Community Mobilisation through Women's Groups to improve the Health of Mothers and Babies

GOOD PRACTICE GUIDE

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Acronyms

BADAS	Diabetic Association of Bangladesh
DFID	Department for International Development UK
NGO	Non-government organisation
PCP	Perinatal Care Project
TBA	Traditional birth attendant
VHC	Village Health Committee
WCF	Women and Children First (UK)

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Summary

Background

This 'good practice' guide, based on the experience of a project in India and Bangladesh called Saving Mothers and Children, describes an approach that has the potential to reduce maternal and newborn deaths, and to address other health problems. The project worked through women's groups, using a participatory learning and action cycle, to mobilise community action to improve the health of mothers and babies.

The project was implemented by an NGO, Ekjut, in India and the Perinatal Care Project of the Diabetic Association of Bangladesh (BADAS) in Bangladesh, together with the University College London Centre for International Health and Development and Women and Children First, an international NGO based in the UK.

In India, Ekjut worked in tribal communities in West Singhbhum and Saraikela Kharswan districts of Jharkhand State and the Keonjhar district of Orissa State. In Bangladesh, BADAS worked with three rural districts, Bogra, Faridpur and Moulavibazar.

Project process and results

The participatory learning and action cycle used by the project has four phases which focus on: assessing the situation and identifying maternal and newborn health problems; identifying strategies to address these problems; taking action; and measuring progress and impact. Each phase includes a series of women's group meetings that cover different topics. Completing the whole cycle takes around two years. Women's group meetings were facilitated by local women who were trained in participatory methods and provided with basic information about maternal and newborn health.

Strategies identified by women's groups to address maternal and newborn health problems included establishing emergency funds to cover transport and medical fees, providing pregnant women with advice and support and, in some

cases, promoting the use of clean delivery kits for home birth. Women's groups also held community meetings to raise awareness of maternal and newborn health problems, discuss their proposed strategies and provide feedback to the community on actions and progress.

In India, the project resulted in a 45 per cent reduction in newborn deaths and a reduction in maternal deaths, as well as a 57 per cent reduction in moderate maternal depression. In Bangladesh, the project resulted in an increase in uptake of health services. In both India and Bangladesh, the project resulted in a significant improvement in hygienic delivery practices, including use of delivery kits, and an increase in exclusive breastfeeding.

Lessons learned

Careful planning is essential. It is particularly important to allow enough time to identify communities where this approach could have most impact, consult the community and secure the support of community leaders and decision makers. It is also important to allow enough time to learn about the community. Piloting the process before starting to work at a larger scale can help to determine whether the approach is appropriate to the context and to learn about local communities.

The participatory learning and action cycle is an intensive process that takes time, but using a systematic approach allows women's groups to develop cohesion and mutual support, work together to identify problems and solutions and take collective action, and is more effective than ad hoc approaches to community mobilisation.

There are advantages both to working with existing women's groups and to establishing new groups, but working with existing groups that are already familiar with participatory approaches is simpler and can be more efficient and effective.

Women's group facilitators play a central role in this approach. Recruiting local women with the right attitudes and skills as facilitators is critical to success.

Positive health outcomes depend on targeting and coverage of women's group membership. Targeting women of reproductive age, in particular pregnant and

newly married women and the poorest and most marginalised women, and achieving high coverage of pregnant women are fundamental to achieving results.

High levels of women's participation can be achieved without financial or other incentives, if meetings address topics that are relevant to them, such as newborn and child health. Covering different topics and using different methods in each meeting – and informing women about the topic for the next meeting – helps to ensure good participation. Reach is further extended as women's group members share knowledge with and provide support to other women in the community.

Political, social, cultural, religious and practical factors can be a barrier to women's participation in women's group meetings and strategies are needed to address these, including securing the support of those who are influential within the community and the family. Participation in women's groups can contribute to wider empowerment. Women reported increased confidence in their ability to take action and to speak out in community meetings. The establishment of emergency funds promoted women's financial independence.

Efforts to mobilise community action to address maternal and newborn health problems must be complemented by efforts to strengthen health systems and increase access to quality maternal, neonatal and child health care. The support and involvement of community and facility health workers and local health officials can help to strengthen community links with health services and enable communities to demand improvements in service provision.

"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 in Bangladesh who had developed eclampsia

Introduction

Globally, each year, four million babies die in the first month of life and more than 350,000 women die from complications of pregnancy and childbirth, most of them in the poorest communities in developing countries. Many of these deaths could be prevented. This good practice guide describes an approach that has the potential to reduce maternal and newborn deaths, as well as to address other health problems.

Facts about maternal and newborn health

Between 350,000 and 500,000 women die every year in child birth – for every woman who dies, at least 30 more suffer a debilitating illness or permanent disability.

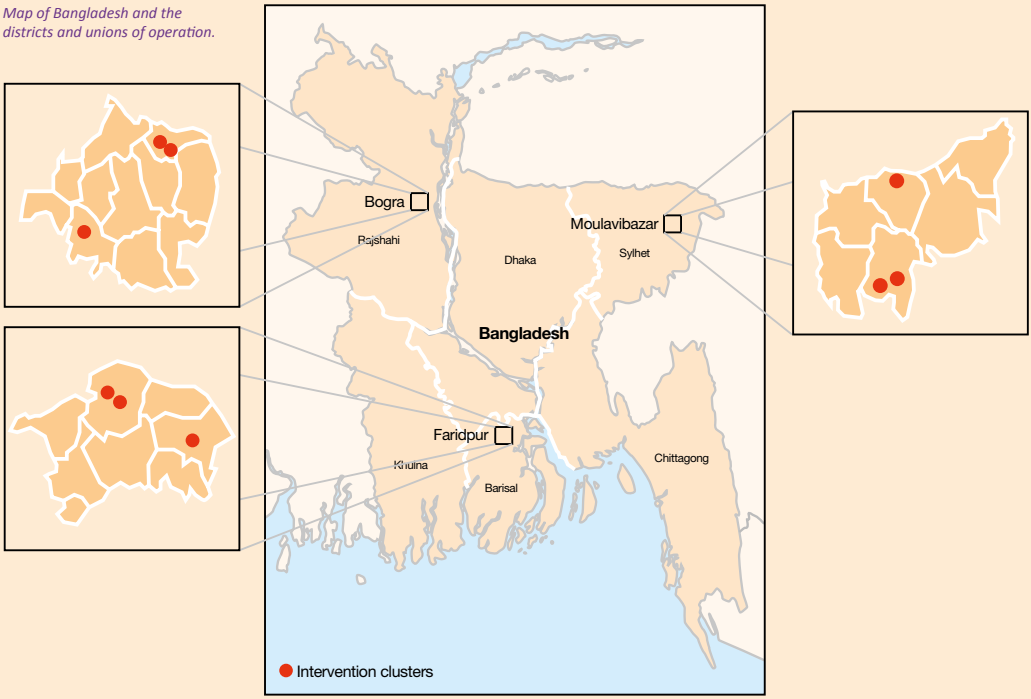
- Most maternal deaths occur during or directly after child birth – the leading cause of maternal deaths is postpartum haemorrhage.
- 8.8 million children a year die before their fifth birthday and a high proportion of these – four million – occur in the neonatal period.
- Almost all maternal deaths and two-thirds of all child deaths are preventable.

What is this good practice guide about?

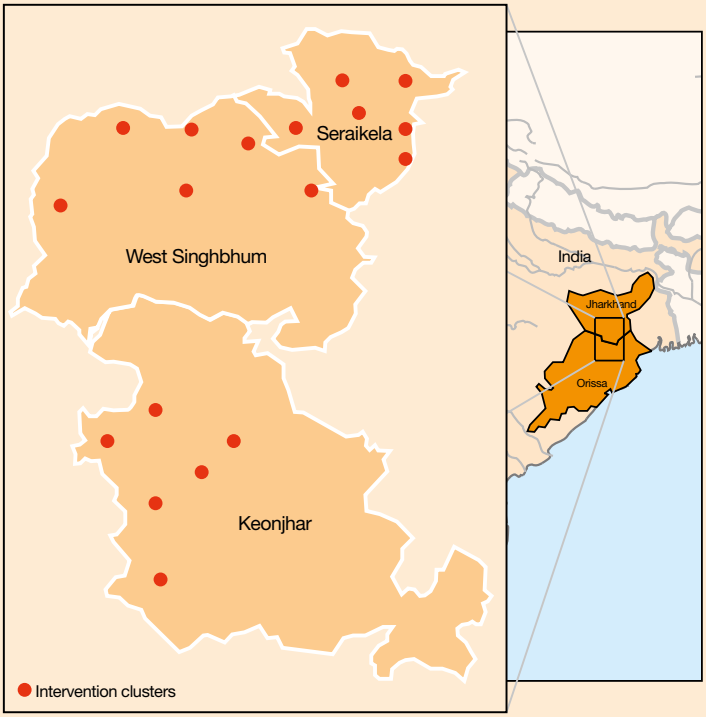
This guide is based on a project in India and Bangladesh called Saving Mothers and Children. The project worked through women's groups, using a participatory learning and action cycle, to mobilise community action to improve the health of mothers and babies.

The aim of the guide is to provide a case study of good practice in working with women's groups to address maternal and newborn health and to share lessons learned from this experience. While the guide describes an approach used in rural communities in India and Bangladesh, this can be successfully adapted to different contexts.

Map of Bangladesh and the districts and unions of operation.



Map of India, the States of Jharkhand and Orissa and districts of operation.



What is the Saving Mothers and Children project?

Saving Mothers and Children aimed to test whether the success of projects in rural Bolivia and Nepal, which reduced maternal and newborn deaths, could be repeated in some of the poorest communities in India and Bangladesh[1].

The approach was developed initially by the Warmi project in Bolivia, which was implemented by Save the Children from 1990 to 1993 in 50 communities in Inquisivi province. Women's groups used a participatory learning and action cycle to improve maternal and newborn health in their communities, identifying and prioritising problems and taking action to address them. The project led to a 67 per cent reduction in prenatal and newborn mortality and important changes in home and health care-seeking practices.

The approach taken by the Warmi project was adapted and tested through a randomised controlled trial in Makwanpur district in Nepal in 23 villages from 2001 to 2003. This led to a 30 per cent reduction in newborn mortality and improvements in care seeking. Over 75 per cent of the women's groups in Nepal were still active in 2010.

In India and Bangladesh, Saving Mothers and Children was implemented by Ekjut and the Perinatal Care Project of the Diabetic Association of Bangladesh (BADAS) in Bangladesh, in collaboration with the University College London Centre for International Health and Development and Women and Children First, an international NGO based in the UK.

In India, Ekjut worked with 244 women's groups in tribal communities – in West Singhbhum and Saraikela Kharswan districts of Jharkhand State and the Keonjhar district of Orissa State – between 2004 and 2008. Coverage of women's groups was one for every 468 people.

Work with women's groups was complemented by efforts to strengthen health services and to improve links between communities and primary health care services. Ekjut worked with health staff to improve their morale and motivation

1 The project was a randomised controlled trial – which compared the differences between communities where the project worked with women's groups and communities where it did not – and so project partners in India and Bangladesh had external support for design and implementation and conducted more comprehensive monitoring and evaluation than is usual for a community project.

and promoted dialogue between communities and district health officials.

When the project started, the Government of India had recently commenced the National Rural Health Mission scheme and, as part of this initiative, planned to establish Village Health Committees (VHCs). In anticipation, Ekjut identified a 'committee' of two or three people in each community and held regular meetings with them to increase awareness of health rights. When VHCs were established, Ejkut met with them to explain about health rights and the services communities should receive from the health department. Ejkut also organised joint meetings between VHCs, community health workers and district health officials.

In India, the project resulted in:

- A 45 per cent reduction in newborn deaths and a reduction in maternal deaths.
- A 57 per cent reduction in moderate maternal depression.
- A significant improvement in hygienic delivery practices including hand washing, using a safe delivery kit and clean cord cutting.
- An increase in exclusive breastfeeding.

In Bangladesh, BADAS worked with 162 women's groups in three rural districts – Bogra, Faridpur and Moulavibazar – between 2006 and 2008. Coverage of women's groups was one for every 1,414 people[2].

Work with women's groups was complemented by efforts to strengthen health services. This included improving links between communities and health facilities and referral systems and training health workers and traditional birth attendants (TBAs) in essential newborn care, including resuscitation of newborns with birth asphyxia.

In Bangladesh, good home care practices were more frequently employed in project areas than non-project areas, including:

- hygienic home delivery practices and the use of safe delivery kits.
- delayed infant bathing for at least 24 hours.
- exclusive breastfeeding for the first six weeks.

2 BADAS has since increased coverage to around one women's group per 400 population.

Why is community mobilisation important?

Most efforts to improve the health of mothers and babies have focused on strengthening health service delivery of maternal and newborn care. Improving access to health services and the quality of care provided is essential but reducing maternal and newborn deaths also requires action at community level. Community mobilisation is a key intervention in the Global Consensus on Maternal, Newborn and Child Health.

Project partners defined community mobilisation as 'a capacity-building process through which community members, groups or organisations plan, carry out and evaluate activities in a participatory, sustained way to improve their health and other conditions, either through their own initiative or stimulated by others'[3].

Community mobilisation differs from, and can be more effective than, health education, as it aims to empower communities to change their situation. This involves the community taking the lead, making decisions and taking coordinated action. Community mobilisation is a communication, education and capacity-building process, which enables communities to discuss issues, share ideas and improve their knowledge and skills, and where the community works together to plan, carry out and evaluate activities.

> *"Working with villagers has shown me that they are intelligent. Before joining this project I thought we had to give cash to motivate people. But here, we have been able to motivate people to help themselves"*
>
> BADAS Perinatal Care Project staff

3 Source: Grabman H et al (2007) Demystifying community mobilisation: An effective strategy to improve maternal and newborn health.

Community mobilisation can:

- Increase awareness of maternal and newborn problems and address the causes of these problems.
- Improve maternal and newborn care practices, which is especially important where access to services is limited and many women give birth at home.
- Create demand for maternal and newborn health care services.
- Empower women and change community attitudes towards women.
- Enable communities to lobby for better health services.

However, community mobilisation is a process that takes time, it is not a one-off activity. The time needed for initial planning, including learning about the community, selecting and training facilitators, meeting with stakeholders and establishing women's groups will depend on the context and how familiar the communities are with participatory learning and action. Sources of information about community mobilisation are listed in Annex 2.

Why work through women's groups?

In many communities, women have few opportunities to improve their own health or that of their families. Where local health committees exist they are often dominated by community leaders and men. However, women do meet informally or through self-help groups and women's groups can build on this. Working with women is critical to improving maternal and newborn health. Women's groups have several advantages. For example, they:

- Give women an opportunity to discuss issues that affect them during pregnancy and childbirth and provide mutual support.
- Build on women's interest in improving the health of their families.
- Help women to learn from each other and to learn more about maternal and newborn health.
- Encourage women to share knowledge with their families and other women in the community and address misconceptions.
- Can reach the poorest and most marginalised women.
- Empower women to work together to identify problems and find solutions.
- Create a sense of unity and encourage self help.

- Help women to develop confidence and to express themselves.
- Can increase women's influence on community decision-making and acceptance of women's participation.

Who is the good practice guide for?

This guide is mainly intended to help NGOs and community organisations to support community mobilisation to improve health, in particular the health of mothers and babies. We hope it will also be useful for other agencies that have an interest in maternal and newborn health or fund and support community work.

How is the good practice guide organised?

The guide is organised in two sections:

- Section 1 describes the process of working through women's groups, highlighting some of the issues you need to think about.
- Section 2 provides an overview of the cycle of women's groups meetings. It does not describe meeting topics and activities in detail as this information is available in the manuals produced by project partners.

Lessons learned from project experience are included in both Sections 1 and 2 and are indicated by this sign.

The guide includes examples of some of the participatory methods used by the project, but is not intended to provide a comprehensive overview of participatory approaches, as these are described in many other publications. Links to project manuals and tools and selected additional sources of information are provided in Annex 2.

We would like to hear your views about the guide, which is available as a CD and on partner websites, and how it could be improved. Please share your ideas with us using the feedback form in Annex 3.

1 Getting Started: Working With Women's Groups

Working with the community

Deciding whether, and where, to work with women's groups

To help you decide, you need to think about whether working with women's groups to address maternal and newborn health in a particular community is appropriate. Issues to consider include the poor health of mothers and babies, and the extent to which communities have access to maternal and newborn health care. If you do not have this information, you will need to collect it from the community and from health services.

Working with women's groups is likely to have the most impact in communities where maternal and newborn deaths are high and access to health services is limited. When death rates are low and health services are good it is much less likely to have a direct effect on mortality.

Maternal and newborn health in India and Bangladesh

Despite progress in recent years maternal and neonatal mortality remain high in India and Bangladesh. Project areas were selected because communities in these areas are among the poorest, have limited access to health services and experience higher than average rates of maternal and newborn death.

In India:

- The maternal mortality ratio is 450/100,000 live births (2005) and the lifetime risk of maternal death is 1 in 70 (2005).
- The neonatal mortality rate is 37/1000 live births (2008) and 55 per cent of under-five deaths occur in the first month of life.

In Bangladesh:

- The maternal mortality ratio is 320/100,000 live births (2005) and the lifetime risk of maternal death is 1 in 51 (2005).
- The neonatal mortality rate is 37/1,000 live births (2008) and 62 per cent of under-five deaths occur in the first month of life.

Sources: WHO and UNICEF (2010) *Countdown to 2015 decade report (2000-2010): taking stock of maternal, newborn and child survival,* Bangladesh Maternal Health Services and Maternal Mortality Survey 2010 and Bangladesh Demographic and Health Survey 2007. *Note that there are significant gaps in data on maternal and newborn health. Recently published data from both India and Bangladesh indicate reductions in MMR in particular, see *The Special Bulletin on Maternal Mortality in India 2004-06*, Sample Registration System, Office of Registrar General, India (2009) and the *Bangladesh Maternal Health Services and Maternal Mortality Survey (2010)*.

You also need to consider community characteristics – for example, whether communities are well-established and where they are located – to decide whether community mobilisation, working with women's groups, is a suitable approach.

☑ Working with women's groups is most effective in rural communities and in communities that are well established. In communities where the population is more transient – where people come and go – women are less likely to participate in all the meetings and it is more difficult to build a strong group and to plan and implement group action.

Ideally, it is best to work in communities where your organisation already has well established links and where the community is interested in community mobilisation and in tackling maternal and newborn health. Community mobilisation is more difficult if you do not already have links or the community is not motivated.

Finally, think about practical issues, such as how easy it is to reach the community, as this will affect your ability to monitor activities and provide support to women's group facilitators.

Deciding who to consult

Find out who makes decisions and influences what people think and do, including about maternal and newborn health. This will vary between communities but may include community and religious leaders, local politicians, community health workers and volunteers, teachers, traditional healers and traditional birth attendants. In some communities, other family members, such as husbands and mothers-in-law, influence women's decisions about pregnancy, childbirth and newborn care.

Involving the community in the planning process, and in selecting local facilitators, helps to create community ownership and to ensure that the process of organising women's group meetings goes smoothly.

You need to consult decision-makers and influential people in the community and obtain their support. Start by introducing your organisation, discussing what you plan to do and the reasons why, and how you plan to do it. It is important to be clear about the problem you plan to address. Be clear also about what your organisation can contribute to the community, to avoid creating false expectations.

☑ Be prepared for opposition from those whose interests or beliefs may be threatened by your plans. It is especially important to explain about the role of the facilitator to community leaders and community health workers and how they share the same objectives. In one community, community health workers saw the facilitators as rivals, because their job also involves providing the community with information about mother and child health. In another, the president of a women's group restricted meetings, saying that women knew everything already. In another community, men opposed the meetings.

You may also need to seek permission from local government officials and traditional and religious leaders to work with existing women's groups or establish new groups.

In Bangladesh, the project approached community leaders to obtain permission to establish women's groups, organised orientation meetings with community leaders and other community members, and conducted village mapping exercises. In India, project staff met with village councils, headmen and elected local government representatives to obtain permission to work with women's groups.

Once you have permission, organise a meeting with the wider community to discuss what you plan to do and to answer questions. Be prepared to explain why you want to work in the community, what the community mobilisation process involves, who will participate and how you will keep the community informed about progress. Community meetings can also help you to learn about the community.

☑ Allow enough time to approach the community, seek permission and support, and to learn about the community. In India, the project allowed two to three weeks for this important step.

Finding out about existing community and women's groups

You will need to find out what activities other organisations and the community are carrying out or are planning, especially if these involve community mobilisation or working with women's groups. This is important to ensure that you do not duplicate efforts and that your plans complement or support existing activities.

The next step is to find out if there are already any active women's groups in the community that you can work with. In Nepal, the project strengthened women's groups that had been set up by community health volunteers. In some communities in India, there were women's livelihoods and savings groups that were already familiar with participatory approaches and Ekjut worked with these. In Bangladesh, there were existing micro-credit groups, but these were not familiar with participatory approaches and for this, and other reasons, the project established new women's groups. In some communities, facilitators had to address misinformation that women had acquired from previous health groups.

Project staff used a range of approaches to identify existing groups. They met with district level NGOs to find out about existing groups. They also identified existing groups through community mapping or through visiting communities, and found about the activities of existing groups, how often they met and who attended meetings.

Advantages of working with existing groups	Advantages of working with new groups
■ Benefit from local knowledge ■ Saves time ■ Participants are familiar with being part of a group ■ Rapport and trust is already established	■ Participants may be more open to **new ideas** ■ Opportunity to include other **women including the poorest and most marginalised** ■ No conflict of interest with existing **groups** ■ More focused on specific goal

☑ It is usually better, and easier, to work with and strengthen existing women's groups than to establish new groups, especially groups that are already familiar with participatory learning and action.

If there are existing groups, you need to meet with the leaders of these groups to explain about the maternal and newborn health meetings and to find out if they share common aims and approaches and are interested in participating in the meeting cycle. Again, this can also help you to learn more about the community and to establish a good relationship with community members.

It is also important to understand the characteristics – social, political, economic and cultural – of the community. Find out about people's day to day lives, including significant events during the year that may affect when meetings are held. Learn about how people communicate respectfully with each other and about traditional practices concerning maternal and newborn health. In India, more time was needed to learn about tribal communities, who have their own specific languages and practices.

Find out also about the availability of health services, including the location and opening times of facilities, the extent to which services are used, and how the poorest and most vulnerable in the community feel about using health services.

☑ To measure the effect of your project you need to be able to compare the situation before you started and the situation at the end of the process. So it is important to collect some baseline information against which to measure changes in practices and in maternal and newborn health. To learn more about this see page 35, which addresses possible evaluation methods.

Participatory activities, such as mapping, are a useful way to find out about the community. Participatory activities can also help to highlight problems and encourage the community to support action to address them. Sources of information about participatory activities are listed in Annex 2.

Identifying, training and supporting facilitators

Identifying, training and supporting facilitators

Selecting women's group facilitators

Local women were selected as facilitators in India and Bangladesh. Another option that could be considered is to use community health workers or community health volunteers as facilitators.

Facilitators are central to the success of working through women's groups and choosing the right facilitators is essential. Facilitators should:

- Be female.
- Be from the community or a 'daughter-in-law' of the village.
- Be able to speak the local language and understand the local culture.
- Be married, and preferably, a mother.
- Be able to read and write.
- Be able to move around freely and have the support of their family.
- Be committed to participatory learning and believe that this approach can work.
- Be able to manage a group and have some leadership qualities.

☑ Facilitators should live in or near to the communities where they will work with women's groups. In Bangladesh, bad weather and flooding prevented facilitators who lived further away from travelling to communities for meetings. In India, the community opposed a facilitator who belonged to a different village council and was seen as an outsider.

Preferably, facilitators should also have some understanding or experience of participatory methods and some knowledge of maternal and newborn health, but this is less important than having the right attitudes and skills. Training can help facilitators to develop their knowledge and to learn to use participatory methods,

but cannot develop the attitudes or skills required.

Attitudes – a good facilitator is:

- Committed to community mobilisation and participatory approaches.
- Flexible and adapts to community priorities.
- Respectful and values the views of all group members equally.
- Non-judgmental and accepting.
- Positive and enthusiastic.

Skills – a good facilitator can:

- Motivate people.
- Build trust and good relationships with women and the community.
- Communicate ideas and information.
- Listen to, and learn from, women and the community.
- Encourage discussion, use local words and ask questions in a sensitive way.
- Resolve disagreements and conflict.

Involve the community in selecting facilitators, to make sure they are acceptable. Be clear about the characteristics you are looking for in a facilitator when you ask the community to make suggestions. In India and Bangladesh, potential candidates were interviewed to see if they had the right attitudes and skills. Allow two to three weeks to select facilitators.

Agreeing the roles and responsibilities of facilitators

You need to define the roles and responsibilities of facilitators. It is helpful to develop a brief job description and to discuss this with facilitators before you start training, to make sure they are clear about what they will be expected to do.

During the project, facilitators had the following roles and responsibilities:

- Strengthening existing women's groups or, if needed, forming new groups.
- Inviting women of reproductive age to join a group and to attend meetings.
- Organising monthly group meetings.

- Maintaining attendance registers and records of group discussions, activities, successes and challenges.
- Facilitating monthly group meeting discussions.
- Supporting women's groups to identify and prioritise maternal and newborn health problems.
- Helping groups to identify what action they can take to address priority problems.
- Supporting groups to plan, implement and monitor their actions.
- Maintaining good relations with community leaders, health workers and local government officials.

☑ Do not expect facilitators to work with too many groups. During the project, facilitators were responsible on average for between 13 and 18 groups. Experience suggests that convening between 10 and 15 meetings a month is a manageable workload for each facilitator.

You also need to be clear about what facilitators can expect from your organisation. In India, they were paid 200 Rupees (approximately US$4) for each meeting they facilitated. They also received maternity and medical benefits and financial assistance for medical emergencies. In Bangladesh, facilitators were paid a monthly salary of 6,000 Taka (approximately US$80).

Training facilitators

Facilitators need basic training to make sure they have adequate knowledge of maternal and newborn health issues and a good understanding of the participatory methods they will use during women's group meetings. How you organise the training depends on your organisation and the availability of facilitators.

In India, initial training was kept short because women with families did not want to be away from home for too long. Women could bring their babies and older children to the training if they wanted to. Training covered the participatory learning and action cycle, contents and detailed planning for each meeting, use of

participatory communication techniques, managing conflict and ensuring equal involvement of the poorest women. In Bangladesh, training covered maternal and newborn health issues, community mobilisation, working with groups, the participatory learning and action cycle, participatory communication techniques and participatory monitoring.

Facilitators in India and in Bangladesh received follow-up refresher training between four and six months after their initial training.

More detailed information about training for facilitators is available in project partner training manuals. Links to these materials are included in Annex 2.

Supporting the work of facilitators and managing the process

Facilitators need support and supervision during the cycle of meetings. Lack of adequate support can create difficulties in retaining and motivating facilitators and affect the quality and results of the women's group process.

☑ Make sure that coordinators or supervisors are based near enough to communities to provide regular support and supervision to facilitators.

You will need to identify staff to provide this support and supervision. Project partners in India and Bangladesh appointed coordinators to do this. The choice of coordinators is crucial because they are the main link with the facilitators. Project partners highlighted the importance of employing well-educated, skilled and experienced staff as coordinators.

Coordinators helped to organise community meetings and met regularly with community leaders and health workers to maintain good relationships. Coordinators also trained facilitators and each coordinator supervised and supported around five facilitators. They met regularly with facilitators – at least once a month – to review progress and records, help plan and organise group meetings, answer questions and address any problems facilitators had during meetings or with the community. In addition the project used peer support for facilitators. To give extra support to a facilitator who was experiencing difficulties, she was paired with another facilitator who was performing well.

☑ This type of project requires strong and supportive management, including the ability to manage activities at a distance, flexibility, good team work, intensive staff inputs, and a commitment to community development.

Staff also included an overall manager, responsible for planning, management and ensuring that all aspects of the project ran smoothly and district managers, responsible for coordinator supervision and support. There were also staff

responsible for training, monitoring and evaluation, advocacy and health system strengthening activities.

Establishing women's groups

Deciding how many groups you need and who should participate

The number of women's groups needed depends on the size of the population in the area that you plan to work in.

☑ Project experience suggests that you need a minimum of one group for every 500 people in order to make a difference to maternal and newborn health. So, for example, if the population of the community is 500, you will need one women's group. If the population is 5,000, you will need 10 women's groups, and if it is 500,000, you will need 1,000 groups.

The people most affected by a problem should be actively involved in assessing their situation, deciding what to do, taking action and measuring what difference their actions make. To address the health of mothers and babies, membership of women's groups should therefore give priority to women of reproductive age, especially those who are pregnant. Including newly married and adolescent girls is also important.

☑ Women's groups should include as many newly pregnant women as possible to have maximum impact on maternal and newborn health. Targeting and working with the poorest women is essential, because they will benefit most from the intervention. This also means that your work is more likely to demonstrate results. In Nepal, 37 per cent of pregnant women participated. In India, the proportion of pregnant women attending groups increased from 18 per cent to 55 per cent during the project. In Bangladesh, involving pregnant women was sometimes more difficult, in part due to local beliefs about women leaving the house during pregnancy or after delivery.

Facilitators visited households and invited women of reproductive age to join a group and attend meetings. During the visits, facilitators explained the purpose of the meetings and the benefits for women and for the community of participation in women's groups. In most cases, women were highly motivated to participate because the health of infants and children is a subject that interests, and is very relevant to, them.

How to encourage women to attend group meetings

- Explain why the issue is important to them and their community.
- Do not raise expectations – be honest about what your role is.
- Hold meetings at a convenient time and location.
- Remind participants when the next meeting will be held, at each meeting and between meetings and make sure they know what the topic is for the next meeting.
- Celebrate every success, however small.

In some communities, facilitators initially had to make a lot of effort to encourage women to participate. They also used women who were supportive to convince other women in the community to participate. In other communities, it was important to get influential women to participate to persuade other women to join.

To ensure maximum participation, the optimum size of a group is 20. With more than this it is more difficult for everyone to participate and for the facilitator to manage the group. Meetings should be attended by at least 10 group members to make them worthwhile. If not enough women come to a meeting, the facilitator and the women who have come can go around the village to fetch the other women. If attendance is very low, it is better to cancel the meeting and rearrange it on another date.

If women do not attend, find out why and try to address the factors that stop them from participating. Women are often busy with child care, work

and household tasks, so it can be difficult for them to join a group or come to meetings. Political, socio-economic and cultural issues can be a barrier. Community or party politics can influence women's participation. In Bangladesh women who were better-off or of a higher social status were sometimes reluctant to sit in the same group as poorer or lower status women, although discussing common concerns helped to address this. Some better-off women also thought they did not need the information. Some very poor women involved in daily labour found it more difficult to attend.

Religious or traditional beliefs were a challenge in India and Bangladesh. In some communities women do not go out during the first one or two months after delivery so did not attend meetings during this period. In others it was difficult for women to leave the house without permission and some women were prevented from joining groups or attending meetings by their husband or their mother-in-law.

☑ Sensitise men, religious leaders, mothers-in-law and others about why it is important for women to attend group meetings. To overcome opposition from husbands and mothers-in-law, facilitators visited them to explain why maternal and newborn health is important or invited them to come to a meeting to learn about what the group is doing. Project staff in Bangladesh suggested that it would be useful to form a men's group to raise awareness of maternal and newborn health and generate support for women's groups after men in some communities requested this assistance.

The project did not provide any incentives, so some women, who had received a financial incentive for participating in other NGO activities, were reluctant to be involved. Most were persuaded when the facilitator explained about the maternal and newborn health situation and that improving their knowledge about health problems and taking action together to prevent and manage these problems could save lives and also save them money in the longer term, for example by avoiding having to pay health care costs associated with maternal and newborn problems.

Involving other community members

Although this approach prioritises involving women of reproductive age, in particular pregnant women, it is important to be flexible about group membership. Involving other community members, including community and religious leaders, men and mothers-in-law, can help to generate wider support for actions taken by women's groups to improve the health of mothers and babies.

In Bangladesh, care during pregnancy improved as a result of involving mothers-in-law, who allowed their pregnant daughters-in-law to rest, eat nutritious food and avoid heavy work. Project staff also report that the number of women having institutional deliveries increased, as opposition to this decreased in more conservative communities.

Membership should be decided by the group itself. Some groups in Bangladesh requested that adolescent girls and mothers-in-law be invited to meetings. In India, adolescent girls, older women, men and traditional birth attendants participated in group meetings. In both Bangladesh and India, women brought their babies and children to group meetings.

Involving other community members can change the dynamics of meetings. Facilitators need to ensure that everyone participates equally and that men and older women do not dominate the discussions. To allow women to participate fully, in some cases facilitators encouraged men to talk after the group had completed their meeting discussions.

Community health workers and local health officials were also invited to attend some meetings in India and were given time and space to talk to the group. Meetings discussed how women's group members could help during health worker visits to the community for example, by encouraging other women to bring their children to be immunised and weighed and pregnant women to attend for check ups. Women's groups also helped to make the community aware of services and entitlements, for example, the government maternal health voucher scheme in India.

Organising women's group meetings

Organising group meetings

Deciding how often and where groups will meet

Plan for approximately 20 group meetings, to cover the four phases of the participatory learning and action cycle and all the topics (see Section 2). Ideally, meetings should be held monthly and should take no longer than two hours.

Allow some flexibility in the timeframe in case it is not possible to hold a meeting every month. Sometimes meetings may need to be cancelled because of religious or other festivals, planting or harvesting, weddings, funerals and other meetings, or flooding during the rainy season.

☑ Project staff in Bangladesh suggested that shorter meetings, lasting up to one and a half hours, twice a month would be better, because women sometimes forgot what the group had discussed the previous month and a two hour meeting was too long for some women.

Let the group decide where and when to meet. The meeting place should be somewhere that everyone can get to easily and where women feel comfortable and can talk freely without distractions. In some communities, women preferred to meet in the morning but in others, where there was electricity, meetings were held in the evening. Timing may change depending on the season. For example, during summer, women may prefer to meet when it is too hot for physical work.

☑ Good time management is essential. Facilitators should be well prepared for meetings and arrive on time. Manage discussions so that everyone has a chance to speak but make sure that meetings do not go on beyond their allotted time.

At the start of each meeting, facilitators should:

- Talk informally to participants.
- Encourage the participants to sit in a circle.
- Welcome the participants and thank them for coming to the meeting.
- Review what was discussed and agreed at the previous meeting.

- Explain what this meeting is about.

During each meeting, facilitators should:

- Sit at the same level as the women in the group.
- Ensure the poorest and most marginalised women participate equally.
- Use simple, clear words and methods.
- Treat women with respect and give everyone a chance to speak.

At the end of each meeting, facilitators should:

- Thank women for attending the meeting.
- Summarise what has been discussed and agreed.
- Agree the date, time and topic for the next meeting.

Sustaining action

During the process partners took steps to try to ensure that activities and impact would be sustained after project funding ended. These included building community commitment and seeking funds from other sources, establishing links with health services and extending the role of women's groups.

Building commitment and leveraging funds

Think about building community support for women's groups to continue meetings and to sustain activities in the community. There will always be newly pregnant women who need information and support to ensure that they and their babies are healthy. Community meetings are a good way to build community commitment and to mobilise people outside the group to take action. Linking up with youth groups is a good way to ensure that adolescent girls and boys learn about maternal and newborn health issues before they have children.

It is particularly important to secure the support of community leaders and local government officials, especially if facilitators are to continue to receive some remuneration for their work. Community leaders and government officials will need to be convinced that working with women's groups will result in improvements in maternal and newborn health, which is why it is important to monitor and evaluate the process and its impact.

Possible evaluation methods your organisation can use include:

- Using existing data sources, for example, Demographic and Health Surveys, Multiple Indicator Cluster Surveys or local surveys, to measure impact on health outcomes (maternal and infant deaths and practices). This can be complemented by a process evaluation using data collected routinely by facilitators about group attendance, problems and strategies identified, actions taken and changes as a result of these actions.
- Identify a sample of women of reproductive age in the intervention area and carry out a baseline and end of project survey to monitor changes in home care practices and health seeking behaviours. This can be complemented with a process evaluation, as described above.
- Select 2-3 clusters, covering a population of 2,000-3,000 to act as 'sentinel sites' and use a simple surveillance system to monitor births and deaths. This can also be complemented by a baseline and end of project survey and a process evaluation.

Of these, the second and third options are the most 'robust' evaluation approaches.

The support of local government officials is essential if you plan to expand the project approach to new communities. In India, the project was scaled up successfully from three to eight districts by 2009. This was helped by the fact that women's group meetings are mandated under the National Rural Health Mission scheme. The main difficulty was caused by frequent transfer of government officials, which required staff to repeat efforts to create awareness and secure support.

One important lesson learned from project experience is the importance of thinking at the planning stage about how activities will be sustained, and of starting to look for funding, including from local funding sources, before the end of the project. Think about how you can secure funds from a wide range of sources to support women's group and community mobilisation activities. In addition to international donors, you might consider approaching national and local sources of funding including corporate and individual donors and government bodies.

Establishing links between women's groups and health services

Think about improving links between women's groups, communities and health services. This can help health workers support the work of women's groups and improve uptake of maternal and newborn care services. Establishing links with NGOs that provide support for better health, for example organisations that provide mosquito nets for pregnant women and young children, could also be considered.

During the project some women's groups invited community health workers to attend group meetings, while others held regular meetings with health workers from local facilities. Some women's groups chose representatives to speak on their behalf and voice their demands at community health committee meetings. Both project partners are planning to strengthen links between women's groups and community or village health committees, including encouraging women's group representation on these committees.

Working with women's groups can result in significant improvements in maternal and newborn health but cannot provide the medical interventions that are sometimes necessary to save the lives of mothers and babies. So community mobilisation must be complemented by efforts to improve access to good quality health services.

"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 in Bangladesh

Project staff in India and Bangladesh highlighted poor quality health care as a problem. If a facilitator recommends that women go to a health facility and they receive poor quality care it can undermine women's trust in the facilitator. In Bangladesh, staff suggested that it would have been useful to provide more orientation for health workers at the start of the project, to ensure that women referred receive good quality care.

In India, Ekjut provided support to Village Health Committees, promoted dialogue between VHCs, local health workers and district health officials and shared their findings with government officials and hospital management societies. Ekjut also advocates for better health services, noting that advocacy is more effective if it is based on strong evidence and is undertaken in partnership with other organisations that are also seeking to improve health services.

In Bangladesh, the Perinatal Care Project is actively involved in district family planning committees, health committees at district and community levels, and health service user forums as well as meeting regularly with community clinic committee members. Project staff in Bangladesh also suggested that it would be useful to develop a standard referral card to monitor the extent to which women's groups refer women to health facilities and which referrals are followed up.

Extending the role of women's groups

Think about how women's groups can build on and sustain their activities.

In India and Bangladesh, women's groups have continued to meet regularly. Meetings have started a second cycle, addressing child and women's health. These meetings are addressing issues identified as priority topics by women's groups, these include malaria, tuberculosis, nutrition, family planning, condom use, safe abortion and sexually transmitted infections.

In Nepal, women's groups continued to operate after the trial was completed and funding ended. Women's group facilitators who had previously been paid

continued to work without pay and two years later over 75 per cent of groups were still meeting regularly. The most significant factor in determining whether a group continued or not was the existence of an emergency fund for maternal and child health problems.

In other studies in India and Nepal, volunteers are being used to facilitate women's groups from the start and this appears to work well. Mostly these volunteers are government-appointed community health volunteers. However, volunteers need some remuneration for the time they spend in training, as this takes them away from their usual income-generating activities and may require incentives if they have a heavy meeting workload.

2. Working Together – The Participatory Learning and Action Cycle

The participatory learning and action cycle has four phases. Each phase includes meetings that cover different topics. The diagram shows the cycle used in India.

The participatory learning and action cycle.

The topics to cover in each phase are listed below. Each project partner took a slightly different approach and you can adapt the order in which meetings cover the topics to your local situation.

Phase 1: Assessing the situation

Meeting 1 Establish the group and introduce the project

Meeting 2 Find out what people think and do about maternal and newborn health

Meeting 3 Identify maternal health problems

Meeting 4 Identify newborn health problems

Meeting 5 Prioritise problems

Meeting 6 Identify the causes of problems

Phase 2: Deciding what to do

Meeting 7 Identify how problems can be prevented

Meeting 8 Identify how home and facility care can be improved

Meeting 9 Discuss strategies to address problems

Meeting 10 Prioritise strategies

Meeting 11 Plan and prepare for community meeting

Meeting 12 Community meeting

Phase 3: Taking action

Meeting 13 Plan actions in detail

Meeting 14 Decide how to monitor progress

Meeting 15 Review progress

Meeting 16 Community meeting

Phase 4: Measuring progress

Meeting 17 Prepare to evaluate impact

Meeting 18 Learn from others

Meeting 19 Review evaluation findings

Meeting 20 Plan for the future

The purpose of and methods used for each meeting are described briefly below. For more detailed information, see the manuals listed in Annex 2.

☑ Plays, games, storytelling, picture cards, puppets, role play, songs and dance were among the most popular and effective methods used for women's group meetings, as in many project communities most women had low levels of literacy. Based on their experience, project staff recommend field-testing and, if necessary, adapting picture cards, flip charts and other materials before using them in meetings.

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

Women's Group Facilitator in India

Meeting 1: Establish the group and introduce the project

Purpose

- To introduce the project and the participants
- To explain how your organisation will work in the community
- To explain the role of the facilitator
- To discuss the benefits of working together as a group
- To discuss what being a member of the group means
- To explain the cycle of meetings and how long this will take

Use participatory approaches for introductions, such as working in pairs. The project used something called the stick game to help women think about the benefits of working together.

To play the stick game ask someone in the group to volunteer. Give them a stick and ask them to break it in half. The stick will break easily. Now give the volunteer a group of sticks and ask her to break the sticks. She will not be able to break it. The individual stick was broken but the group of sticks was not. Ask the women to discuss the game – which is more effective the individual or the group of sticks? Then ask them to discuss the possible benefits of working together as a group.

Notes

Meeting 2: Find out what people think and do about maternal and newborn health

Purpose

- To find out what women think about pregnancy, childbirth and motherhood
- To find out about beliefs and practices relating to pregnancy, childbirth and motherhood in the community

Listen and learn by asking questions about marriage, childbearing and what women do during pregnancy and after birth. In India, the project used picture cards showing women before pregnancy, during different stages of pregnancy, and after birth and asked women to describe how this affects what women do, for example, their work, diet and how much rest they take. In Bangladesh, facilitators used body mapping, where women were asked to draw a picture of a pregnant woman and to draw a spot on each part of the body where problems can occur during pregnancy.

You also need to find out about delivery and infant feeding practices, before working with the group to identify maternal and newborn health problems, so that you understand what people in the community think and do. Facilitators can use the questions in the box below, remembering to ask why things are done the way they are.

- Where do women in this community usually deliver?
- Who usually delivers your babies?
- Who else is usually present during the delivery?
- Who is usually the decision-maker regarding the delivery?
- In what position do women deliver?
- What is used to cut the cord?
- What is put on the cord after it is cut?
- How soon after delivery are babies wiped?

Notes

Meeting 3: Identify maternal health problems

Purpose

- To find out what problems women experience during pregnancy, delivery and after delivery
- To find out how common women think these problems are in their community

The project used picture cards, showing the 12 most common maternal health problems, during pregnancy, delivery and after delivery. Symptoms, prevention and management of these problems are written on the back of each card. The facilitator asks the women to look at the pregnancy cards, and decide which one they want to discuss first. The group discusses the picture, what they think is the problem and how common it is in the community. The process is repeated for the delivery and post-delivery cards. Ask the group if there are other problems that are not shown and, if there are, ask them to draw picture cards for these problems.

☑ In some groups, women were reluctant initially to look at the picture cards because they felt that these things should not be discussed in a group. There were also objections from some men in the group, who felt that bringing men and women together to discuss issues using the pictures was not culturally appropriate. However, most groups accepted their use when the facilitator asked if the problems shown were familiar to them and explained that the purpose of the picture cards was to help them understand more about these problems.

Another approach is to draw a timeline covering pregnancy, delivery and the first month after birth, and ask the group to list the problems that can occur during this timeline.

Notes

Meeting 4: Identify newborn health problems

Purpose

- To find out about newborn health problems
- To find out how common women think these problems are in their community

☑ Be prepared to provide additional information. Discussions during group meetings about maternal and newborn health problems often resulted in women asking for more information. If facilitators were unable to answer questions or provide more information, they made a note of the question or issue, told the group they would address this at the next meeting and asked project staff for help.

The project used picture cards, showing the 10 most common newborn health problems, and followed the same process as the one described above for maternal health problems.

Notes

Meeting 5: Prioritise problems

Purpose

- To prioritise problems the group would like to focus on

Start with maternal health problems. Project facilitators used the picture cards to remind women about maternal health problems, and prevention and management of these problems. Then they used a voting exercise. Each woman is given six stones and asked to prioritise, putting three stones on the card showing the problem they think is the most important, two stones on the second most important and one stone on the third most important. Things they might want to think about when they are choosing include how serious the problem is, how common the problem is, and how easily they can take action to tackle it. The facilitator adds up the stones and discusses with the group what they have chosen as the most important problems. The process is repeated for newborn health problems.

India

In India, maternal health problems identified by groups, in order of priority, were: prolonged labour; malaria, pre-eclampsia and convulsion; retained placenta; obstructed labour (breach birth); post-partum haemorrhage; inflamed breasts and cracked nipples; obstructed labour (prolapse); anaemia; post-partum fever; bleeding in early pregnancy. Newborn health problems identified by women's groups were: diarrhoea; small baby; fever; not crying or not breathing after birth; umbilical cord infection; not feeding well; stiff and bent backwards; yellow at birth (jaundice); blue hands and feet.

Bangladesh

In Bangladesh, maternal health problems identified included severe abdominal pain; eclampsia; fever and excessive bleeding and newborn health problems identified included pneumonia; birth asphyxia; fever and cord infection.

Notes

Meeting 6: Identify the causes of problems

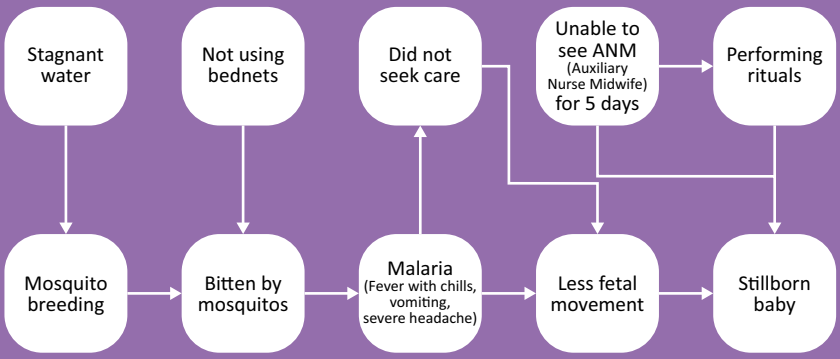
Purpose

- To discuss the causes and solutions of the problems mothers and babies experience in the community

The project used storytelling, based on picture cards showing immediate and underlying, and social and medical causes of priority problems, to help women understand the causes and effects of the problems. This included identifying wider causes such as poor access to health facilities, lack of money for transport and poor quality health services. After telling the story, the facilitator used but why questions to prompt group discussion about causes and possible solutions to problems.

Example from India: How to develop a story: cause and effect

Choose a problem card and on separate cards draw pictures of the immediate and underlying causes of the problem.



Arrange the cards in order in terms of what causes lead to other causes and ultimately to the problem (as above). To make the story more interesting and relevant think about practices common in the community, then write the story down to use with the women's group.

Example from Bangladesh

But why… did Rohima's son die?

Q: Why did Rohima's son die?
A: Tetanus

Q: But why did the tetanus bacteria attack Rohima's son and not someone else?
A: Because Rohima did not have a TT injection

Q: But why did Rohima not have a TT injection?
A: Because only the peon was at the health post

Q: But why was the peon alone in the health post?
A: Because the doctors were absent

Q: So what are the other reasons why Rohima son died?
A: Because Rohima used an old blade to cut the cord

Q: But why did Rohima use an old blade?
A: Because she did not have a new one

Q: But why did Rohima not buy one?
A: Because she was busy working in the home

Q: But why was Rohima busy working at home?
A: Because they need food to eat and she was processing the rice

Q: So what are the other reasons why Rohima's son died?
A: The hospital did not have the medicines

Q: Why did the hospital not have the medicine?
A: Because it is expensive

Q: But why are life-saving drugs so expensive?
A: Because it has taken a long time to make them

Q: Let's go back again for a minute. Are there any other reasons why Rohima's son died?
A: Because they did not go straight to the district hospital

Q: But why did Rohima and her husband not go straight to the hospital?

A: Because they did not have the money

Example from India

A story about malaria during pregnancy

Janaki lived in a remote village and when she was pregnant she decided to visit her relatives who live on the outskirts of a nearby town. Her relatives advised her to use a mosquito net because they knew there were lots of cases of malaria in the town. However, she ignored their advice and stuck to her usual practice of burning neem leaves. Soon afterwards she returned to her village but after a week she started to have fever with chills, severe headache and vomiting. She didn't seek any care. She noticed that her baby's movements had reduced and thought about seeing the community health worker, but the next health day was five days away, so instead she listened to the advice of her relatives who advised her to have 'puja', and sacrifice two chickens and a goat. Soon afterwards she delivered a stillborn child.

Another method you can use is to draw a tree, with roots, a trunk and branches. Put the problem card on the trunk. Start by asking the group to think about the roots of the tree, and list all the possible causes of the problem. Put the relevant cause's cards on the picture at the root of the tree. Then ask the group to discuss the effects of the problem, and write or draw these on pieces of paper and place them on the picture on the branches of the tree.

Notes

Meeting 7: Identify how maternal and newborn problems can be prevented

Purpose

- To help the group learn about prevention of maternal and newborn health problems
- To discuss how they can prevent maternal and newborn health problems

The project used two sets of picture cards – the maternal and newborn health problem picture cards used in the earlier meeting, and picture cards showing how problems can be prevented. The group selects which of the problems they would like to discuss and then looks at the relevant prevention cards, discussing which of these could help to prevent the problem in their community.

Notes

Meeting 8: Identify how home and facility care can be improved

Purpose

- To help the group to learn about home care practices
- To discuss what home care practices can help to address maternal and newborn problems
- To discuss health facility and emergency care for maternal and newborn health problems
- To discuss reasons for delays in dealing with emergencies and how to prevent delays

Again, the project used two sets of picture cards – the maternal and newborn health problem picture cards and picture cards showing home care practices. The group looks at the home care cards and then discusses, for each problem, which home care practices could help to prevent the problem. The same approach was taken for facility and emergency care, asking the group to identify which maternal and newborn health problems require facility care and which of these problems are emergencies.

Find out where people in the community go when there is an emergency. The project used the voting with your feet game to do this. Draw circles on the ground and put one of the following pictures next to each circle – this could include a hospital, primary health care centre, community health worker, traditional healer, traditional birth attendant and other places or people. Hold up a problem card and ask the women to decide which circle to join. Discuss with women in each circle why they think it is the appropriate place or person to seek help from for that problem. Repeat the game for other priority problems.

Groups can also act what the community usually does when there is a maternal or newborn health emergency and then discuss what delays occurred in the story and how these could be reduced. Ask the group whether women and infants die because of these or other delays. Ask them what other reasons there are for delays – for example, delays in recognising that there is a problem, delays in

seeking care or delays in receiving appropriate care at a health facility – and how these could be addressed.

Notes

Meeting 9: Discuss strategies to address problems

Purpose

- To identify strategies arising from the solutions
- To understand barriers before prioritising strategies

Remind women about the priority problems they identified and the solutions they suggested in previous meetings.

The project used the bridge game to help women think about the current maternal and newborn health situation – where they are now – and what they would like to change – where they want to be. Use this game to prompt discussion about barriers to changing the situation and possible strategies to address these barriers.

Facilitators also used but why questions to encourage the group to identify strategies. For each strategy discuss the barriers faced, and the strengths women have as a group to overcome these barriers.

☑ In Bangladesh strategies were developed to address problems identified, which included shortage of money, lack of transport, limited awareness among women in the community and poor attitudes among heath facility staff.

"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 in Bangladesh. 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."

Notes

Meeting 10: Prioritise strategies

Purpose

- To review and prioritise the strategies identified in the previous meeting

Remind the group which strategies they identified in the previous meeting. You can draw a picture of each strategy and ask the women to choose the most important strategies using voting or another method.

Look at which strategies have received the most votes. Start by asking if these strategies address the most important problems. Then discuss each strategy, one by one, asking if the strategy is feasible. For example, one group decided initially that building a hospital should be one of their strategies. After further discussion, they realised that this was not feasible and focused on things that they could do themselves as a group.

At the end of the meeting you should have a list of priority strategies. Encourage the group to prioritise a realistic number of strategies. If the group is too ambitious and tries to do too many things they are less likely to achieve their objectives.

In India and Bangladesh, priority strategies identified by women's groups included:

- Invite community health worker to meetings to talk about delivery kits.
- Counsel pregnant women on the benefits of iron tablets, tetanus toxoid injections, antenatal care, and family planning.
- Encourage pregnant women to prepare for childbirth and to use a delivery kit.
- Make available an emergency fund to pay for transport and health care.
- Organise community awareness campaigns e.g. on the risks of early pregnancy and delays caused by rituals and encourage greater family support for pregnant women.
- Contact the appropriate authorities to ensure traditional birth attendants are trained.

Project staff noted that women's groups efforts to increase awareness, provide advice and support to pregnant women, promote the use of delivery kits and establish emergency funds to enable women to access transport and treatment, made an important contribution to successful outcomes.

Notes

Meeting 11: Plan and prepare for community meeting

Purpose

- To discuss the reasons for holding a community meeting
- To decide who to invite and how to conduct the community meeting

Discuss why the group might want to hold a meeting with the community. Reasons might include: to raise awareness of maternal and newborn health problems, share what the women's group has discussed, present and discuss strategies to address maternal and newborn problems, and gain support from the community for the women's group activities and for action to improve maternal and newborn health.

When the group is agreed on the purpose of the meeting, they decide what needs to be done to prepare for the meeting. This includes who to invite and how to invite them, what methods they will use to present to the community, who will be responsible for different tasks and what support they need from the facilitator and your organisation. Allow time for the group to rehearse and practise for the community meeting, including the methods they will use to present information and to discuss the issues with the community.

Notes

Meeting 12: Community meeting

There is no standard approach to holding a community meeting. Each community is different and each women's group decided what to cover at the community meeting. The following describes how women's groups planned and implemented community meetings in India and in Bangladesh.

India

Purpose

- To share the learning of the previous 8-9 months by the women's group members with the larger community
- To disseminate prioritised strategies for preventing the prioritised problems
- To seek assistance from the community to help implement strategies

During the community meeting the women's group members summarised their activities, and highlighted their prioritised problems and prioritised strategies to the larger community and key stakeholders including village headmen, government officials, health workers, school and NGO staff and to villagers who had not attended the meetings.

Methods most frequently used by women's groups to disseminate information to community meetings included street plays, picture cards, storytelling and dance. Some groups also used puppets or told stories using songs or traditional folk media. At some community meetings, women's groups asked key stakeholders to open the meeting. Asking community health workers to inaugurate meetings helped to acknowledge their role in the community.

During the preparation for the community meetings, facilitators helped the group to rehearse the methods they had chosen to use. In some cases, women's groups were worried about performing in front of the whole community, so men took the initiative to perform the play while the women presented the games and the findings from the meetings.

Groups used locally available resources, for example, using saris as a back drop, leaves for decorations, jute woven mattresses for seating the attendees, water bottles for 'IV fluids'. The groups did not receive any funds or other resources from Ekjut for the community meetings, and group members voluntarily contributed money for arrangements such as microphones and food.

Group members took responsibility for inviting people personally to come to the meeting, either verbally or through a written note or using traditional methods of invitation that are normally used to invite friends and relatives for marriages, as the community meeting was like a day of celebration for them.

At the end of the community meeting, stakeholders were asked to share their views about the experience. These experiences were recorded by the facilitator who also recorded information about the meeting including dissemination methods used, the number of male and female participants and key stakeholders attending.

Notes

Bangladesh

Purpose

- To disseminate the prioritised problems to the community
- To develop strategies to overcome these problems jointly with the community
- To seek assistance from the community to help implement strategies

The meetings started by thanking the community for attending and introducing the women's group activities. The women's groups described the problems they had prioritised and the barriers they had identified. Then they presented the strategies they had selected to overcome the problems and the resources they had available to help them implement their strategies. During this process, community members were encouraged to participate and make suggestions. The support and encouragement of facilitators was important to build the confidence of women's groups in their ability to conduct the meetings.

The groups used brown paper, poster paper and picture cards to present their information. Meetings were chaired by local leaders or government health officials to demonstrate their support and involvement. Meetings ended by thanking the community for participating.

Facilitators recorded the names of those who attended and who had made a commitment to help implement the strategies, as well as the priority problems, barriers, priority strategies shared by the women's group. Some community meetings resulted in increased commitment among health workers to providing health care services to the community, and in some resulted in community members contributing to women's group emergency funds.

Notes

Meeting 13: Plan actions in detail

Purpose

- To review the community meeting
- To decide who will be responsible for taking strategies forward
- To decide what resources the group needs to implement their strategies

Start the meeting by congratulating the group for how they organised and conducted the community meeting. Ask them what they think went well and what they think they could do better next time. Discuss how the response of the community might affect the strategies they have prioritised.

Remind the group what strategies they have decided to implement and check that they are still happy to do this. Then for each strategy in turn, discuss what needs to be done and when, who will do it and how the group will support them.

The group also needs to decide what, if any, resources they need to help them implement their strategies, and whether they need to involve other members of the community.

☑ Emergency funds were managed by the women's group, who decided on procedures including how much money to save each month and who to loan it to. Groups appointed members to take responsibility as e.g. treasurer, cashier and assistant cashier. The key and the locked box with the funds were divided between group members. Three members had to be present when money was disbursed. Funds were used to pay for emergency transport or medical costs. Some groups used the funds only for group members, while others also helped other women in the community. Having a fund meant that women did not need to ask men or others for money. Funds were generally repaid although this was difficult for the very poorest women.

☑ Pregnant women were advised about antenatal care and the importance of regular check ups, danger signs, keeping healthy and preparing for birth, including how to obtain and use delivery kits. Women's group members took responsibility for visiting between five and 15 pregnant women and provided support and advice to women at the time of delivery and after birth through home visits. In Bangladesh, women's groups purchased delivery kits from an NGO and these kits were then sold to pregnant women. Women's groups in Bangladesh also gave advice about maternal and newborn health issues to other women of reproductive age.

Notes

Meeting 14: Decide how to monitor progress

Purpose

- To decide how the group will monitor their progress

Explain that it is important to monitor activities to check that what you are doing is going well and whether it is making a difference. This does not need to be complicated. Ask the group to discuss what they need to measure to be able to monitor their progress and how they can record it. Discuss each strategy in turn. Ask how they will know if things are going to plan and if what they are doing is making a difference.

For example, if a strategy is to encourage pregnant women to take iron tablets, the group can record how many pregnant women they have advised and how many pregnant women take them. If it is to raise awareness about the need for antenatal check ups, the group can record how many women were given this advice and how many went for a check up. If women are not taking iron tablets or going for check ups then it is important to find out why and to try to tackle the reasons.

Encourage the group to take responsibility for measuring progress. Either they can keep records or, if there is no-one in the group who is literate, they can use other methods to measure their progress like simple tallying or pictures or telling stories about what they have done and what happened as a result of their activities in the community. For example, in India, women counted – using stones or leaves – how many pregnant women they had visited, how many women had used the emergency fund and how many women for whom they had organised transport.

☑ Women's groups did not monitor provision of health services, but they did identify gaps in service provision. In India, these were reported to the Village Health Committee who took up the issue with government health officials. In Bangladesh, women's group members attended community clinic meetings and union health committee meetings to establish good relationships with health workers and express the need for improvements in health services.

The project kept records of births and maternal and newborn deaths. Facilitators kept records about the community, for example, number of households, numbers of women of reproductive age, pregnant women and adolescents.

Facilitators also kept records about the women's group process including meeting attendance, reasons for meetings being cancelled, strategies and actions taken and wrote up notes from discussions and case studies. Project partners provided facilitators with standard reporting formats for recording, for example, health problems identified and strategies prioritised by women's groups. An alternative is for coordinators to record verbal reports from facilitators.

It is also important to record other impact (sometimes called unintended consequences) as a result of group meetings. For example, in India, women reported that they were speaking out more at community meetings. These, and other changes, were recorded by facilitators.

Notes

Meeting 15: Review progress

Purpose

- To review progress with implementing the strategies
- To decide whether to organise another community meeting

Discuss progress by asking each woman or group of women who have been allocated responsibility how things are going. Find out if they have faced any problems and ask the group to discuss how these problems could be overcome.

Discuss also how progress is being monitored and whether the group has faced any problems with doing this. Ask the group to explain what the information they have collected tells them about their progress and whether they need to change their strategies. Make sure that you review progress at the start of every meeting. In India, women reported back to the group about their activities since the previous meeting and these activities were recorded by the facilitator.

During this meeting, the group can also decide whether they want to organise another community meeting, to present and discuss what they have achieved and any problems they have encountered. A community meeting can help to generate ideas about how women's groups can address maternal and newborn health problems and overcome problems.

If the group decides to hold another community meeting, as before they need to decide who to invite and how they will invite them, what they will present to the community meeting and how they will do this, and who will be responsible.

In India, women's groups used a traffic light system – green for good progress, amber for some progress, red for little or no progress – to report back on progress to the community.

Notes

Meeting 16: Community meeting

There is no standard approach to holding a community meeting. Each community is different and each women's group decided what to cover at the community meeting (see Meeting 12).

Notes

Meeting 17: Prepare to evaluate impact

Purpose

- To review progress
- To plan self-evaluation of the impact of women's group activities
- To identify successes and challenges to share with other women's groups

This meeting is about planning for Meeting 19. Explain why it is important to evaluate impact, and what evaluation means. Explain that this includes reviewing achievements and challenges, learning from experience and finding ways to improve the way we do things in future.

Meeting 18: Learn from others

Purpose

- To review progress
- To share experience and lessons learned with other groups

The project brought together women's groups from different communities to discuss their strategies, what they achieved, what challenges they encountered and how they overcame these challenges. This provided the groups with an opportunity to learn from each other and to get new ideas about things that they could do in their communities.

Notes

Meeting 19: Review evaluation findings

Purpose

- To review progress
- To evaluate the process
- To review what our evaluation tells us about impact

This meeting focuses on discussing what the group thinks about the process – how the group meetings worked, how they identified and learned more about maternal and newborn health problems, how they decided what action to take, how they implemented activities, how they monitored their progress – and evaluating what impact their activities have had. Impact should consider what difference the women's group meetings and actions have made to group members and to the community as well as the positive changes they have seen.

The project recorded women's comments and also used voting to evaluate the process. The facilitator prepared a chart with pictures representing each group meeting and the community meetings. Start with Phase 1. Give each woman a stone and ask them to put it on the picture of the meeting that they liked the most. Count the stones and start with the meeting that received the most 'votes'. Ask the group to explain why they chose that meeting, what they liked about it and what they learned from it. Repeat the process for each phase.

☑ Project staff in Bangladesh noted that women's groups had improved women's knowledge about danger signs and how to prevent and manage maternal and newborn health problems, as well as their confidence and leadership. Women's groups also led to improved home care practices, better care of pregnant women, increased breastfeeding and higher uptake of health services, including institutional deliveries.

You can ask women to describe ways in which they think their actions have resulted in changes in the group and in the community. Possible questions include: Has participating in group meetings influenced their own attitudes or practices? If so, how has it influenced them and why? Has the group influenced others in their community? If so, how has it influenced others? What helped them to influence the community?

☑ Project staff in India noted that women's groups had encouraged women to share problems and help each other, as well as improving awareness and adoption of better and safer practices, including among the poorest and most marginalised women. Examples of changes in practices included using sterilised blades to cut the umbilical cord, wrapping newborns and starting breastfeeding immediately after birth.

Notes

Meeting 20: Plan for the future

Purpose

- To review progress
- To decide what to do next

The final meeting gives the group an opportunity to discuss what they have achieved and to decide if they would like to continue meeting and, if so, what they would like to focus on next. As noted earlier, women's groups in India and Bangladesh have started a second cycle of meetings, focusing on child health and other women's health issues.

Notes

Annex 1: References

- Azad K et al, 2010. Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: A cluster-randomised controlled trial. Lancet DOI: 10.1016/S0140-6736(10)62042-0.
- Manandhar D et al, 2004. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: Cluster-randomised controlled trial. Lancet 364:970-979.
- O'Rourke K et al, 1998. Impact of community organisation of women on perinatal outcomes in rural Bolivia. Rev Panam Salud Publica 3(1): 9-14.
- Rath S et al, 2010. Explaining the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes: The Ekjut trial process evaluation. BMC International Health and Human Rights 10:25.
- Tripathy P et al, 2010. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: A cluster-randomised controlled trial. Lancet DOI: 10.1016/S0140-6736(09)62042-0.
- WHO and UNICEF, 2010. Countdown to 2015 decade report: Taking stock of maternal, newborn and child survival.

Annex 2: Additional Information

The women's group facilitator's manuals, picture cards, flip charts and other tools developed by the project can be found on the CD and online at:

- BADAS www.badas-pcp.org
- Ekjut www.ekjutindia.org
- UCL Centre for International Health and Development www.ucl.ac.uk/cihd
- Women and Children First (UK) www.wcf-uk.org

The following publications are a useful source of additional information about community mobilisation and participatory methods:

- Akiiki A (2007) Community mobilisation skills. Fountain Publishers, Kampala
- Carter I (2003) Mobilising the community. Tear Fund
- De Negre B et al (1998) Empowering communities: Participatory techniques for community-based programmes. CAFS, Nairobi
- Feuerstein M-T (1986) Partners in evaluation: Evaluating development and community programmes with participants. TALC
- Gajanayake S and Gajanayake J (1993) Community empowerment: A participatory training manual on community project development. PACT
- International HIV/AIDS Alliance (2006) All together now! and Tools together now! 100 participatory tools to mobilise communities for HIV/AIDS)
- Kumar S (2002) Methods for community participation: A complete guide for practitioners. ITDG
- PACT (2007) Community mobilisation manual. PACT Dar es Salaam
- PLA Notes and PLA database. IIED
- Pretty J (1995) A trainer's guide for participatory learning and action. IIED
- Rokotuivana A (1988) Working with women: A community development handbook for Pacific women. South Pacific Commission
- Slocum N (2005) Participatory methods toolkit: A practitioner's manual. King Baudouin Foundation and Flemish Institute for Science and technology Assessment

Annex 3: Feedback form

Please take some time to let us know what you think about this publication and how it could be improved, as well as about your organisation, by answering the following questions. You can send your comments on this form to Ruth Duebbert at Women and Children First, United House, North Road, London N7 9DP, UK or by e-mail to guide@wcf-uk.org or fax to +44 (0)20 7700 3921

1. **How relevant is the topic covered by the guide?**

   Very relevant ☐ Relevant ☐ Not relevant ☐

   Please add any comments or suggestions about how the guide could be more relevant: _____

2. **How clear and easy to understand did you find the guide?**

   Very easy ☐ Easy ☐ Difficult ☐

   Please add any comments or suggestions about how the guide could be improved: _____

3. **How useful did you find the guide?**

   Very useful ☐ Quite useful ☐ Not very useful ☐

   If you have found it useful, please explain how you have used it to help you with your work: _____

If you have not found it useful, please suggest ways in which it could be made more useful: _____

_____

_____

_____

4. What type of organisation do you work for?

National or local government	☐	Faith-based organisation	☐
Donor agency	☐	UN agency	☐
International NGO	☐	Research or academic institution	☐
National or local NGO	☐		

Other ☐ (please specify) _____

_____

5. What are the main activities of your organisation?

Education	☐	Service delivery	☐
Training	☐	Community development	☐
Advocacy	☐		

Other ☐ (please specify) _____

_____

6. Any other comments or suggestions?

_____

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