

EquiNaM

building evidence to support equitable improvement
in newborn and maternal health

Learning from Stakeholders for Health Equity

Report of in-depth interviews

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For further information contact:

Tanja AJ Houweling, PhD

Centre for International Health & Development

UCL Institute of Child Health

&

Department of Public Health

ErasmusMC University Medical Centre Rotterdam

info@equinam.global-health-inequalities.info

<http://equinam.global-health-inequalities.info/>



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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 conducted qualitative interviews with health policy analysts, medical experts, funders, national and international NGO heads, and government representatives on intervention strategies to reach lower socioeconomic groups and reduce socioeconomic inequalities health. We also conducted a series of roundtable discussions 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 interviews 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

A total of 11 experts were interviewed by an Indian researcher using a structured interview guide. Most interviews were conducted by telephone or Skype and lasted between 20 and 40 minutes. One public health practitioner was interviewed in person and one stakeholder responded electronically. Each participant was sent an information sheet and gave consent prior to interview. Spoken interviews were

conducted in English, digitally recorded and transcribed verbatim. Transcripts were analyzed thematically, and information was compared and contrasted across respondents. Information was elicited according to 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?
2. What are the main barriers to reaching lower socioeconomic groups with maternal and newborn health interventions? How can these barriers be overcome?
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. 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/context?
5. What evidence do the stakeholders need and currently miss to ensure that their organisation/project can reach lower socioeconomic groups?

The following stakeholders were interviewed:

Name	Organisation	Type of organisation	Function
Dr. H P S Sachdev	Sitaram Bhartia Institute of Science and Research, Delhi, India	Multi-speciality hospital and research institute	Senior consultant, paediatrics
Dr. Vinod Paul	All India Institute of Medical Sciences (AIIMS), Delhi, India	National level hospital and teaching Institute	In-charge, department of neonatology
Anonymous	Mumbai Corporation of Greater Mumbai (MCGM), India	Municipal government	Medical doctor
Billy Steward	DFID, Delhi, India	International donor organisation	Health and AIDS advisor
Pavitra Mohan	UNICEF, Delhi, India	International donor organisation	Health Specialist
Dr. Sarmila Mazumdar	Centre for Health Research and Development, Society for Applied Studies (CHRD), Delhi, India	Research organisation	Deputy director
Dr. A.J. Faisal	Engender Health, Bangladesh	International organisation	Country representative
Thelma Narayan	Centre for Public Health and Equity, India	National organisation	Co-ordinator
Anonymous	BRAC, Bangladesh	International developmental	Medical doctor

		organisation	
Dr. Neena Khadka	Save The Children, Nepal Country Office	International NGO	Senior Development Manager
Rajkumar Gope	Ekjut, Jharkhand, India	National NGO	Policy and advocacy manager

KEY FINDINGS

Importance given to reducing socioeconomic inequalities in maternal and newborn health

All of the stakeholders interviewed recognised the existence of health inequalities and the importance of addressing them. While the aims of some organizations were explicitly to reduce inequalities between groups, others were framed within the broader goal of improving average outcomes in the population. Pavitra Mohan (UNICEF) reported that their country programme mission is “to give highest priority to reducing inequity. I mean, that’s a kind of basic statement mission of our work. So it is very very central...” Within UNICEF, the framework of intervention is firstly to improve services for the disadvantaged and secondly to empower the community. Within the community services, one of their major thrusts to ensure equity and reach out to the disadvantaged population is by empowering frontline workers in delivering community-based maternal and child health services.

Dr. Sarmila Mazumdar’s view was that, since a large proportion of India’s population live in areas with poor health care coverage, and that mothers and children are often disadvantaged socially, economically, and in other aspects, these are the groups who are most in need of health care services. She further added that they specialise in community based research with a vision to contribute to maternal, new born and child health addressing issues of inequalities. A Health expert reported that while all his funding organisation programmes are aimed at the poorest and other excluded groups and that they give high weightage to reducing inequalities. The funding organisation has incorporated a monitoring processes to their interventions in order to understand the impact on these groups and devise strategies to reach them. Within a universalization framework, the funding organisation seeks to identify the barriers that specific populations face and as well as methods of overcoming them. At the same time a health expert recognized that there is “a trade off between absolute inequity and ... increasing coverage broadly.”

According to Ekjut’s policy and advocacy manager, their programmes have also given high importance to reducing inequalities by reaching out to the poorest and most marginalized groups in rural India which have a considerable tribal (indigenous) population. A senior developmental manager from Nepal reported that Save the Children places importance on maternal and newborn inequalities by trying to “reach the unreached”. Of a total of 75 districts in Nepal, Save the Children has selected 20 in which to focus on child rights programming. Within these districts, their aim is to work with Dalits (persons lower in the social hierarchy) and other marginalised communities.

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

Supply-side barriers

Limited availability of and access to public health services

An important barrier identified by experts in Nepal, Bangladesh and India was in equitable access to health facilities and services. A number of reasons were given for this. Dr Faisel reported that, in Bangladesh, the poorest often lack the resources to live in urban areas and, since they tend to live far away from health services, distance and communication constraints are major barriers that prevent health services, including maternity care, from reaching them. Stakeholders in India reported similar difficulties and Dr. Khadka (Save the Children) said the mountainous terrain in the northern part of Nepal makes it difficult and expensive to reach remote populations. An important consequence of this is that people in isolated or underserved areas often seek care from traditional healers or unqualified practitioners. A health expert (funding organisation) reported that the Indian government had conducted extensive mapping of areas with poor health indicators to identify areas where services were most needed.

Another barrier was the limited range of health services provided within some government programmes. For example, a health expert (funding organisation) reflected on India's Village Health and Nutrition Day (VHND), a monthly event in villages across India aimed at providing basic health information and services to women, children and adolescents). In his view, the strong focus of the VHND on immunization tended to overlook other services. This was largely a result of issues of scheduling and coordination, administration in the community, and the limited knowledge of frontline workers to provide more services.

In urban areas other barriers were described. According to an Indian public health doctor, the tenfold increase in Mumbai's population has not been matched by an increase in infrastructure and staffing, placing excessive strain on existing resources. Dr Faisel described the difficulties in locating and providing services to some of the lowest socioeconomic groups in urban areas who live in precarious or temporary accommodation.

Inadequate supply of health professionals

Some stakeholders affirmed that a major barrier to ensuring equitable access to health services was understaffing in public-sector facilities. Dr. Paul highlighted the inequities caused by the disproportionate ratio of physicians to population: "The doctor-population ratio all over India is probably one doctor for probably twelve to fifteen thousand people ... in the cities, we are close to about one doctor for perhaps thirteen hundred people ... therefore, if the supply is weak, the supply tends to become weak for the poor region and poor people and inaccessible people. So that, I think, is one great one barrier." Related to this, a public health doctor in Mumbai reported that inadequate human resources had led to work overload of staff and denial of annual leave, which inevitably had a detrimental effect on performance and effectiveness.

Another stakeholder pointed out that the inadequate resources in the public sector has increased the private provision of some public health services. Dr Sachdev, (Sitaram Bhartia Institute of Science and Research) was against the privatisation of the public health system. He felt that, although the public health system might not have the funds to cater to all services, it absolves itself by allowing the private

sector to fill the gap. As a consequence, the high fees charged by the private sector prevent lower socioeconomic groups from seeking care. He also pointed out that the quality and performance of private providers are not known.

Cost and quality of care

The combination of poverty and the cost of health services and treatment was considered one of the key barriers to accessing care. Specialised care and surgical interventions are often out of reach of the poor. A potential barrier identified in India (where childbirth is free for the first and second delivery), women giving birth to more children knew they would have to pay. Dr Paul acknowledged that, in India, there are some concerns about the quality of services offered to users of public health facilities. These included the coverage of services and level of care, the functioning of health facilities, the quality of staff and the treatment of clients. Although a health expert (funding organisation) mentioned a number of government initiatives aimed at improving quality in various states, he felt that there was still a need to address basic deficiencies and draw on evidence of what works to improve quality.

Inadequate training and support in community-based programmes

Despite the achievements of India's National Rural Health Mission (NRHM), a few stakeholders suggested that differential levels of training across states and weak supported supervision of some Accredited Social Health Activists (ASHA's) had affected their ability to function as effectively as they might, to improve their skills, and to upscale the programme. A health expert (funding organisation) felt that, although the Village Health, Nutrition and Sanitation Committee and the *Rogī Kalyana Samiti* (Patient Welfare Committee) could play an important role in increasing the accountability of health services in underserved areas, he was concerned that the committees often suffered from a lack of clarity of their roles and an unwillingness to fulfil them.

Poor programme planning and implementation

A few stakeholders gave examples of deficiencies in programme planning and implementation. Dr, Mohan (UNICEF) pointed to the limited capacity of different levels of health management to plan, innovate, scale up, learn from mistakes, and take corrective action to meet programme objectives. He suggested that, while the NRHM in India provides opportunities and resources to reach out to disadvantaged groups, it did not provide a "very clear road map" of how to do so effectively. Another barrier is the failure of policy makers and programme planners to tailor strategies to different population groups. Dr. Faisal's personal view was:

I think the first barrier is where we take everybody alike. The first barrier for a programme person like me and those who have actually planned the programme – we don't want to think separately for the different groups of population. So, as such we come up with a programme which is applicable, which we think is applicable for everybody.

Dr Nayaran (CPHE) made the point that, despite the existence of research and documentation on health equity, health professional and activists often fail to read them. As a result, they miss out on crucial debates that might contribute to the planning and implementation of effective strategies.

Political barriers

A number of experts questioned the political will to plan and implement equitable health programmes and improve the quality of health care. Dr Faisal felt that programme managers and health providers are not pro-active enough and fail to pay sufficient attention to implementing the strategies that target lower socioeconomic groups. This view was supported by another stakeholder who mentioned that, in

Bangladesh, a national strategy that had been developed and approved two years ago was yet to be implemented. One respondent in India felt that equitable change and inadequate funding in the public health sector was largely due to a lack of political will.

Demand-side barriers

Stakeholders identified a number of factors that result in a low demand or underutilisation of health services.

Poor perceptions and awareness of services

Poor perceptions or experiences of institutional care were identified as potential barriers to seeking care. There was also a recognition that, even when services and programmes for marginalised groups do exist, some people do not utilize them. Dr Faisal noted that marginalized communities are often unaware of the various free or subsidized programmes available to them or are under the misconception that they will have to pay high prices, even in public-sector facilities where services are free. Among the reasons that stakeholders gave for this were low education and illiteracy, a general lack of health knowledge and awareness of entitlements to health services.

Social and cultural barriers

Stakeholders identified a variety of social and cultural issues that could both affect the ability of marginalized groups to access services, and for health programmes to reach them. An Indian public health doctor said that some pregnant women do not prioritise their health and fail to understand the importance of antenatal care. Gender barriers were considered likely to compound this problem in settings where priority was given to the health of males. Sarmila Mazumdar gave a personal example of a nutrition intervention study in the rural areas of Haryana in which caste had acted as an important barrier to accessing services:

One of our nutrition intervention trials required counseling by Anganwadi workers and conduction of women group meetings. In the Harijan Mohalla [a lower caste area], we found that the response was unusually low. On exploring, it was found that the workers in the area belonged to higher castes. They disregarded and looked down upon lower caste (Harijan). As a result, despite meetings being conducted, the attendance was poor. A worker from the local community was selected, leading to a remarkable improvement in response from women.

It is noteworthy here, that adapting the programme to make it culturally acceptable to the local community resulted in improvements in utilisation of services. Changing behaviour, however, was considered difficult and required persistent and sustained follow-up. Dr Sachdev (Sitaram Bhartia Institute of Science and Research) believed that there are cases where it is difficult to intervene in a community due to caste and illiteracy barriers. He felt it is important for people to be educated and literate, and to go beyond their caste barriers for any kind of change to take place. Dr Narayan (CPHE) summarised the challenge that social and cultural barriers can present: “One of the biggest barriers is our society mindset, you know, our hierarchical divisions of caste, class and gender are very, very, pretty strong. It requires a major ... sustained effort to overcome, it is quite ingrained.”

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

A number of factors and strategies to reach poorer and otherwise marginalised groups were identified. While some were tried and tested, others were based on personal experience and opinions.

Improving health services

A common argument was for increasing coverage of health services for marginalised groups and ensuring that health facilities are located near them. A public health doctor in India said that the provision of free or inexpensive services is effective because it removes financial barriers to seeking care. Other successful strategies included partnering with nongovernment organizations to establish services in district hospitals and rural medical centres. In Bangladesh, experiences of delivering programmes and interventions in partnership with government had also been positive. Some stakeholders felt that improving the quality of existing health infrastructure and services was necessary and would encourage people to seek institutional care. It was also felt that efficient referrals systems, in which patients were accompanied by facility staff would also help.

Taking services to the people

Various stakeholders advocated the outreach of health services to lower socioeconomic groups in order to improve coverage in settings where services are underutilised or not available. One Indian public health doctor said, “taking services to the doorstep of the poor, like home visiting, that helps the poor.” Dr Sachdev (Sitaram Bharia Institute of Science and Research, Delhi) reiterated this point, saying that even in the public health system it is essential that we take the services to the poor, providing them with facilities that are close to their house, then we can expect a change in the health scenario. The range of services could include giving information about health and health services, or specific interventions by health professionals (e.g. immunisation).

Community-based strategies

Stakeholders described several benefits of community-based initiatives and the involvement of ‘frontline’ workers. One believed that, “The bottom-up approach is what works best in cases of reducing inequity in maternal and neonatal health.” One benefit is that field-based workers can reach out to isolated or marginalised populations with health services. A benefit of using community health workers is that they are usually recruited locally, so share a common background and closeness to other community members. Since they also speak local languages and dialects, residents can identify with them.

The local knowledge that community workers have helps them to reach populations not covered by existing interventions and to follow-up with those who had already been a part of them. Although some families are inevitably left out,

“...the strategy is that, if you work with the frontline workers the chances that you will reach the marginalised is much higher than work[ing] with higher level health workers because their ability to reach out physically and socially is much more.” (Dr. Pavitra Mohan, UNICEF, Dehli)

Furthermore, involving partner organizations can help to understand and address some of the barriers to health service utilisation. Dr Mazumdar (Centre for Health Research and Development, Society for Applied Studies) also believed that programmes which focus on the home and community effectively facilitate upward linkages to services aimed at lower socioeconomic groups.

Participation and community engagement

Community-based programmes were also considered effective in promoting the participation and engagement of local populations, including the marginalised. Involving local people in the planning of interventions could ensure that the needs and expectations of the community are incorporated. Likewise, interventions that understand and adapt to local realities (for example, making them culturally acceptable, developing materials in the local language etc.) attracted the marginalised. By engaging local people, communities could be mobilised to identify their needs and plan strategies. For CHRD, women with positive experiences can act as “positive deviants” by sharing their experiences with peer groups and discussing the benefits of an intervention.

Examples of interventions that have reached lower socioeconomic groups

According to a public health doctor in India, providing free or subsidised services had improved access to the poor by removing financial barriers. He said that data on **cash transfer** schemes such as the **Janani Suraksha Yojana** (cash incentives for institutional delivery), had shown that the poor had accepted and were utilizing them.

CHRD had been successful in establishing **specialized newborn care units** at a district hospital in rural India. They found that **raising awareness** about these services, and **providing them free of cost**, enabled families in remote areas and socioeconomically disadvantaged population to access care. They also believed that families’ **trust** in health services increased when sick newborns were referred efficiently, accompanied by a health worker, and when the newborn recovered.

Several stakeholders praised aspects of India’s **National Rural Health Mission** (NRHM). The NRHM was initiated in 2005 by the Government of India to improve the availability of, and access to, quality health care for rural populations, especially the poor, women and children. A key actor within the NRHM is a **locally-recruited community health worker** known as an **ASHA** (Accredited Social Health Activist). The momentum of work that the ASHA has created nationwide is tremendous:

NRHM actually has made a difference ... something did happen on the ground and on the positive side. The ASHA project has achieved certain momentum ... [The] ASHA programme for one, as you know, has 8.5 lakh that’s 850 thousand ASHA women which is the largest such programme in the world – and there is quite a substantial number who are dalit and adivasis [persons belonging to the lower social hierarchy]. The most effective part of the ASHA is that she is selected from within the community itself. (Thelma Narayan, Health Policy Analyst and Director of Centre for Health and Public Equity, India)

Dr Sachdev also commended the impact of the NRHM on reducing maternal and infant mortality rates. He believed that the system of home visits and continuous engagement of ASHAs with village women had improved their health seeking behaviour in a number of villages. Thelma Narayan (CPHE) said, “On the positive side, I would say, the health management processes that have started with block programme managers, district programme managers, block and district accounts managers ... this is the first time it has happened in the health system of India and [it] acts in a very positive way.”

Dr. Faisal gave an example of a successful intervention to provide **surgical procedures for poor women with fistula** in Bangladesh. In 2003, they conducted a national assessment and found that 2/1000 women

in the country had a fistula. In a setting where service utilization is low and the poor cannot afford hospital treatment, they **encouraged leaders, business people and shop owners in the community to take responsibility for generating funds to transport** women to the hospital. The surgery was provided free of cost.

Pavitra Mohan (UNICEF) described **an intervention to improve the equitable coverage of immunisation** in several Indian states, including Bihar, Chhattisgarh, and Jharkhand. He said that **intensive micro-planning** (i.e. in and with communities) had helped ensure that **areas in need of intervention were identified and included** in the programme. He also explained that **frontline workers in disadvantaged areas** had been effective in reaching excluded groups (both physically and socially) and providing home-based postnatal care.

Ekjut's randomized controlled trial of a women's group intervention in around 400 villages in Jharkhand and Orissa (now Odisha) achieved a one-third reduction in the newborn mortality rate and, furthermore, a 73% reduction among the most marginalized groups. Ekjut used secondary data to **identify districts with socioeconomically vulnerable populations**, then linked up with local partners to identify marginalized areas within these districts. Key factors in the success of the intervention included **identifying and understanding marginalised communities**, using **local facilitators** to organise participatory meetings, developing **attractive materials** (e.g. visual aids games, and the sharing of stories) and conducting meetings in **local languages**.

Thelma Narayan (CPHE) provided examples of creative initiatives to reduce discrimination and improve health services for marginalised groups. In one, simple **'exit polls'** were conducted **with users of a primary health care centre** in the Dharmapuri district of Tamil Nadu at the facility. Among the positive changes that resulted were improved services and some reduction in corrupt practices. In another, a basic **'equity index'** was developed to collect feedback on health services from members of **low caste communities**. Dr. Narayan reported that the presence of the intervention itself, and measuring and reporting the results, had made a difference.

Dr. Khadka (Save the Children) described a USAID-funded project to increase utilization of family planning services in Nepal. The project **targeted marginalized women and focused on teaching reading and writing skills**. Through this, they were able to deliver key messages on maternal, newborn and child health. She reported that the project had produced positive results both in reaching marginalized women and improving their literacy and increasing high FP services uptake and improved maternal, newborn and child care practices.

Gaps in evidence

Areas where gaps exist in evidence included population data, qualitative research, and **systematic, empirical evidence of effective interventions** in order to inform policy. Dr. Faisel felt that greater effort should be made to improve the **quality of data specifically on lower socioeconomic groups**, those that do not access health care and those who health providers do not reach. Another stakeholder highlighted the need for good quality studies to make informed policy decisions:

We should have a good literature available to let people know what helps. For example, there is a belief that user fees are very good, but the literature is totally to the contrary. So, a lot of people believe in user fees: policy makers, common health people, but they don't understand that, actually, this literature that doesn't support user charges. Dr. Paul

Dr. Narayan (CPHE) expressed a need for qualitative methods to collect **ethnographic or anthropological data on people's experiences of a project**. Rather than project implementers documenting their own experiences, it was considered essential to gather knowledge from the participants themselves. Dr. Sachdev (Sitaram Bhartia Institute of Science and Research) seemed to support this view.

The strongest view was that more evidence was required on **which health programmes and interventions 'work'** and research on lessons about areas where health systems and programmes are functioning well.

I think we have extremely good examples of good quality services including improving access and quality in different parts of the country. But we do not capture them well enough ... to say that, what are the lessons that one could take from there and transfer elsewhere. So, this whole art of replication and scaling of the evidence that we require, that why something worked in a given area, why it didn't work in another area, what are the potential factors that would make an innovation work elsewhere. But some of the key critical areas that we are talking of for community-based services or referral services, what has worked where. For example, how is some state is able to ensure better retention than others, and, and what are those key factors that can even be used elsewhere. Those are the kind of gaps... (Dr Pavitra Mohan, UNICEF)

A health expert (funding organisation) also felt that there is insufficient evidence of **what types of community mobilisation actually change health outcomes**. This information could be utilised for replication and evaluating the potential to scale up. He also considered it necessary to gather more evidence to understand what projects look like when they are scaled up, what are the requirements and what are the impacts.

Dr. Paul felt that evidence is required on "**quantifying the role of different barriers**" and to understand **how implementation works so that barriers can be removed** and coverage increased. Similarly, Dr. Khadka acknowledged that Save the Children is struggling with knowledge gaps of how to "reach the unreached".

CONCLUSIONS

Our interviews with 11 stakeholders from India, Nepal and Bangladesh, gave a broad perspective of socioeconomic inequalities in maternal and newborn health, its causes and potential solutions. All stakeholders recognized socioeconomic inequalities in health as an important problem, though not all their organisations had explicitly formulated aims to reduce these inequalities. Problems in the public health sector, in terms of availability of services and personnel in areas where lower socioeconomic groups live, and costs of care to the household, were mentioned as important barriers to reaching lower socioeconomic groups.

In order for health services to benefit lower socioeconomic groups, it was argued that they should be either free or subsidised. The utilisation of health services was considered to improve when "taken to the doorstep" of the poor through a more equal distribution of facilities and strategies such as community-based initiatives. It was also largely agreed that the marginalised groups targeted by interventions needed

to take a bottom-up approach by including them in programme planning, implementation and monitoring.

While community health workers can play an important role in reaching marginalised communities, they need to be well-supported, and their activities need to be adapted to the social and cultural circumstances in the community. Two structural barriers to reducing socioeconomic inequalities in maternal and newborn health were mentioned. First, a lack of political will was mentioned by some. Second, many stakeholders mentioned the lack of available data on what works to reach lower socioeconomic groups, the lack of qualitative data on people's experiences of health interventions, and the lack of sharing of successful experiences.

We interviewed only a relatively small number of stakeholders, mostly from India. It is important to realize that our findings may not apply to all settings. Moreover, the involved stakeholders were all people who were interested in the topic of socioeconomic inequalities in health, and recognized the importance of addressing this problem. Learning about structural barriers to reducing inequalities, may also require similar interviews with key policy makers, administrators and implementers who are less disposed to spend resources to addressing this important public health problem.

Our findings highlight the need for more systematic capturing and sharing of experiential and other evidence on what works, where, and why to reach lower socioeconomic groups with health interventions. Systematically capturing experiential knowledge of an even broader group of stakeholders is a first step to highlight barriers to reaching those most in need and solutions in real life situations. This should include the more systematic capturing and sharing of the experiences of marginalised communities with health interventions. This experiential evidence should be combined with systematic monitoring on who is being reached in health interventions, as well as evaluation of the health equity impact of programs, including of that seem effective in reaching lower socioeconomic groups.

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