

## Facilitating Gender Friendly Spaces around Maternal and Child Health Care

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### Abstract

Traditional health practices, lack of skilled care services and strong patriarchal norms in the families are preventing women from enjoying their Right to Health particularly the Reproductive health. Contextual need therefore is identification and address of root causes both at societal and systemic level. The paper presents experience of an action research done jointly by APMSS and Care India-AP. Implemented in 380 villages of 7 districts in combined AP State, it aimed to create women friendly spaces within the household by building social norms around reproductive health. Target families were those having pregnant women, lactating mothers and children of the age 7 months to 2 years. Implementation strategies were: Targeted interventions at family level for facilitating change in gender roles, Systemic/Institutional interventions to mainstream the change process, Community level interventions to sustain the momentum and to create enabling environment. Presence of strong women's collective (*Sangham*) at village level taking responsibility of implementation was the core element. APMSS and Care India-AP extended resource support. Village level institutions (PRIs, AWC) supported *Sanghams* and actively participated in the programmes. Despite challenges, overall results were promising in breaking myths around maternal health and in bringing more men into the women and child care roles. Certain systemic practices like NH day were streamlined. The project demonstrated the need for participatory approaches in development as against welfare model, particularly in women's health sector.

*Keywords: Pregnancy, maternal health, gender friendly spaces*

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Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Sustainable Development Goal<sup>1</sup> 3 targets to “Reduce the global maternal mortality rate (MMR) to less than 70 per 100 000 births, neonatal mortality rate (NNMR) to 12 per 1000 live births”. WHO health fact sheets under maternal health show that in 2017, approximately 810 maternal deaths occurred due to preventable causes relating to pregnancy and child birth. (WHO- Maternal Mortality, September 2019) The MMR in low income countries in 2017 is 462 per 100 000 live births versus 11 per 100 000 live births in high income countries. This higher number of maternal deaths reflects inequalities in gender, lack of quality health care services, and class variation between the rich and poor. In particular, young adolescents in the age group of 10-19 years face a higher risk of complications in pregnancy and child birth compared to women in the age group of 20-24 years.

Corresponding to this, if we glance at our country’s gender gap status in health and survival attainment indicator, we are in 150<sup>th</sup> rank in the Global Gender Gap Index 2020 (GGGI, WEF, 2020). As per the Sample Registration System (SRS) report by Registrar General of India for the last 3 years, India’s MMR in 2015-17 has been 122 and it was reduced to 113 per 100,000 live births in 2016-18. For Telangana, it was 76 and 63 respectively per 100,000 live births.

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<sup>1</sup> The Sustainable Development Goals are a call of all nations of the world to promote prosperity while protecting the planet. Out of the 17 goals identified, Goal 3 relates to Good health and wellbeing. Each goal sets targets and timelines to achieve the objectives. Goal 5 relates to Gender Equality.

(MoHFW, Maternal Mortality Rate, released by PIB, Delhi, 12 Feb 2021). Further the latest National Family and Health Survey (NFHS - 5) 2019-20 statistics also indicate similar trends.

**Table-1**

*Overview of the Telangana State statistics (NFHS- 5)*

<b>Indicator</b>	<b>Urban</b>	<b>Rural</b>	<b>Remarks</b>
Marriage before 18 years	16.7%	27.4%	Present age of sample is 20-24 years
Women age 15-19 already mothers/pregnant	3.1%	7.4%	
Sex Ratio at birth	873/1000 males	907/1000males	Children born 5 years prior to survey
Pregnant women who had antenatal care at least 4 times	71.1%	70.0%	
Consumption of IFA tablets during pregnancy	37.0%	32.7%	For a minimum period of 180 days
Institutional deliveries		96.6% (public facility 53.6%)	
Colostrum feeding		36.0%	
6 months exclusive breast feeding		73.4%	
Children given semi solid diet 6-8 months		50.1%	
Married women experiencing physical violence during any pregnancy		5.1%	18-49 years age group
Neonatal Mortality Rate	13.8%	18.8%	
Infant Mortality Rate	22.0%	29.3%	

*Source: NFHS survey – 5, Telangana - 2019-20 (rchiips.org – Telangana). Results of the Survey conducted from 30<sup>th</sup> June to Nov 2019 among a sample of 27,518 women, 3863 men across 27,351 house holds*

A critical reflection of the above figures indicates that traditional/cultural practices, taboos, rural-urban divide, poverty, low information levels, lack of skilled care before, during and after child birth, lack of decision making to women, inadequate health care facilities continue to be the major factors hampering maternal health status. Gender inequalities, patriarchal norms and values are the overarching reasons preventing pregnant women from enjoying their Right to Health. Thus arises the need for identification and address of the root causes both at societal and system levels in order to improve maternal health.

In this context, present paper tries to reflect on the experiences of a short duration (6 month) pilot project taken up during 2008-09 towards improving maternal health and examine its relevance in the present context. A partnership initiative by Andhra Pradesh Mahila Samatha Society (APMSS)<sup>2</sup> and Care India – AP<sup>3</sup>, it was implemented in 380 villages covering 19 mandals across 7 districts in the then united Andhra Pradesh state.<sup>4</sup>The objective was to create women friendly spaces within the household by building social norms around women and children's health care. It was envisaged that an enabling environment is created for male participation in child health and nutrition, workload will be shared within the household, women can take decisions with regard

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<sup>2</sup>APMSS was a part of Mahila Samakhya programme of GoI, initiated in 1989 as an outcome of the NEP 1987. The principal objective of the programme was "Education for Empowerment of Women". The programme was withdrawn by the Govt. of India in 2015-16 with the dissolving of five year plans. In the then united Andhra Pradesh State, the programme was launched in 1993 and extended phase wise. By the time of its closure, it was spread to 15 districts covering 8 districts of Telangana. The village level women's collectives – Sanghams were the forums for collective reflection, analysis and action. Health of women and children was the foremost issue identified by the women and accordingly several interventions were taken up. While women/sangham decided the direction of the programme, team members played facilitative role and built capacities of the grassroots women's collectives – Sanghams and Federations.

<sup>3</sup>Care India – AP is a unit of CARE, a not for profit organization working in India for the past 70 years focusing on alleviating poverty and social injustice. As part of its INHP component, CARE worked towards improving maternal and child health by collaborating with State government and ICDS programme.

<sup>4</sup>Medak, Mahabubnagar, Karimnagar, Nizamabad, Warangal, Srikakulam and Vizianagaram districts.

to the variety of foods to be consumed at family level and finally there would be strategic shift in gender and reproductive roles of men and women. Target families were identified as families with pregnant women, lactating mothers and children in the age group seven months to two years. Apart from these, adolescents and newly married couples were also identified while doing the village mapping for sensitization and creation of enabling environment for future healthy mothers and babies.

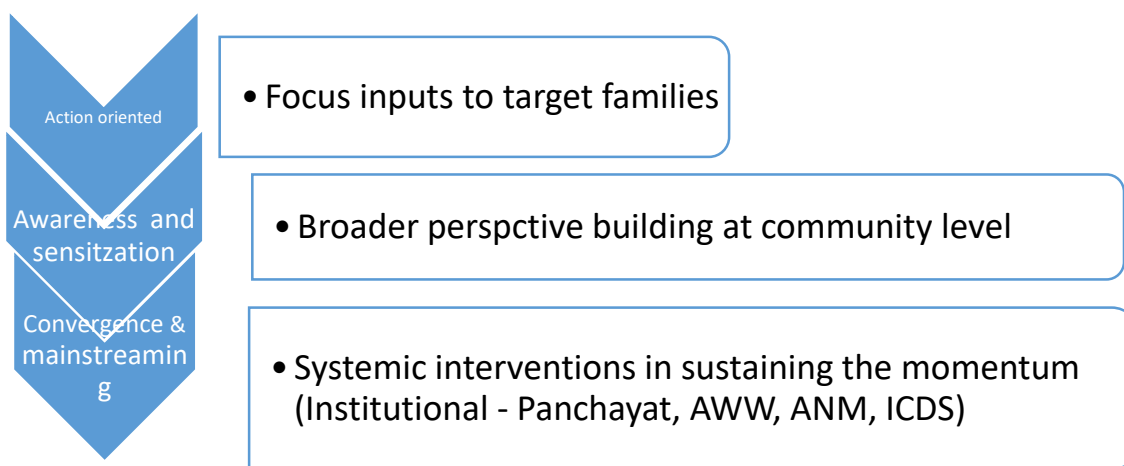
The project was designed as an action research titled, “*Gender Just Families*” (GJF) since the narrative was expected to produce methodologies, indicators and new evidence around gender factors influencing child feeding and caring in children below two years of age. The initiative also aimed to serve as an advocacy product for governments and other agencies to replicate towards having a gender just, enabling environment for child caring. Area of implementation was chosen to be such geographic areas common to INHP (Care India – AP) and APMSS at the mandal level. APMSS has a strong presence in all the identified villages and a good network of mandal level federations<sup>5</sup> in four of the 7 districts. The presence of federation and district teams ensured better coordination and support.

A Village Facilitator (VF) was identified to implement the activities and coordinate village level interventions. She was supported by the mandal and district coordinators of APMSS. The GJF project used VF to be the bridge between them and the community.

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<sup>5</sup>As the sanghams facilitated by APMSS grew strong, they federated at mandal level into forums and got registered as women’s organizations for bringing effective change in women’s position and condition. In one mandal each of Medak, Mahabubnagar, Karimnagar and Nizamabad districts respectively mandal level federations implemented the project directly with support from APMSS.

They were trained to interact with the target group and apprised of the methodology that would be used to conduct focus group discussions, role play, games and verbal exchanges (one-on-one and one-on-group) with men and women separately and jointly, as also with other influencers in the village such as PRI members, AWWs etc.. They also involved other family members, especially the mothers-in-law whose support was crucial if any difference had to be made in the women's life. Responsibility for selection of VF was thrust on the village level sanghams<sup>6</sup> who identified a representative on its behalf as a village facilitator who in turn would be supported by them and the mandal federation.



*Figure 1: The project model*

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<sup>6</sup>From the beginning of the project, it was clear that the village level sangham plays major role in implementation. Hence one sangham member who can give at least 20 days in a month for the 6 months was identified to work as VF. The selection criteria also included experience of working as ASHA worker/health resource group/committee member in the Sangham, capable of reading and writing and such woman who truly believes and understands the need to address gender stereotypic roles in mother and child care.

Another unique strategy followed by the project was the cluster approach. 4-5 villages were grouped into one cluster for effective skill building exercise. Project team from APMSS (District Programme Coordinator, respective mandal coordinator and VFs of the cluster) would gather in the cluster village for practical demonstration of conducting Focus Group Discussion (FGD). This improved skills and confidence of all VFs, especially those who needed further support to implement activities. Since APMSS had strong presence in the districts, clusters were already demarcated in the programme<sup>7</sup> and the same were adopted for this project.

Additionally use of wide range of IEC material like posters, banners, flipbooks, calendars, games, etc. helped in taking project objectives and messages clearly to the targeted population. They were developed keeping in mind the need for sensitization of communities on gender and women and children's health issues. Focus was on having a blend of materials that included textual, visual, pictorial and anecdotal content. There were also games like the *snakes and ladders* game which was adapted to the GJF project objectives. In any type of material, the messages were clear, easy to understand even by the illiterate/neo-literate people. Technical matters relating to child care, importance of hygiene while giving supplementary food, enhancing men's role, complications during pregnancy due to irregular health checkups, care during pregnancy, lactation, etc. were simplified to suit the needs of the targeted population.

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<sup>7</sup>In the process of facilitating mandal level women federations as collectives of village sanghams, cluster formed the intermediary level and acted as a unit of federation. 4 to 5 nearby villages were grouped into one cluster and one governing body member was elected from each cluster to the federation. APMSS facilitated clusters as units for capacity building of the village level sanghams.

*“I was unaware of the simple ways in which we could care for a pregnant or lactating mother. The training made me realize the importance of looking after the mother and new born in the initial months after delivery. I also learnt PLA methods like chapathi diagram and studying of the village map for identifying village problems.” - Anasuya, VF, Nizamabad.*

## Baseline Survey

Since it was a short duration project, basic indicators relating to project objectives were drawn as reference points and a quick baseline survey was taken up in the villages. Methodology was Participatory Learning Assessment (PLA) exercises, secondary data and an open ended questionnaire. Important observations both qualitative and quantitative are summarized below:

**Table 2**

### *Baseline Markers*

<b>Profile of Respondents</b>	<b>Information on pregnant women</b>	<b>Reproductive/Gender roles</b>	<b>Supplementary Nutrition to child – status</b>
Rural, low socio economic group, neo literate	33% pregnant women consumed less than 20 IFA tablets	39% women stated that men do not know nutritional needs of children.	7-8 months child – 36% gave thrice, 37% twice, 29% gave milk, 27% rice and only 6.3% fruits
Daily wage labourers –	94.7% pregnant women ate	28% of pregnant women’s husbands	9-18 months child – 53% gave 3 times, 22% 4 times



agriculture, construction	whatever food was available. Less than 45% ate vegetables. Only 2% could eat fruits, egg, milk, meat and fish.	decided what she should eat. 35% of pregnant women's mothers-in-law decided the food to be cooked/eat. 10% women took decision by themselves. Less than 3% took advice of ANM, AWW	and 4% five times. 43% gave rice, 15% milk, 11% cereal and 10% fruits. Less than 5% gave vegetables, homemade <i>Uggu/Ukkiri</i> or cerelac
Low/scanty information about services available for mother and child health,	Having knowledge about AWW services, NH day. Participation is very low/limited	7-8 month old - 78% of women took care of their child's needs. Only 2.3% fathers got involved. 9.3% took advice of AWW	9-24 months child – 40% gave 3 times, 33% 4 times and 13% 5 times. 50% gave rice, 13.04% milk and 10.12% fruits, 5% vegetables
Minimal participation in AWW activities, NH day	Limited accessibility to village level health services/systems	9-18 month old – 45% women decided the food given to child, 28 % mother-in-law and 8% took advice of AWW	
Prevalence of myths and taboos around child birth, nutrition, breast feeding			

The baseline survey enabled VFs to establish clear understanding of women's status and children's health issues in the village. It also helped unearth perceptions regarding men's role in health care. Based on these observations, they could map households that needed greater focus with respect to better care during pregnancy and of infants. Being members of sanghams they had an added advantage of familiarity with the socio-cultural norms of the villages and belong to the very village where they had to work with families and community.

## **Implementation Experiences**

In accordance with the three-pronged approach, activities were planned at regular and sequential intervals. Focus activities for targeted families included regular Home visits, FGDs with men, women and mixed group of the target families by the VF. Community sensitization was taken up through Gramasabhas and Ward meetings. Culminating these, community celebrations were held on special/festive occasions which involved competitions, food demonstrations, felicitations etc. Simultaneously systemic interventions like observation of Nutrition and Health Day (NH day) at AWC level, participation of the VF or the mandal/district team in ICDS Sector meetings in order to mainstream the project objectives and evince support from the administration through convergent action.

Since VFs resided in the same village they were able to interact with the community more regularly and follow-up on nutrition and health care matters. It was easier for them to engage in freewheeling discussions that provided insights on relationships and roles within the household, instances of gender bias or any other inequalities that might have persisted or good practices that any of the family members had adopted vis-à-vis pregnancy, women's health and child rearing.

VFs used constructive approach in initiating dialogues with men or elder family members including in-laws. The questions posed were on the premise that men cared for their wives and children, which made them introspect practical issues that were involved around

pregnancy and child care.<sup>8</sup> Without intimidating they were told about how in small ways they could step up their participation and contribute towards building a happy and healthy home.

Post discussion it was noticed that men had visibly shed some of their prejudices and were willing to at least engage in conversation presenting pros and cons of helping their wives and contributing within the household. Although there were some who remained silent, not wanting to comment on the subject, there were a few who tried to laugh the suggestion off and make light of it. However, the heartening thing was that the discussion challenged deep rooted social barriers. Domestic matters, usually considered private, had been brought to the surface. Issues that women dealt with at a physical, mental, emotional and psychological level were highlighted. Most of the audience concurred that they had not really paid attention to the burden that most women carried within the house, taking it for granted as given role of a woman. Further discussion on the issue contributed in they appreciating woman's role in the larger interest of the family and in understanding that they should share that burden thereby making her feel good about herself.<sup>9</sup>

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<sup>8</sup>Like for example when a man was asked, "do you know what your wife and children eat? Have you seen them taking their medicines and supplements during pregnancy and lactation and do you know if your child is immunized and if in response the man remained silent, it was a good starting point for taking up the issue of their active involvement in the lives of those who were central to their existence.

<sup>9</sup>At the end of the sessions most men agreed to outline a series of tasks that they could undertake with immediate effect. Some of these tasks included: lifting heavy items; purchasing fruits, eggs, non-vegetarian food, vegetables; fetching water; bathing children; changing clothes and preparing list of items to be purchased in consultation with their wife.

Where there were challenges in conducting FGDs, VFs adopted innovative approach of mixed group FGDs and cross sharing of women and men's expectations of each other on the reproductive roles. It gave an opportunity to women to express their support areas and for men to understand that they needed to do more. VF further elaborated the points and reiterated the importance of men's participation in health care issues. This led to men introspecting and realizing their role in supporting pregnant women and in child care issues.

Sensitizing community members through awareness meetings and Gramasabhas was another key component of the project. Methods of transacting messages were street plays, film shows, games and talks on various aspects of maternal and child health. Initially in many villages, community members did not show interest to participate. They felt that it was not culturally and socially acceptable to talk about these women's issues openly. VFs generated broader discussion on men and family's role in health care and gender balance within households while identifying gaps in the existing health care services in the village. Village local leaders, Sarpanch, Ward members, sangham women, AWW, ANM, ASHA worker attended and discussed village concerns relating to health. They also conducted nutrition and health education meetings for pregnant and lactating women and children. Need for convergent action between the village Panchayat and village health systems was emphasized towards reducing maternal and infant mortality rate, achieving total

immunization, and better access to AWC services, particularly the conduction of NH day once every month with every one's participation.<sup>10</sup>

*“I accompany my wife to the NH day every month and if I am unable to go, my mother goes. We make sure that we accompany and drop her. Whenever I am not going to work, I stay with her. Earlier we were not like this. But now, we like to participate in the NH day. We have learnt a lot about mother and child care.” –Raju, Ramakistapur, Warangal*

Community festivals like Saamuhika Sreemantham<sup>11</sup>, community dining, etc. were organized towards the end project phase with a view to bring momentum on the subject of mother and child health care, to educate women on the importance of nutrition and health care besides sensitizing all the stake holders from family to community. These were a great success in creating an enabling environment that could encourage, foster men's involvement in reproductive roles.

### **Challenges faced**

The whole process of implementation was not a smooth walk for the VF or the APMSS and Care India-AP teams. Key objective of the GJF project was to create an enabling

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<sup>10</sup> Nutrition and Health Day is organized at AWC every month and should be attended by the village sarpanch, ward members, ANM, AWW, ASHA worker, pregnant, lactating woman and children. Women are educated on services provided at the AWC and on the need to have early registration, maintaining growth monitoring of pregnant woman and children below 2 years, immunization, supplementary food distribution, hygiene, age at marriage, importance of hospital delivery, importance of hospital delivery, initiation of complementary feeding (age appropriate foods, quantity and quality) and nutritious food demonstrations. In the case of children not having age appropriate weight, counselling was done for mothers to improve children's nutritional status by the AWW and ANM.

<sup>11</sup> A ritual organized to celebrate pregnancy and child birth in the family. Department of WCD owned it to collectively celebrate at AWC for all pregnant women in the community.

environment through convergent action between the community and village level health institutions for bringing significant change in women and children's health issues as also initiate strategic shift in gender roles within the families. It was not easy for the men, elders and in many cases women themselves to look at gender roles in a different perspective. Many traditional/ deep rooted practices, myths and taboos surfaced during the discussions. Men could not be convinced that the world had changed and with women working outside the home and contributing to the family economy, they needed more support particularly during pregnancy and the initial 2 years of child care. Stigma associated with a man sharing reproductive roles or lending hand in domestic chores was difficult to break. Frequent household visits, discussions with families and communities using IEC materials, explaining the care required for women during pregnancy and child birth and extensive discussions through different formats made communities realize the need for participating in these issues shedding some of their perceptions if not all.

Adding to this, the AWW or the ANM felt threatened initially that the VF intruded into their boundary of work and they may be questioned for any inefficiency or lack of accessibility. Participation in the ICDS Sector meetings, intervention of district and State project teams from APMSS and Care India- AP cleared the cloud of suspicion, understand and support the project initiatives.

### **Project Outcomes**

The action research project is pilot based and implemented for 6 months from October 2008 to March 2009. Spread across 380 villages it was a task that involved collective strengths

of both partner organizations, more importantly field level federations and sanghams of APMSS. Though it was a short duration project, the results were surprising and contributed a long way in presenting a model for the village level systems and structures towards improving maternal and child health issues. Particularly in the context of the present day statistics in this area as stated in the beginning of the paper, this field level research experience presents a successful collaborative model between the Government and Civil Society Organizations at grassroots level that can bring desired outcomes.

The End line survey observed several changes in the way men and families had begun to respond to situations and the way communities perceived caring for women during pregnancy. Brief discussions with men folk in the villages revealed several changes in men’s attitudes towards gender roles in their households. The results of the End line survey taken up by Care India- AP are presented below:

**Table 3**

*End line Results*

<b>Qualitative Outcomes</b>	<b>Quantitative Outcomes</b>
Men were accompanying their wife for health checkups and were closely monitoring the growth of the newborn.	97.6% pregnant women received antenatal checkups. 68.2% respondents were informed of birth spacing methods by the VF.
Earlier pregnant women ate after all the family members had finished eating but now many women had started eating along with their family members. Earlier, there was hardly any conscious attempt to see if the woman was eating nutritious food or not. But post project, all family members ate at	75% women were advised by VF on new born care, 27.8% by ANM and 25% by AWW

the same time with some of the men actually overseeing what their wife was eating.

Increased family members' participation in NH day

Men became aware that nutritious food was important during pregnancy and that food like milk, eggs, vegetables, and green leafy vegetables, fruits, meat and fish should be added to the expectant mother's diet. There was maximum increase of fruits consumption in the last two pregnancies.

78.3% and 65.2% of women were informed of the complications due to heavy work load by GJF staff and ANM respectively.

Institutional delivery increased by 8.9% during the last two deliveries

Women learnt how to wrap the new born in a clean cloth to ensure the child was warm

Exclusive breast feeding for six months. Six months onwards complementary feeding was initiated with porridge, dal (pulses) water, rice and dal. The respondents understood that along with breast milk, supplementary feeding was necessary after six months. They were aware that immunization was provided but were unaware of the schedule. Only a few could recollect when polio drops were given. Post Endline, they had made note of the immunization records/schedule.

81.6% women attended NH day with their family members. 92.7% pregnant women and lactating mothers attended NH day – 28.1% for THR, 18.8% for measuring weight.

Consumption of green leafy vegetables (19.8%), milk (15.4%), eggs (28.8%), and pulses (26.4%) increased. 95.7% women received information about the importance of nutrition from GJF staff while 52.2% from ANM and 26.1% from village health worker

During current pregnancy, 75.6% women were accompanied by their husbands to ANC. 80% were accompanied by their husbands to the place of delivery.

87.8% pregnant women took decision regarding leisure and rest during pregnancy while 60.98% were advised rest by their husbands

95.1% women said that their husbands shared household work when they were pregnant. 80.5% women said their husbands fetched water, 75.6% women said their husbands monitored taking of IFA.

34.8% women had fed colostrum to their newborn.

73.9% mothers were aware of the nutritional needs of their child. 73.9% respondents got information on growth monitoring from GJF staff followed by 39.1% and 30.4% from ANM and village health worker respectively.



Husbands of lactating mothers in Mahabubnagar district reported that they purchased food items from outside based on the likes of their women. They even chopped vegetables and bathed older children while the wife was feeding and accompanied her to the hospital for check-ups.

91.3% respondents got the information on role of men in child care from GJF staff followed by 39.1% and 21.7% from village health worker and ANM

Attitudinal change among women - they felt that men could get involved in household activities: 87% said they could change clothes of the children; 26.1% said men could wash clothes; 82.6% claimed men could fetch water and 47.8% - could cook  
Increased convergence between village level institutions and health services in many villages. The changed relationship forged unity of services and helped in reaching out to the community more effectively.

8.7% home deliveries were recorded in the current pregnancy and 12.5% in the previous pregnancy

Of the 76.7% mothers who were informed about family planning, 63.6% by VF and ANM; 48.5% from AWW

## Breaking Myths

During home visits VFs observed that while it was relatively easy to convince men, it was difficult to convince the mothers-in-law. In these households, even if the men were convinced about helping at home or supporting their wife during pregnancy, it became difficult to do so openly, for fear of their mothers objecting, taunting or reprimanding them. It therefore seemed wise to first sensitize the mothers-in-law. Also most decisions pertaining to women and child care were taken by family elders and this was a long followed tradition within the family. For the VFs to initiate a discussion on the subject was sometimes fraught with resistance, denial and even anger. There were times when the mothers-in-law refused to see merit in an altered diet plan because she was convinced that what she had prescribed was vetted by earlier generations and could

therefore not be wrong. For example, elder women felt that feeding colostrum was harmful for the infant's health. Breaking these myths needed ingenuous rounds of talking and convincing. Another myth that was difficult to break was the belief that if pregnant women drank toddy, it would enhance fetal movement. This was practiced not only for mothers but also young children to ensure they got good sleep. This practice was dangerous as women and children would fall asleep for long hours and wouldn't have a chance to eat well. The field staff convinced many families that they could feed their children milk and not toddy and the babies would still sleep. They also explained that toddy could prove harmful and was best done without.

### **Some Voices**

*"If things continue like this, we hope to see a lot of smiling homes. It is a nice sight to see men and women share the domestic work load."* – Pochamma, VF, Medak

*"I learnt that pregnant women should not lift heavy weights. Now I insist on fetching water every morning and evening."* - Sailu, husband of Rama (pregnant, age - 23 years)

*"When I went to fetch water all my friends teased me and asked to me stop this as their wives would also ask them to do so; but I didn't. Seeing me at least 10 more men have followed suit."* - Balamallu, Venkatarapalli, Warangal

## **Project learnings**

Creating a society that sees men and women at the same level, be it at the family or community, is no mean task especially in a patriarchal society like India where gender roles are pre-defined. Making communities realize that women need additional care and support specifically during periods of pregnancy and childcare and enabling them to change their age old habits and share household work while engaging women in decision making processes pertaining to health and child care was a major challenge for the GJF project. Men agreed that women shared a greater burden during pregnancy and lactation period and that a change in attitude was necessary. While they understood that, they also found that it is difficult to break age old barriers of conditioning. They were afraid that they would be ridiculed and mimicked by their male friends. But with time, by illustrating households and individuals who had made the transition they began to ease out and started to overcome their reluctance.

Collaborative efforts of the village facilitators, mandal coordinators and support from the village sangham members, federations, AWWs, ANMs, and PRIs helped in creating enabling environment to facilitate attitudinal change in the gender perceptions of the society. It is a process and will take long time for sustaining. It can definitely be said that this pilot project has created initial momentum in that direction.

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