EquiNaM

building evidence to support equitable improvement in newborn and maternal health

Learning from Stakeholders for Health Equity

Report of roundtable discussions

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BACKGROUND

Progress towards the Millennium Development Goals (MDGs) has been highly uneven. Poor and otherwise disadvantaged groups lag behind their more fortunate compatriots for most MDGs. Inequalities in maternal and newborn health are huge, and effective interventions are known but rarely reach those who need them most. Few of the poorest women in developing countries receive professional care during delivery, while the majority of their richer compatriots do. The link between socioeconomic disadvantage and health disadvantage has enormous consequences: one third of global childhood deaths are attributable to socioeconomic mortality inequalities within countries. Little is known about how to effectively reach disadvantaged groups, and how to address socioeconomic inequalities in health.

Fresh evidence is needed to understand what works, in which contexts and why, to reach disadvantaged groups and reduce socioeconomic inequalities in health. Well-designed experiments, in the form of randomised controlled trials, are important for understanding the equity-impacts of development activities. They are, however, rare and are not always able to capture the barriers to effective implementation in real life situations. Policy-makers and practitioners have valuable experience of what does and does not work on the ground to reduce health inequalities. This tacit knowledge is rarely written up and shared.

Our project aimed to collect, collate, synthesize and share experiential evidence from a large group of policy maker and practitioner stakeholders, on what works, where, and why to reach lower socioeconomic groups with maternal and newborn health interventions and reduce socioeconomic inequalities in health. We organised a series of roundtable discussions with health policy analysts, medical experts, funders, national and international NGO heads, and government representatives in India, Bangladesh, Nepal and Malawi. In them, we discussed intervention strategies to reach lower socioeconomic groups and reduce socioeconomic and health inequalities. We also conducted a series of qualitative interviews with other stakeholders, the findings of which are documented in an accompanying report.

The project is a collaboration between University College London, the Society for Health, Nutrition, Education, and Health Action (SNEHA) in Mumbai, and partners across India, Bangladesh, Nepal and Malawi. It was funded by the New Ideas Initiative, which was set up by the Development Studies Association and DFID. Our work is linked to a larger project, EquiNaM, that aims to build evidence to support an equitable improvement in maternal and newborn health (http://equinam.global-health-inequalities.info/).

AIM

The aim of the roundtable discussions was to gather tacit knowledge from policy makers and practitioners on what works, where, and why to reach lower socioeconomic groups with maternal and newborn health interventions and to reduce socioeconomic inequalities in maternal and neonatal health.

METHODS

The New Ideas Initiative, through its various partners, organized 7 roundtable discussions in Malawi, Bangladesh, India and Nepal with a range of stakeholders including bilateral agencies, the medical fraternity, national and international developmental organizations, funders, public health sector representatives and experts from academia.

In total 130 expert stakeholders participated in roundtable discussions at each of the sites. Two roundtable discussions took place in India (Mumbai and Jharkhand), one in Bangladesh, three in Nepal (Kathmandu, Makwanpur, and Dhanusha), and one in Malawi. All the discussions were moderated by a specialist in maternal and neonatal health and lasted an average of three hours. Each participant was given a consent form to complete and hand over to the host organization. The roundtables began with an introduction to the host organisation and topic of discussion, followed by a presentation about the EquiNaM project, which included the research and stakeholder engagement component. Information was also given about the interventions that the host site had conducted on maternal and newborn health. The presentation set the atmosphere to discuss intervention strategies on maternal and neonatal health and how to reduce socioeconomic and health inequalities. Each site submitted a roundtable report to the researcher in Mumbai with which to compile the collective report. Analysis was thematic, comparing the information provided in site reports. The discussions were developed around the following questions:

1. What importance do the stakeholders and/or the organisations they represent attach to ensuring their policies/programmes/projects contribute to reducing socioeconomic inequalities in maternal and newborn health? Are the aims of the organisations/projects/programmes framed in terms of improving average outcomes and/or in terms of reducing inequalities between socioeconomic groups? Why? Please provide the explanations that the stakeholders gave.

2. What are the main barriers to reaching lower socioeconomic groups with maternal and newborn health interventions? How can these barriers be overcome? Provide concrete examples of barriers and how they were overcome, as mentioned by the stakeholders.

3. According to the stakeholders, what works well to reach lower socioeconomic groups with maternal and newborn health interventions? Which factors contribute to successfully reaching lower socioeconomic groups? How? In which settings will these factors be important? Will these factors be different in other settings? Refer to concrete experiences mentioned by stakeholders.

4. Details on concrete examples: Provide several examples given by the stakeholders of interventions that worked well in terms of reaching lower socioeconomic groups. What is the explanation given by the stakeholders in terms of why these interventions worked well? Which factors contributed to the success? In which type of setting/context was this success achieved? Will these factors be different in other settings/contexts?

5. Gaps in evidence: what evidence do the stakeholders need and currently miss to ensure that their organisation/project can reach lower socioeconomic groups?

The table below provides details of each of the 7 roundtable discussions:

Site	Location	Date	Time	Number of participants	Stakeholder organisations represented
PCP BADAS	Dhaka, Bangladesh	2.5.12	10.00 am-1.30 pm	12 (plus PCP BADAS team)	NGO: 9 National government: 1 Academics: 2
Ekjut	Jharkhand, India	16.5.12	10.30 am-1.30 pm	17 (plus Ekjut team)	NGO: 13 State government: 2 Academic: 1 Consultant: 1
SNEHA	Mumbai, India	24.4.12	2.00-5.00 pm	11 (plus SNEHA team)	NGO: 3 Funder: 3 International organisation: 1 Public health institution: 1 National medical body: 2 Academic: 1
MIRA	Dhanusha, Nepal	27.4.12	11.30 am-1.30 pm	22 (plus MIRA team)	National NGO: 17 International NGO: 1 National government: 3 Academic: 1
MIRA	Makwanpur, Nepal	2.5.12	7.40-10.15 am	19 (plus MIRA team)	National NGO: 9 International NGO: 1 National government: 5 State government: 4
MIRA	Kathmandu, Nepal	2.5.12	11.30 am-1.30 pm	10 (plus 12 MIRA team)	NGO: 1 Bilateral agency: 2 International NGO: 2 Academics: 1 (National) medical body: 4
MaiMwana	Malawi	23.5.12	9.00 am-12.45 pm	8 (plus MaiMwana team)	NGO: 6 State government: 2

KEY FINDINGS

Importance given to reducing socioeconomic inequalities in maternal and newborn health

Across the roundtable discussions there was a unanimous view on the importance of reaching lower socioeconomic groups and reducing inequalities in health outcomes. At the same time, in some, emphasis was given on addressing health inequities by targeting specific vulnerable groups, while in others it was on improving overall health outcomes.

In the Nepal (Kathmandu) discussion, significant weightage was given to the **importance of disaggregated socioeconomic data**. Natasha Mesko from DFID said, "**Income inequality is [only] one of the important aspects of inequality**. Government has a 'gesi' framework – gender and social exclusion framework – which is used to mainstream gender, social exclusion and income issues through this program". The view from the Nepal (Dhanusha) roundtable was that great importance should be given to reducing

socioeconomic inequalities by **targeting specific groups such as those below the poverty line, Dalits (lowest in the social hierarchy), and specific age groups**. In all of the roundtable discussions in Nepal, **geographical exclusion** was considered a major issue and it was felt that an inclusive policy of development was required to address the problem of higher marginalisation of groups in inaccessible areas.

In Malawi, the stakeholder organisations attached significant importance to reaching vulnerable and lower socioeconomic groups. Their policies and programmes specifically aim to reach women of reproductive age, young girls, under-five children, HIV positive women, babies (neonates), children of HIV-positive women, and adolescents, while secondary groups include male family members and the entire community.

In Jharkhand, India, stakeholders reported that their organisations seek to reduce socioeconomic inequalities by working with exploited groups, populations living below the poverty line, **scheduled castes** (lowest in the social hierarchy), **scheduled tribes** (indigenous population), and **primitive tribal groups** (a more vulnerable section of the indigenous population).

In Bangladesh, a number of stakeholders affirmed that their interventions reach out to lower socioeconomic groups by targeting women, marginalised groups, and local leaders in an effort to increase health service utilisation.

Some stakeholders in Mumbai, Jharkhand and Nepal believed that a **universal approach** to health would also capture people from vulnerable groups. The position was that, when universalised approaches are used, although persons belonging to non-poor sections avail of welfare schemes, programmes and projects, a much larger proportion of marginalised people also use them. In contrast, a **targeted approach** only reaches a limited number of groups and individuals. Also, within the universalisation approach, there is a process of 'self-selection' in which many middle and upper class people naturally opt out of subsidized government programmes, with the result that marginalized groups are able to benefit from a greater share of the provisions within the schemes.

The universal *vs.* targeted approach was put into perspective by Mr. Balram, Advisor to the Supreme Court Commissioner on Right to Food (Jharkhand, India). He said that the state administration is mandated to reach out to communities residing in the most difficult and remote places. At the same time, "the administration's motivation is to show overall coverage and maintain a good performance record as far as possible." So, the state expenditure is focused on ensuring or maintaining a certain level of coverage while also, "extending itself to specific vulnerable communities that have been excluded historically e.g. particularly vulnerable tribal groups." Civil society organizations have financial and human resource constraints but they are mandated to show positive change in their area of operation, which, in turn, is expected to influence policy decisions. In order to do so **organizations tend to "work in easier geographical areas or with more accessible socioeconomic groups**".

Barriers to reaching lower socioeconomic groups with maternal and newborn health interventions and how to overcome them

Poor state of public health facilities

A common opinion across Nepal, India, Bangladesh and Malawi was that the public health sector suffers from a range of systemic deficiencies that hamper the provision of health services to the poor. One of the

issues was the ***overburdening of services.*** In Mumbai, it was pointed out that, although the population in the countries has increased, the services have not expanded in equal proportion. In the Malawi and Nepal discussions it was noted that a ***lack of infrastructure*** and ***budget constraints*** that hinder the functioning of health facilities. In Jharkhand, it was observed that unfulfilled vacancies and a ***shortage of personnel*** in ICDS (Integrated Child Development Scheme) centres, prevented some potential beneficiaries from lower socioeconomic groups from accessing the scheme.

Lack of access to health facilities

This was a common theme in discussions in Nepal, Malawi and India. Since a substantial proportion of the population lives in remote or inaccessible areas, distance from health facilities makes it difficult for them to utilise services. An issue discussed in Mumbai and Nepal was the **behaviour of some health care providers** (especially the lower-level staff) in the public sector. There are reportedly often rude to clients of a lower socio-economic position, which deters women from seeking care at the facility. One of the stakeholders, Dineshwor Sah (Asman, Nepal) said:

> "*If a rich person dressed in a shirt and pants [trousers] visits a health post, staff will make him sit in the nearest chair, but if a person wearing rough and torn [thotro] clothes is standing at the side he will be left there standing.*"

Given these conditions, it was pointed out in Nepal and India that the poor often resorted to the ***alternative of seeking care at a local private health facility***. As some local practitioners' fees can be inexpensive, and because they often have more cordial attitudes compared to some public health staff, the poor preferred them. However, some felt that the quality of health care provided by these practitioners was lower than in public sector facilities.

Social and cultural barriers

In the Bangladesh discussion, it was highlighted that the **web of poverty** in which the poor find themselves is a huge barrier to addressing inequality. In order to address this, stakeholders expressed a need to tackle the larger issue of helping lower socioeconomic classes out of their 'downtrodden' situation.

In the Nepal discussion it was highlighted that **women had no say** in some family decisions and the utilisation of health services. Traditional **cultural norms surrounding child-bearing** was also seen as an barrier for some women to access institutional care. For example, in India, women sometimes go to their mother's house to for childbirth, denying them the opportunity for an institutional delivery in their own areas. In Nepal and Malawi, experts described a lack of involvement of men in the care of the mother and child.

In a programme context, within the Jharkhand Rural Health Mission (JRHM) it was found that, because some of the health workers in tribal areas did not belong to these geographically inaccessible tribal communities, they were not holding health camps. The JRHM took special measures to identify **tribal women, enrol them in the programme and give rigorous training** under the scheme.

Problems with targeting

A barrier discussed in Jharkhand was that reportedly a large proportion of the poorest sector of society do not own ***Below Poverty Line (BPL) card***. A BPL card entitles a household to a monthly ration of rice or wheat at highly subsidised rates. As some targeted health and nutrition services are also linked to BPL card ownership, poor people without a card are being missed by these targeted interventions. Poor migrant

labourers in cities tend to be excluded from targeted programs, as they often do not have necessary identity proofs, such as ration cards or BPL cards.

What works well to reach lower socioeconomic groups with maternal and newborn health interventions?

Identification of vulnerability

Stakeholders in India and Nepal discussed the idea of tackling inequalities in maternal and neonatal health by identifying the geographical areas, communities and social groups most in need, and targeting them for intervention. For example, before starting a recent programme in urban slums of Mumbai, SNEHA used the United Nations Human Development Report and a locally-adapted **'vulnerability scorecard' to identify the poorest communities** in which to work. Similarly, measuring '**wealth ranking'** had worked very well to identify poor women in an intervention by the NGO, Women Centred Skill Development, in Nepal.

In the Mumbai roundtable, it was pointed out that the needs of the community might differ from the services that the organization provides. In order to better understand these needs, and develop appropriate strategies, it was considered very worthwhile conducting family profiling and micro-planning exercises with the community.

Community engagement

An overarching experience across India, Nepal, Bangladesh and Malawi was that intervention strategies have been successful when communities are engaged throughout the intervention. In the Malawi stakeholders meeting, there was consensus that interventions should take a bottom-up approach by **including target groups from the planning stage**, because top-down approaches did not tend to yield substantially positive results. Projects which ensure that communities are involved in the objectives are more acceptable to them. Some stakeholders also felt it was important for communities to act as **project implementers** and that they should also be responsible for **monitoring** them. Others thought it essential that marginalised groups be **made aware of their health rights** in order for them to claim them. A district health officer from Nepal said that political instability in Nepal had made it is difficult to supervise the health workers, so communities who realize they are not getting their entitlements should raise their voice against the health facility.

The **Sahiyya movement in Jharkhand (India)** is a good example where an entire cadre of women have been trained throughout the state to provide community-based health interventions. The programme comes under the State Rural Health Mission of Jharkhand and the National Rural Health Mission of the Government of India. Sahiyyas are **identified and selected at the hamlet level** and provide a range of services to improve the maternal and neonatal health in the community, including running **'help desks'** in health facilities. Currently, there are 103 tribal Sahiyyas. They have a broad outreach in the rural areas of Jharkhand and have also acted as deterrents to malpractice in public health facilities There were several instances where these help desks had held the health system accountable to vulnerable communities and lower socioeconomic groups in Jharkand. For example, Sahiyyas had protested against an auxiliary nurse-midwife (ANM) who refused to give a mother her newborn because she was unable to pay a Rs. 500 bribe. Sahiyya help desks have helped reduce bribery at hospitals, and more people are benefitting from the programme (anonymous).

In the roundtables in Bangladesh, Nepal and Malawi it was considered crucial to engage, not only with women, but also other family members such as the husband and mother-in-law. Because men do not take an active interest in women's reproductive health, there needed to be a consistent ***engagement with the men-folk*** to bring about any equitable change in access to health services. Other strategies included the need to have communication in **local languages**. In the Mumbai roundtable discussion, it was felt that ***winning the trust*** of the community was also a crucial component of successful interventions. Leena Joshi (Tata Institute of Social Sciences), pointed out that it is important, in order to be accepted by the community, to be being located geographically within it. The members of the slum community should feel secure that, at any point, if they required help the organization was present for them.

The ***need for awareness and education*** of the lower socioeconomic classes was an over-arching observation across the stakeholders meetings. It was felt that, since many community people are unaware of their basic health entitlements, an important strategy is to raise their awareness. For example, in India it was mentioned that some lower socioeconomic groups are unaware of the Janani Suraksha Yojana scheme (financial incentive for institutional delivery) and, as choose home births. Likewise, in Bangladesh it was emphasized that the due to a lack of knowledge of subsidized health care services, poor groups often do not utilize them.

Mr. Nilendu from CRY India felt that, while engaging with the community, there are times of hopelessness when a number of roadblocks hinder the process of change in interventions. In such situations, it is important to give them a **sense of 'wins'** (small achievements) in order to maintain momentum.

Nature and provision of health services

In Bangladesh, a strategy voiced by a number of stakeholders was the provision of ***free services*** for poor women to increase the utilization of health services. Non-governmental organizations such as Manoshi-BRAC and Smiling Sun Franchise Program provided free services for women from lower socioeconomic groups.

Some felt that, given that women may not come to the health facility, it was important to take the services to their doorstep through ***home visits.*** Stakeholders in Bangladesh, Nepal and Malawi felt that the ***branding of services*** was important in reaching poor communities by increasing their awareness of services in a way that appealed to them.

Accessibility/availability/affordability/quality and quantity of public health care services:

Stakeholders in all countries felt that there were a number of issues within the public health system that needed to be addressed if the poor sections needed to access them optimally. There was a serious concern regarding the lack of access to public health services in certain areas where they are most needed. This came out clearly in the more isolated hinterlands of Nepal and tribal areas in India. It was considered imperative that governments place priority on reaching out to them.

Experts from Nepal and Mumbai reflected that government health services should be decentralized but that this was not followed in practice. For any pro-poor programmme to be successful, a **decentralized bottom-up approach** should to be followed.

It was highlighted that in Mumbai's public hospitals, patients had to spend for medicines and tests as well as the bed and the doctor's consultation charges. This often made it very expensive for the poor. Therefore,

services **should be cheap and functional**. In the Mumbai roundtable, it was emphasized that ***quantity of services*** was a pre-requisite for ensuring that larger numbers of marginalised were covered by health services and increasing the likelihood that lower socioeconomic groups utilise health facilities more. Finally, it was of prime importance to have **quantity in proportion to the population to serve** those the bottom of the socioeconomic ladder. It was also felt that there had to be a strong network of ***referral services*** of secondary and tertiary hospital in order to tackle complicated cases.

Work was also needed with the lower-level hospital staff. A strong view-point from Mumbai, Jharkhand and Bangladesh related to the negative behaviour of some of these. Therefore, ***behaviour and communication skills*** need be imparted to these workers to encourage more a positive atmosphere of care within health facilities. Some representatives from Mumbai felt that having a empathetic attitude towards the health issues of lower socioeconomic classes needed to be added to the medical curriculum.

The stakeholders in Mumbai, Jharkhand and Nepal felt that there needed to be a significant ***increase in the staffing levels*** within the public health facilities. In Nepal, it was felt that the training of Health Management Committees should be undertaken.

Policy Level interventions

In Jharkhand, a classic policy was mentioned on ***'wage benefits':*** an incentive program for loss of earning while treating a child for malnutrition. In the Jharkhand roundtable it was felt that the hamlet and not the revenue village (an administrative division that may consist of one or more hamlets) needed to be set as a baromter for deciding the setting up of Village Health and Sanitation Committees. Dr. Rohit, President of Indian Association Pediatrics, referred to the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) as a successful programme to manage child illness at the community level. The IMNCI is a WHO-UNICEF facility-based strategy using a simple system for nurses and other health workers to effectively manage a range of common neonatal and childhood health problems.

Gaps in evidence

The stakeholders highlighted with a variety of gaps in evidence that would be required to address the issue of inequity in maternal and neonatal health. Although there were cross-cutting issues between the roundtables, some were specific to certain discussions.

Understanding Equity

In the Jharkhand discussion, it was pointed out that more data are required to understand and address inequalities in order to ensure that benefits were reaching the most marginalised. Another important point of view was that it is crucial to define which types of data are required.

Understanding the community perspective

It was also discussed that in many communities there are a range of traditional practices related to maternal and neonatal health and care, which might explain why local people sometimes do not participate in NGO programmes and health services. It would, therefore, be useful to analyze the social behaviours that prevent certain groups from doing do. These views came out in the Malawi and Jharkhand, India discussions.

Lack of disaggregated data

In the Nepal (Kathmandu) discussion, one of the main evidence gaps identified was that the government Health Management Information System did not have disaggregated data on socioeconomic groups. This was a major impediment to planning effective and targeted intervention strategies.

Lack of high quality data

Mr Gurjeet Singh from the Right to Food Campaign (Jharkhand, India) pointed out that the practice of under-reporting in most state-run departments seriously undermined the actual reality of the situation. For instance, he claimed that the mortality and morbidity figures are not accurate as departments seek to maintain a good performance record in spite of negative ground realities. This resulted in a number of schemes not reaching the lower socioeconomic groups. In the Malawi discussion there were descriptions of "cooked data", (falsified or exaggerated data) due to a lack of clarity on what was required, and a lack of seriousness towards the actual process of data collection. There was a need to help data collectors and those responsible for monitoring understand the importance of gathering good quality data. These data need to be accurate, of high quality, and representative.

Monitoring impact

It was felt in the Mumbai and Malawi discussion that indicators needed to be formed to measure the impact of interventions. Although maternal and neonatal health interventions exist, there is a gap in actually monitoring outcomes. Although there is reporting on specific programmes, the actual factors that lead to change are often omitted. There is a lack of documentation on ***capturing the processes of change.***

Lack of programme documentation

In the Mumbai discussion, it was pointed out that among a huge number of NGO workers, there was a major block towards systematic documentation. Mr. Nilendu (CRY) felt that NGO field staff are extremely emotional about action-oriented work and will go to any length in their intervention but, when it comes to documenting their work, there is a major mental block. He felt that, if NGO staff started to systematically document data on malnourishment in their intervention areas, it would provide enough evidence to take action against the authorities who are not implementing the schemes properly.

Sharing of data between organizations

From the Bangladesh and Malawi roundtable discussions, it emerged that there was a lack of meaningful coordination, effective networking, and sharing of findings (including success stories) among organizations working in maternal and neonatal health.

CONCLUSION

The information gathered in the 7 roundtable discussions in India, Nepal, Bangladesh and Malawi brought to light a range of inequalities in maternal and newborn health, its causes, and strategies to address them. Although there was consensus on the need to reduce inequalities, some stakeholder organizations implemented interventions that focused on improving average health outcomes. There was considerable debate on the benefits of universalised and targeted approaches, and while some stakeholders felt that universal health care strategies should include marginalised groups, others believed that interventions were needed to target these groups.

A number of supply- and demand-side barriers to reaching lower socioeconomic groups were identified. On the supply side, these included an insufficient number and unequal distribution of public health facilities, shortages of health personnel, deficiencies in quality and poor staff behaviour. Among the social and cultural factors were class, caste, gender, illiteracy barriers, poor perceptions of and experiences with services, and poor awareness of health entitlements. Combined, these contribute to inequality in uptake of health interventions. Importantly, these factors result in attrition towards private sector care, itself often expensive and largely unregulated.

At the same time, stakeholders identified a number of strategies, programmes and interventions implemented by government and nongovernment agencies that were believed or shown to be effective in reaching lower socioeconomic groups and reducing inequalities. Examples included the Janani Sureksha Yojana (cash incentive for institutional delivery), and the National Rural Health Mission (NRHM), which seeks to improve the availability and accessibility of quality health care in rural India. While government health schemes would benefit from raising awareness about their availability, community-based programmes might look at ways to improve training and supportive supervision of community-based health workers.

Nongovernment organisations and agencies have also been responsible for implementing effective programmes, especially those that followed a bottom-up approach involving and engaging with marginalised groups. It is crucial that we gain a much better understanding of how and why these initiatives work, in what contexts, and how it might be possible to scale them up.

The roundtable discussions in all of the partner sites were considered useful and important. They enabled experts in a variety of disciplines and from a range of organisations to share ideas and experiences and consider future strategies to reach out to marginalised groups towards and make further strides towards reducing inequalities in maternal and newborn health. From feedback we received from the participants, we believe that these types of activities should be repeated and expanded.

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