



Saving Mothers and Children in Bangladesh and India



What is the Project?

This ground-breaking project is improving maternal, newborn and child health in deprived communities in South Asia through two complementary approaches:

- Mobilising communities to address their maternal, newborn and child health challenges;
- Strengthening healthcare to increase use of better services.

The project has three key elements:

- Increasing coverage of effective interventions across Bangladesh and India;
- Working with key partners, policymakers and stakeholders to ensure ownership, commitment and sustainability of the interventions;
- Influencing maternal, newborn and child health policy and practice in Asia and internationally.

Successes so far include:

- Up to a 45% reduction in neonatal mortality in our study areas in India;
- Improved uptake of health services and home care practices in our study areas in Bangladesh;
- Reduced moderate maternal depression by 57% in our study areas in India.



Community Mobilisation through Women's Groups

Community-based interventions are urgently needed to improve both the supply of and demand for maternal and newborn care. Effective demand-side strategies, particularly through community mobilisation approaches, empower women to recognise and press for their right to quality health services, and increase resilience to community health challenges. They are as important as the requirement to invest in health systems to make health information and services more accessible on the supply side.

Women's groups provide opportunities not otherwise available to bring women together to discuss key issues affecting them during pregnancy and childbirth. The meetings enable women to develop their own knowledge about maternal, newborn and child health which they can then use to educate others and challenge existing power structures. They bring women with similar needs together to discuss topics that are of concern to them – for example, lack of access to high quality healthcare facilities. These women's groups have developed various practical strategies to meet their healthcare

needs – for example, emergency funds, improved healthcare facilities, home visits, counselling for pregnant mothers, and clean home delivery kits. Women's groups enable women to identify and prioritise maternal, newborn and child health issues, support each other to find local and practical solutions, and build links with local health services. Working through women's groups is an approach that is effective, evidence-based, and which has the potential to be scaled up to reach all women and make a significant impact on their lives, their children's lives and the lives of wider community members.



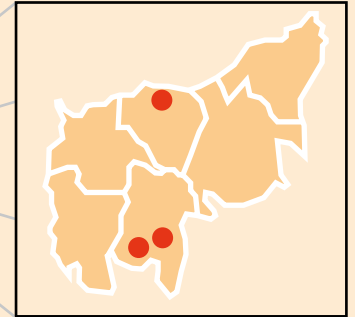
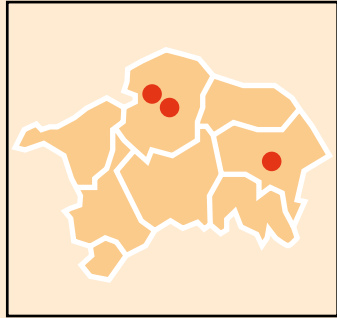
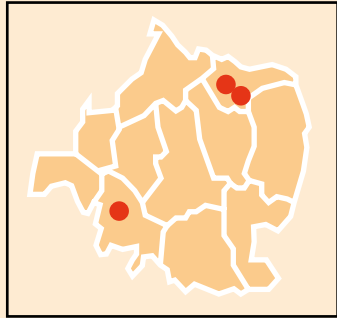
Maternal, Newborn and Child Health in Bangladesh and India

An estimated 4 million newborn deaths occur globally every year, 98% of them in developing countries. Urgent efforts are required to reduce mortality rates through cost-effective and scalable interventions.

India accounts for 20% of maternal deaths worldwide, 21% of all under-5 deaths, and 25% of all neonatal deaths. Jharkhand and Orissa have neonatal mortality rates (NMR) of 49 and 45 per 1,000 live births, respectively, and maternal mortality ratios (MMR) of 371 and 358 per 100,000 live births. These are disproportionately high compared with India's national estimates of 39 per 1,000 (NMR) and 301 per 100,000 (MMR).

Around 40% of their total combined population lives below the poverty line. The average life expectancy among women in both states is around 60 years, and an estimated 63% of women cannot read.

In Bangladesh, around 85% of births occur at home, and approximately 45% of under-5 deaths occur in the first month of life. In Bangladesh, the NMR has declined from 63 per 1,000 live births (1985-1989) to 37 per 1,000 (2002-2006). The MMR is 320 per 100,000 live births.



● Intervention clusters

Project Partners

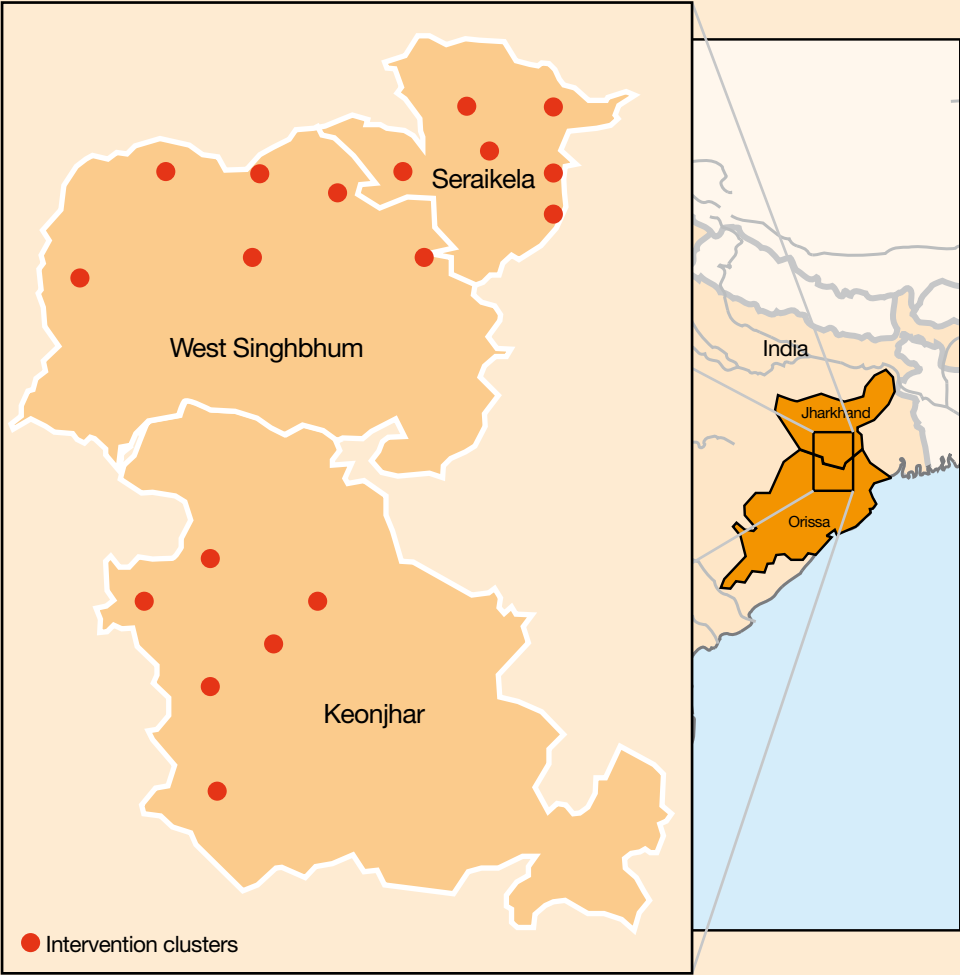
The programme brings together four consortium partners: Perinatal Care Project at The Diabetic Association of Bangladesh (**BADAS**) in Bangladesh, **Ekjut** in India, the **UCL Centre for International Health and Development** and **Women and Children First** in the UK.

In **Bangladesh**, **BADAS**, a Bangladeshi, non-profit voluntary socio-medical organisation works closely with the Government of Bangladesh, and is the second largest provider of healthcare after the government.

The Perinatal Care Project at BADAS is increasing and influencing community mobilisation, and advancing health system strengthening and advocacy in safe motherhood and essential newborn care in the districts of Bogra, Faridpur and Moulavibazar.

In **India**, **Ekjut** – a voluntary organisation working towards building healthier communities and collaborating with a leading development agency PRADAN – has a field presence in the West Singhbhum and Saraikela Kharswan districts of Jharkhand and the Keonjhar district of Orissa.

Ekjut is increasing the number of women's groups with which it works within rural indigenous communities to eight districts in the Ranchi, Godda and Khunti districts of Jharkhand, and the Raygada and Mayurbhanj districts of Orissa. It is also strengthening health services through Village Health and Sanitation Committees and innovative approaches such as "Appreciative Inquiry", which improves staff motivation by building on what they do well.



UCL Centre for International Health and Development (CIHD) works to promote the health, nutrition and welfare of children and their families in less developed countries. Research undertaken aims to develop the scientific basis for improvement in clinical practice and public health using robust epidemiological, laboratory and social science methodologies. CIHD is committed to capacity-building with partner organisations in developing countries to disseminate work as widely as possible.

Women and Children First (WCF) is a UK based international NGO at the forefront of working to improve the health and wellbeing of women and children in poor communities, with a particular focus on pregnancy and the first month of life. By promoting safe motherhood and newborn care, WCF develops effective and sustainable solutions to maternal, newborn and child health problems and strengthens accessible and appropriate health services.

Building on experience in the field, WCF is also engaged in an evidence-informed advocacy programme, striving to bring about changes related to the continuum of care in maternal, newborn and child health that make a real difference to people's health and welfare.



Project Activities

This project is currently funded by The Big Lottery Fund for five years – 2008-13 and builds on previous successful work undertaken in Nepal, India and Bangladesh.

A randomised controlled trial¹ conducted in Nepal showed a 30% reduction in newborn mortality in rural areas as well as a reduction in maternal mortality (Manandhar et al, 2004). Between 2004 and 2008 Ekjut and Centre for International Health and Development (CIHD) also conducted a trial to gauge the impact of community mobilisation on birth outcomes. From 2006 to 2008 BADAS, CIHD and Women and Children First collaborated to

improve the care of mothers and newborn infants through women's groups in Bangladesh.

The previous work in Bangladesh and India set out to test the effect of a similar intervention with participatory women's groups on birth outcomes. One trial was conducted in three rural districts of Bangladesh, and the other was with largely tribal communities in the Indian States of Jharkhand and Orissa – two of the poorest States in India. The Indian trial also looked at the impact of membership of women's groups on maternal depression.

In India, Ekjut is:

- Working with women's groups to devise effective health promotion strategies during pregnancy, delivery and the post-partum period;
- Tracking change to monitor the effectiveness of this work;
- Strengthening links between the community and primary healthcare providers to promote improved health services and increase their use.

In Bangladesh, BADAS is:

- Mobilising communities through community groups to address their maternal, newborn and child health challenges;
- Strengthening health services and advocacy in three districts to improve timely use of better quality services.

1 Randomised controlled trials are studies in which people or entire communities are allocated at random to receive one of several interventions, one of which is the standard of comparison or control. Randomised controlled trials are a rigorous way of evaluating the impact of an intervention, and, if cost data are collected, to assess its cost-effectiveness.



Results – India

244 women's groups implemented a participatory learning and action cycle; the coverage of which was 1 per 468 population. In year one, 18% of newly pregnant women attended the groups, rising to 55% in year three. 67.3% of people attending the groups were married women of reproductive age, but adolescent girls also attended (23.3%), as did men (9.4%). Each group met monthly for a total of 20 meetings and was facilitated by a woman selected from the local community using criteria identified by the community. Facilitators joined a seven-day residential training course to review the cycle's contents and practice participatory communication techniques, then received ongoing support through fortnightly meetings with district coordinators.

Each women's group took part in a participatory learning and action cycle as shown overleaf.

Evidence shows:

- A 45% reduction in newborn mortality rates in comparison with women who did not participate in the project, even though their access to and use of healthcare services was the same;
- A 57% reduction in moderate maternal depression in the final evaluation year;
- Substantial improvements in home care practices: mothers were more likely to have birth attendants wash their hands, use a safe delivery kit and a plastic sheet, boil the thread used to tie the cord and cut the cord cleanly. The proportion of mothers practising exclusive breastfeeding was also higher among women who had participated in the project.
- There may be some contribution to an observed reduction in maternal mortality; the study was not designed in a way that could demonstrate a direct connection, but maternal deaths were markedly lower among women who had participated in the project.



Results – Bangladesh

The total population within the study areas was 478,611, and 162 groups were formed. The coverage of women's groups was 1 per 1,414 population, and included 8% of women of reproductive age in the intervention population groups. Women's group facilitators visited every 10th household within the intervention populations and invited married women of reproductive age to join the groups. The groups initially only included women of reproductive age but others joined later as group members requested that mothers-in-law, adolescents, and other women should also attend.

Two trials were carried out in the same study area: a community-based intervention involving participatory women's groups and health services strengthening to improve maternal and newborn health outcomes, and an intervention that involved training traditional birth attendants (TBAs) in resuscitation of newborns with symptoms of birth asphyxia.

Community leaders were approached and permission obtained to establish the women's groups; 451 community orientation meetings were conducted with community leaders and members, together with village mapping exercises to identify the location of health facilities as well as social and religious meeting places.

Evidence shows:

- Some improved hygienic delivery practices such as using a safe delivery kit, exclusive breastfeeding for the first six weeks and avoiding early bathing.
- Important lessons have been learned, particularly for scaling up participatory women's group approaches, including that population coverage is significant, and that the proportion of newly pregnant women enrolled in the trial is also a critical factor.



Lessons Learned

- Community mobilisation enables communities to come together to plan, carry out and evaluate activities to make sustained improvements to their health. Community mobilisation can make deep and lasting improvements to the health and well-being of community members by increasing their health knowledge and enabling them to identify and address important healthcare needs.
- Findings from these studies suggest that population coverage and the proportion of newly pregnant women enrolled may need a threshold level to impact on birth outcomes.

More Information

Azad, K et al. *Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: a cluster-randomised controlled trial*. The Lancet 2010, 375: 1193-1202.

Manandhar D, Osrin D, Shrestha B, Mesko N, Morrison J, et al. *Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster randomized controlled trial*. The Lancet 2004, 364: 970-979.

Tripathy, P et al. *Effect of participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial*. The Lancet 2010, 375: 1182-1192.



Views from India

“The women have benefited from savings groups, and believe that as a group they can solve many problems.”

(Women’s Group member)

“I like to attend Ekjut meetings because in every meeting there is something new to know. What we know from the meeting will tell others so that they could know.”

(Women’s Group member)

“We discussed that the play is the best way to communicate to the people about whatever we have learned. In a play the crowd gathers in large numbers. Those who have not been coming to the meetings earlier, will be motivated to come for the community meeting if we present to them a street play.”

(Women’s Group member)

“I enjoy having meetings in this village. All the women are not literate but they understand whatever is discussed.”

(Women’s Group Facilitator)

“We used to only discuss about economic activities, but it is good to see them learning so much about their health needs.”

(Sharbani, Programme Officer, PRADAN
– a large Indian NGO working with self-help groups in underserved communities)



Views from Bangladesh

“We advise pregnant women to eat nutritious food, take adequate rest, and get vaccinated with tetanus toxoid. We refer women to the nearest health facility if problems arise and also accompany women to health facility.”

(Amirun Bibi acting as ‘Mini- facilitator’ and disseminating information among the larger community)

“Perhaps my daughter and I would not be alive today if our group members hadn’t convinced my family to admit me in the hospital. I will be grateful to our Women’s Group members forever.”

(Shahnaz, a Women’s Group member who had developed eclampsia)

“We are happy that we could help Momena with money from our Emergency Fund and she was treated in time.”

(Sobeda, the leader of Teghor Women’s Group. Momena developed pre-eclampsia with headache, swelling of the feet and puffy face).

Tofazzal, Momena’s husband also expressed his gratitude and said:

“Now I understand the importance of the emergency fund and the importance of group meetings. I am grateful to all the group members for their support.”

Partners



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Donors who support the project



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For further information on the issues raised in this brochure please e-mail the partners listed above.

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