BREAKOUT ROOM 1

Contribution Analysis | Health Sector

Suraksha Mata Community Health Worker Programme, Madhya Pradesh, India

Evaluation Question

To what extent did the community health worker programme contribute to improved maternal health outcomes, and through what mechanisms?

Context for International Participants | This dataset is set in Madhya Pradesh, a large state in central India with a predominantly rural population and historically high maternal mortality rates. Community Health Workers (CHWs) — here called Sevikas — are a frontline health cadre deployed across South and Southeast Asia to bridge gaps between formal health systems and rural communities. The national scheme referenced (PM Suraksha Yojana) is a government cash transfer of INR 6,000 (approx. USD 72) paid to women who deliver in a health facility. ANMs (Auxiliary Nurse-Midwives) are government-employed paramedics who staff rural health sub-centres. VHNDs (Village Health and Nutrition Days) are monthly community outreach sessions. The MMR (Maternal Mortality Ratio) measures deaths per 100,000 live births. These structures and their tensions — between NGO-delivered programmes, government health systems, and national cash transfer schemes — are directly analogous to programme architectures in Sub-Saharan Africa, Southeast Asia, and Latin America.

SECTION A

Programme Document: Suraksha Mata Community Health Worker Programme

1. Background and Rationale

1.1 The Maternal Health Crisis in Madhya Pradesh

Madhya Pradesh (MP) has historically recorded some of India's highest maternal mortality ratios, driven by a complex intersection of factors: low rates of institutional delivery, inadequate antenatal care, poor nutrition, high anaemia prevalence among women of reproductive age, weak rural health infrastructure, and deep-seated cultural preferences for home delivery attended by traditional birth attendants (dais). Despite significant national investment in maternal health through the Janani Suraksha Yojana (JSY) and its successor PM Suraksha Yojana (PMSY), progress in MP has been uneven across districts and population groups, with tribal and remote populations consistently underperforming on key maternal health indicators.

In 2021, the state MMR stood at 173 per 100,000 live births — significantly above the national average of 97 and far from the Sustainable Development Goal target of below 70 by 2030. The six districts selected for the Suraksha Mata Programme — Betul, Harda, Raisen, Sehore, Vidisha, and Chhindwara — collectively accounted for 14% of MP's maternal deaths despite representing only 9% of its population, reflecting the disproportionate burden carried by predominantly rural, partially tribal districts with poor road connectivity and understaffed health facilities.

Formative research conducted by Aarogya Foundation in 2020–21 identified three primary barriers to institutional delivery in target districts: (1) distrust of public health facilities among first-time mothers and their families, rooted in documented experiences of disrespectful care, long waiting times, and informal payments demanded by facility staff; (2) logistical and financial barriers to reaching facilities, particularly for women in villages more than 10km from the nearest primary health centre; and (3) the gatekeeping role of male household heads and mothers-in-law in delivery decisions, which often overrode women's own preferences. Standard behaviour change communication campaigns had failed to adequately address these barriers because they targeted women individually without addressing the social and structural context of decision-making.

1.2 The Case for Community Health Workers

The Suraksha Mata Programme was designed on the premise that trusted, proximate, sustained contact between trained community health workers and pregnant women — beginning in the first trimester and continuing through the postpartum period — could address all three identified barriers simultaneously. CHWs drawn from the community would carry credibility that external health workers lacked. Regular home visits would enable relationship-building with families, including male household members and mothers-in-law. And CHWs equipped with information, facilitation skills, and linkage to transport subsidies would be positioned to reduce logistical barriers in ways that facility-based staff could not.

This model drew on documented evidence from analogous CHW programmes in Bangladesh (BRAC's Shasthya Shebika model), Ethiopia (Health Extension Workers), and MP's own prior experience with ASHAs (Accredited Social Health Activists) under the National Health Mission.

However, Aarogya Foundation's formative research identified a critical gap in the ASHA model as implemented in MP: ASHAs were incentivised primarily for facilitating deliveries rather than for the quality and continuity of relationship-building across the pregnancy continuum. The Suraksha Mata model was designed to correct this by providing Sevikas with a fixed monthly honorarium (INR 3,500) supplemented by smaller delivery-specific incentives, and by explicitly designing the performance management system around visit quality and continuity rather than delivery counts alone.

1.3 Funding and Organisational Context

The Suraksha Mata Programme was funded through a five-year grant of USD 4.2 million from the European Union's Global Health Initiative, with co-funding of approximately USD 800,000 from the Government of Madhya Pradesh's State Health Society under the National Health Mission. Aarogya Foundation, an Indian NGO with 22 years of experience in community health programming, served as the prime implementing organisation. The State Health Department was the formal government partner, providing integration with the public health system, access to government health data, and facilitation of CHW interactions with ANMs and Medical Officers at facility level.

The programme was designed to operate as a complement to — not a replacement for — the existing government ASHA programme. Sevikas were positioned as a supplementary cadre working in villages where ASHA coverage was thin or where ASHA performance had been consistently weak. This created an immediate tension in several districts, where ASHAs perceived Sevikas as competitors rather than collaborators, a dynamic that the programme design had anticipated but underestimated in severity.

A programme management unit (PMU) was established in Bhopal, headed by a Programme Director with district-level coordinators in each of the six target districts. A technical advisory committee comprising maternal health specialists, social scientists, and government representatives met quarterly to review programme data and advise on course corrections. An independent midterm evaluation was conducted in mid-2023 and a final external evaluation is currently in progress (this dataset is drawn from the final evaluation fieldwork).

2. Theory of Change

2.1 Inputs

The programme theory begins with a defined set of inputs: 240 trained Sevikas (40 per district), each covering approximately 5–6 villages and a caseload of 50–60 pregnant women annually; a smartphone-based case management application (SevikaCare) for visit logging, risk flagging, and supervisor communication; transport subsidies of INR 500 per woman for institutional delivery in facilities more than 5km distant; monthly Village Health and Nutrition Days (VHNDs) co-facilitated by Sevikas and government ANMs; a 12-day residential training curriculum for Sevikas covering antenatal counselling, danger sign recognition, facilitated referral, and postpartum care; and a layered supervision system comprising block-level supervisors (one per 20 Sevikas) and district coordinators.

2.2 Causal Pathway and Assumptions

The programme's theory of change operates through five linked causal steps, each resting on explicit assumptions that the evaluation is designed to test.

Step 1: Recruitment and Retention of Sevikas

Assumption: Women from target communities with secondary education and community trust can be recruited, trained to standard, and retained for the programme duration. This

assumption proved partially correct. Recruitment was largely successful — 247 Sevikas were trained against a target of 240, with Sevikas drawn from the programme's own target villages in 89% of cases. Retention, however, was more variable than anticipated. By programme end, 214 Sevikas remained active (87% retention), with attrition concentrated in Harda and Raisen districts, driven primarily by Sevikas finding better-paid employment in urban centres as COVID-19 restrictions lifted.

Step 2: Quality and Frequency of Home Visits

Assumption: Sevikas will make at least three home visits per pregnant woman per trimester, of sufficient quality to build trust and transfer actionable knowledge. Programme MIS data suggests an average of 4.2 visits per woman per trimester — above target. However, the midterm evaluation raised significant concerns about data quality: in Harda and Raisen, where smartphone app adoption was lowest, visit logs were frequently entered in bulk retrospectively. Independent spot-checks by the evaluation team found actual visit rates approximately 20–30% below logged rates in these districts.

Step 3: Shift in Knowledge, Attitudes, and Intentions

Assumption: Regular, trusted interaction with Sevikas will shift women's knowledge of danger signs and delivery options, and will shift family attitudes toward institutional delivery. The endline survey found significant improvements in knowledge of at least three ANC danger signs (from 31% to 74%) and stated preference for institutional delivery (from 58% to 84%). The evaluation design cannot definitively attribute these changes to Sevikas rather than to the broader information environment, including mass media campaigns, PM Suraksha Yojana promotion, and general health literacy improvements.

Step 4: Behaviour Change — ANC Uptake and Institutional Delivery

Assumption: Shifts in knowledge and family attitudes, combined with the removal of logistical barriers through transport subsidies, will translate into increased ANC attendance and institutional delivery rates. This is where the evidence is strongest but also most contested. Institutional delivery rates in programme districts rose from 61% to 78% over the programme period. However, comparison data from non-programme districts in MP show an increase from 58% to 71% over the same period — suggesting a secular trend that would have occurred without the programme, driven largely by PM Suraksha Yojana incentives and facility upgrades. The programme's incremental contribution is estimated at 4–7 percentage points above trend, though confidence intervals on this estimate are wide.

Step 5: Improved Maternal Health Outcomes

Assumption: Increased ANC attendance and institutional delivery will translate into reduced maternal and neonatal mortality and morbidity. The MMR in programme districts declined from 178 to 142 per 100,000 live births over the programme period — a reduction of 36 points. The state average declined from 173 to 156 — a reduction of 17 points. However, attributing the differential reduction to the programme requires ruling out numerous alternative explanations, including district-specific facility improvements, population compositional changes, and the quality of MMR recording systems, which varies substantially across districts.

2.3 Key Risks and Mitigation Strategies

The programme design identified seven key risks at inception. Three materialised in ways that required active management:

Risk 1 — ASHA-Sevika conflict: Partially mitigated through joint training sessions and a formal protocol establishing complementary rather than overlapping roles. In practice, conflict remained a persistent feature in Sehore and Vidisha, where ASHA incentive structures created competition for the same beneficiaries. The protocol was observed inconsistently.

Risk 2 — Technology adoption failure: The SevikaCare app was designed for low-literacy users with variable connectivity. Despite this, adoption remained below 60% in two districts throughout the programme. A paper-based parallel system was maintained, but supervisor attention was disproportionately focused on app data, creating a documented monitoring bias against Sevikas in low-connectivity areas. An internal review in 2023 recommended weighting paper and app data equally; this recommendation was implemented but only in the final six months of the programme.

Risk 3 — External shocks disrupting continuity: A severe drought in Raisen district in 2023 disrupted CHW visit schedules for approximately 4 months as Sevikas and beneficiaries alike were affected by livelihood shocks. The programme had a contingency protocol for natural disasters but it had not been operationalised before this event and its activation was delayed by approximately 6 weeks.

3. Implementation Model

3.1 Sevika Selection and Training

Sevika selection followed a community nomination process in which village-level committees — comprising Panchayat members, ANMs, and women's group representatives — proposed candidates meeting basic criteria: female, resident in the village, minimum 10th standard education, aged 21–45, and without existing government employment. Final selection was made by district coordinators following a structured interview. In practice, the nomination process was influenced by Panchayat politics in several villages, with some candidates selected on the basis of social connections rather than suitability; the evaluation found that Sevikas nominated through women's group channels performed better on visit quality metrics than those nominated through Panchayat channels, though this difference was not statistically significant.

Training comprised a 12-day residential module at the district headquarters, covering: maternal physiology and danger signs; antenatal counselling techniques; facilitation of family conversations including negotiation with male household members; operational use of the SevikaCare app; transport subsidy facilitation; and referral linkages with ANMs and Medical Officers. Training was delivered by Aarogya Foundation master trainers, with modules co-developed with the State Health Department. A refresher training of 3 days was delivered at the 12-month mark.

An independent training quality assessment conducted at the 6-month mark found that Sevikas demonstrated strong knowledge of danger signs and counselling techniques but weak skills in app operation and in navigating the transport subsidy process — both of which involved bureaucratic steps that the training had underemphasised. These gaps were partially addressed in the refresher training.

3.2 Supervision Architecture

Each block-level supervisor was responsible for 20 Sevikas, conducting monthly field visits to observe at least two home visits per Sevika, reviewing SevikaCare data weekly, and facilitating monthly reflection meetings at which Sevikas discussed difficult cases and shared solutions. The design assumed supervisors would spend 60% of their time in field visits and 40% on administrative functions. A time-use study conducted at the midterm found supervisors spending approximately 35% of time in field visits and 65% on administrative functions, primarily due to reporting requirements from the PMU and district health office. This imbalance was a consistent source of Sevika dissatisfaction throughout the programme.

District coordinators were responsible for programme-government relations, data quality oversight, and escalation of systemic issues to the PMU. The quality of district coordination varied significantly: Betul district, consistently the strongest performer, had a coordinator with prior experience in maternal health programming and strong personal relationships with district health officials. Raisen, the weakest performer on most indicators, had two coordinator changes during the programme and a period of 3 months with no coordinator in post.

3.3 VHND Integration

Village Health and Nutrition Days — monthly outreach sessions at which ANMs provide ANC services, immunisations, and nutrition counselling — existed before the programme but were poorly attended in target villages, with an average of 5–8 women per session at baseline. The programme tasked Sevikas with mobilising women for VHNDs, creating advance lists of pregnant and recently delivered women expected to attend, and following up with non-attenders. By the second year of the programme, VHND attendance in target villages had increased to an average of 22 women per session — a figure corroborated both by ANM registers and independent spot-checks.

However, the quality of VHND services was not within the programme's control. Several ANMs reported being overwhelmed by the increased attendance and unable to provide adequate time to each woman. Two ANMs in Chhindwara district formally complained to the District Health Office that Sevikas were creating unrealistic expectations among beneficiaries about the services available at VHNDs. This tension was never formally resolved during the programme period.

3.4 Transport Subsidy Mechanism

The INR 500 transport subsidy was available to women delivering in a government facility located more than 5km from their village, as measured by road distance. Eligibility was determined by ANMs and confirmed by Sevikas. Disbursement was made through the woman's bank account within 30 days of delivery, using Direct Benefit Transfer (DBT) infrastructure. In practice, disbursement timelines varied from 2 weeks to 4 months depending on district administrative efficiency, and a significant minority of eligible women — particularly those without active bank accounts or with accounts in their husbands' names — faced barriers to accessing the subsidy. A programme review in 2023 found that 18% of women who completed the subsidy application never received payment, primarily due to bank account discrepancies. The programme was unable to resolve these systemic issues within its operating mandate.

The 5km threshold was a source of ongoing controversy. Multiple transcripts in this dataset reference women who lived more than 5km from the facility by travel time but fell within 5km by straight-line distance — a measurement basis that the programme had adopted for administrative simplicity but that was experienced as arbitrary and unfair by communities with poor road infrastructure.

4. Budget Overview

Total programme budget: USD 5.0 million (EU grant: USD 4.2 million; Government of MP co-funding: USD 0.8 million)

Allocation by category:

— Human resources (Sevika honoraria, supervision staff, PMU): 42% (USD 2.1 million)

— Training and capacity building: 11% (USD 0.55 million)

— Technology (SevikaCare app development and maintenance): 8% (USD 0.4 million)

— Transport subsidies (direct beneficiary transfers): 14% (USD 0.7 million)

— Monitoring and evaluation: 9% (USD 0.45 million)

— Programme management and overheads: 16% (USD 0.8 million)

Cost per institutional delivery facilitated (estimated incremental deliveries attributable to programme): USD 218–340, depending on attribution assumptions. The wide range reflects uncertainty in the counterfactual estimate.

SECTION B

Interview Transcripts

Eight interviews were conducted between October and December 2024 as part of the final evaluation fieldwork. Interviews were semi-structured, lasting between 60 and 120 minutes. All interviews were conducted in Hindi (or a local dialect) by trained qualitative researchers and translated into English. Minor edits have been made for readability; ellipses (...) indicate pauses or trails in speech. Square brackets indicate interviewer or translator notes. Names have been changed to protect respondent identity.

Transcript 1: Sevika | Sehore District | 8 years of service | Age 34

Interview conducted at interviewee's home, early evening. Her husband was present for the first 15 minutes and left after the interviewer requested a private conversation. Two of her children were present throughout. Interview duration: 95 minutes.

Interviewer: Let's start from the beginning. How did you come to be a Sevika?

Interviewee: My neighbour's sister was in the programme and she told me they were looking for women. I had finished 12th standard, I was at home, I was bored honestly. My husband was not keen — he said it was not proper work, going to strangers' houses, talking about pregnancy and delivery. But my mother-in-law supported me, which surprised everyone. She said, 'Let her do something useful.' I went for the selection interview and I was chosen. That was in January 2022. I have been doing this work for nearly three years now.

Interviewer: What did the training feel like? Was it useful?

Interviewee: The residential training was twelve days. I had never stayed away from home for more than two nights. The first two days I cried at night. By the fourth day I was fine. The training itself — some parts were very good. The sessions on danger signs, on how to recognise when something is going wrong with a pregnancy — I still use that every day. The role-play exercises where we practised talking to families, pretending to argue with a mother-in-law — those were uncomfortable but I understand now why they did it. It prepared me for real situations. The part that was not useful — the phone application. They showed us on a phone and it looked simple. But my phone is an older model and the app ran slowly. Some of my colleagues had smartphones their husbands owned and they were not allowed to take them to training. Two women had never used a smartphone before. The trainer moved through the app module too fast. I spent the first month after training calling my supervisor every other day to ask how to do something on the app. That was embarrassing.

Interviewer: Describe what a typical week of work looks like for you.

Interviewee: I have fifty-four women in my caseload at the moment — that is pregnant women and women who have delivered in the last three months who I am still following up. A full caseload. Monday I visit the western part of my area — five villages, I do about eight to ten visits depending on how many women are home. Tuesday I write up my notes from Monday and enter into the app if connectivity is there. Wednesday I go to the eastern villages. Thursday is usually reserved for anything urgent — a woman who reported a danger sign, a delivery I need to follow up on. Friday is VHND day — I help the ANM didi with the session, I bring the women. Saturday I rest, or I catch up on paperwork. Sunday is family. But this is the plan. The

reality is different. A woman calls me at 10pm — her water has broken, she is in labour, the family is not sure whether to go to the hospital. I go. A supervisor calls me for an unexpected meeting. My own child gets sick. The plan bends constantly.

Interviewer: Tell me about a situation where you felt you genuinely made a difference.

Interviewee: There is one woman I think about often. Savitri, third pregnancy, thirty-one years old, her first two children were born at home and survived but the second birth was very difficult — she bled heavily after. By the time I started visiting her she was four months pregnant and already terrified. Her husband's family had decided she would deliver at home again because the second hospital delivery had cost money — they had taken an autorickshaw at midnight and paid three hundred rupees that they did not have, and then at the hospital they were made to wait four hours and the staff was rude to her husband. So the family had decided: no hospital this time. I visited Savitri seven times before I even raised the subject of delivery. We talked about food, about the children, about her back pain. I brought her iron tablets. I sat with her mother-in-law — who is the real decision-maker in that house — and talked about whatever she wanted to talk about. By the sixth visit, Savitri's mother-in-law was asking me questions about the cash transfer. She had heard from another woman in the village. So I explained everything — the cash, the process, what she would need to do. The eighth or ninth visit, I brought the ANM didi with me. She examined Savitri and found her blood pressure was elevated — not dangerous yet, but a warning. She spoke directly to the mother-in-law about the risk. That visit changed everything. The mother-in-law saw that this was medical, not just a programme person telling them what to do. Savitri delivered at the PHC. There were no complications. The cash came through in three weeks. The mother-in-law told two other women in the village that the hospital was better than she had thought. I am proud of that, but I am also aware — if the blood pressure had been normal at that visit, I do not know if the mother-in-law would have agreed. Sometimes the biology helps me.

Interviewer: And situations where you couldn't make a difference — or failed?

Interviewee: Yes. There is a woman in my area — Rekha — whose husband works in Gujarat and comes home once a year. Her mother-in-law is the one who controls everything. She is an elderly woman who has delivered eleven children herself, at home, with a dai. Her position is: I survived, my daughters-in-law will also survive. She is not hostile to me. She gives me tea when I visit. She listens politely. And then she does exactly as she intended to do. Rekha delivered at home in July. A dai attended. Both survived, thankfully. But the delivery was long — about eighteen hours — and Rekha told me later that she had been frightened. She wanted to go to the hospital. But she could not say that to her mother-in-law. She whispered it to me during one of my visits and asked me not to repeat it. I could not get through to that household. I tried everything. I brought the ANM. I brought a woman from the village who had delivered at the hospital and had a good experience. Nothing moved that mother-in-law. I reported the situation to my supervisor. She said there was nothing more to do — you cannot force anyone. That is true. But it stays with me.

Interviewer: Let's talk about the cash transfer programme — PM Suraksha Yojana. How does that interact with your work?

Interviewee: This is a question I have complicated feelings about. On one hand, the cash makes my work easier. Families who are resistant to the hospital idea become less resistant when they understand there is money involved. I am honest about it — I tell families about PMSY in the first or second visit because I know it changes the conversation. If I waited until the eighth month to mention it, I would be leaving a tool unused. On the other hand, sometimes I wonder what is driving the change. When a family agrees to a hospital delivery, is it because they trust me? Because they understand the medical reasons? Or because they want the INR 6,000? I had one case where the family agreed to the hospital delivery, collected the cash, and then for

the next pregnancy went back to the dai. They were not converted. They were transactional. That concerns me because the programme is supposed to create lasting change, not just a financial transaction. Also — and I say this carefully — the PMSY cash sometimes creates problems. I have seen families who resent me because the cash did not come or came late. They associate me with the government scheme even though it is not my programme. If the bank account has a problem, they call me. I am not a bank. But I am the person they know, so I become responsible for everything in their minds.

Interviewer: The smartphone application — you mentioned difficulties with it earlier. How has that affected how you're seen within the programme?

Interviewee: This is a sore point. My supervisor is a good man but he is under pressure from the district coordinator to have clean data on the app. So when he reviews my work, he looks at the app first. If there are gaps in my app records — because my phone had no internet, or the app crashed, which happens often — he calls me and asks why I am not visiting. But I am visiting! I have my paper register. But the paper register is not what matters to the people above. In Betul district, I have heard that the Sevikas have better phones and better connectivity. Their app data looks clean and their supervisors praise them. Here in Sehore, connectivity is poor in half my villages. I am doing the same work, maybe more, but my record looks worse. That is demoralising. I brought this up at the reflection meeting last year. My supervisor agreed and said he would raise it. I am not sure what happened after that. The situation did not change noticeably.

Interviewer: What do you think this programme has achieved? Honestly — not the programme answer, your own view.

Interviewee: Honestly? Two things that I am certain of. First, more women in my villages are going to the hospital for delivery than before. That is real. I can name them. I know which families changed and why. Second, more women know that they have rights — the right to the cash, the right to respectful care, the right to ask questions of the ANM. That knowledge is new and it matters. What I am not certain of: whether the change will last after the programme ends. My supervisor said the programme will continue in some form, but the Sevika structure as it exists — the honorarium, the training, the supervision — I do not know. If I stop visiting, will the families I have worked with maintain the hospital preference? I think the older, more established families, yes. The ones who have had a good hospital experience, yes. The ones who were always resistant and only went for the cash — I am not sure. And the thing that nobody talks about openly: the ASHA is still there. In most of my villages, the ASHA is a different woman than me. We have an official protocol that says we work together. In some villages we do. In others, the ASHA sees me as a threat to her incentives and we avoid each other. When the programme ends, the ASHA will still be there. Whether she continues the work I am doing — that depends on whether she wants to and whether she is supported. I have no visibility into that.

Interviewer: One last question — if you could change one thing about the programme, what would it be?

Interviewee: The postpartum follow-up requirement. We are supposed to visit within 48 hours of delivery. I have fifty-four women. If three of them deliver in the same week — which happens — I cannot physically visit all three within 48 hours, do my regular visits, attend the VHND, enter my app data, and attend a supervision meeting. The 48-hour rule exists on paper. It is not observed. I have never been penalised for missing it because my supervisor also knows it is not realistic. But postpartum complications are real. This is when women die. The programme's weakest point is also the most dangerous point. I do not understand why the design has not been corrected. I raised it at the midterm review. It was noted. Nothing changed. I am still trying to be in three places at once.

Transcript 2: ANM (Auxiliary Nurse-Midwife) | Betul District | 11 years of service | Age 39

Interview conducted at the sub-centre where the interviewee works. The interview was interrupted once by a patient seeking medication. Interview duration: 80 minutes.

Interviewer: How has the Suraksha Mata Programme changed your work?

Interviewee: Let me be honest with you from the start. When I was told there would be a new set of health workers — Sevikas — coming to my area, I was not happy. I have been working in this block for eleven years. I know every family. I know the dai in each village. I know which mother-in-law will come around and which will never change. The idea that an NGO was going to send women to do what I have been doing felt insulting. That was my first reaction. My actual experience after three years is different. The Sevika in my area — her name is Priya — she is excellent. She does what I have never had time to do: she sits with families, she builds relationships, she negotiates. I do not have time for that. I am responsible for eleven villages, a sub-centre, immunisation sessions, reporting to the block health office. I run from one thing to another. Priya does the slow, relationship work that I cannot. So I will say this: the programme has made my job more effective, even though I was resistant at the beginning. More women come to VHNDs. More women register for ANC early. My immunisation coverage is up. These are things I was not able to achieve on my own.

Interviewer: Tell me about how the VHND has changed.

Interviewee: Before the programme, VHND was a session I conducted with six, sometimes eight women. I would set up, wait, check whoever came, pack up. It was demoralising. I was following a government protocol with no one to follow it with. Now, Priya sends me an advance list the week before. I know how many women are coming, their names, their pregnancy status, any risk factors she has noted. I can prepare. When twenty-two or twenty-five women come, it is a different kind of work — it is real. I can still not give every woman the time she deserves — that is a problem of numbers, not of willingness. But the session has purpose now. The challenge is that more women has meant more things they expect. They have heard from Priya that they can ask questions, that they are entitled to full examinations, that they should not be rushed. That is true! They are entitled to these things. But my government supplies are calculated for a much smaller attendance. I sometimes run out of iron tablets by the middle of the session. I have to send women away with a promise to provide supplements on the next visit — a promise I am not always able to keep. I have raised this supply issue with the block health officer four times. It is still not resolved.

Interviewer: What's your sense of why institutional delivery rates have gone up in your area?

Interviewee: Multiple things. The government cash transfer — huge. When the PMSY cash transfer of INR 6,000 came in strongly, families started calculating. Even families who had philosophical objections to the hospital started thinking about the money. That was before the Suraksha Mata Programme even started. So when I think about what drove the increase in institutional delivery, I cannot separate the cash from the CHW from the facility improvements. We had a new female Medical Officer posted at the PHC in 2023. This was significant. Women in this area were much more willing to go to a facility where there was a female doctor. There had been bad experiences before with male staff who were dismissive, who examined women roughly, who made comments. A female MO changed the atmosphere at the PHC. Priya told me that she noticed immediately — after the female MO was posted, she had fewer arguments with families about going to the hospital. So what did the programme specifically contribute? I believe Priya — and the Sevikas more generally — served as a bridge. The government schemes and infrastructure created conditions that made hospital delivery more attractive. But many

women and families still did not cross the gap. The Sevikas closed that gap for a significant number. That is a real contribution. It is just not the only contribution, and it may not be the largest one.

Interviewer: What about the cases where things went wrong — where outcomes were poor despite the programme?

Interviewee: I will tell you about one case that I think about. A woman in village Pahadia — she was registered with Priya, she had attended VHNDs, she was a programme success in the data. Her delivery was at the PHC. But postpartum she had an infection. She came back to the sub-centre five days after delivery with a fever and abdominal pain. I referred her to the district hospital. She survived but she was hospitalised for twelve days. When I reviewed what happened, the problem was the postpartum period. Priya had not visited within 48 hours — she had visited at day five, which is when she noticed the fever. By that point the infection was established. The 48-hour visit requirement exists precisely to catch this. But Priya was managing three deliveries that week and physically could not do all the 48-hour visits. This is a design flaw. Not Priya's failure. The caseload, the geography, the postpartum protocol — together they create a situation where the most dangerous period is also the period with the least oversight. The programme managers know this. I have told them. The midterm evaluation noted it. The fact that it has not been corrected tells me something about where the programme's priorities actually lie — and it is not in postpartum care.

Interviewer: You mentioned tensions with Sevikas in other areas — not Priya specifically, but elsewhere?

Interviewee: Yes. I have colleagues in other blocks where the relationship between ANM and Sevika is not functional. In one case, the ANM felt that the Sevika was reporting her to the NGO — that if she did not do a good VHND session, the Sevika would tell the programme supervisor, who would tell someone who would tell the government. There is some truth to this — Sevikas do provide feedback to supervisors, who do share it upward. Whether it reaches government ears, I am not sure, but the ANM's fear was real. In another case, the Sevika in that block was not from the village community — she was brought in from outside because no suitable woman could be found locally. She never built the trust that Priya has built here. She was seen as an outsider, a government agent, someone who did not understand local dynamics. Her visit rates were low, families did not open their doors for her. So the programme works partly because of who the Sevika is and partly because of the relationship she has with the ANM. Both of these are human factors that you cannot fully design for. You can create conditions that encourage good relationships. You cannot guarantee them.

Interviewer: Looking back over the three years — what's your overall assessment?

Interviewee: More women are delivering safely in this block than before the programme. That is real and it matters. Some of those women might have delivered safely without the programme — the cash transfer was already working before Suraksha Mata arrived. But some would not have. Priya has reached families I would never have reached. Families that were resistant, isolated, sceptical of government — she is not government, she is their neighbour, and that matters. What concerns me going forward: the programme is ending. Priya will stop receiving her honorarium in May. She has told me she will try to continue her community health work, but without a salary she will need to find other income. The trust she has built — three years of trust — does not automatically transfer to the ASHA or to me. It lives in her relationships. When she leaves, some of that will leave with her. I have been doing this work for eleven years. I have seen programmes come and go. The communities adapt. But there is always a gap after the programme ends when things slip. My hope is that the women who have had good experiences at the PHC will continue coming — that the hospital is now normalised

for them. My fear is that the families who only came for the cash will stop coming when the Sevika is no longer following up with them.

Transcript 3: Beneficiary | Raisen District | Age 26 | Third pregnancy, two previous home deliveries

Interview conducted at a community centre. The beneficiary travelled approximately 4km on foot to reach the interview location. She was accompanied by her sister-in-law, who was not present during the interview. The interview was conducted in Bundeli (local dialect) with Hindi translation. Interview duration: 70 minutes.

Interviewer: Can you tell me a bit about your family and your situation?

Interviewee: We are a family of seven — my husband, his parents, his younger brother, my two daughters, and me. My husband works in the fields during sowing and harvest and does daily labour in the off-season. In drought years like last year, there is less work. My father-in-law is old and cannot work much. So the money is always tight. My daughters are four and two years old. This pregnancy was not planned.

Interviewer: Did you have a Sevika visiting you during this pregnancy?

Interviewee: Yes, she came. Her name is Jyoti. She started coming in my third month. She came maybe twelve or thirteen times through the whole pregnancy. She is from my husband's cousin's village — not from our village, but close. We knew each other a little before. The first few visits I was shy with her. I am not someone who talks easily about pregnancy things with people I do not know well. But she is patient. She never made me feel stupid for not knowing things. She explained about the iron tablets — why I needed to take them, what they would do. I had never taken iron tablets properly before my first two pregnancies. Halfway through the packet I would stop because they made me nauseous. Jyoti told me to take them at night with a little food and it is better. It was better. I finished the whole course this time.

Interviewer: Your previous two deliveries were at home. What was different this time?

Interviewee: My first delivery, I was nineteen. My mother-in-law called the dai — that is what she always does, what her mother did. I did not question it. The delivery was long — maybe sixteen hours — but both I and the child were fine. My mother-in-law said, 'See? The dai knows what she is doing.' My second delivery was harder. Something went wrong at the end — I do not know the medical name. I bled a lot after the baby came out. The dai was frightened, I could see it in her face. My mother-in-law told her to press on my stomach. I was very weak. They prayed. Eventually it stopped. I recovered. But I remember thinking: I could have died. And nobody would have been able to do anything. So when I found out I was pregnant the third time, something in me had already decided — I will go to the hospital. But I did not say that to my mother-in-law right away. I said nothing for the first few months. Then Jyoti came, and over the months she also talked to my mother-in-law. She did not pressure her. She talked about what is available, what the PHC is like now, that there is a lady doctor now. My mother-in-law is not against modern medicine — she took tablets for her own knee pain — she was just against the hospital for delivery because of old bad stories. The lady doctor made a difference. Jyoti knew that would be important.

Interviewer: Tell me about the delivery itself and the experience at the PHC.

Interviewee: The labour started at two in the morning. My husband woke Jyoti — she had given us her number and made us promise to call, even in the middle of the night. She came within thirty minutes. She helped us arrange the transport — her supervisor had the number of a man with a vehicle who does this. We reached the PHC at around four-thirty. At the PHC, the night duty staff was a male nurse — the lady doctor was not there. I was scared. The nurse was not

unkind but he was businesslike, not warm. He checked me, said the baby was coming soon. A female ANM from the night shift came and she stayed with me. The delivery was in two hours. My daughter was born healthy. I had no complications this time. The ANM was good. She explained what was happening during the delivery. Nobody shouted at me, which I had heard sometimes happens. They gave me tea afterward and let me rest until the morning shift came. I was discharged at noon. Jyoti visited me at home at day three and day seven. She checked the baby, checked my stitches, asked if I had eaten.

Interviewer: Did you receive the government cash transfer?

Interviewee: We applied. Jyoti helped us with the paperwork. But it has now been four months and we have not received it. My husband went to the PHC three times and they said the account verification is pending. We have a bank account but it is a joint account with my husband's name first. There was some problem with that. Jyoti contacted her supervisor. The supervisor said she would follow up. We are still waiting. I am not angry at Jyoti — she has tried. I am frustrated with the process. The money would matter — we have a debt from the transport and from medicine we bought after the delivery. If the money came, we could clear the debt. I do not understand why it is so complicated. Other women in the village received their money within a month. Why is ours different?

Interviewer: How do you feel about your daughters growing up in this area? Would you want things to be different for them?

Interviewee: My older daughter, Guddi, she goes to school. I want her to study as far as possible. I want her to know things I do not know — how the hospital works, how to talk to doctors, what her rights are. Jyoti knows these things. I want my daughters to know these things. For my health — I know more now than I did after my first two pregnancies. I know what postpartum warning signs to watch for. I know I should eat better food. Jyoti told me about a nutrition programme at the anganwadi — I am going to go after my rest period. Before I did not know these things were available. But knowing and being able to do are different things. Knowing I should eat more protein does not give me the money to buy it. Knowing I should rest for forty days does not mean my mother-in-law will allow me to rest. These are not things Jyoti can change. She can give me information. What I do with it depends on my situation.

Interviewer: If you were going to tell someone about this programme — what it did and what it didn't do — what would you say?

Interviewee: I would say: Jyoti helped me go to the hospital when I was not sure I could. She built trust with my family over many months, which nobody had ever done before — not the ASHA, not the ANM, not any government person. The fact that my delivery went well — I cannot say for certain it would not have gone well at home. But after what happened with my second delivery, I am very glad I was at the hospital. What the programme did not do: it did not fix the money problem with the bank. It did not make the PHC warmer or better staffed. It did not change the fact that my mother-in-law makes the real decisions in our house — it worked with that reality, which is different from changing it. And it did not visit me in the first 48 hours after I came home, which I was expecting. Jyoti came on day three. I understand she is busy. But I was nervous alone at home with a newborn and nobody checking.

Transcript 4: District Health Officer | Harda District | Age 52 | IAS officer, posted to health

Interview conducted at the District Collectorate. The interviewee was precise, data-oriented, and periodically consulted a file he had prepared in advance. He requested a copy of the interview questions beforehand — this was shared. Interview duration: 65 minutes.

Interviewer: From a district health administration perspective, how do you understand what has happened to maternal health indicators in Harda over the past three years?

Interviewee: I will give you the numbers first and then my interpretation. Institutional delivery rate: 63% at baseline, 76% at endline. ANC4+ coverage: 41% to 64%. MMR: we are estimating — actual MMR measurement has significant uncertainty — but our internal estimate suggests a decline from approximately 165 to approximately 138. These are meaningful changes. My interpretation: these changes are the result of at least three simultaneous interventions. PM Suraksha Yojana — the cash transfer — has been the dominant pull factor in Harda, I believe. Families in this district are primarily agricultural labourers with limited cash income. INR 6,000 for a hospital delivery is significant money. The program theory of PMSY is simple and effective: create a direct financial incentive aligned with the public health goal. Second: the Suraksha Mata Programme and its Sevikas. I will not dismiss their contribution. They have reached households that the ASHA and ANM never effectively reached. There are families in my district where the first sustained relationship with a formal health system came through a Sevika. That is real. But I want to be precise: the Sevikas amplified an existing pull created by the cash transfer. They did not create the pull independently.

Interviewer: And the third factor?

Interviewee: Infrastructure and staffing. In 2023, we received funding under the state's District Hospital Strengthening programme to upgrade two PHCs in Harda. New equipment, better lighting, functional labour rooms. More importantly — and this is the factor that I think is most underestimated in programme evaluations — we got two additional ANMs posted, and one of them is a female Medical Officer. Women who previously refused to go to the PHC because they did not want to be examined by a male doctor now have an option. If I were designing an attribution study for this district, I would try to separate the time periods: what happened in 2022, before the facility upgrade? What happened in 2023 and 2024, after? I suspect the trajectory steepened after the upgrade. But we do not have disaggregated monthly data at the district level that would allow me to test this rigorously. Our data systems are not designed for that kind of causal analysis.

Interviewer: How do you view the relationship between the NGO-run programme and the government health system?

Interviewee: This is always a complicated relationship. I will be candid with you. NGOs come with their own theory of change, their own monitoring systems, their own reporting lines to their donors. They are in my district for three years and then they are gone. In the meantime, they generate a great deal of data that goes to Brussels or wherever the donor is, and relatively little that integrates into my district health information system. Aarogya Foundation has been better than most. They share data with us regularly. They come to my office for quarterly reviews. They respond when I raise issues. But the fundamental structure creates tensions. When Sevikas identify a problem at a PHC — long waiting times, a rude staff member, a stockout — that information goes to the programme supervisor, to the district coordinator, maybe to the PMU in Bhopal. Does it reach me in a systematic way? No. I hear about systemic problems through informal channels. The ASHA tension is also real in Harda. My ASHAs feel — not without reason — that the Sevikas have been positioned as a critique of their performance. The message is implicit but clear: the government system was not working, so an

NGO has come to fill the gap. For women who have been doing this work for seven, eight years on a small incentive, that is difficult to absorb.

Interviewer: What happens when the programme ends in May? Are you concerned?

Interviewee: I am concerned about two things. First: the Sevikas. The best ones — and there are some genuinely excellent women in this programme — will lose a reliable income. Some will find other work. Some may continue doing informal community health work without payment, because they believe in it. A small number might be absorbed into the ASHA system if vacancies arise. But the structured programme — the training, the supervision, the SevikaCare tracking — that ends. The informal relationships will persist in some form; the system will not. Second: the data. The programme has three years of individual-level data on pregnancies, deliveries, antenatal visits, and postpartum outcomes in my district. That data currently sits in servers managed by Aarogya Foundation. I have been promised a data handover to the district health office. I have been promised this for six months. It has not happened yet. If it does not happen before May, I lose visibility into everything that was tracked. That is a governance failure that the programme and the donor should be held accountable for.

Interviewer: One more question — if you were advising someone designing a similar programme for another district or country, what would you tell them?

Interviewee: Three things. One: do not design the CHW as a parallel structure. Design her as a complement to the existing health worker — the ASHA, the ANM — with a formal protocol that has teeth, not just a letter of understanding that nobody follows. The protocol works only if both the NGO and the government health department enforce it. Two: invest in data systems that serve the government, not just the donor. If your data goes only to an NGO dashboard in Bhopal and to a donor report in Brussels, you have not built anything that will last. The government health officer needs to be able to see the data, use it, and hold people accountable for it. Three: be honest about what you are measuring. I have seen programme reports that show a large improvement in institutional delivery and attribute it entirely or primarily to the CHW programme. I have seen the same reports exclude or minimise the contribution of the government cash transfer. That is intellectually dishonest. It also creates false confidence about what works. If the real driver was the cash transfer plus the female MO plus the infrastructure upgrade, and you report it as the CHW programme, you will design the wrong programme next time.

Transcript 5: Sevika | Chhindwara District | Age 29 | 2.5 years of service | Recently resigned

The interviewee resigned from the programme in September 2024, approximately 8 months before the programme end date. The interview was arranged through a former colleague. It was conducted at a tea stall near the interviewee's home. She was open and detailed in her responses, and said she had wanted to speak to someone about her experience. Interview duration: 100 minutes.

Interviewer: You resigned before the programme ended. Can you start by explaining why?

Interviewee: It was not one thing. It was many things that built up over two years until I could not continue. The pay — INR 3,500 a month — seemed reasonable when I started. But I was spending between INR 400 and INR 600 a month on my own transport to do visits. My villages are spread out, there is no direct public bus between some of them, I was paying autorickshaw fares from my own pocket. The programme said transport would be reimbursed. There was a form. I submitted the form every month for four months and received reimbursement for one month. The rest — the district office said the receipts were not in the correct format, or the

form was wrong, or there was a budget issue. After four months I stopped submitting because the effort was not worth the amount. So effectively my take-home was INR 2,900–3,100 a month for work that was eight, sometimes ten hours a day. My husband found a job in Nagpur in 2023. He wanted me to come with him. I wanted to stay because I felt responsible to my women — I had built these relationships, I could not just leave. I stayed. But by 2024 I was supporting myself and sending some money to my husband rather than the other way around, which was not the plan, and I was exhausted, and the relationship was strained. When my supervisor told me I was underperforming because my app data was incomplete — I had never once been told I was doing poor work before that, my women liked me, my visit rates were high — I just... I decided it was not worth it anymore.

Interviewer: Tell me about the supervision. You mentioned your supervisor said you were underperforming — what happened?

Interviewee: My supervisor — I will not use his name — he is not a bad person. He is under pressure himself. The district coordinator wants clean data. The PMU wants clean data. So the supervisor pushes the Sevikas for clean app data. My app data had gaps because my phone was old and the battery died frequently in the field. I was logging visits on paper and entering them later, sometimes two or three days later. This creates data that looks suspicious — multiple entries on the same day, irregular patterns. The supervisor came to me in August and said my visit rate for the previous month looked low. I showed him my paper register. He looked at it, acknowledged that the numbers were higher than what the app showed, and then said — and I remember this precisely — 'You need to find a way to make the app reflect reality.' He meant well. He was not saying I was lying. He was asking me to solve a technical problem that I did not know how to solve. A phone that keeps dying is not something I can fix with a form. What I needed was a replacement phone or a power bank. I requested both. The power bank was approved after three months. By then I had already decided to leave.

Interviewer: Tell me about the women you worked with. What do you feel you were able to accomplish?

Interviewee: I built real relationships with about thirty women. I know their families, their situations, their fears. I attended fifteen hospital deliveries as a support person over two and a half years — women who wanted me there, who called me at two in the morning, whose mothers-in-law I had been talking to for six months. Eleven of those fifteen women had never previously delivered at a hospital. For those eleven women, I believe I was a significant part of why they made that choice. There is one woman — Durga — who I think about often. She was nineteen years old when I first visited her, newly married, first pregnancy, completely silent when I came. She would sit in the corner and look at her hands while her mother-in-law talked to me. Over about four months she started speaking. Small things first — she told me she liked school before she had to stop. She told me she had wanted to become a teacher. She was not allowed to continue after marriage. By her sixth month she was asking me questions about her body, about what would happen in delivery, about breastfeeding. She delivered at the PHC. She was confident with the hospital staff — she asked questions, she refused a procedure she did not understand until it was explained. The ANM told me afterward: 'Your woman is different.' That change in her is not in any dataset. But it is real. And it came from her. I just created some space for it to happen. When I resigned, I visited each of my women and told them. Durga cried. She asked who would come now. I told her about the ASHA. She said, 'But didi, you are not like the ASHA — the ASHA just comes when there is an injection or a form.' I had no good answer for that.

Interviewer: Do you think the programme achieved what it set out to do?

Interviewee: Yes and no. It achieved better numbers — more hospital deliveries, more ANC visits. That is real. But it achieved them in a particular way that the programme design did not

fully anticipate: partly through financial incentives that the programme did not control, partly through the relationship work that we Sevikas did, and partly through government infrastructure changes that happened to coincide. What the programme did not achieve: lasting systems change. The Sevikas will leave and the system will revert. The ANM is overloaded. The ASHA is not equipped or motivated to do sustained relationship work. The data that the programme built — the SevikaCare records, the individual tracking — will not be used by anyone when Aarogya Foundation leaves. I know because my supervisor told me in a candid moment: 'The data handover to the government has not happened and probably will not happen before May.' Three years of data, gone. The thing that keeps me up at night: Durga's next pregnancy. She will not have me. She will have whoever the ASHA is in her area and whatever the PHC can offer. I hope it is enough. I cannot know.

Interviewer: If you could say one thing to the programme designers — to the people who built Suraksha Mata — what would it be?

Interviewee: Pay your field workers properly and on time. Fix the transport reimbursement. Give them functioning phones. Listen when they tell you the caseload is too large and the postpartum protocol is unrealistic. These are not big asks. They are basic. And treat the resignation of a field worker not as an administrative event but as a signal that something is wrong in the system. When I resigned, I received one phone call from the district coordinator to confirm my last working date. Nobody asked me why. Nobody sat with me and heard what I am telling you now. I had been in this programme for two and a half years. I knew things about what worked and what did not work that nobody had documented. That knowledge walked out the door with me.

Transcript 6: Dai (Traditional Birth Attendant) | Vidisha District | Age 58 | Approximately 30 years of practice

Interviewee was interviewed at her home, which also serves as an informal meeting point for women in her village. The interview was initially reluctant — she agreed to participate after the interviewer explained that the evaluation was trying to understand community perspectives, not just programme data. An intermediary known to the interviewee was present for the first ten minutes and then stepped out. Interview conducted in Bundeli with Hindi translation. Interview duration: 75 minutes.

Interviewer: Can you tell me about your work as a dai and how long you've been doing it?

Interviewee: My mother was a dai. Her mother before her. I have been attending births in this village and the three villages nearby for thirty years. I have attended perhaps four hundred births. I have seen one mother die — she had something very wrong with her blood, it could not have been prevented. All the others lived. All the babies — most of them lived. I lost perhaps twelve babies over thirty years, mostly very early premature ones. When the government started saying that dais were dangerous, that every delivery must be in the hospital, I was hurt. I am not dangerous. I know what I am doing. I know when a delivery is normal and when something is wrong. When something is wrong, I send the family to the hospital. I have always done that. It is the government's story that dais are the problem. The real problem is that for many years the hospital was worse than my hands.

Interviewer: Has the Suraksha Mata Programme affected your work?

Interviewee: Yes. I am being honest with you because you asked honestly. In the last two years, fewer families in my area call me for delivery. Maybe sixty or seventy percent of what I used to do. The rest have gone to the PHC. I do not know exactly why for each family — I am not always told. Some have told me directly: the Sevika convinced them. Some have told me: the

cash. Some have told me: they heard the PHC has a lady doctor now. Some have told me their daughter-in-law's own choice, which is new — a generation ago a daughter-in-law did not have that kind of say. I do not resent the Sevika in this area — Kamla, Kamlabai. She is respectful to me. She does not tell families I am dangerous. She refers to me as someone who has experience but that for safety the hospital is better now. That is honest. I can accept that framing. What I cannot accept is when the government trainers come and say that all home delivery by dais is unsafe. They have never been present at a birth. They have never done what I have done.

Interviewer: Do you see cases where you think the hospital was not the right choice? Where families went and regretted it?

Interviewee: Yes. I will tell you one case. A woman in a nearby village — I will not say her name — she went to the PHC because the Sevika and her mother-in-law both said to go. Her labour was slow — eighteen hours. At the PHC they gave her something to speed the labour. After that it was very fast and very painful and she felt she had no control. She told me afterward she felt like she was not a person during that time, just a body being managed. Her baby is healthy. She recovered. But she says she does not want to go back to the PHC for the next delivery. I am not saying the PHC was wrong medically. I do not know enough to judge that. I am saying that what matters to a woman during delivery is not only the medical outcome. She wants to feel safe, to feel respected, to feel she has some control. Sometimes the hospital gives that. Sometimes it does not. I try always to give it. That is something I know how to do that a hospital system does not always know how to do.

Interviewer: What do you think will happen to your work in the next five years?

Interviewee: I think I will attend fewer and fewer deliveries. The government wants to eliminate home delivery. The cash transfer is a big pull. The PHC is better than it was. The Sevikas are persuasive. And the new generation of daughters-in-law — some of them want the hospital because they have seen it on television, because their friends went. My daughter does not want to learn my work. She says it is old-fashioned. She wants to be an ANM. She has applied to the training programme twice. I hope she is accepted. It is better to have a job with a government salary than to do this work for a small payment per delivery. When I stop, there will be no one to replace me in this village. For normal deliveries that is probably fine — if most women are going to the PHC. But there will always be cases where the PHC cannot be reached in time — a delivery that comes on suddenly, a woman who lives very far, a monsoon night when the road is flooded. In those cases, who will be there? Not the ANM — she is at the sub-centre. Not the Sevika — she is not trained for delivery. Nobody. I have raised this question with the Sevika. She raised it with her supervisor. I do not know if it reached anyone who could do something about it. I suspect not.

Transcript 7: Block Health Officer | Betul District | Age 44 | Government Medical Officer

Interview conducted at the Block Health Office. The interviewee was forthcoming and spoke with evident frustration about systemic issues. He had not been briefed by the District Health Office before the interview and was not aware this was part of the programme evaluation — he thought it was an academic research project. When clarified, he said he would speak in the same way regardless. Interview duration: 55 minutes.

Interviewer: How have things changed in your block over the past three years in terms of maternal health?

Interviewee: Betul has been a success story, they tell me. Our institutional delivery rates are the highest in the programme, our ANC coverage is the best, our app data is clean. The

programme coordinators bring visitors here to show how it is done. I am glad for the recognition but I want to be precise about what has actually driven it. Betul has better road connectivity than the other programme districts. My block has a stronger ASHA cadre than average — I have seven ASHAs out of twelve who are genuinely motivated and have been in post for more than five years. The Sevikas here were recruited from families that are already more health-literate than average. The PHC here has had a stable staff complement for three years — no major posting changes. All of these are baseline advantages that have nothing to do with the programme design. When the programme points to Betul as an example of what works, I want to ask: what worked in Betul might be the combination of a good programme with a context that was ready to receive it. That is not the same as saying the programme works everywhere.

Interviewer: What is your day-to-day experience of working with the Sevikas?

Interviewee: Practically speaking, they make my life easier in specific ways. VHND attendance is dramatically higher. My ANMs are less stressed because they spend less time mobilising women. When I need to communicate something urgently — a vaccine drive, a new government scheme — I can reach the Sevikas' supervisor and they will spread the information much faster than the government channel. What is sometimes frustrating: the programme runs on its own timeline that does not always align with mine. They have quarterly reviews in Bhopal. I have monthly reviews with my district health officer. When there is a problem I want to address quickly — a Sevika whose conduct has been questioned, a village where there is a conflict with the ASHA — the NGO process moves slowly. They have their protocols, their HR policies, their need to document everything. I understand why. But in government we sometimes move faster on personnel issues and it can be jarring to work with an organisation that has a different tempo.

Interviewer: You mentioned the ASHA-Sevika dynamic. How has that played out in Betul?

Interviewee: Better than in other districts from what I hear, but not perfectly. The key was that we held a joint orientation meeting in the first month — my office, the Aarogya Foundation coordinator, all the ANMs and all the Sevikas in the block. We laid out the roles clearly. The Sevika covers relationship-building and ANC counselling. The ASHA covers immunisation follow-up and VHND mobilisation. They share the beneficiary list but they do not duplicate visits except by agreement. In practice, some overlap still happens. One ASHA in my block complained that the Sevika was getting credit with the family for a delivery that the ASHA had also been working on. The incentive — the small per-delivery incentive the ASHA receives — she felt she had lost it because the family associated the hospital visit with the Sevika. I mediated that. I told the Sevika's supervisor. We agreed that in future they would make joint visits for deliveries in ambiguous cases. It helped. But not every Block Health Officer did what I did. In some blocks the programme and the government health office never sat down together properly. The role protocol was a document, not a practice. Where that happened, the tensions were much worse.

Interviewer: What's the honest picture of what this programme has achieved versus what it claims to have achieved?

Interviewee: I think the programme has genuinely contributed to improved maternal health coverage in Betul. But I want to push back on how it presents the causal story. In programme reports I have seen, the improvement in delivery rates is presented as primarily a result of the CHW model. The PMSY cash transfer is mentioned in a footnote. The infrastructure improvements are not mentioned at all. From where I sit, the order of contribution is something like: cash transfer 40%, facility improvements 25%, CHW programme 25%, secular trend and background factors 10%. I have no rigorous basis for those percentages — I am giving you my honest estimation from three years of watching it happen. But the programme's own

materials suggest something like: CHW programme 70%, other factors 30%. That is not an honest representation. Why does this matter? Because if a government or donor looks at this programme report and decides to replicate the CHW model in a context without a robust cash transfer or without facility improvements, they will not get the same results. They will be confused about why it is not working. The causal story you tell shapes the replication decisions you make.

Transcript 8: Programme Director | Aarogya Foundation | Age 47 | Based in Bhopal

Interview conducted via video call. The interviewee had access to programme data during the interview and referenced specific figures. She was reflective and candid, including about programme failures. Interview duration: 90 minutes.

Interviewer: Looking back across the three years, how do you assess what the programme achieved?

Interviewee: I will start with what I am most confident about, then move to what I am uncertain about, then to what I think we got wrong. That structure feels honest. Most confident: we reached women and families that the existing system was not reaching. I have village-level data that shows the change — families that had zero contact with formal health services before the programme who now have a relationship with the PHC. That is real and it was the programme's primary purpose. The Sevikas built trust that I genuinely believe cannot be built any other way — not through mass communication, not through incentives, not through facility upgrades. It requires presence, relationship, time. Also confident: the Sevikas themselves changed. Women who entered as shy, uncertain, sometimes barely able to articulate themselves in a formal meeting are now running reflection sessions, managing complex case data, negotiating with government officials on behalf of their beneficiaries. That personal development was not in our theory of change. It happened anyway. We have tried to document it though we are not sure what to do with it in the evaluation report.

Interviewer: And the uncertainties?

Interviewee: The attribution question haunts me. We chose not to do a randomised evaluation — it was not feasible given the government partnership and the small geographic scale. We have a comparison group from adjacent non-programme blocks, but it is imperfect. The honest answer is that we do not know with confidence what proportion of the improvement in delivery rates or ANC coverage is attributable to Sevikas versus the cash transfer versus the facility improvements that happened to coincide. Our internal estimate — which we share in technical reports but soften in donor communications, I will admit — is that the programme contributed approximately 5–8 percentage points above trend to the institutional delivery increase. The total increase was 17 percentage points. So roughly a third. Some of my colleagues think even that is optimistic. Some think it is conservative. I do not know who is right. The PM Suraksha Yojana dynamic is particularly difficult to disentangle. We designed the programme assuming the cash transfer was a background factor. In practice, it was often the foreground factor — it was the reason many families agreed to the hospital, and the Sevika's role was to facilitate and follow through rather than to persuade. That is still a meaningful contribution. But it is different from the theory of change we wrote.

Interviewer: What do you think the programme got wrong?

Interviewee: Three things I would do differently if I were starting again. First: the technology choice. We invested heavily in the SevikaCare app based on evidence that digital data tools improve programme management. That evidence comes from contexts with reliable electricity and mobile connectivity. In Harda and Raisen, connectivity is poor and the investment

underperformed. Worse — the app created a monitoring bias against Sevikas in low-connectivity areas that we did not detect and correct quickly enough. By the time we changed the monitoring protocol to weight paper records equally, the reputational damage to some Sevikas was done. Second: postpartum care. The 48-hour visit protocol was aspirational, not operational. We knew it at the design stage and included it anyway because it was in the clinical guidelines and donor requirements. We should have either funded the caseload reduction needed to make it operational, or negotiated a different protocol, or been transparent in reporting that it was not being met. We did none of these things well. The postpartum gap is the programme's most significant clinical failure. Third: the ASHA relationship. We designed a protocol. We ran orientation sessions. But we never meaningfully addressed the incentive misalignment. ASHAs are paid per delivery facilitated. Sevikas were also receiving small delivery-facilitation incentives. In villages where they overlapped, both had a financial stake in the same outcome. The protocol told them to cooperate. The incentives told them to compete. You cannot fix that with a protocol meeting.

Interviewer: The programme ends in May. What worries you most?

Interviewee: The Sevikas. I am genuinely worried about them as individuals. The best ones — the women who were transformed by this work, who have real skills, who are known in their communities — some of them will find their way into ASHA roles, or into other NGO programmes, or into the ASHA facilitator role at the block level. Some will not find anything and will return to domestic work, carrying skills and a sense of professional identity that has nowhere to go. I have been working with the State Health Department to see if a subset of the Sevikas can be formally absorbed into the ASHA system. The state is sympathetic but the process is slow and the ASHA vacancies are limited. I expect that maybe 20–30 Sevikas out of 214 will find a formal continuation in the government system. The rest will disperse. I have also been trying to ensure the data handover happens. The individual-level case data in SevikaCare represents three years of pregnancy tracking for over 36,000 women. It should be in the government system. The State Health Department has agreed in principle. The IT systems are not compatible. We are working on an export format. I am not confident it will be complete by programme end. The communities, I am less worried about. The women who had good hospital experiences will continue going. The families who built a relationship with the PHC through the Sevika have a relationship they can continue. That is durable, even if the Sevika is gone. That is the argument I make to myself when I am feeling pessimistic about sustainability. I am not sure I fully believe it.

Interviewer: Final question — what would you want an evaluator, reading your programme data and these interviews, to understand that the data alone cannot tell them?

Interviewee: That the numbers tell you something happened. They cannot tell you why, or how, or for whom in ways that matter for replication. An evaluator reading our endline data will see a 17-percentage-point increase in institutional delivery and will have to decide what that means. The number is real. The causal story behind it is complex, contested, and partly unknown even to us. The transcripts — the ones you are collecting, the ones we collected internally — are where the mechanism lives. A Sevika sitting with a resistant mother-in-law nine times before the conversation turns. A woman who had a terrifying second delivery deciding before the programme even reached her that she would go to the hospital this time, and the Sevika facilitating a decision already made. A dai who is not the enemy of safe delivery but the holder of knowledge about respectful care that the PHC has not learned. A district health officer who understands the causal complexity better than the programme reports acknowledge. All of that is in the interviews. None of it is in the app data. If an evaluator reads only the quantitative report and makes a recommendation about whether to replicate this programme, they are making that recommendation on a fraction of the evidence. I hope

whoever reads what you collect takes the qualitative seriously. I know that is not always how these things work.