs</td>
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<tr>
<td></td>
<td>35% has 1-2 ANCs</td>
<td>SCs and Muslims had lower records of 3 ANCs</td>
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<td>More than two-third (69%) of the women reported to have taken TT injections during the first ANC check up.</td>
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<td>Proportion of women who had their first check up within first trimester was lower among Muslim women (66%) and higher among women from others social groups in the study (75%).</td>
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<td>Household (HH) visit by outreach health workers during pregnancy</td>
<td>50% women reported being visited by ANM/ASHA/AWW</td>
<td>AWW most likely to visit pregnant women, followed by ANM and ASHA.</td>
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<td>HH visits by health workers were less in Jharkhand and Rajasthan states and to Muslim women.</td>
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<td>Place of delivery</td>
<td>Overall 32% at home, 21% each at PHC and District hospitals. Only 8% gave birth at sub-centre and 10% at CHC (block level).</td>
<td>Delivery at home higher in Chhattisgarh (46%) followed by Bihar (43%).</td>
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<td>Assistance during last delivery</td>
<td>45% assisted by doctors, 38% by ANM and the rest by traditional birth attendants (TBAs). Only 43% accompanied by ASHA workers.</td>
<td>Majority of the deliveries in Odisha assisted by doctors (77%). About half of the deliveries were assisted by ANM in Bihar. Relatively lesser proportion (35%) of Muslim women assisted by doctors.</td>
</tr>
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</table>
NOTES

► Such as NRHM (National Rural Health Mission), ICDS (Integrated Child Development Services), PDS (Public Distribution System) etc.

► Information about SC/ST population was collected from NGO partners/ Files shared by Oxfam/ Census 2001

► Calculated at USD with average prevailing conversion rate of INR 60 = USD 1.

► Reservation in India is an affirmative action- it sets aside a certain percentage of government jobs and vacancies in educational institutes for members of backward and historically excluded communities.

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