EquiNaM
building evidence to support equitable improvement in newborn and maternal health

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SNEHA®

Policy Brief

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UCL Institute for Global Health

Community health interventions in informal settlements: reaching the most vulnerable

A. Background

Systemically unequal social and economic policies and practices limit opportunities for vulnerable populations to access essential services such as health care. Health inequalities have hampered India's progress towards the Millennium Development Goals and, despite recent gains, the health status and outcomes of women and children remain poor [1].

Social and economic inequalities are critical contributors to disparities in the health of women and children in urban India [2,3]. Rapid urbanisation has exacerbated sharp inequalities between the wealthy and the poor in access to health programs and infrastructure. Mumbai's population now exceeds 16 million and around 40% of its residents live in informal urban settlements [4,5]. Ensuring that health interventions reach the most vulnerable women and children in these areas is both crucial and challenging.

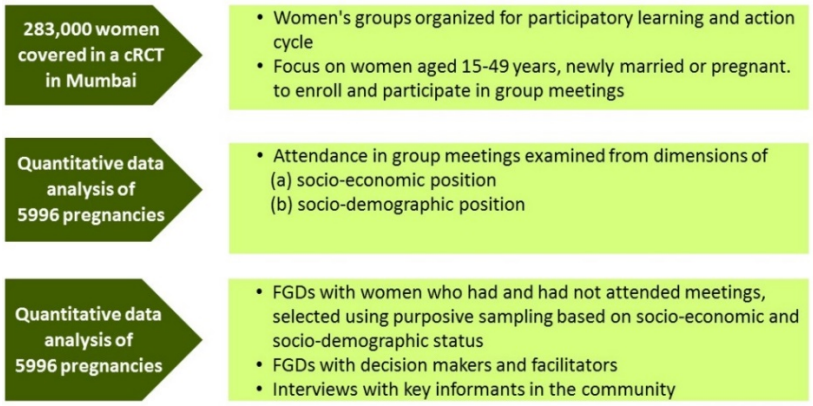
In order to understand which interventions serve those who most need them, it is important to determine how a program's outputs are distributed across subgroups within the population it serves (known as a 'programme incidence analysis') and to analyse why any differences occur.

This policy brief describes the findings of a programme incidence analysis of a cluster randomised controlled trial of participatory women's groups aimed at improving perinatal health in informal urban settlements in Mumbai. The trial was conducted by the Society for Nutrition, Education, and Health Action (SNEHA) and University College London (UCL) [6]. It was one of seven similar trials conducted in South Asia and Africa: an urban site in India (Mumbai) and sites in rural India, Nepal, Bangladesh and Malawi.

The Mumbai trial covered a population of 283,000 in 48 informal urban settlements across the city (divided into 24 intervention and 24 control areas). The primary target group consisted of women aged 15-49 years and included newly-married and pregnant women. In the intervention arm, women's groups were formed and met every fortnight for 3 years (2006-2009) under the guidance of a local, trained facilitator.

In their groups, members discussed their own experiences and knowledge of perinatal health and health care, and collectively planned strategies for local health action. A total of 244 groups were formed and a mean of five women attended each meeting (range 2–20); individual women attended 15 meetings each (range 1–50). While 150 groups were sustained to the end, member numbers dropped from an initial 2,948 to 656. The attrition in groups and membership occurred in the later phases of collective strategizing. Convening community groups was feasible and learning and behaviour change possible, but achieving the impetus necessary for wider change was challenging.

Figure 1. Data sources for program incidence analysis in Mumbai



The program incidence analysis involved a secondary analysis of Mumbai trial data on 5996 births, and a qualitative analysis of 30 focus group discussions (FGDs) and in-depth interviews with women who attended group meetings and those who did not, group facilitators, and community stakeholders (Figure 1). The quantitative analysis examined attendance using two key variables:

- Socio-economic position of women, measured using maternal education and household economic status.
- Socio-demographic position of women, measured using age and gravidity (primigravida vs. multigravida).

B. Key findings

Generally low attendance overall

- Of all women who had recently delivered a baby, only 1% to 3% attended group meetings. The low attendance in the urban site was striking in comparison to the other sites, where attendance ranged from 10-55%.

Women across all socioeconomic strata attended the meetings

- Attendance was as high among women from lower, middle and higher socioeconomic strata. These similarities contrast with reports that interventions systematically reach higher socio-economic groups first. In the last year of the trial in rural India, attendance was lowest among the elite, probably because their perception of the need to attend reduced once they felt they knew enough.

Facilitator (left) with women's group discussing new-born care

Socio-demographic position of women was a strong determinant of attendance

- Most women who participated in meetings were 25 years or older. Younger married women (under 20) and those who were pregnant for the first time attended much less than older women.
- Gravidity had a strong positive effect. Women who already had children were one-and-a-half times more likely to attend than primigravid women.

Qualitative factors that contributed to attendance

Role and profile of the facilitator

- The facilitators played a key role in group membership and participation. They conducted house-to-house visits to encourage women to

attend, especially those from lower economic strata.
- Having facilitators with similar backgrounds to residents and an understanding of the local context increased their acceptance and promoted community engagement.

Characteristics and perceptions of the meetings

- Meetings were held at convenient times for women and sometimes in their homes. Discussions were guided by stories, games and picture cards, eliciting women's curiosity and interest to learn.
- In general, women felt that the meetings were "open to all" regardless of age, background, or experience; they were a forum in which to listen, share and learn.

Cultural beliefs and inhibitions

- Community members felt that younger, newly married women were uncomfortable discussing reproductive health issues in the presence of older, more experienced women.
- Cultural beliefs about the vulnerability of primigravid women and newly-weds, and social restrictions and stigma associated with women's movement outside the home prevented some younger women from attending meetings.
- Less conservative families allowed or even encouraged the younger women to join a group. Some of them made special efforts to attend meetings when their in-laws were out of the house.

C. Recommendations

- In some low perinatal mortality settings, community-based strategies might be replaced by interventions that focus on health system improvements such as satisfaction with services and quality of care.
- Community-based health interventions that are well-designed, participatory in approach, and conducted at convenient locations and timings by skilled facilitators can achieve participation from residents of informal urban communities, irrespective of their socioeconomic position. Public health planners and program managers should keep these features in mind when designing and implementing programs.
- Low economic status is not necessarily a substantial barrier to participation in community-based health programs. However, demographic and socio-cultural factors should also be considered in order to promote more equitable coverage and access.
- In poor urban settings where age at marriage and first pregnancy is low, maternal and newborn health interventions must effectively reach young, newly-married, and primigravid women. Based on our recent experience, strategies might include going door-to-door to identify individual women, making frequent home visits to encourage participation, and organising fun, relevant events such as baby showers.
- A deeper understanding of the socio-cultural milieu of urban informal settlements prior to implementation is warranted. Factors that influence decisions whether to attend activities such as group meetings require adequate consideration.

Potential strategies to improve the impact of community-based perinatal health programs in urban settings include:

- Ensuring community participation in intervention design, objective-setting, and strategy-building from the outset.
- Including key household decision makers in discussions about the purpose and nature of intervention activities, and inviting mothers-in-law to attend separate group meetings. This might help reduce social and cultural barriers to attendance of young women. Ways of separately involving men are also worth considering.

- Using multi-level strategies that establish the intervention in the community which also respond to the needs and expectations of the community. These could include covering topics other than perinatal health, raising people's perceptions about the organisation and intervention by providing individualised services for vulnerable women (e.g. home visits and accompanying them to health facilities), and organising broader group and community activities.
- Publicising group members' positive experiences of participation in the intervention such as motivation or knowledge acquired from group meetings. Also, supporting individual women to act on new knowledge, for example, in their interaction with family or by accompanying them to health facilities. Sharing success stories can help improve individual and community perceptions about the benefits of group membership and positive health behaviours.

References

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