

Reaching every woman through the Zambian Safe Motherhood Action Group initiative

EVIDENCE BRIEF

A global commitment to reaching every woman, every child and every adolescent aims to end preventable deaths within a generation. In order to achieve this challenging agenda, innovative, evidence-based and scalable approaches that provide a means to identify and reach individuals who are left behind are needed. Channelling health resources to where they are needed the most is especially important in countries where there are severe constraints on public finances.

The More Mobilising Access to Maternal Health Services in Zambia programme (MORE MAMaZ) (2014-2016) built on a successful predecessor programme (MAMaZ) and mainstreamed a focus on social inclusion into the training of Safe Motherhood Action Group (SMAG) volunteers and front-line health providers in five districts. Working with District Health Management Teams (DHMTs), the programme built local capacity to identify and support the least-supported women and girls, in order to ensure that they benefitted from the maternal and newborn health (MNH) interventions and resources available in the district. These efforts resulted in attitudinal changes, positive examples of inclusion at community level and increased uptake of health services.

Summary

- Health outcomes are known to be worse in a relatively small group of particularly excluded individuals.
- Traditional methods of identifying the hard-to-reach are not always appropriate as they risk missing vulnerable individuals who may not fall neatly into common categories of at-risk groups.
- A more nuanced approach to targeting, using factors such as the extent to which women look after themselves and the extent to which they feel supported and respected, may be more effective in identifying those who most need attention.
- Appropriate orientation and training of community volunteers and health care providers can overcome barriers to reaching the most excluded and help Zambia achieve the goal of leaving no-one behind.



Including socially excluded women in groups has positive health and social benefits

“Women who are more vulnerable than ourselves exist here. In the past we used to think they are just lazy, anti-social or mentally disturbed. The SMAGs have taught us that they are people just like us and they just find themselves in that situation for various reasons and they need our help.”
Community member,
Chitambo District

Background and context

Studies of maternal and child mortality in rural communities in Europe, Asia and Africa have found that mortality often tends to cluster among a small group of women. A recent study in Northern Nigeria, for instance, found that 80% of child deaths occurred among 20% of women.¹ In this case, the clustering occurred in a rural population that was generally poor, which did not have large differences in education levels, and which was relatively homogenous from a socio-cultural perspective. Many of the usual explanations for clustering – poverty, education levels, cultural differences – therefore did not apply. In this case, a perceived lack of support and respect from husbands, other family members and the wider community, were strongly associated with the clustering.

The international development community strongly promotes the need to focus health interventions

and resources on groups perceived to be ‘high risk’. Groups include, among others, the disabled, young people, and people living with HIV/AIDS. One problem with this approach is that these groups include people who are well-supported and have a relatively low risk of morbidity or mortality. Another challenge is that many socially excluded or otherwise vulnerable individuals do not fall neatly into one or other at-risk group, and may therefore be missed. Broad-spectrum targeting may not therefore be the only or indeed the best way to reach individuals who are left behind.

When the Comic Relief-funded MORE MAMaZ programme began in 2014, social exclusion was accepted as a fact of life in the programme’s five rural intervention districts. At community level, social exclusion and vulnerability were largely associated with poverty and hence, where support was given, this was generally in the form of financial and in-kind support. There

were many different ideas, including some underlying prejudice, about how these individuals had come to be socially excluded or vulnerable, and different views on whether they deserved to be supported at all. Yet what was clear was that communities were aware of who these individuals were, and where they were located.

A survey of front-line health providers in the programme’s intervention districts found that when under pressure, they admitted to discriminating against the individuals who were least likely to challenge them – those who lacked confidence, did not communicate well, and who generally lacked social support. The least-supported individuals therefore bore the brunt of health providers’ frustrations with everyday health systems challenges. MORE MAMaZ used an integrated and comprehensive community engagement approach that was embedded in the district health system in order to address these challenges.

Strategy

MORE MAMaZ and its DHMT partners in five districts used two complementary strategies to reach the hard-to-reach:

Mainstreaming a focus on social inclusion into community volunteer training:

A focus on social inclusion was mainstreamed into the training of Safe Motherhood Action Group volunteers (SMAGs). SMAGs were trained to facilitate community discussion groups on a wide range of maternal health topics. These sessions provided an opportunity for communities to reflect on the women and girls who were most likely to need help in order to achieve a safe pregnancy and delivery. Discussion group participants were encouraged to consider the wide range of situations that could potentially lead to vulnerability or social exclusion. The idea was to increase understanding at community level of the range of situations and issues – in addition to poverty – that could leave women and girls in a vulnerable position, lead to their exclusion from the community, or restrict their access to health and other services.

SMAGs encouraged communities to think about the range of situations and issues – in addition to poverty – that could leave women and girls in a vulnerable position or lead to their social exclusion

The SMAGs also conducted door-to-door visits to the homes of pregnant and newly-delivered women. Households in which the occupants failed to participate in community discussion groups were earmarked for special attention. The SMAGs took time to find out what the constraints to participation were and offered support to resolve these.

The SMAGs helped their communities to establish community systems to support pregnant women. These included food banks, emergency savings schemes and community-based emergency transport schemes. The emphasis was on ensuring that these systems were accessible to all women and girls who needed them.

Training health providers in communication skills and social inclusion:

A training provided to front-line health providers focused on improving their communication skills so that they could increase their support to under-supported women. The training focused on making health providers aware of the social factors that caused vulnerability or led to social exclusion, and encouraged them to probe the reasons why they were rude to, or neglectful of, some but not all clients. The training gave providers methods to control their own frustrations, recognise people who looked as

Situations leading to vulnerability or social exclusion

- Women affected by gender-based violence (GBV)
- Women lacking social or economic support due to seasonal out-migration
- Women lacking the support of husbands or their families due to marital conflict, jealousy, disputes over land, unreasonable behaviour etc
- Neglect of co-wives in polygamous relationships
- Widowed or divorced women who have become pregnant and who lack support
- Young unmarried pregnant women who lack the support of their partner or family.

Programme approach

- A community empowerment process facilitated by trained SMAGs mobilised communities around a maternal and newborn health agenda.
- Community systems provided safety nets for pregnant and newly delivered women, addressing barriers of access, affordability and lack of social support. This included Emergency Transport Systems (ETS), savings schemes, food banks, child-care schemes, and mothers’ helpers.
- A community monitoring system generated data on the maternal and newborn health activities and changes in the community.
- A system of mentoring and coaching support helped communities make the transition from increased awareness to sustained change.

though they suffered from neglect, poor support or abuse, and ideas about how to work with communities to ensure that these women and girls were supported within the community.

Results

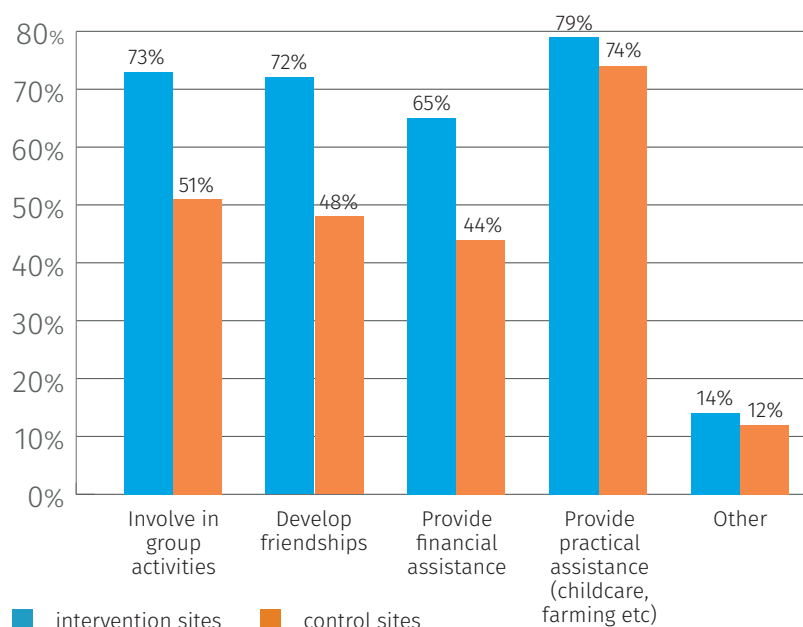
In the MORE MAMaZ intervention sites significant steps were taken to promote social inclusion. The programme's endline survey found that 73% of women and 70% of men in intervention communities were aware of efforts to include socially excluded women and girls in group activities. The respective percentages in control sites were 51% and 61%. Moreover, socially excluded women and girls in intervention sites received substantially more support, and a wider variety of support, than in control sites (Figure 1). They were more likely to have been involved in group activities, and more efforts were made to develop friendships with these women. Both types of support are known to improve mental and emotional well-being.

Women's involvement in participatory group activities is an evidence-based strategy for improving maternal and newborn health.² Hence, the programme's strategy to draw the hardest-to-reach women and girls into these groups was an appropriate and highly effective way to improve their maternal and newborn health.

Communities could cite many examples of steps taken to support the least-supported women. The importance of linking these women and girls to other resources and institutions within the community was also recognised.

"Most of the least-supported women are coming to the meetings now. They are participating. This is a change in the community."
Female community member, Mkushi District

Figure 1: Types of support provided to socially excluded women



Note: These results capture feedback given by female community members

Steps taken to identify and support the least-supported women and girls

"We help those women who are not coming for under-five or antenatal care services. We befriend them and bring them closer. This has really helped and now they are coming for health care." Female community member, Mkushi District

"Once we identify these people in the community, we talk as SMAGs and reach out to them and offer help....We found a 12 year old who was pregnant and who had already had a baby. Another young girl who delivered is a double orphan. We are looking after her.... We cook food and take it to her. The baby is now two months old." Female SMAG, Mongu District

"Bana Monica [Monica's mother] never used to mix with other people and she never went to deliver at the health facility....I befriended her after getting information from the SMAGs and she slowly began opening up about her problems and challenges. When she was pregnant with her sixth child I gave her some of my old clothes and encouraged her to attend ANC. She went and eventually delivered at the facility. She was so grateful that now she is one of the strongest advocates of facility delivery in this community." Female community member, Chitambo District

"Some of the isolated women in our community have started coming for the discussion groups. They've seen the benefits of going to the health facility, especially the women who have become pregnant by someone else's husband." Female SMAG, Mkushi District

A review of the training in communication skills and social factors given to health providers working in rural health facilities found that it:

- Helped to improve communication between health staff and their clients
- Led to a stronger, more nuanced and supportive focus on under-supported women in clinics
- Resulted in stronger collaborative links between health centre staff, SMAGs and communities
- Helped considerably in their acceptance of and willingness

to provide services to young unmarried pregnant women.

Almost all the health centres involved in the training reported that attendances by under-supported women and their children increased as a result of the training. Health providers reported that they spent more time with clients who appeared to lack confidence. They counselled these women, tried to interview domestic partners and suggested and arranged other forms of community support for the women.

¹ Klouda, T., and Green, C., 'Identifying the left behind in health care: lessons from Northern Nigeria', *Deliver2030.org blog*, <http://deliver2030.org/?p=6752>.

² Prost, A., et al, 2013, 'Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis', *Lancet*, 381: 1736-46.

Health providers' improved focus on under-supported women

"Before the training we did not bother to pay attention to the reasons for women's circumstances. Like looking dirty, unkempt and late for clinic. After the training we became more aware – we began to pay attention to these people and identify their situation better."

"Some women who say they don't have husbands, we link to the social cash transfer and they are given suggestions to join groups."

"They are now noticed, understood and treated with respect, which is raising their self-esteem."



SMAGs can identify and support socially excluded women

Lessons learned

- Rather than focus on general categories of the hard-to-reach (i.e. the disabled, women living with HIV/AIDS, the poor), MORE MAMaZ adopted a more nuanced approach to targeting which focused on women's and girls' social situations. This approach helped to ensure that the individuals who were most in need of support were not missed. Rural communities initially found it challenging to move beyond poverty as the main driver behind vulnerability and social exclusion. Over time, however, understanding of the range of social situations that could lead to social exclusion and vulnerability began to broaden.
- The SMAGs' training on social inclusion was reinforced via a system of mentoring and coaching support provided by DHMTs, health facility and programme staff. Every opportunity was taken to review and discuss positive examples of inclusion, and to encourage further efforts in this area.
- MORE MAMaZ hypothesised that two sets of indicators would provide a proxy for vulnerability and social exclusion: the extent

to which women looked after themselves and their surroundings (indicative of women's mental health); and the extent to which they felt supported and respected, particularly by husbands and families. The programme's endline survey found that these indicators were significantly associated with service utilisation, the quality of service obtained, and women's perceptions of the extent to which disabling social norms had changed at community level:

- Women who indicated that they did not receive the support and respect that they needed were almost three times as likely as those who had support and respect to disagree with the notion that GBV was on the decline (27% versus 10%)
- Women who looked after themselves better were significantly more likely than those who did not, to deliver at a health facility (59% versus 45%)
- Women who had home deliveries were almost twice as likely to have felt that they lacked support and respect compared to women who delivered in a health facility (22% versus 12%)

- Women who delivered without a skilled birth attendant were also significantly more likely to have felt that they were not adequately supported, compared to those who delivered with a skilled birth attendant (17% versus 12%).

This suggests that interventions that intend to target hard-to-reach individuals would benefit from including a stronger focus on the social factors that affect health care access and outcomes.

Policy implications

Implications for policy makers include:

- Socially stratified data collection is key to ensuring that health interventions leave no-one behind. The Ministry of Health has an important role to play in ensuring that all surveys stratify their results by social situation. The proxy indicators for social exclusion and vulnerability used by MORE MAMaZ need to be further tested to determine their usefulness and sensitivity in this regard.
- As the national SMAG initiative is rolled out to new districts, adequate attention and time need to be given to the components of the National SMAG Training Manual that focus on social inclusion. Over time, it will be important to review and improve these aspects in line with implementation experience.
- The short training given to health providers in communication skills and social inclusion led to rapid and significant attitudinal and behaviour changes. Such changes will help to create an enabling environment for Zambia to realize national policy commitments to reaching every woman, every child, and every adolescent. It is recommended that the Ministry of Health considers rolling out this training for health providers nationwide, and that it takes steps to institutionalise the training by integrating it into pre-service and in-service training curricula.



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MORE MAMaZ is funded by Comic Relief. The programme is implemented by Transaid, Health Partners International, Development Data and Disacare in partnership with the Ministry of Health and District Health Teams.