Increasing women's economic and decision-making autonomy and use of health services though income generating activities (IGA) in Sikasso, Mali

World Vision PLAN INTERNATIONAL Save the Children Canada Johnson & Johnson FOUNDATION

BEST PRACTICE

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INTRODUCTION

PRETERM BIRTH IS THE LEADING CAUSE OF DEATH AMONG CHILDREN UNDER FIVE AROUND THE WORLD, AND A LEADING CAUSE OF DISABILITY AND ILL HEALTH LATER IN LIFE.

In Mali, 88,000 babies are born too soon each year and 9,170 children under five die due to direct preterm complications[1]. (Every Preemie Scale) due to direct preterm complications. The Born on Time (BOT) project aims to prevent preterm births by targeting risk factors related to unhealthy lifestyles, maternal infections, inadequate nutrition, and limited access to contraception that can lead to babies being born too soon.

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— Every Preemie Scale, 2017

BOT is the first public-private partnership dedicated to the prevention of preterm birth in targeted communities of Bangladesh, Ethiopia and Mali, bringing together the collective expertise of World Vision, Plan International, Save the Children, the Government of Canada and Johnson & Johnson. This project supports women and adolescent girls before, during and after pregnancies by strengthening health systems to provide quality, gender-responsive, adolescent-friendly, maternal, newborn and reproductive healthcare. BOT uses a combination of approaches that include health system strengthening, demand generation via Social and Behavior Change Communication (SBCC) and strengthening data collection and utilization.

Save the Children is delivering Born on Time in Mali within five health districts of the Sikasso region: Koutiala, Kadiolo, Kignan, Niena and Sikasso. The project is working to prevent preterm birth through a community-based and health systems strengthening approach that targets risk factors associated with lifestyle, infection, nutrition and contraception (LINC).

[1] https://www.healthynewbornnetwork.org/hnn-content/uploads/Mali20171.pdf

This strategy involves empowering women and adolescent girls, and engaging their male partners and families, to address gender discrimination and barriers that significantly impact newborn and maternal health. The project is also building the capacity of regional health facilities to improve health service delivery, increase the uptake of health services, and improve the collection and utilization of data on preterm births.

In the intervention areas of the BOT project in Mali, the demand for and utilization of maternal and newborn health / sexual and reproductive health (MNH/SRH) services in the health facilities is low. Indeed, according to the baseline assessment report carried out in April 2017, the rate of pregnant women that attended at least 4 antenatal consultations was 12%, and that of facility-based deliveries attended by qualified personnel was also 12%.

Sikasso is one of the poorest regions in Mali with 66.2% incidence of poverty compared to 7.4% in the capital city, Bamako and the national average of 35.6% according to EMOP 2016. Maternal mortality also remains high in the Sikasso region with 325 deaths per 100,000 live births according to the DHS 2018. Financial access to health services was indicated as a major barrier to the use of health services, as maternal and child health care in CSCom (primary health care centres) is chargeable for all users. The price of a prenatal consultation is 1500 CFA ($2.50 USD) in addition to the additional expenses for medication, etc. which still remain unaffordable by many.

According to the assessment report of the financial capacity of women's groups carried out in 2017, there were no women's groups aged 15-49 who had previously received solidarity funds. As such, none of the women's groups members carried out income-generating activities (IGAs) in the intervention areas. According to the project evaluation report regarding the use of MNH/SRH services by members of women's groups carried out in 2018, the rates for ANC (minimum four visits), assisted deliveries, PNC and FP were respectively 2%, 14%, 9% and 6% for the members of these women's groups before the project support.

In addition to no or limited income, gender inequalities and harmful social norms exacerbate barriers to accessing health care for women and girls. Most of the focus group participants (including women and men) from the Baseline evaluation in April 2017 recognized that husbands are the decision makers regarding the health of their wives and children. The decision-making power of women regarding their health and well-being within households and the community was deemed very low. In fact, less than 15% of women said they could decide about the use of health services and only 5.4% of women said they could decide together with their husbands about the use of health services.

Following numerous consultations and analysis undertaken during the inception period, the BOT team decided to support women aged 15-49 to organize themselves in groups to carry out income-generating activities. The objective was to enhance their self-esteem and confidence, increase their economic and decision-making power within the household, and improve their access to affordable health care.

After providing the women's groups with solidarity funds, the project found that all of the women receiving these solidarity funds implemented IGAs and as such have contributed to the wellbeing of their households by supporting certain expenses. There has been a reported increase in the use of maternal health services by these women, as well as improved confidence and sense of self worth, particularly in relation to male peers. For example, most women have reported feeling like equal partners with their husbands as they contribute financially to their household expenses.

The project has set up 75 women's groups to benefit from solidarity funds, composed of 2,250 women. Results have shown an increase in use of MNH/SRH services. In fact, members of women's groups report improved utilization of ANC, institutional delivery, PNC and FP services. According to the monitoring data and the cohort analysis, all members who delivered in the last two years were able to access and use MNH/SRH services according to their needs.

RESULTS

Since the implementation of the activities of the solidarity funds, 75 women's groups were created, for a total of 2,250 WRA in total. Every group (composed of 30 members) received an initial capital of 1,190$ CAD (granted by BoT project) to help start the income-generating activities (IGA). Examples of IGAs in those villages are producing and selling soap, oil, agricultural products, fish, seeds and fertilizers, donuts.

The table below describes the results generated from the group's IGA.

Every amount borrowed is reimbursed with 10% interest. Results show that on average women were able to double their capital after one year running their business. The new capital that each group was able to produce has been used as a health insurance for women and children under 5 when they need SRH/MNH services (see following section). Also, part of these funds were also distributed to 14 other women's groups in neighboring villages whose members also carry out income-generating activities.

INITIAL CAPITAL PER GROUP	500,000 FCFA ($ 1,190 CAD)
AVERAGE BENEFIT PER GROUP	109,869 FCFA ($251 CAD)
AVERAGE BORROWED AMOUNT PER WOMAN	16,666 FCFA ($ 33 CAD)
AVERAGE EARNED AMOUNT PER WOMAN IN YEAR 1	33,332 FCFA ($76 CAD)
AVERAGE EARNED AMOUNT PER WOMAN IN YEAR 2	66,664 FCFA ($152 CAD)

"Last time there was a parent who wanted to marry his teenage daughter; with my friends we prevented this marriage through our advocacy to the chief of the village as well as to the parents of this teenager."

— One member's testimonial

Impact on SRH/MNH access

The cohort data (2,225 women) has demonstrated an important increase in the use of SRH/MNH services by all members according to their needs. The table below describes the rate of core indicators prior to the creation of the solidarity fund group, 1 year after its implementation and 2 years down the road. Some of the groups also supported adolescent girls (total of 28) in accessing SRHR information and FP methods.

COHORT INDICATORS	PRE-INTERVENTION [2]	1 YEAR INTERVENTION	2 YEARS INTERVENTION
At least 4 ANC visits	2%	68%	100%
At least 1 PNC visit	14%	69%	100%
Assisted deliveries	9%	74%	100%
FP consultation	6%	76%	100%
Growth monitoring visits for children under 5	14%	84%	100%

Impact on promoting positive behavior

The project has reinforced women's capacities to become advocates and sensitize the community on the prevention of prematurity through the LINC approach and the promotion of gender equality. They educated their neighbours on prematurity prevention and gender equality on a monthly basis.

With their financial contributions to support ASRH services for girls, the women's groups along with adolescent girls themselves are now advocating within their communities to prevent child, early and forced marriage (CEFM) as well as early and unwanted pregnancies. One adolescent reported: "Last time there was a parent who wanted to marry his teenage daughter; with my friends we prevented this marriage through our advocacy to the chief of the village as well as to the parents of this teenager".

Members of women's groups benefiting from solidarity funds also reported changing perceptions and attitudes in their households. For example, many have observed that husbands exhibit more positive attitudes towards them, and increasingly consider women to be equal partners in the management of the family's needs and assets. Women became contributors to the management of their households and many women have self-reported being able to pay for their children's school fees.

As one member described: "I have the financial means which allow me to access health services, to pay the contributions for the weddings of members of my family and my husband's family, to contribute in the purchase of food for my household, to pay school fees for my children and to give money to my husband when he is in need". Another member has stated: "I thank the BOT project for changing the status of my life. For the moment, my husband and his family take me more into consideration".

2 The intervention refers to the creation of women's solidarity fund

LESSONS LEARNED

Income-generating activities, the loan and repayment system, good collaboration between women's groups and health facilities, support for members of women's groups by their husbands and village leaders as well as supervision / monitoring / coaching / mentoring of the members of women's groups by BoT project teams and health district management teams worked very well.

It was key to consult WRA to learn directly from them about the barriers they face and their ideas and solutions to overcome these barriers to ensure greater buy-in, sustainability, and ownership of and within these groups. It was important for the project to support the women's groups members as leaders themselves in their groups and IGAs rather than perceive them merely as recipients of loans. In addition to increasing their access to credit, savings, and decision-making within their households, many women have also reported more solidarity and support between themselves by having a space to learn and share together regarding their IGAs, health, or gender inequalities and/or discrimination that that they may be facing.

Other effective interventions that led to the success for these solidarity funds and IGAs was the preparation and buy-in from the community through participatory dialogues early on, the empowerment of local state services in the supervision of these groups, the effective male engagement strategy, and the mentoring of women in financial management.

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CONCLUSION

BY PARTICIPATING IN WOMEN'S GROUPS, WOMEN HAVE INCREASED THEIR ECONOMIC AND DECISION-MAKING POWER, RESULTING IN GREATER ACCESS TO HEALTH SERVICES. INCREASED KNOWLEDGE ON GENDER EQUALITY, AS WELL AS THE RISK FACTORS FOR PRETERM BIRTH, WHICH HAVE ALL SUPPORTED WOMEN ON THE PATH TO BETTER HEALTH AND WELLBEING.

Women are able to support preventive follow-up services for their children and pay for ASRH services in the community. They financially support the expenses of their households, including the education of their children. They decide together with their husbands regarding the management of their households and are increasingly recognized and respected by their husbands, their neighbours and their communities as equals, which has motivated them to continue their IGAs.

Husbands were engaged early on in the project to be supportive and respectful of their wives' IGAs and savings as a means to improve women's control and decision-making power and deter husbands from taking and misusing the funds. As a result, men have since reported to greatly appreciate the financial support of their wives for the functioning of households. Many men have gone on to educate their neighbours on ways to prevent prematurity and help members of the community adopt healthy behaviors, improve gender equality and reduce GBV, while working towards reducing risk factors for preterm birth.

This best practice, by strengthening the financial capacities and decision-making power of women, while simultaneously working with men, religious and community leaders, and mothers-in-law to transform harmful gender norms, roles and expectations of women and girls, has worked very well for women's empowerment and greater gender equality among targeted villages in the region.

... As a result, men have since reported increased appreciation of the financial support their wives are providing for the functioning of households.

For all those who intend to adopt this best practice or for those who want to strengthen the economic and decision-making power of women in order to improve their access to and utilization of MNH/SRH services, the project recommends this best practice; but for it to work well, the following recommendations must be taken into account:

- Involve beneficiary women, their husbands, village leaders and local government services in identifying viable IGA

- Conduct a preliminary study of the viability and profitability of income-generating activities and estimate the minimum amount to be given to each women's group
- Start the practice at the start of the project because it requires a lot of time for the women to seize management tools and for all of the members of the groups to receive and repay the loan
- Provide training for women beneficiaries in fund management and gender equality, empowerment and leadership
- Conduct several supervision, follow-up, coaching and mentoring visits to members of women's groups benefiting from solidarity funds
- Increase the initial amount that a woman can borrow (instead of 33$CAD, consider an amount around 70$CAD) so she can have a more profitable IGA and generate a bigger capital faster
- Use the socioecological approach to engage multiple actors at the same time to create greater change, e.g. husbands, religious and traditional leaders, mothers-in-law, health and protection service providers etc. by training them on gender equality, women and girls' empowerment and rights, including MNCH/SRHR, to enable an environment where women can exercise their rights, access and control resources, makes decisions about these resources including when to seek health care without the risk of experiencing backlash or violence as a result
- Monitor the time/work burden of WRA to ensure that the project is not adding to women's time poverty. As WRA typically have a very high workload, both productive (economic, agricultural, etc.) and reproductive (care work), similar project interventions should use a gender transformative approach to transform harmful gender norms by engaging men and boys in care work. Not only will this improve relationships within the household between spouses, parents and children, it will grant women more time to invest in their IGAs and/or more leisure time and thus a better quality of life. A robust male engagement strategy must be included as part of the gender transformative approach to challenge and transform unequal power dynamics and discriminatory gender norms that men and boys often benefit from and reinforce. This will allow for greater transformation within households and communities, but must be implemented in a meaningful and intentional manner as a means to also reduce all forms of GBV, including intimate partner violence, and not just during pregnancy, and not just while women and pregnant.

BORN on TIME

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