International Journal of Advanced Research and Multidisciplinary Trends (IJARMT)
An International Open Access, Peer-Reviewed Refereed Journal
Impact Factor: 6.4 Website: https://ijarmt.com ISSN No.: 3048-9458

Assessing the Effects of a Community-Based Intervention on Health and Economic Well-Being

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Abstract - Empowered women have attained a higher level of development and are better positioned to demand equal access to healthcare services. Forming women's groups to raise awareness about maternal and child health (MCH) is a core strategy of community-based interventions, providing effective and innovative ways to improve their access to health care. The present study evaluated a community-based intervention designed to enhance women's utilization of MCH services and awareness, as well as improve their access to employment and savings accounts through peer-led outreach in two regions of India. Peer educators served as facilitators, bridging communication among women and fostering a supportive environment within families and communities. The intervention was implemented in Rohtak and Karnal, two underutilized districts in Haryana. Two development blocks were randomly selected from each district, and 24 villages with high population underprivilege were chosen from each block. A mixed-methods approach, including a non-experimental post-test-only design of the project group, was used to evaluate the intervention. Following the sessions, there was a notable increase in women's awareness of MCH. Women maintained records of their savings, either from regular community funds or earnings through employment schemes. These emergency savings accounts helped women manage unforeseen expenses such as starting small businesses, medical emergencies for family members, children's education, and more.

Keywords*:* Community-Based Intervention, Health, Economic Well-Being, maternal, child health, non-governmental organizations

INTRODUCTION

Community-based interventions are vital components of public health systems aimed at enhancing economic and health well-being at the local level. These initiatives typically involve collaborative efforts among healthcare providers, community leaders, non-governmental organizations (NGOs), and community members to address prevalent health issues and socioeconomic inequalities within specific populations. Evaluating such interventions is essential to determine their relevance, feasibility, and overall impact on the targeted communities. This session will explore the significance of assessing the effects of community-based interventions on health and economic well-being, along with the key considerations and methodologies employed in such evaluations.

Primarily, evaluating community-based interventions provides critical insights into their effectiveness in reducing health disparities and improving the overall well-being of a population. These interventions often target multiple determinants of health, including access

to healthcare services, promotion of healthy lifestyles, social determinants, and environmental factors. By analyzing the outcomes, researchers and policymakers can assess whether the strategies implemented have led to measurable improvements such as decreased disease prevalence, adoption of healthier behaviors, and enhanced quality of life among community members.

Moreover, assessing the economic impact of these interventions is crucial for understanding their cost-effectiveness and long-term benefits. Community programs often require significant investments in terms of funding, personnel, and infrastructure. Evaluating the balance between implementation costs and benefits—such as savings in healthcare expenditures, productivity gains, and overall economic development—helps stakeholders make informed decisions about resource allocation. Economic analyses enable prioritization of interventions that offer the greatest return on investment in both health outcomes and financial sustainability.

Beyond health and economic outcomes, it is equally important to examine the sustainability and scalability of community-based interventions to ensure their lasting success and broader applicability. Sustainability refers to the community's ability to maintain the intervention independently and continue reaping its benefits over time. Scalability involves the potential to replicate and adapt the intervention in other communities with similar needs and contexts. Understanding the factors that influence both sustainability and scalability allows stakeholders to design interventions that are not only effective in the short term but also adaptable and resilient across diverse settings and populations.

To effectively evaluate the impact of community-based interventions, a comprehensive approach that integrates both qualitative and quantitative research methods is essential. Qualitative techniques—such as participant observations, focus group discussions, and interviews—offer valuable insights into the experiences, perceptions, and contextual factors that influence the outcomes of the intervention. On the other hand, quantitative methods—including surveys, randomized controlled trials, and economic analyses—focus on systematically measuring outcomes and assessing their statistical significance. By synthesizing findings from these diverse sources, researchers can gain a holistic understanding of how the intervention influences both health and economic well-being.

Evaluating the effects of community-based interventions on health and economic outcomes is crucial for guiding program development, refining strategies, and fostering positive change within communities. Employing thorough assessment methods while considering factors like adaptability and sustainability enables stakeholders to improve the effectiveness and longevity of interventions designed to reduce health disparities and support equitable economic growth at the local level.

LITERATURE REVIEW

Goudet et al. (2018) the authors conducted a comprehensive review of program options aimed at improving maternal nutrition interventions in South Asia. They examined a variety of locally implemented practices, programs, and initiatives addressing maternal malnutrition and its related consequences. By evaluating the outcomes of these interventions, Goudet et al. sought

to identify effective strategies that could be scaled up or replicated to enhance maternal and child health outcomes in similar contexts.

Hariton and Locascio (2018) Hariton and Locascio highlighted the importance of randomized controlled trials (RCTs) as the gold standard for assessing the effectiveness of interventions, especially in the field of maternal nutrition. RCTs are widely regarded as the most rigorous evaluation method because they minimize bias and allow researchers to establish causal links between interventions and outcomes by randomly assigning participants to treatment and control groups. Their review likely focused on the critical methodological aspects of conducting RCTs for maternal nutrition interventions, including considerations such as sample size, blinding, randomization procedures, and outcome measurement.

Kwan et al. (2019) Kwan et al. examined the application of the RE-AIM framework in program design and evaluation within community and clinical settings. The RE-AIM framework offers a comprehensive approach to assess the reach, effectiveness, adoption, implementation, and maintenance of interventions. By utilizing this framework, researchers can evaluate both the impact and adaptability of programs in real-world contexts. Kwan et al. likely demonstrated how the RE-AIM model can be applied to maternal nutrition interventions across various settings, aiding program planners and evaluators in developing, executing, and assessing interventions that are both practical and impactful.

Nguyen et al. (2017) the study conducted a cluster-randomized program evaluation to assess the integration of nutrition interventions into an existing maternal, newborn, and child health (MNCH) program in Bangladesh. The intervention package likely included a comprehensive set of strategies aimed at low-income pregnant women and their infants, such as promoting dietary diversity, providing vitamin supplementation, and encouraging targeted breastfeeding practices. Researchers evaluated the effectiveness of this integrated approach by comparing improvements in maternal dietary diversity, micronutrient intake, and exclusive breastfeeding practices against those observed under standard MNCH services. The findings offer valuable insights into the potential benefits of incorporating nutrition interventions within ongoing MNCH programs to enhance maternal and child health outcomes.

Raj et al. (2016) the study conducted a cluster randomized controlled trial (RCT) targeting married men and couples in rural India to evaluate an intervention focused on gender norms and family planning. The intervention likely aimed to empower women, promote equitable gender attitudes, and increase access to family planning services and contraceptive use. Using a rigorous RCT design, the researchers assessed the intervention's impact on various outcomes, including contraceptive uptake, women's agency, and reproductive health knowledge. The findings underscore the importance of addressing gender norms and actively involving men in maternal and reproductive health interventions to achieve positive outcomes for women and their families.

TYPOLOGY OF COMMUNITY-BASED INTERVENTIONS

Merzel and D'Afflitti's review highlights that the term "community-based" commonly refers to interventions where the community serves as the setting. Here, the community is primarily defined by its geographic boundaries, such as neighborhoods, schools, churches, workplaces,

community centers, or other local organizations. These interventions can take place within specific community institutions or span an entire city through mass communication or other broad strategies. Community-based interventions may operate at various levels, including educational programs or targeted approaches involving individuals, families, informal groups, organizations, and public spaces. Often, these interventions involve community participation through advisory councils or coalitions to tailor programs to local needs or modify strategies according to community characteristics. The core objective in this model is to change individual behaviors to reduce disease risk across the population, recognizing that population-level change results from the cumulative impact of individual changes.

Alternatively, "community-based" can mean the community itself acts as the driver of change. In this perspective, the focus is on creating healthier social environments through broad, systemic shifts in public policies, services, and institutions. Community change—especially changes linked to health outcomes—is the intended result, with community health indicators serving as the goals of interventions. Large public health campaigns often adopt this approach. For instance, community indicator projects track metrics beyond individual behaviors, using data as a tool for response and evaluation. Examples of such indicators include the number of days air quality exceeds Environmental Protection Agency standards, the amount of park and recreational space per capita, and the percentage of residents living below poverty levels. Progress in these indicators over time is used to measure success, with intervention strategies linked directly to these markers.

The third interpretation, known as "community as asset," emphasizes the importance of community ownership and engagement for sustained improvements in population health. This approach mobilizes internal community resources, often crossing neighborhood boundaries, to address a selected set of local health-related issues. Interventions in this model combine external resources and stakeholders with community assets to influence a broad range of local institutions and systems. Whether the health issue is predefined or determined by the community itself, the goal is to achieve health outcomes through collaborative action. Notable public health initiatives employing this model include the Healthy Start program, the federal Substance Abuse Prevention Community Organization initiative, and “Healthy Cities” campaigns across various states.

In summary, these three paradigms—community as setting, community as focus, and community as asset—offer distinct but complementary frameworks for understanding and implementing community-based health interventions, each emphasizing different roles for the community in promoting health and well-being.

Finally, the fourth "community-based" paradigm, known as community as agent**,** is the least commonly applied in public health. While closely related to the previous models, this approach emphasizes understanding and strengthening the naturally occurring, resilient, and adaptive units within communities. As Fellow Steuart explains, human communities fulfill our fundamental needs through various social structures such as families, informal neighborhoods, schools, workplaces, faith-based organizations, and political systems. These organically formed units offer the advantage of direct, skilled intervention while addressing the needs of

many community members. However, communities are also defined by whom they include or exclude, and the very networks that bind them may face disruption or decline.

In this paradigm, the goal of community-based programs is to engage deeply with these naturally occurring social units—viewed as essential sites and methods for intervention. This requires a thorough assessment of community patterns and processes before any action is taken, as well as insider knowledge to interpret the community context accurately. The aim is to empower these response units to better address the concerns of community members. Strategies may involve fostering connections among community organizations to enhance collaboration, strengthening informal social networks, building links between individuals and supporting institutions, and revitalizing neighborhood associations. Importantly, this approach calls for addressing common community issues, many of which may not be directly health-related. Ultimately, it emphasizes starting interventions from where the people themselves are.

These models of community-based interventions are significant because they represent diverse perspectives on what community means, the role of public health in addressing community challenges, and the types of outcomes to expect. Although these paradigms are often presented as distinct categories, no single model is applied exclusively in community health promotion efforts. While the community as setting model is limited in scope—especially given the profound political, social, and economic challenges many communities face—the other models offer more dynamic and empowering approaches. Merzel and D'Afflitti note the difficulties in comparing programs that adopt different models with varying goals and methods. Many earlier initiatives primarily relied on the community as setting approach, whereas more recent efforts increasingly draw upon the other three models.

The latter three paradigms—community as target**,** community as asset, and community as agent—recognize that desired outcomes may include changes not only in individual behaviors but also in the broader community environment. Indeed, it can be argued that the two primary objectives of contemporary public health are to strengthen community health and to build the community's capacity to manage health-related issues effectively.

CIVIL SOCIETY, COMMUNITY CAPACITY, AND COMMUNITY-BASED HEALTH PROMOTION

In recent years, there has been a significant surge in research and discussion around urban revitalization, intermediary organizations (such as effective nonprofits, places of worship, and neighborhood watch groups), and social capital. While these concepts originated within political theory, they have since expanded into various disciplines and popular discourse, highlighting a broader context for community-based programming. Within this framework, civil society can be seen as the "setting of settings" for community health development. Civil society organizes people's actions through networks, religious institutions, associations, and clubs—it is neither the market nor the state, nor merely a collection of individuals pursuing self-interest. Instead, it represents a collective striving toward shared goals, encompassing both formal and informal community governance and civic engagement, including voting. The core value of civil society demands broad participation across its institutions and partnerships, ensuring that even the perspectives of marginalized group members are included. Thus, the

aims of civil society align closely with public health objectives focused on reducing health disparities.

The success of community-based health promotion depends heavily on the strength of civil society, especially as we increasingly recognize and harness the capacity of communities to address local challenges. Community capacity is a critical mediator between the implementation of health initiatives and their population-level outcomes. Key elements of community capacity include knowledge and skills, leadership, a sense of efficacy, trustful relationships, and a culture of openness and learning. Understanding the social fabric and dynamics of a community enables better coordination of health promotion efforts and provides access to resources and strategies that external experts alone cannot offer—essential for tackling complex health problems like substance abuse, violence, infant mortality, and more.

More importantly, emphasizing community capacity shifts the focus from traditional intervention models to community empowerment as the pathway to improved health. This approach may involve deliberate efforts to nurture new and existing leadership, strengthen neighborhood associations, and encourage collaboration across organizations and sectors. Initiatives may also aim to create opportunities for community participation, foster trust and communication between community groups and institutions, and facilitate dialogue that supports collective decision-making. Community capacity, therefore, represents both an ideal outcome of community interventions and a vital resource and prerequisite for sustainable health improvement.

HEALTH OUTCOMES ASSESSMENT

Evaluating health outcomes involves assessing how a community-based intervention influences various aspects of the target population's health. This evaluation typically integrates both objective and subjective measures to gain a comprehensive understanding of changes in behavior and health status. Quantitative data may include health indicators such as disease incidence and prevalence, mortality rates, hospital admissions, and changes in physiological parameters like blood pressure, cholesterol levels, or body weight. These objective measures provide unbiased evidence to evaluate the intervention's effectiveness in improving overall health outcomes.

On the other hand, subjective assessments focus on capturing the personal experiences and perceptions of those impacted by the intervention. This may involve conducting focus groups, interviews, or surveys to gather information on behavioral changes related to health, attitudes, and overall well-being. Such qualitative data enrich quantitative findings by offering context and deeper insight into how the intervention affects individuals' lives.

Health outcomes evaluation may also target specific population groups, particularly vulnerable or marginalized communities, to ensure that health disparities are appropriately addressed. Additionally, it is important to monitor for any unintended negative consequences or adverse effects of the intervention to minimize potential harm.

Overall, assessing health outcomes is vital for determining the feasibility and impact of community-based interventions on health improvements. It informs future initiatives and guides policy decisions aimed at promoting better population health and well-being.

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I. ECONOMIC WELL-BEING EVALUATION

Assessing the impact of a community-based intervention on the economic well-being of individuals and families involves evaluating changes in financial stability, income levels, employment status, and overall economic conditions within the target population. This evaluation seeks to understand how the intervention has contributed to improving economic outcomes and alleviating poverty or financial hardship among community members.

A key aspect of this assessment is analyzing shifts in household income and wages following the intervention. This may include collecting data on family income, employment types, sources of income, and access to financial resources such as credit, social assistance, and investment opportunities. By examining changes in income distribution and poverty rates, evaluators can determine the extent to which the intervention has helped families achieve greater economic independence.

Beyond income, economic well-being evaluations also consider access to essential services that affect financial stability and quality of life, including healthcare, education, and housing. Improvements in access to affordable housing, medical care, and educational opportunities serve as important indicators of enhanced economic well-being.

Additionally, the evaluation may explore the intervention's impact on local economies by measuring job creation, business development, and overall economic growth. Tracking changes in employment rates, entrepreneurship, and neighborhood economic activity allows evaluators to assess the intervention's effectiveness in fostering a more vibrant and sustainable local economy.

Qualitative methods such as focus groups, interviews, and case studies provide valuable insights into participants' experiences and perceptions of how the intervention has influenced their financial well-being. These subjective data complement quantitative findings by revealing the nuanced ways in which the intervention affects individuals' aspirations, livelihoods, and financial behaviors.

Overall, evaluating economic well-being is crucial for understanding the broader financial effects of community-based interventions. By combining quantitative indicators with qualitative experiences, evaluators can gain a comprehensive view of the intervention's impact, guiding evidence-based strategies and informed decisions aimed at promoting economic transformation, poverty reduction, and social inclusion within communities.

METHODS

A. Evaluation design

The intervention was evaluated using a mixed-methods approach that included a non-experimental post-test-only design conducted within community settings. No baseline or control group was available for comparison. The intervention took place over a period of more than thirty months, from April 2023 to September 2024. Following the conclusion of the intervention, qualitative post-intervention data were collected and analyzed during October and November 2024.

The study area for evaluating the impact of a community-based intervention on economic and health well-being encompasses the regions served by Vivek Pathology in Karnal and Dr.

Lalpathlabs & Paliwal Diagnostics in Rohtak. Located in the Indian state of Haryana, the communities of Rohtak and Karnal represent diverse socio-economic backgrounds and reflect the healthcare access disparities commonly found in many rural settings. These areas often face challenges such as inadequate healthcare infrastructure, limited availability of diagnostic facilities, and socio-economic vulnerabilities among the population. Within their respective communities, Dr. Lalpathlabs, Paliwal Diagnostics, and Vivek Pathology play a vital role as primary healthcare providers offering essential diagnostic services crucial for disease detection and management. This project focuses on assessing the effectiveness of community-based interventions in enhancing economic well-being and improving health outcomes in these regions. Through comprehensive data collection and analysis, the study aims to provide valuable insights into how targeted interventions can influence healthcare accessibility, health awareness, and socio-economic empowerment in these marginalized communities.

The final data collection was conducted using a representative sample from the intervention sites. Additionally, quantitative indicators were monitored for the intervention population (n = 200), and this data was incorporated into the routine management information system. The evaluation focused on all relevant stakeholders who participated in the intervention, provided informed consent, and were available to attend the assessment sessions. These stakeholders included young married women (aged 15–35), peer educators, married women and their spouses, community health workers, obstetricians, clinical staff, VHSNC members, and MGNREGA workers. Routine observational data was collected by the project's outreach workers, while the final qualitative research was conducted by a team from the Department of Community Medicine at the Institute of Medical Sciences, Banaras Hindu University, Varanasi.

Management information system data

An online administrative data system was developed to monitor the intervention. A cohort of 200 young married women was tracked using specific indicators, including socio-demographic factors such as age at enrollment, age at marriage, education, religion, social caste, and possession of a Below Poverty Line (BPL) card, as well as their participation in group education sessions. The administrative data system captured five key outcomes, which were compared with baseline data: (a) status of the most recent delivery (institutional or otherwise); (b) whether postpartum care was received within 48 hours of delivery; (c) whether the women had a bank or postal savings account; (d) enrollment under the MGNREGA employment scheme; and (e) utilization of MGNREGA benefits.

All paper-based data collected by outreach workers during the intervention was regularly entered into this administrative database. Four additional indicators were used to assess the intervention's progress at three intervals—after the first 15 months, midway through the project, and during the final eight months. These indicators included the number of women reached, formation of women's groups, training of peer educators, and the number of referrals made by obstetricians or community health workers. Continuous data entry into the online system facilitated ongoing monitoring of the intervention's progress.

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RESULTS

The results are presented in two sections: the qualitative endline evaluation and the analysis of data collected from the administrative data system.

Table 1 presents the socio-demographic characteristics distinguishing the two groups, Rohtak and Karnal. These characteristics include mean age at enrollment and marriage, average years of education, religious affiliation, social caste, and possession of Below Poverty Line (BPL) cards. Both groups share similarities, such as an average enrollment age of around 30 years and a predominance of Hinduism. However, notable differences exist: Karnal exhibits a lower average age at marriage (15 years versus 18 years in Rohtak), a higher average duration of education (11 years compared to 5 years in Rohtak), and a significantly greater proportion of scheduled castes. Conversely, Rohtak has a higher prevalence of BPL card ownership than Karnal. These differences reflect socio-demographic variations between the groups, likely influenced by distinct social and economic contexts. Table 1 summarizes these characteristics of the intervention population as recorded in the administrative data system.

Table 1: Distribution of women's sociodemographic traits per district (n = 200), as determined by the management information system

Socio-demographic variables	**Rohtak (n = 105) N (%)**	**Karnal (n = 95) N (%)**
Mean (SD) age of women (years) at the time of enrolment	30 (9.5)	30 (10.3)
Mean (SD) age of women at marriage (years)	18 (2.5)	15 (8.4)
Mean (SD) years of schooling (years)	5 (4.0)	11 (2.6)
Religion		
- Hindu	70 (92.8%)	60 (93.3%)
- Muslim	20 (6.9%)	20 (6.3%)
- Christian	10 (< 0.3%)	5 (< 0.2%)
- Missing cases	5	10 (< 0.2%)
Social class		
- Scheduled castes	30 (35.6%)	50 (90.6%)
- Scheduled tribes	20 (7.1%)	5 (1.3%)

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- Other marginalized castes	40 (53.1%)	20 (4.5%)
- Non-marginalized class	10 (3.3%)	10 (1.3%)
- Missing cases	5 (< 0.9%)	10 (2.3%)
Possession of below poverty line card		
- Yes	60 (64.5%)	20 (40.4%)
- No	40 (35.5%)	60 (58.4%)
- Missing cases	5	15 (< 1.2%)

According to baseline data, a higher percentage of women in Karnal (46.9%) held bank or postal accounts compared to Rohtak (39.9%). However, this trend shifted in the Management Information System (MIS) data, which showed a significant increase in women with accounts in Rohtak (55.8%) surpassing Karnal (45.7%). Regarding the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), Rohtak initially had a slightly higher enrollment rate (31.5%) than Karnal (29.5%), but MIS data revealed that this gap widened, with 40.1% enrollment in Rohtak and 36.8% in Karnal. Notably, among those enrolled in MGNREGA, Rohtak reported significantly higher scheme utilization (95.2%) compared to Karnal (80.5%). Institutional delivery rates were high in both areas, with Rohtak nearly universal at 98.8% as per MIS data. The proportion of women receiving postpartum care within 48 hours of delivery was similar across both regions, showing only minor differences between baseline and MIS figures. Overall, the data indicate improvements in financial inclusion and MGNREGA participation in Rohtak relative to Karnal, alongside consistently high rates of institutional deliveries in both locations, although postpartum care rates remained stable (Table 2).

Table 2: When comparing data from the management information system and baseline, the result indicators' frequency and percentage distribution are shown.

Variables	**Baseline**		**MIS Data**	
	Rohtak (n = 235)	**Karnal (n = 230)**	**Rohtak (n = 105)**	**Karnal (n = 95)**
Women who owned a post office or bank account in their names	97 (39.9%)	110 (46.9%)	11,318 (55.8%)	9,240 (45.7%)
In MGNERGA, women registered to work	75 (31.5%)	69 (29.5%)	8,355 (40.1%)	7,593 (36.8%)

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Women who used the MGNREGA scheme out of those who were registered to work	33 (43.5%)	34 (48.8%)	7,924 (95.2%)	6,236 (80.5%)
Women who gave birth in a facility	190 (80.2%)	164 (69.7%)	796 (98.8%)	97 (89.3%)
Women who got postpartum care within 48 hours of giving birth	33 (13.8%)	28 (12.1%)	750 (79.1%)	87 (79.1%)

DISCUSSION

This study evaluated a community-based intervention designed to raise awareness and improve women's access to financial resources, such as business and investment funds, alongside enhancing their utilization of maternal and child health (MCH) services. The peer-led intervention appeared to increase women's knowledge about available MCH services. Similar intervention models combined with various assessments have proven effective in promoting health awareness among women. Participatory behavior change through communication with peers emerged as a successful strategy for improving maternal and child health outcomes. The intervention was grounded in theoretical frameworks including social support and empowerment, social cognitive and social learning theories, social network analysis and systems management, and strengthening peer-led approaches.

Beyond increased use of iron-folic acid (IFA) tablets and contraceptives, there were notable shifts in how women engaged with maternity and child health services. Low IFA consumption among women has been widely documented, despite visits from health workers. Factors contributing to this include inconsistent use, side effects experienced by women, and low tablet dosages provided at health facilities. In a study conducted in Bangladesh, Nyugen et al. identified significant improvements in pregnant women's access to free IFA and calcium supplements through a multi-faceted cluster randomized controlled trial. This approach included community mobilization, nutrition-focused counseling, and distribution of free supplements. The study attributed changes in IFA use to performance-based incentives for health volunteers and close supervision by skilled healthcare providers.

Women's financial independence and social status, family economic conditions, and socio-cultural and religious beliefs all influence their autonomy in utilizing family planning services. Additional barriers to family planning uptake include early marriage, fears about side effects, partners' lack of education, inadequate supply, and the approachability of health workers. These complex factors were not comprehensively addressed by the current intervention. Therefore, further evidence-based programs focusing on individual needs and these determinants as a whole are necessary to improve family planning service uptake. A systematic review of 63 studies titled "What works in family planning interventions" reported significant

improvements in knowledge, attitudes, communication, and intentions through demand- and supply-side programs; however, their impact on sustained and consistent use of family planning methods remained limited.

There has been a notable change in how family members, particularly mothers and spouses, are consulted regarding maternal health, which has influenced women's utilization of health services. A recent successful survey assessing the feasibility of a community-based intervention concluded that improving women's health behaviors requires the involvement of influential family members, such as husbands and mothers-in-law. While birthing specialists expressed reservations during discussions, quantitative data showed an increase in the number of women receiving postpartum care within 48 hours of delivery. This discrepancy may arise because healthcare providers often consider adherence to a full schedule of seven postpartum visits, a standard that many women struggle to meet. Poor compliance with postpartum care remains a challenge, with similar interventions facing limited success. The findings underscore the importance of educating women, engaging men, and providing culturally appropriate local care to improve postpartum health outcomes.

Women's employment opportunities increased following the intervention, either through participation in MGNREGA or other avenues. Previous studies have demonstrated that MGNREGA effectively promotes women's empowerment, social justice, and financial inclusion, especially among marginalized communities. However, challenges remain in the program's implementation and the enrollment of vulnerable groups. For instance, in Haryana, women's participation in MGNREGA was only 20%, despite higher engagement among scheduled castes and tribes (48%). This highlights the need for targeted policies and actions to enhance and expand women's participation. MGNREGA is thus recognized as a key initiative for improving women's social and economic status.

The study also revealed that many women have learned to save money for emergencies or medical expenses, such as timely access to healthcare facilities. Nevertheless, fewer than half of the women regularly accessed a bank account in both study regions. This low usage may be attributed to limited financial literacy, lack of support from spouses or family members, and poor banking infrastructure in rural areas. The study did not explore reasons for women's limited banking access, representing a gap that future research should address. A cross-sectional study in Rajasthan similarly found that rural women had inadequate financial literacy, poor savings habits, and limited record-keeping practices. Their dependence on male family members for financial advice likely contributes to this deficit and restricts their involvement in financial decision-making. Financial literacy programs tailored for women may help bridge these gaps. According to recent surveys, over 33% of women in Haryana reported having savings accounts in the past year—a figure that has steadily increased over the last decade. Concurrently, women's healthcare utilization has improved despite ongoing gender disparities in India. Much of this progress has been supported by income from employment and savings. These findings highlight the importance of integrating financial and health education alongside efforts to increase women's workforce participation.

The Kudumbashree program in southern India offers a successful example of a focused intervention that combines poverty alleviation with the strengthening of women's social networks. This program not only supports women's income-generation activities but also builds their confidence, resilience, and critical thinking skills related to their health and well-being. The intervention was considered successful in transforming the functioning of the Village Health, Sanitation, and Nutrition Committees (VHSNCs), enhancing both the capacity and awareness of committee members regarding their responsibilities. Previous studies have identified challenges in the effective operation of VHSNCs, emphasizing the need to strengthen their authority and support their development.

CONCLUSION

Evaluating the impact of a community-based intervention on economic and health well-being highlights its vital role in promoting holistic development. The final assessment revealed significant improvements in maternal and child health awareness and increased utilization of maternal and child health services within the intervention areas, alongside greater access to employment opportunities and support from family members. The study demonstrated that a peer-led approach can yield positive outcomes and underscored the importance of addressing both health and economic factors to empower marginalized women. Furthermore, sustained engagement from multiple stakeholders—including husbands, mothers-in-law, and community health workers—emerged as a promising and sustainable strategy for enhancing health outcomes. Although some indicators, such as iron-folic acid (IFA) consumption and family planning uptake, showed limited change, the findings provide optimism for future progress through more comprehensive and strengthened interventions. The study also emphasizes the need to improve the implementation of programs like MGNREGA to ensure job security and economic stability for underprivileged populations in India.

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