Male engagement as a strategy to improve the delivery and utilization of maternal, newborn and child health services: Evidence from an intervention in Odisha, India

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1. Background

Despite the sharper pace of decline in maternal mortality ratio (MMR) during the recent period (2006-2012), India will fall short in meeting the maternal health Millennium Development Goal (MDG) by 2015 [1,2]. While the trend in under-five mortality rate seems to be in congruence with the MDG target, the increase of the share of neonatal deaths in under-five deaths from 41% to 55% between 1990 and 2012, and the persistent high levels of neonatal causes which accounted for about 43% of all under-five deaths in 2013, remain a cause of concern [2,3]. Equally important are the wide geographical disparities that persist in India's maternal, newborn and child health (MNCH) indicators. The recent estimates suggest that MMR varied from as low as 66 per 100,000 live births in the State of Kerala to 235 in Odisha and 328 in Assam. Besides, under-five mortality remains more than 80% higher in rural India than in rural areas [1,4,5].

In response to persistently poor levels of maternal and child health in rural India, the National Rural Health Mission (NRHM) was launched in 2005 as a framework for the provision of accessible, affordable and quality health care in deprived and underserved communities in rural areas [6,7]. At the center of the Reproductive and Child Health (RCH) Programme, which is run under the umbrella of NRHM, are the Accredited Social Health Activists (ASHAs), local women trained as health educators and promoters to generate demand for, and facilitate access to MNCH care in their communities. The RCH Programme also acknowledges the central role of men in women's reproductive health, training health workers to provide husbands of expectant women with information on maternal and child health care and family planning [4,6].

Women's autonomy and rationale for male engagement in rural India

In India and other parts of the developing world, gender-based power inequalities in decision making around care-seeking have been acknowledged as a fundamental constraint to women's access to reproductive health services, and ultimately, a hindrance to efforts to improve health outcomes [8, 9]. In these settings, women are largely dependent on their husbands for health-related decisions, making the behaviour, knowledge and attitudes of men an integral element of the reproductive health status of the family [8,10,11]. According to India's 2005/06 National Family Health Survey, the main reason pregnant women did not make ANC visits or did not deliver in a health facility is that husbands did not think it was necessary or did not allow it. The report concludes that men's participation in maternal health care needs to be strengthened, and the information provided to men needs to be more comprehensive [12].

The programme of action developed at the 1994 International Conference on Population and Development (ICPD) emphasized the need for equity in gender relations, especially men's

shared responsibility and active involvement to promote reproductive and sexual health [12,13]. During the 1980s indeed, there was an increasing recognition that men were an important factor in the health of women and children [13], and through abuse or neglect, their actions had direct consequences on the health of their partners and their children [14,15]. Overall, husbands' social support and perceived social norms were identified as underlying factors associated with delivery care utilization [15, 16]. As a result of this awareness, there was a paradigm shift after the ICPD meeting from "men as clients" to "men as partners", with the former entailing the need to address men's reproductive health needs, and the latter emphasizing the central role men play in supporting women's health, and implying recruiting men and raising their awareness about danger signs in labor, transportation plans, the benefits of family planning for women's health, among others [13].

While many studies have shown that well-designed male involvement health programmes have the potential to generate changes in attitudes and behaviours of men [12], a number of barriers to male involvement in maternal and child health have been identified. The most prominent barriers include low levels of knowledge, social stigma, shyness and embarrassment, work obligations, hospital's restrictions on the husband's entrance into most areas of the hospital, and lack of communication between husbands and wives [17].

The aim of this study is to examine the influence of a male engagement project on the delivery and utilization of MNCH care in a rural district of India. Specifically, the research questions guiding the analysis are: To what extent did male CHWs complement the work of their female counterparts and fill important gaps in community MNCH service delivery? What is the perceived influence of male CHWs engagement with men on the utilization of MNCH services and their overall acceptability in the community?

The Male Health Activists project: Overview

The project was designed to overcome some of the challenges ASHAs face in delivering their services, in particular encouraging men to take a more active role in the health of mothers and children. It consisted of recruiting and training male community health workers known as Male Health Activists (MHAs) to complement the work of female ASHAs and target outreach to men as a way to extend community-based delivery of health services for women, neonates and children. The aim of the project was to improve the coverage of MNCH services delivered by the formal health care system, and improve home-based management of MNCH, and care-seeking for prevention and treatment services.

The project was implemented in Keonjhar district in the State of Odisha which is among the six states with high rates of maternal and child deaths. In terms of health outcomes, 12 out the 13 blocks in Keonjhar are classified by NHRM as RCH difficult or high focus blocks, with two of these (Banspal and Harichandanpur) considered by the government as the most difficult in terms accessibility and low service utilization. The selection of the project sites was guided by the 'vulnerability' index developed by NHRM which classifies each village on a 5-point scale

(with V0 being least vulnerable and V4 being most vulnerable). In consultation with the local government officials, the project selected a total of 205 villages ranked V2-V4 in six out of a total 13 blocks of Keonjhar District, representing 22% of all V2-V4 villages. The area covered by the project had a population of about 600,000 and represented 20% of all V2-V4 villages' population [18]. The pilot was launched in February 2011 for a period of approximately two years. A total of 205 MHAs (one per village, on average) were recruited, trained and paired up with ASHAs.

2. Methods

Data source

This study uses data from the evaluation of the MHA intervention which relied primarily on endline qualitative investigations. Specifically, we use data from eleven In-depth interviews (IDIs) with ASHAs in the intervention area; with eleven women in project sites who had delivered at home, community health center or district hospital in the few months preceding the date of the interview; and with seven husbands of such women. The interviews with women and men were designed to assess knowledge, attitudes and behavior related to RMNCH, and to understand MHAs' involvement and the support (or lack thereof) they provided. The interviews with ASHAs, on the other hand, sought to understand the role and relationship of MHAs vis-à-vis other health workers, and to assess the type and extent of support provided by MHAs. The interviews were conducted by locally-based interviewers who used pre-tested semi-structured guides in the local language (Odiya). Responses were audio-recorded, transcribed verbatim and translated to English. Informed consent was obtained from each respondent after describing the study objectives.

Data coding

The data for this paper was coded manually, based on five themes which emerged from the data and the interview guides: Challenges and difficulties faced with access to and provision of MNCH care; Opportunities for increased access to, and provision of MNCH care; Perceived roles of MHAs; and Positives and negative aspects of MHAs' work. The third author of the paper conducted the coding.

3. Results

The data show that male CHWs greatly complemented the work of ASHAs, especially with regard to facilitating access to facility delivery, mobilizing women and their children to attend Village Health and Nutrition Days, and raising awareness of men on maternal, newborn and child care.

Access to skilled birth attendance

Almost all ASHAs interviewed stressed the crucial role played by MHAs around and during delivery, especially at night when they facilitate transport and provide security, a role that female CHWS would hardly assume. An ASHA while regretting the lack of support from husbands some of whom spend their time drinking and getting drunk, remarked: '*To take the*

patient during the night is something I can't do; now the vehicle also is not there, he can arrange a vehicle from somewhere outside. So whatever happens, he (MHA) helps with.'

Support with transport for night deliveries was also largely echoed by some of the women interviewed as a justification of the role of MHAs.

> *Because in the middle of the night they will go to the hospital no matter how far it is…or will make phone calls. Why is it good that they stay? In the night…he can go running for the patient [Women in Banspal who recently had a facility delivery].*

The data also indicate that once at the facility, MHAs handled some tasks outside of the delivery room as needed, which range from keeping track of the family's personal items, obtaining medicines, and in cases where a blood transfusion was necessary, acting as an advocate to obtain donated blood, as evident from this response from an ASHA.

> *Male ASHA [MHA], he is a male; how can he touch the female? He does all other work like getting the medicine and other things which the Doctor writes, he gets those things, and shops are bit far.*

Raising awareness among men

Most female CHWs interviewed pointed to increased engagement of MHAs with men, which to some degree, resulted in positive behavior change. An ASHA noted: '*After his appointment, the husbands who do not understand, whatever we say they 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*'. The interviews with men, and with women to a lesser extent, did not seem to confirm this trend. In general, most women reported not knowing if MHAs talked to their husbands or not. Men on the other hand, seemed too busy with work and other activities, and as a result, did not pay close to the invitations made by MHAs.

Support to Village Health and Nutrition Days

The role is MHAS in community mobilization for health events was illustrated by the following quote from a woman we interviewed: *'the far away village is atop the hill and there is a jungle in the middle way. 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.'*

5. Conclusion

These findings suggest that community health strategies that include male CHWs specially trained and equipped with tools to engage with men are likely to be effective.

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