Male Engagement as a Strategy to Improve the Delivery and Utilization of Maternal, Newborn & Child Health Services:

{Evidence from an intervention in Odisha, India}

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Background

- India is falling short of the Millennium Development Goal (MDG) 5 on improving maternal health by 2015.

- The National Rural Health Mission (NRHM) was launched to support provision of accessible, affordable and quality health care in deprived and underserved communities.

- Accredited Social Health Activists (ASHAs), local women, are trained as health promoters to generate demand for, and facilitate access to MNCH care in their communities.

- Gender-based power inequalities in reproductive health decision-making are a fundamental constraint to women’s access to reproductive health services and a barrier to improved health outcomes.

- Being females, ASHA’s reach to the male members of the community is limited.
Objectives

- **The aim:** describe the influence of a male engagement project on the utilization and community-based delivery of MNCH care in a rural district of India.

- Specific questions:
  
  - To what extent did male CHWs complement the work of their female counterparts and filled important gaps in community MNCH service delivery?
  
  - What is the perceived influence in the community of male CHWs’ engagement with men on the utilization of MNCH services?
The Intervention

• Male Health Activists (MHA) project implemented in the district of Keonjhar in the State of Odisha, in 205 villages in 6 out of 13 blocks of the districts, representing a population of about 600,000.

• Launched in February 2011, for approximately two years.

• Intervention designed to overcome some of the challenges ASHAs face in delivering their services.

• Recruitment and training of 205 male CHWs known as MHAs to complement the work of ASHAs and target outreach to men as a way to extend community-based delivery of MNCH services.

• The State of Odisha is among the six states with higher rates of maternal and child deaths; Keonjhar district has some of the worst MNCH indicators, ranks 24th out of the 30 districts on the human development index.
ASHAs are unable to respond adequately to the community level needs in MNCH care due to security issues as well as gender barriers. ASHAs (and other health-workers) are supported in the delivery of community-based services. Improved home-based care practices and increased use of facility-based services. Improved coverage of MNCH services.

**Intervention**

Male household level decision-makers (husbands) take informed MNCH care decisions.

**Line of accountability**

Male health activists are paired with ASHAs to mobilize communities and facilitate access to MNCH services through a supportive role; in particular MHAs work with men to improve their involvement in household level MNCH care.
Data & Methods

- Qualitative data from the endline evaluation of the MHA intervention

- In-depth interviews (in Nov-Dec 2012) with:
  - ASHAs (n=11)
  - Anganwadi Workers [AWW] (n=4);
  - Auxiliary Nurse Midwives [ANM] (n=2)
  - women who had delivered at home, community health centers, or district hospitals (n=11)
  - husbands of such women (n=7).

- MHAs were also interviewed, but the data is not used in this paper

The data for this paper is based on the following themes:
- Challenges and difficulties with access to and provision of MNCH care;
- Opportunities for increased access to, and provision of MNCH care;
- Perceived roles of MHAs;
- Positive and negative aspects of MHAs’ work
Results

Respondents’ narratives reflected gender-based divisions of work and space in three core areas of delivery and use of MNCH services:

1. Escorting women to health centers for facility-based deliveries;

2. Mobilizing women and children to attend Village Health and Nutrition Days and Immunization Days; and

3. Raising awareness among men on MNCH and family planning
**Escorting women to health centers for facility-based deliveries**

- Most of the intervention villages are located in forest and hilly areas and are not connected with motorable roads, making it impossible for the free transport system provided under the NRHM framework or private vehicles to reach pregnant women. A woman who recently had a facility delivery commented:
  
  ‘In the night ASHA Maa [ASHA] can’t go anywhere, ASHA Bapa [MHA] is Purusha [meaning male] so he can go, he can help everything’

- Once at the facility, female and male CHWs roles were seen by men as complementary. An ASHA argued:
  
  ‘He [MHA] cannot enter in to the delivery room. He brings the medicine which is required and all things he [the health professional] tells; he [MHA] tells the husbands. I can convince the mothers but not the husbands’.
Mobilizing women and children to attend Village Health and Nutrition Days and Immunization Days

MHAs played facilitative roles in the planning and implementation of Village Health and Nutrition Days (VHNDs) and Immunization Days, the centerpieces of community-based MNCH service delivery. One of the ASHAs commented:

‘There is a jungle in the middle way; the far away village is atop the hill and a single woman alone can’t go. But he [MHA] goes alone by cycling and keeps the cycle in the mid-way and climbs the hill’.

An AWW was more emphatic:

‘We have many households here and there; he [MHA] being a male goes by the cycle and calls them. We girls cannot go to all the places, so he can cycle all the houses and get the reports.’
Raising awareness among men on MNCH and family planning

- Respondents viewed MHAs as opportunity to engage with men on family planning and MNCH issues

- Most female CHWs interviewed pointed to increased engagement of MHAs with men, which to some degree, resulted in positive behavior change. An ASHA reported:
  ‘... the husbands [...] avoid and shout at us. He [MHA] convinces the males more. Men used to say that ASHA is coming and misguiding our wives. But the MHA makes them sit and he tells them that it is for your good only. Whenever he does they understand’

- However, most women reported not knowing if MHAs talked to their husbands or not
Limitations

- Lack of baseline data

- Possible bias in recalling the situation that prevailed before the introduction of male CHWs by the project
Conclusion

• **New insights regarding barriers** that continue to limit the scope and reach of the ASHA program

• **Complementarity of male and female CHWs** in the delivery of, and increased demand for, MNCH services

• Facilitative roles of MHAs suggest including male CHWs as a part of the NRHM’s model for increased delivery of, and demand for MNCH services

• Female CHWs are performing important roles in challenging places to improve MNCH outcome

• The introduction of male CHWs to reinforce these successes as shown by this study, **should operate in ways that do not contribute to widening gender inequalities** in favor of men that are rampant in many rural communities in the developing world.
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• Evaluation was conducted by Options Consultancy Services, UK and its in-country partner, DCOR Consulting, India.

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