Engaging policy makers in research on inequalities in maternal and newborn health

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Background: evidence gap

Unfortunately, little is known about:

• **how to** effectively **reach** poor and otherwise disadvantaged groups

• **how to address** socio-economic inequalities in mortality

• Where **effective interventions** are known, they **rarely reach** those who need them **most**
Our approach

To support equitable improvements in newborn and maternal health we integrate:

Research

- generate evidence using high-quality data collected in cluster randomised controlled trials

and

Stakeholder engagement

- learn from & engage with stakeholders to support uptake of our newly generated evidence base
Our research

Cluster RCTs of women’s group interventions working through participatory learning and action cycles in India (2), Nepal (2), Bangladesh (1), Malawi (1)

37% reduction in maternal mortality and 23% reduction in neonatal mortality (Prost et al. Lancet 2013)
Research questions

Quantitative and qualitative research to understand:

1. *What were the socio-demographic and socio-economic differences in attendance in women’s groups?*
   - Secondary analysis of trial data
   - Combined population > 2 million
   - Prospective surveillance of birth outcomes through post-partum interview

2. *Where there were differences, why was this the case, and how can these be changed?*
   - Purposive sampling of women attending/not attending groups, focus group discussion & interview
Research questions:

3. What are the differential effects of the women’s group intervention on Neonatal Mortality Rates among lower and higher socio-economic groups?
   - Secondary analysis of trial data from 4 cRCTs having impact on neonatal mortality

4. Where there were differences or similarities, why was this the case, and how can this be changed/maintained?
   - Purposive sampling of those affected, interviews FGDs
Stakeholder engagement
Methods

Engaging with and learning from stakeholders to:

• draw on **experiential learning** regarding:
  – what works to reach lower socio-economic groups
  – how to reduce inequalities in newborn and maternal health.

• **increase awareness** about the large inequalities in maternal and newborn mortality

• **increase uptake** of evidence
Stakeholder engagement

Y1: Start-up consultations: stakeholders provided with project information
- Meetings/workshops with stakeholders
- Presentation & discussion at conferences
- District Assembly Meetings (Malawi)
- Stakeholder interviews
- Literature review

Y1: Study announcement: stakeholders provided with project information
- Website announcements
- Information sheet
- Generic PPT presentation

Y2: Regional workshops: stakeholders react to first findings & start-up consultation doc.
- Delhi workshop
- Malawi workshop

Y3: Dissemination: of conclusions & recommendations to stakeholders
- Through women’s groups
- Workshops/meetings with policy makers
- Policy briefs
- Conference & meeting presentations
- Peer reviewed publications
- Press activity

Uptake of recommendations: Stakeholders set policy & research agenda
- New research proposals
- Operational & policy change
Stakeholder engagement

Year 1: Start-up consultations (March-May 2012)

Main objectives:

• to incorporate learning from stakeholders regarding what works to ensure an equitable achievement of MDG4 and 5;
• to build a platform for ongoing engagement.

Methods:

Purposive sampling at each site of stakeholders for roundtable discussions (n = 7 round tables)

Purposive sampling at each site for semi structured telephone interviews (n = 11)
We asked:

In your experience…

• What works to address inequalities?
• What are the barriers to reducing inequalities in maternal and newborn health?
• Where are the evidence gaps?
Data management and analysis

• Written consent to participate, some gave consent to be identified
• Data from interviews were transcribed verbatim
• Roundtable discussions were minuted, and reports made of the minutes, some recorded
• Reports were circulated to participants who found no discrepancies
Participants

• Round table discussion participants from:
  NGO/INGO (60); Bilateral donors (2); Academic (5); Local and national government (13); Other (10)
• Interviews
  Government (1); INGO/NGO (5), Bilateral donor (2); Academic (3)
Results

• Results were more similar for rural sites of Nepal (Dhanusha and Makwanpur), Bangladesh, India (Jarkhand and Orissa), and Malawi.

• There were some different results from the urban Indian site (Mumbai).

• There was triangulation between the data coming from interviews and focus group discussions.
What works to reduce inequalities?

- Taking services and activities to the community, working directly with the marginalised
- Engage the community in planning and implementing programmes

- Free/subsidised programmes
- Many examples shared, which we documented and shared with participants
What are the barriers to reducing inequalities?

- Who are the marginalised?
- Universal vs Targeted
- Lack of decentralisation
- Geography, scattered populations
- Low quality of care
- Lack of awareness of entitlements, and lack of awareness about what is good for health
What are the barriers to reducing inequalities?

• Discrimination and social hierarchy (particularly in Asian sites)
• Lack of co-ordination among NGO and government, lack of disaggregated data, difficulties in identifying the marginalised
Where are the evidence gaps?

- Routine monitoring and sharing of data - barriers to writing down what works and how
- Disaggregated data to monitor the impact of programmes on the marginalised
- Effect of interventions at scale
- What works to motivate health workers?
- Few sites: what is the impact of involving men in maternal and newborn health discussions?
Limitations

- Barriers to addressing inequalities are not necessarily addressed by research – structural constraints
- Engage those already interested in the issues
  - strengths and weaknesses
- Limited involvement of government officials and public health practitioners, health workers
- Women and families were not integrated – separate data collection with them to explore secondary trial analysis
- Didn’t take things forward immediately – who will continue past the end of the grant?
How does our research fit with tacit knowledge?

Some similarities:
Community based
Low cost/no cost
Local employees
Supporting CB HW
Addressing awareness

Some sites target marginalised, larger reductions in Neonatal Mortality Rate (Tripathy et al. 2012)
Disaggregated data analysis
Dissemination

Year 3: Regional workshops with research teams and stakeholders

- Asia: India (Delhi)
- Africa: Malawi

Disseminate findings from secondary analysis of trial data and qualitative data
Disseminate findings from stakeholder engagement process – sharing of what works
Discuss how to utilise findings
More information:

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