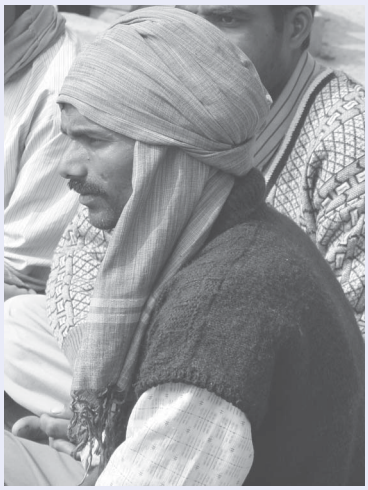
PRIME II Voices

Involving Men in Partnerships for Safe Motherhood

"Now there is no conflict. The man is not in a position of taking the side of his wife or his mother… they are all thinking on a similar track."



Healthier birth practices and newborn care, with improved reproductive health outcomes, are more readily assured when all the household's decision makers are informed and agree about what to do during an obstetric or neonatal emergency. Reaching out to men is a key component of the PRIME II Project's strategy to increase the number of pregnant women and families who take steps to prepare for births and possible complications in Uttar Pradesh, India.

Most births in rural areas of Uttar Pradesh take place at home, without the presence of a skilled health provider. Modern medical care and emergency services are often out of reach without advance planning for transportation and funds. To create a framework for community and household mobilization and empowerment, PRIME II collaborated with Shramik Bharti, a local nongovernmental organization, to introduce Community Partnerships for Safe Motherhood (CPSM) in 11 villages and 29 hamlets of Maitha Block, a rural region near the city of Kanpur.

The CPSM model relies on democratically elected community health committees and trained village health guides. The committees and guides register pregnant women, facilitate access to prenatal and postpartum care during visits by public-sector auxiliary nurse-midwives, help identify transportation resources and establish emergency loan mechanisms. Home birth teams—often the pregnant woman and her mother-in-law—attend training workshops led by the village health guides, in which they learn to recognize and respond to critical complications of labor, delivery and newborn care. Integration of postpartum family planning counseling and services with improved maternal health care is emphasized in the CPSM model.

Developed by the American College of Nurse-Midwives, a PRIME II supporting institution, the six Home-Based Life-Saving Skills (HBLSS) modules used in the training workshops focus on changing deep-seated beliefs and behaviors regarding prenatal and postpartum care, paying special attention to postpartum hemorrhage and neonatal sepsis. Highly visual "Take Action Cards" facilitate sustained recall of the HBLSS messages.

PRIME and Shramik Bharti specially adapted the HBLSS training for workshops with male community members. Qualitative data from interviews with participants reveal the effects of these sessions in changing the nature of household negotiations about behaviors during pregnancy, planning for a birth and deciding what to do in the case of complications. Men stated that they now felt responsible not only for such pragmatic tasks as arranging transportation and financing in the event of an emergency, but also for taking action as a member of their home birth

team. "Females are hesitant to explain and discuss their complications," emphasized one participant. "If male members understand the home-based life-saving skills information, problems can be solved more easily."

Workshop participants also mentioned the impact of focus groups in which the men talked about local women who had died or suffered complications during or after a home birth. These concrete and familiar examples were used to illustrate that promoting healthier practices might mean doing things differently from "the way we always have" or "the way my mother did." As a CPSM field facilitator summed up, "We felt that if only women were trained, it would not be possible to solve the problem of reducing maternal mortality. Because we know and we have read… and we have seen the mentality that India has a male-dominated society."

While ensuring referrals for life-threatening problems—and reliable and affordable transportation to referral facilities—remains a challenge, an evaluation of the CPSM program in Uttar Pradesh shows that healthier practices have indeed been successfully encouraged. Women who had completed the HBLSS series were significantly more likely to put their newborn to the breast within one hour of birth (76% as opposed to 2% at baseline)—a break from centuries of local tradition. The women were also more likely to accept tetanus toxoid injections (76% vs. 37%) and accept a modern family planning method in the immediate postpartum period (61% vs. 14%).

Fostered by the home birth teams and village health committees—and the consensus within households encouraged through involving men in the CPSM model—these positive trends promise healthier and safer pregnancies and deliveries for the women of Maitha Block, with far-reaching application of these successful strategies around the world.

The PRIME II Project, funded by USAID and implemented by IntraHealth International and the PRIME partners, works around the world to strengthen the performance of primary providers as they strive to improve family planning and reproductive health services in their communities.

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