Recognizing Maternal Health as a Community Issue
Using a Survey Tool to Develop Social Accountability Interventions Amongst Community Leaders in Three Districts of Gujarat

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SAHAJ (Society for Health Alternatives), a non-government organization (NGO) and two other partner NGOs have been working since 2012 with tribal and marginalized communities in three districts of Gujarat to strengthen social accountability for maternal health. This paper discusses the results of an evaluation conducted during April 2016-March 2017 to assess the changes in community leaders' knowledge, attitudes and understanding towards maternal health.

The evaluation was conducted in 45 control and 43 project villages. This evaluation assessed the effectiveness of the NGOs' interventions (from a gender and rights perspective) wherein the organizations' staff disseminated focused messages about maternal health, government entitlements, and strategies for improving accountability among community members. The evaluation consisted of three components: a baseline quantitative survey (April 2016), longitudinal qualitative research consisting of participant observation of periodic review meetings and field activities (April 2016-March 2017), and an end-line survey (March 2017).

Significant improvements were seen in knowledge levels of antenatal care (ANC) services available, high-risk symptoms, handling emergency obstetric situations, maternal-health entitlements, and maternal death reviews. Significant improvements were also seen in views and understanding towards maternal health as a Gram Sabha (village council) issue and on the responsibilities of the Panchayat (village government) towards maternal health. There was also an increase in the number and variety of maternal health issues discussed in Gram Sabha meetings and increased participation of community members and local health system-actors.

In a setting with community organizations and strong NGO support, systematic multi-method dissemination of key maternal health messages, along with discussions and actions through the Panchayat, can succeed in making maternal health a community issue.

Keywords : Maternal health, community action, social accountability, Panchayat, Gram Sabha, Gujarat

In 2015, the world was transitioning from the Millennium Developmental Goals (MDGs) ending in December 2015 to the Sustainable Developmental Goals 2030 (SDGs) adopted in September 2015 by the United Nations General Assembly. Around this time, India hosted the 'Global Call to Action Summit-Ending Preventable Child and Maternal Death' in August 2015 demonstrating

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India's commitment to SDGs, specifically improving maternal health and achieving the SDG target of reducing maternal mortality ratio (MMR) to less than 70 per 100,000 (PTI, 2015).

India's MMR declined from 560 per 100,000 live births in 1990 to 167 in 2011-13 (RGI-SRS)[2] (Press Information Bureau [PIB], 2015). However, India accounts for 17 per cent of global maternal deaths, and shows a wide disparity in maternal mortality ratios across states and income groups (El-Saharty & Ohno, 2015). In the state of Gujarat in Western India, MMR decreased from 122 in 2010-12 to 112 in 2011-13. In terms of the percentage of reduction of maternal mortality ratio, Gujarat ranked 11th with 30 per cent reduction amongst the 15 larger states of India (Comptroller and Auditor General of India, [CAG], 2016).

Several initiatives and programmes have been started by the government of India to achieve the Maternal Health targets of SDGs. These include programmes such as the Village Health and Nutrition Days (Government of India [GoI], 2007), and the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) launched in 2016 which mandates antenatal clinics by a Medical Officer and private Obstetricians and Gynecologists, on the 9th of every month (GoI, 2017). In 2011, the Government of India launched the Janani Shishu Suraksha Karyakram (JSSK) (GoI, 2013) which assures cashless antenatal care, deliveries, and neonatal care in public health facilities up to 30 days after birth.

It is therefore surprising that recent data from the National Sample Survey Organization (NSSO 71st Round) indicates that families were incurring 'Out of Pocket Expenditure' to the extent of around Rs. 2750 (average of rural and urban OOPE)[3] for childbirths in the public sector facilities (NSSO 71ST Round, January-June 2014). Other studies have also confirmed the poor quality of maternal health services in government health facilities, out of pocket expenditures in spite of JSSK, lack of awareness on various maternal health entitlements and poor functioning of village health and sanitation committees (Neil, Naeve, & Ved, 2017, Chattopadhyay, Mishra, & Jacob, 2017, Jan Swasthya Abhiyan [JSA], 2017).

Government programmes such as the JSSK are stated to have built-in grievance redressal mechanisms. However, they often fail to be accountable to the users and to the local communities. The government's monitoring system does not pick up the ground realities. This is why social accountability through 'health literacy' becomes important especially for community leaders who can play an active role in demanding quality services.

Social accountability is an approach towards building accountability that relies on civic engagement. In social accountability it is the ordinary citizens and/or civil society organizations who participate directly or indirectly in demanding accountability (World Bank, 2004). Health literacy as developed by Ratzan and Parker (2000) is, "the degree to which individuals can obtain, process, and understand basic health information and services to make appropriate health decisions" (as cited in Flaherty, 2011). An essential prerequisite for citizens to engage in demanding accountability is for them to be aware of their rights and entitlements through various government schemes and programmes.

[2] The sole source of data for fertility and mortality in India.

[3] An average of Rs. 5544 was spent per childbirth in rural areas, and Rs. 11685 in urban areas. The average amount spent per childbirth as an in-patient of a private hospital (almost Rs. 17,000 in rural and Rs. 22,000, in urban) was more than nine times of that spent in the public hospital (Rs. 2600 in rural and Rs. 3100 in urban) in both rural and urban area.

Successful community participation and mobilization strategies have been observed earlier with women's groups in states like Odisha and Jharkhand in India. In these states, Ekjut, a non-governmental organization, used participatory approaches to develop knowledge, skills and 'critical consciousness' of women's groups for better maternal and neonatal health outcomes (Rath et al., 2010). A four-country study by Prost et al., (2013) that included India concluded that 'with the participation of at least a third of pregnant women and adequate population coverage, women's groups practicing participatory learning and action are a cost-effective strategy to improve maternal and neonatal survival in low-resource settings.' Recent studies have recommended working with women's groups as a way of reducing maternal mortality and achieving better maternal health outcomes (Global Health Vision, 2015, Perry et al., 2015, Lunze et al., 2015, Mangham-Jefferies et al., 2014, Azad et al., 2010). A rights-based approach to maternal health interventions in recent years has been mostly about strengthening community voices (Dasgupta et al., 2015, Bayley et al., 2015).

Learning from such efforts and with the intention of making maternal health into a community issue and responsibility, SAHAJ, an NGO based in Vadodara, Gujarat, with her partner organizations implemented during 2016-18, the second-phase of an ongoing maternal health accountability project.

About the project

'Ensuring better maternal healthcare outcomes through community action and social accountability mechanisms' was a partnership of SAHAJ, Vadodara with two other organizations, ANANDI (Area Networking and Development Initiatives) working in Dahod and Panchmahals districts (two of the most deprived districts of Gujarat) and KSSS (Kaira Social Service Society) working in Anand district. Both ANANDI and KSSS work with poor and marginalized communities. The project involved marginalized groups in the study areas and adopted a gender, equity and rights perspective. During the first-phase of the project from 2012- February 2016, the project raised the consciousness of service users on their entitlements to quality antenatal, delivery and postpartum care. The first phase produced five report cards on the quality of maternal health care as reported by pregnant and lactating women. The report cards documented an overall poor quality health care services and facilities (George, Sri, & Ved, 2016).

During Phase two of the project, we aimed at involving community leaders to further the cause of maternal health issues in the community. Community leaders for our intervention study were defined as: leaders from the village self-help groups (SHGs), leaders of women's collectives (Sangathan)[4] and Panchayat members (with a preference for women Panchayat members). What did these leaders think was their responsibility towards pregnant women in their village? Did they as leaders feel that they had any role to play in ensuring maternal health?

We designed a formative evaluation of knowledge, attitudes, and practices of community leaders to help us to plan the project activities, and the key messages to increase their 'maternal health literacy' and motivate the leaders towards their responsibilities. The baseline evaluation became a guide for deciding the focus areas and developing the intervention plans and visual materials. Following this, there were intensive inputs for nine months (June 2016 to February 2017), wherein

[4] SHGs are women's Self-Help Groups who do savings and credits through their monthly meetings. Sangathan is a federation comprising of two leaders from each SHG, and representatives of the Village Development Committee. The Sangathan also meets every month to discuss different issues brought up by the members. For the intervention, these monthly meetings were an important forum for discussing messages related to maternal health and for promoting community action.

key messages were disseminated through different methods like discussions through innovative learning games, distribution of pamphlets, campaigns, wall paintings and other visual materials along with meetings and focus group discussions. Also, ongoing support and hand-holding were provided to the community leaders before the Panchayat and Gram Sabha meetings.

Phase Two of the project thus became an intervention study with the objectives of a) formative evaluation of the community leaders' knowledge, attitudes, and practices related to maternal health, b) a series of field level activities to enhance these, and c) an end-line survey to assess the changes. Table 1 gives details of the interventions involved in the two phases and Table 2 gives a brief description of the study areas.

Table 1: Interventions in Phases One and Two

Project period	Stakeholders	Project activities
Phase 1: 2012-2016	-Pregnant and lactating women -Women from self-help groups and collectives -Village Development Committees -Health system providers	-Community meetings for maternal health awareness -Educational materials developed like birth preparedness poster, Toran (banner type) on antenatal services, a documentary film on traditional birth attendants (Hoyani) -Community monitoring of maternal health services through 'healthy mother' tool, VHND monitoring checklists of services provided -Community participation in maternal death reviews -Community Dialogues and Meetings with field level health workers and officials
Phase 2: 2016-2018	In addition to the above, -Panchayat and Gram Sabha members	In addition to the above: -Conducting surveys -Raising maternal health issues in Panchayat and Gram Sabha meeting through women and community leaders -More educational material developed like posters on high risk symptoms, women's views on safe delivery, antenatal services; pamphlets on maternal health entitlements; board games; wall paintings -Strengthening community action and accountability -Improving relations with field level health workers -Dissemination of project outcomes

Table 2: District Wise Study Design and Sample Selection

S. No	Dahod and Panchmahals Districts (under ANANDI) (poorer districts)	Project activities	Project
1.	Area context: This is a poor, rural and tribal belt, amongst the poorest districts of India with challenging socio-economic context. Many villages are situated far off from roads, and they have poor transport facilities.		
2.	Selection of villages	Villages where the maternal health project is not directly implemented in Phase 2, but some villages may have been part of Phase 1	Villages where ANANDI was working on the maternal health project in Phase 1
3.	Number of villages	25	23
4.	Number of respondents at	Baseline- 123 Endline- 117 Total- 240	Baseline- 120 Endline- 114 Total- 234
5.	Taluka/Blocks chosen	Baria (Dahod) and Goghamba (Panchmahals)	
6.	No. of PHCs, Sub-centers and population covered in the project area	Four PHCs and 14 Sub-centres. Population covered 33,602	
7	Category of respondents	Around 24-32 per cent Panchayat members (percentages varied at baseline and end-line and also between control and project villages) Rest SHG/Sangathan women leaders	
8.	Gender of respondents	Around 80-90 per cent were women (percentages varied at baseline and end-line and also between control and project villages)	
S.No.	**Anand District (under KSSS)** ***(better off district)***	**Control**	**Project**
1.	Area context: This is a more urbanized district and socio-economically a better-off district. The district has very good road connectivity and transport facilities. The government health infrastructure is adequate, and there is a flourishing private sector.		
2.	Selection of villages	Villages where KSSS never worked and no other NGO worked on maternal health	Villages where KSSS was working in Phase 1. These villages were selected for Phase 2.
3.	Number of villages	20	20
4.	Number of respondents at	Baseline- 97 Endline- 103 Total- 200	Baseline- 96 Endline- 99 Total- 195
5.	Taluka/Blocks chosen	Anand and Umreth	
6.	No. of PHCs, Sub-centers and population covered in the project area	Four PHCs and 11 Sub-centres. Population covered 73,819	
7.	Category of respondents	Around 38-43 per cent Panchayat members (percentages varied at baseline and end-line and also between control and project villages) Rest SHG/Sangathan women leaders	
8.	Gender of respondents	Around 78-80 per cent were women (percentages varied at baseline and end-line and also between control and project villages)	

Methodology

Study design

The study adopted a quasi-experimental before-after design in selected areas of three districts of Gujarat, as shown in Table 2. The quantitative data from the surveys were triangulated with observations during ongoing field activities and supervision visits by the SAHAJ team. Monthly reports of the partners' teams, as well as quarterly review meetings, also provided rich qualitative information.

Sampling

Project and control villages were selected after discussions with the field teams based on logistics and outreach. The project villages selected were the villages where KSSS and ANANDI were currently working on the maternal health project, while the control villages included villages where the maternal health project had not been implemented.

Respondents - women leaders from SHGs and women's Sangathan (collectives) and Panchayat members (especially women members) - were selected purposively based on their availability and willingness to participate in the survey. Only verbal consent was taken by the teams.

As far as possible, vocal leaders were chosen as respondents. This is because many women Panchayat leaders are elected against the women's reservation quota (33 per cent of total seats) and do not have the competence to be leaders. So male family members often run the show.

Five respondents were selected from each village: two from Panchayat and three from at least two SHGs/ Sangathan. If a Panchayat member could not be contacted after some visits, they were replaced with an SHG/ Sangathan member. Further details related to the study design and sample selection are given in Table 2.

In the end-line survey, attempts were made to interview the same respondents, but because of non-availability of all the original respondents, some new members exposed to the maternal health activities had to be taken. Also, Panchayat elections took place after the baseline survey and some new Panchayat members had to be included in the end-line survey.

Baseline data collection was done in March-April 2016 and end-line in April 2017 in 45 control villages (N=220 at baseline and end-line) and 43 project villages (N= 216 at baseline and 213 at end-line) across three districts.

Study team

The ANANDI and KSSS field staff – local women familiar with the dialect, with minimum 12 years of schooling and considerable community organizing experience - were oriented to the survey tool and trained to ask questions and fill in the forms. Training sessions were held at their offices and in the field by the SAHAJ team. During actual data collection, the SAHAJ team accompanied them to provide on-the-job support and suggestions for improvement. Coordinators from the two partner organizations also closely monitored their teams.

Research tools and data analysis

The survey form included questions on knowledge and attitudes or perceptions based on topics or issues where we wanted to bring about changes. The form was finalized after several revisions and pre-testing in the field. The final version covered a range of issues the following issues:

- knowledge of antenatal and postnatal services
- indications of high-risk pregnancies
- symptoms of obstetric complications
- maternal health entitlements/schemes
- the nearest primary health centre
- perspectives on the responsibility of self and of Panchayat members towards maternal health
- importance of Gram Sabha meetings on maternal health issues
- maternal death reviews.
- functioning of and funds allocated to Village Health and Sanitation Committees.

The survey tool had mostly close-ended questions with one open-ended question.

Calculating knowledge levels: The number of correct/incorrect responses were converted to scores and coded as poor and good levels of knowledge.

Statistical analysis: Frequencies (Mean±SD) were calculated with independent t-tests to see the mean differences in knowledge levels using Statistical Package for Social Sciences (SPSS). Significance (P value) was taken at $\leq .05$. (Table 2 about here)

The findings based on the baseline and end-line comparisons were discussed in a review workshop with the three partner teams. The teams referred back to their monthly reports and their field notes to incorporate qualitative information and explanations.

Limitations

One limitation of the formative study was that the NGOs are not research organizations and thus lack the confidence to carry out a 'research study'. The analysis was initially done in terms of simple frequencies based on which interventions could be initiated. Later towards the end of the project period, further analysis was done, and tests of significance applied.

Another limitation is that while the partner organizations follow highest standards of respect, participation and informed decision making in their community-based work, and the same standards were applied to this intervention study, a formal ethical review was not done because of unavailability of a research ethics review committee.

Findings

The following thematic sections present some of the main survey findings, supported by qualitative analysis of documentation of outcomes based on monthly reports, field visit reports and periodic review meetings of partners.

Knowledge and attitude related to maternal health care

Improvements were seen more in the project groups about knowledge related to ANC services, symptoms of high risk during pregnancy, and handling emergencies during deliveries. (Table 3 about here)

The poor knowledge levels reflected in the baseline survey exposed the need to make community leaders aware of the free ANC services and importance of the Village Health and Nutrition Day (VHND). The issue was addressed through dialogues, meetings using games and visual media like posters and wall paintings to inform them of their rights. This eventually made the community leaders and the pregnant and lactating women demand the services including diagnostic tests and medicines, and facilities (including infrastructure and better roads, water facilities and electricity) and also demand improvement in the quality of care.

Lack of knowledge of high-risk symptoms during pregnancy at baseline also emerged as another important issue. With the inputs mentioned above, the knowledge levels improved significantly in all the project villages as seen. The reports of the field staff showed that women and their families were better prepared to deal with emergencies and if necessary, the Female Health Workers were informed to provide extra care.

A majority of the respondents had poor knowledge levels at baseline about handling complications during delivery. As a result of the interventions to create community awareness about emergency situations and how they could help, lists of villagers who were ready to donate blood and to provide emergency transport, were made in many villages and displayed in the Panchayat office. The community leaders became aware that they could help the women merely by accompanying them to health facilities. Community leaders, especially the Panchayat members, revealed that they had never considered this as a part of their responsibility, or imagined that they could be of help in such situations.

In all the districts, respondents in the intervention villages felt that Maternal Death Reviews (MDR) should be carried out. They had improved knowledge levels and knew at least one of the following: that MDR helps to reduce maternal deaths; increase accountability; improve quality of health services. They also understood that it should be done by both, government officials and the community.

Table 3: Knowledge and Attitude Related to Maternal Health Care

Knowledge & Perceptions	Per cent scoring	Poorer districts				Better-off districts			
Where can you get each of the ANC services?		**Control**		**Project**		**Control**		**Project**	
		Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
	Poor	89.4	71.7	80.3	29.8	19.6	21.9	72.8	34.3
	Good	10.6	28.3	19.7	70.2	80.4	78.1	27.2	65.7
	P –value	0.000*		0.000*		0.697		0.000*	
Can you name the various high risk symptoms?	Poor	80.5	65.0	70.1	15.8	95.9	90.6	90.3	10.1
	Good	19.5	35.0	29.9	84.2	4.1	9.4	9.7	89.9
	P –value	0.007*		0.000*		0.147		0.000*	
Do you know what all can be done to handle emergency situations?	**Poor**	82.9	75.8	77.8	57.0	99.0	92.7	86.4	8.1
	Good	17.1	24.2	22.2	43.0	1.0	7.3	13.6	91.9
	P –value	0.173		0.001*		0.029		0.000*	
Can you tell us why you think MDR should be done?	**Poor**	91.9	85.8	78.6	58.8	99.0	93.8	93.2	44.4
	Good	8.1	14.2	21.4	41.2	0.0	6.2	6.8	55.6
	P –value	0.136		0.001*		0.053		0.000*	

*p<0.05

Knowledge related to government schemes and entitlements

By the time of the end-line study, respondents from project villages in all districts could name the various maternal health entitlements. The flyers and board games on entitlements specially created to spread awareness were highly appreciated in these villages.

Table 4: Can You Tell Us About the Benefits Under Each Maternal Health Schemes, and Who Can Get These Benefits? Per Cent Responses

Poorer districts	**Janani Shishu Surksha Karykram (JSSK)**							
	WHOM				**WHAT BENEFITS**			
	Control		**Project**		**Control**		**Project**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Correct answer	**0.9**	4.3	4.1	2.7	0.9	0.0	4.1	1.8
Incorrect answer^	99.1	95.7	95.9	97.3	99.1	100	95.9	98.2
P Value	0.227		0.000*		0.000*		0.000*	
	Janani Surksha Yojna (JSY)[10]							
	WHOM				**WHAT BENEFITS**			
	Control		**Project**		**Control**		**Project**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Correct answer	50.5	23.9	46.9	32.4	45.7	29.3	39.8	53.2
Incorrect answer^	49.5	76.1	53.1	67.6	54.3	70.7	60.2	46.8
P Value	0.000*		0.000*		0.001*		0.000*	
Better off district	**Janani Shishu Surksha Karykram (JSSK)**							
	WHOM				**WHAT BENEFITS**			
	Control		**Project**		**Control**		**Project**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Correct answer	**5.5**	0.0	18.0	6.2	5.5	0.0	14.0	5.2
Incorrect answer^	94.5	100	82.0	93.8	94.5	100	86.0	94.8
P Value	0.001*		0.000*		0.022*		0.003*	
Better off district	**Janani Shishu Surksha Karykram (JSSK)**							
	WHOM				**WHAT BENEFITS**			
	Control		**Project**		**Control**		**Project**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Correct answer	18.2	16.0	22.0	69.1	25.5	33.9	26.0	76.3
Incorrect answer^	81.8	84.0	78.0	30.9	74.5	66.1	74.0	23.7
P Value	0.282		0.015*		0.436		0.005*	

^ Including Don't know responses

*$p<0.05$

Regarding the Janani Shishu Suraksha Karykram (JSSK)[5] scheme – an important programme to prevent any out of pocket expenditure on pregnancy, childbirth and newborn-related health care through public sector facilities - in all three districts most did not know the details/components or eligibility or answered incorrectly, even at the end-line.

For Janani Suraksha Yojna (JSY)[6] , respondents in all three districts had better knowledge (compared to JSSK) in both control and project villages at baseline. However, the better- off district had better scores by end-line compared to the poorer districts.

Attitudes and perceptions related to maternal health

Responsibility of self towards maternal health

When asked what the respondents thought about their responsibility towards maternal health, by end-line, besides the general answer that they would 'help in emergencies,' a higher proportion of respondents in the project villages mentioned that they would donate blood, (not mentioned at baseline). In the project villages, the end-line answers included: blood donation, helping by giving/arranging for money, accompanying the pregnant women, calling 108[7] /ANM, providing information on schemes and making blood donors' lists. None of the respondents mentioned 'Don't Know' during the end-line - they were able to think of some responsibility towards maternal health.

Table 5: What Do You Think Is Your Responsibility Towards Maternal Health? Per Cent Responses

Poorer districts	**Control**		**Project**	
	Baseline	**Endline**	**Baseline**	**Endline**
Donate blood	1.6	6.7	0.8	10.5
Will help during emergency	69.9	47.5	75.2	61.4
Awareness regarding health	22.8	31.7	11.1	21.9
Others*	25.2	27.5	22.2	44.7
Don't know	8.1	17.5	12.0	0.9
Poorer districts	**Control**		**Project**	
	Baseline	**Endline**	**Baseline**	**Endline**
Donate blood	3.1	1.0	2.9	34.3
Will help during emergency	57.7	32.3	56.3	82.8
Awareness regarding health	15.5	24.0	23.3	48.5
Others*	22.7	53.1	31.1	74.7
Don't know	12.4	15.6	13.6	-

As multiple answers, simple frequency percentages calculated
Others*: Would accompany/send someone, take her to hospital, call 108, call doctor, give own vehicle, money etc.

[5] Janani Shishu Suraksha Karyakaram (JSSK) scheme includes free and cashless delivery (including C-section, free medicines, diagnostics, food, blood provision, and transportation

[6] Under the JSY, eligible pregnant women are entitled to cash assistance irrespective of the age of mother and number of children for giving birth in a government or accredited private health facility.

[7] Emergency Government ambulance service

Role of Panchayat members in maternal health

Regarding what could be the Panchayat's responsibility for maternal health, some district wise variations can be seen. The project villages had better scores by end-line compared to control villages; the change is more marked in the better off district. During the review meeting to discuss the findings of the end-line survey, the field teams attributed this to the intensive community discussions and use of materials such as the board game developed to facilitate such discussions. The field reports also revealed that the Panchayat members admitted that they were increasingly clearer about their roles to safeguard maternal health in the community.

Table 6: Attitudes and Perceptions Related to Maternal Health

Knowledge & Perceptions	per cent scoring	Poorer districts				Better-off districts			
What do you think can be the Panchayat's responsibility towards maternal health?		Control		Project		Control		Project	
		Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
	Poor	96.8	93.3	100.0	80.7	100.0	100.0	95.1	53.6
	Good	3.2	6.7	0.0	19.3	0.0	0.0	4.9	46.4
	P –value	0.221		0.000*		-		0.000*	
In the Gram Sabha that you attended was there any discussion on maternal health?	Poor	27.1	26.3	28.9	62.5	6.3	17.1	4.9	36.5
	Good	72.9	73.7	71.1	31.3	93.7	63.4	95.1	63.5
	P -value	0.554		0.164		0.190		0.000*	

*p<0.05

Maternal health in Gram Sabha meetings

Making maternal health a wider community issue was one of the main objectives of this project, and this could be achieved to a great extent. Table 6 shows that in the baseline, more than 93 per cent in Anand, the better off district, said that maternal health was not included in the Gram Sabha agenda. By end-line survey, there was more discussion in both groups, but it was significantly higher in the project villages, while in the control villages there was hardly any change.

The most important aspect of maternal health issues being discussed in the Gram Sabha meetings is how the quality of discussions changed from the baseline to the end-line. The baseline responses, in both project and control villages, indicated general discussion around nonspecific issues like general health, vaccination, malnutrition, the importance of institutional delivery and maternal health schemes of the government.

In the end-line survey, newer subjects of discussion were included, for example: high risk conditions in pregnancy, the negative consequences of tobacco-use in pregnancy, the consequences of anaemia in pregnancy, maternal death reviews, pregnancy detection, early registration, ANC services,

importance of regular ANC check-ups, diet and nutrition during pregnancy, women's health and diseases, blood availability in emergencies, services provided on Village Health and Nutrition Days (VHNDs), opening of bank accounts for pregnant women to enable cash transfers related to health schemes, irregular visits by village nurses, infrastructure issues related to PHCs and sub centres such as toilet, light and water facilities for pregnant women and demand for more sub centres.

So in sum, there were significant improvements in the knowledge, attitudes, and perceptions related to maternal health issues, in the respondents from the intervention villages. However, it is worth noting that such changes in knowledge and attitudes were also found in the control villages in all three districts. The influence on control villages was more pronounced in ANANDI's field area because the control villages had the presence of the Mahila Sangathan. The internalization of issues by the team members and the Sangathan's monthly meetings, and the annual Livelihoods and Food Security Campaign led to the diffusion of the messages to the non-project villages. The KSSS members also reported that the staff of the entire organization had so internalized the maternal health issue that team members working in control areas were also spreading maternal-health-related messages.

Discussion

Maternal health care is a women's human right. How can communities be mobilized to recognize this right and respond to it? How can maternal health be made a public issue beyond the boundaries of the family and the household? These were the concerns that motivated the present intervention.

The baseline survey tool helped to identify gaps in knowledge and perceptions of community leaders regarding maternal health and related services. The findings of the baseline survey constituted the basis for developing the interventions, specific activities and key messages for the changes that were envisaged. The baseline tool also succeeded in raising the curiosity of the respondents and provoked them to begin thinking about some of the issues.

Participatory learning activities to address the gaps were developed and successfully implemented with a rights-based approach. The overall results were improvements in the knowledge, attitudes, and perceptions related to maternal health issues, especially amongst the community leaders from the project villages. The enhanced knowledge through the project activities led to demands for better services through social accountability mechanisms of community monitoring and dialogues with health care providers. Papp et al., (2013) report similar results from efforts focusing on the role of local women, intermediary groups, health providers and elected politicians (Papp, Gogoi, & Cambell, 2013). Flores's study also discusses how methods drawing on community participation and collective action were most effective in influencing responsiveness from authorities. (Flores, 2018). By involving the community and its leaders in all aspects of maternal health - pregnancy registration, accessing antenatal services, safe delivery, and social autopsies of maternal deaths if they occurred - helped to make it a community issue and also improved the quality of services and institutional deliveries.

Some lessons that can be learned from this project include designing interventions that enable local government institutions to put maternal health on their agenda and to respond to women's claims as rights holders. Diffusion of the information on entitlements through the community-based organizations (women's collectives and federation of village development committees) helped

promote awareness of rights and a culture of accountability. Social accountability as demonstrated through this project was not limited to demanding answerability of the health care providers but was extended by the action of women's collectives to demanding accountability from the village institutions the Gram Sabha, Panchayat, Village Health, Nutrition, Sanitation Committees. This exemplifies Yamin's proposition, "adopting a rights-based approach requires demanding and opening of spaces for women to exercise choices and subverting the social - and power relations - that deny them their full humanity" (Yamin, 2010).

Our experience has shown that with some hand-holding to build capacities of the local women leaders to speak up and raise questions, women begin to draw upon the strength of their collectives and occupy mandated spaces and also create new spaces to articulate their issues. Preparatory meetings with the women Panchayat members and with leaders of women's collectives resulted in them attending the Panchayat meetings and the Gram Sabhas with greater confidence and articulating their issues as rights claimants. A big challenge was to gain access to and make the Panchayat leaders aware and pro-active on maternal health issues. During the duration of the project, as elections were held, new members were elected, and the cycle of awareness generation had to be repeated. We realized the importance of an ongoing and institutionalized system of Panchayat members' education of their responsibilities towards maternal health. Another related learning was that overall the Panchayat system is fraught with many fundamental problems – the larger political system does not appear to want local self-governance and decentralization to work. The devolution of powers has not happened to ensure true democracy to function. In this larger context, our project was too ambitious in its aspiration to make it work for women in the short time that we had. As an outcome of our learnings one partner, in fact, decided to work more intensively to enable grassroots democracy with Panchayat members.

Another insight gained was that while monitoring of the implementation of schemes by communities is a critical feature of social accountability, reflecting the participation and voice of users, this cannot be a substitute for internal accountability within the health system. The responsiveness of frontline health providers is possible if internal monitoring, supervision and demanding corrective action systems are in place. The Medical Officer and the Female Health Worker will attend the Gram Sabha meetings if the Taluka Health Officer also deems that these are important. As Fox points out (Fox, 2016), social accountability, and community monitoring will help solve short-term, simpler and local level health system problems. Higher level policy changes to do with human resources and budgetary issues may not be amenable to community demands unless these acquire the shape of a larger mass-based political movement for 'health for all.'

The limitation of the study was that the project period was too short to ascertain how much of the momentum would be sustained and what would be required to sustain it.

Conclusions

This project showed that key focused health promotion interventions with a limited range of key community actors even in a short time frame can be successful in bringing about the desired results. Through the baseline and end-line evaluations of an 18-month field-based project in tribal and rural districts of Gujarat, we saw that Panchayat leaders and Gram Sabhas could be made to respond to maternal health issues of local women in project areas. Scaling up this successful model would require government commitment at a policy level, and this is a challenge that needs to be addressed.

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References

Azad, K., Barnett, S., Banerjee, B., Shaha, S., Khan K., Rego, A. R., Barua, S.,…..Costello A. (2010). Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: acluster-randomized controlled trial. The Lancet, 375(9721), 1193–202. Retrieved December 2, 2017 from http://journals.plos.org/plosone/article/file?type=supplementary&id=info:doi/10.1371/journal.pone.0055012.s001

Bayley, O., Chapota, H., Kainja, E., Phiri, T., Gondwe, C., King, C.,…..Colbourn, T. (2015). Community-linked maternal death review (CLMDR) to measure and prevent maternal mortality: a pilot study in rural Malawi. BMJ Open, 5(4), e007753. doi: 10.1136/bmjopen-2015-007753. Retrieved March 6, 2018 from http://bmjopen.bmj.com/content/5/4/e007753

Comptroller and Auditor General of India. (2016). Report of the Comptroller and Auditor General of India on general and social sector for the year ended March 2016. Report No. 7 of 2016. Government of Gujarat. Retrieved December 1, 2017 from http://www.cag.gov.in

Chattopadhyay, S., Mishra, A., & Jacob, S. (2017). 'Safe', yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India. Culture, Health and Sexuality, 3, 1-15. DOI: 10.1080/13691058.2017.1384572

Dasgupta, J., Sandhya, Y. K., Lobi, S., Verma, P., & Schaaf, M. (2015). Using Technology to Claim Rights to Free Maternal Health Care: Lessons about Impact from the My Health, My Voice Pilot Project in India. Health and Human Rights: An International Journal. 17(2), 135-147. Retrieved March 5,2018 from https://www.hhrjournal.org/2015/12/using-technology-to-claim-rights-to-free-maternal-health-care-lessons-about-impact-from-the-my-health-my-voice-pilot-project-in-india/

El-Saharty, S. & Ohno, N. (2015, January 13). South Asia's quest for reduced maternal mortality: what the data show. World Bank Group. Retrived November 29, 2017 from http://blogs.worldbank.org/health/south-asia-s-quest-reduced-maternal-mortality-what-data-show

Flaherty, M. (2011). Health literacy: An overview of an emerging field. SLIS Student Research Journal, 1(2), Article (4), 3. Retrieved December 1, 2017 from http://scholarworks.sjsu.edu/cgi/viewcontent.cgi?article=1034&context=slissrj

Flores, W. (2018). How Can Evidence Bolster Citizen Action? Learning and Adapting for Accountable Public Health in Guatemala. Accountability Research Center. Accountability Note 2. Retrieved March 6, 2018 from http://accountabilityresearch.org/web/wp-content/uploads/2018/02/Accountability-Note2_English_2-22-18.pdf

Fox, J. (2016). Scaling accountability through vertically integrated civil society policy monitoring and advocacy, Brighton: IDS. Retrieved March 6, 2018 from https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/12683/ScalingAccountability_Online4.pdf?sequence=4&isAllowed=y

George, A., Sri, S. B, & Ved, R. (2016). Strengthening people-centered services through improved accountability. The enabling community action for maternal health project in Gujarat, India. SAHAJ and CommonHealth. March 2016.

Global Health Visions. (2015). Country case study: India. In-depth landscape analysis of accountability for maternal and newborn health in India. Global Health Visions. Retrieved November 29, 2017 from http://globalhealthvisions.com/India_Country_Case_Study_MNH_Accountability.pdf

Government of India, Ministry of Health & Family Welfare, National Rural Health Mission (2007). Monthly Village Health Nutrition Day. Guidelines for AWWs/ASHAs/ANMs/PRIs. National Rural Health Mission 2005-2012, Ministry of Health & Family Welfare, Government of India. Retrieved March 6, 2018 from http://www.nrhmorissa.gov.in/writereaddata/Upload/Documents/VHND_Guidelines.pdf

Government of India, Ministry of Health & Family Welfare, National Health Mission (2013). Janani Shishu Suraksha Karyakram (JSSK). National Health Mission, Ministry of Health & Family Welfare, Government of India. Retrieved March 6, 2018 from http://nhm.gov.in/nrhmcomponnets/reproductive-child-health/jssk.html

Government of India, Ministry of Health & Family Welfare (2017). Pradhan Mantri SurakshitMatritva Abhiyan. National Health Portal. Ministry of Health & Family Welfare. Retrieved November 13, 2017 from https://pmsma.nhp.gov.in/

Jan Swasthya Abhiyan Gujarat. (2017). Health rights in Gujarat: field level enquiries. Steering Committee, JSA Gujarat (Eds.). PATHEY Centre for Budget Analysis and Jan Swasthya Abhiyan Gujarat. March 2017.

Lunze, K., Higgins-Steele, A., Simen-Kapeu, A., Vesel, L., Kim, J., & Dickson, K. (2015). Innovative approaches for improving maternal and newborn health - A Landscape analysis. BMC Pregnancy Childbirth, 15(1), 337.doi: 10.1186/s12884-015-0784-9

Mangham-Jefferies, L., Pitt, C., Cousens, S., Mills, A., & Schellenberg, J. (2014). Cost-effectiveness of strategies to improve the utilization and provision of maternal and newborn health care in low-income and lower-middle income countries: a systematic review. BMC Pregnancy and Childbirth, 14, 243. doi: https://doi.org/10.1186/1471-2393-14-243

National Sample Survey Organization. (2014). Health in India. National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India. NSS 71st Round, (January – June 2014). Retrieved December 12, 2017 from http://mospi.nic.in/sites/default/files/publication_reports/nss_rep574.pdf

Neil, S. O., Naeve, K., & Ved, R. (2017). An Examination of the Maternal Health Quality of Care Landscape in India. Mathematica Policy Research. March 2, 2017. John D. and Catherine T. MacArthur Foundation. Retrieved March 11, 2018 from https://www.macfound.org/media/files/50268_Landscape_Report_2017.03.02.pdf

Papp, S. A., Gogoi, A., & Campbell, C. (2013). Improving maternal health through social accountability: a case study from Orissa, India. Global Public Health, 8(4). doi: https://doi.org/10.1080/17441692.2012.748085

Perry, H., Morrow, M., Borger, S., Weiss, J., DeCoster, M., Davis, T. & Ernst, P. (2015). Care Groups I: an innovative community-based strategy for improving maternal, neonatal, and child health in resource-constrained settings. Global Health: Science and Practice, 3(3), 358-369. doi: http://dx.doi.org/10.9745/GHSP-D-15-00051.

Press Information Bureau. (2015, July 24). Achievements under Millennium Development Goals. Press Information Bureau,

Ministry of Health and Family Welfare, Government of India. Retrieved December 1, 2017 from http://pib.nic.in/newsite/PrintRelease.aspx?relid=123669

Prost, A., Colbourn, T., Seward, N., Azad, K., Coomarasamy, A., Copas, A., ….Costello, A. (2013). Women's groups practicing participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. Lancet, 381, 1736–1746. doi: http://dx.doi.org/10.1016/S0140-6736(13)60685-6

PTI. (2015, August 27). Call to action summit: 184 districts identified for focused healthcare, says PM Modi. The Indian Express. Retrieved November 29, 2017, from http://indianexpress.com/article/india/india-others/call-to-action-summit-clean-hygienic-environ-is-the-stepping-stone-to-a-healthy-nation-says-pm-modi/

Rath, S., Nair, N., Tripathy, P.K., Barnett, S., Rath, S., Mahapatra, R.,…Prost A. (2010). Explaining the impact of a women's group led community mobilization intervention on maternal and newborn health outcomes: the Ekjut trial process evaluation. BMC International Health and Human Rights,10, 25. doi: https://doi.org/10.1186/1472-698X-10-25

World Bank. (2004). Social accountability: an introduction to the concept and emerging practice. The World Bank, Social Development Paper No. 76. Washington. Retrieved on December 1, 2017 from http://documents.worldbank.org/curated/en/327691468779445304/pdf/310420PAPER0So1ity0SDP0Civic0no1076.pdf

Yamin, A.E. (2010). Toward transformative accountability: applying a rights-based approach to fulfill maternal health obligations. International Journal of Human Rights, 7. Retrieved December 12, 2017 from https://www.researchgate.net/publication/279668315_Toward_Transformative_Accountability_Applying_a_Rights-based_Approach_to_Fulfill_Maternal_Health_Obligations