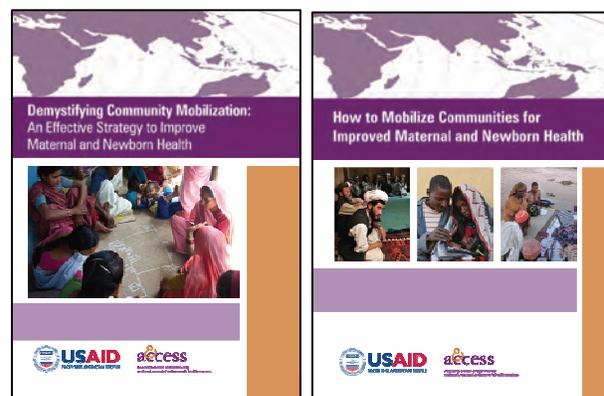


Community Mobilization: An Effective Strategy to Improve MNH

ACCESS APPROACH

The HHCC approach formed the foundation of ACCESS efforts to reduce maternal and newborn deaths that result annually from pregnancy and childbirth complications. At the facility level, the HHCC strengthens the capacity of health service providers in peripheral health facilities and referral hospitals to improve the access to and quality of MNH care. At the household and community level—where women, their families and community members are the focus—the HHCC approach promotes healthy pregnancy and birth practices, better self care, recognition of complications, and timely health service seeking.³⁵ Because communities play a critical role in the process of achieving an effective continuum of care, ACCESS sought to systematically engage communities to improve MNH outcomes through the tested and documented approach of community mobilization.

ACCESS advocated for community engagement as an important complementary strategy within comprehensive MNH programs, and developed two important resources to guide community mobilization programs. The first, *Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health*, presents evidence of the effect of community mobilization in reducing newborn mortality. A complementary manual, *How to Mobilize Communities for Improved Maternal and Newborn Health*, provides the organizing framework and guidance for implementing MNH-focused community mobilization initiatives. In addition to these global contributions to advance community mobilization, the Program supported three large, multi-year country programs in Bangladesh, Malawi and Nigeria that included significant community mobilization components.



WHAT IS COMMUNITY MOBILIZATION?

ACCESS adopted the following definition of community mobilization in its programs: “a capacity-building process through which community members, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis, either on their own initiative or stimulated by others.”

Key Components of Effective Community Mobilization Initiatives

Community mobilization can raise awareness of MNH issues and motivate people to participate in activities that have been prioritized and planned from within the community. It is an empowering strategy that includes the following activities:

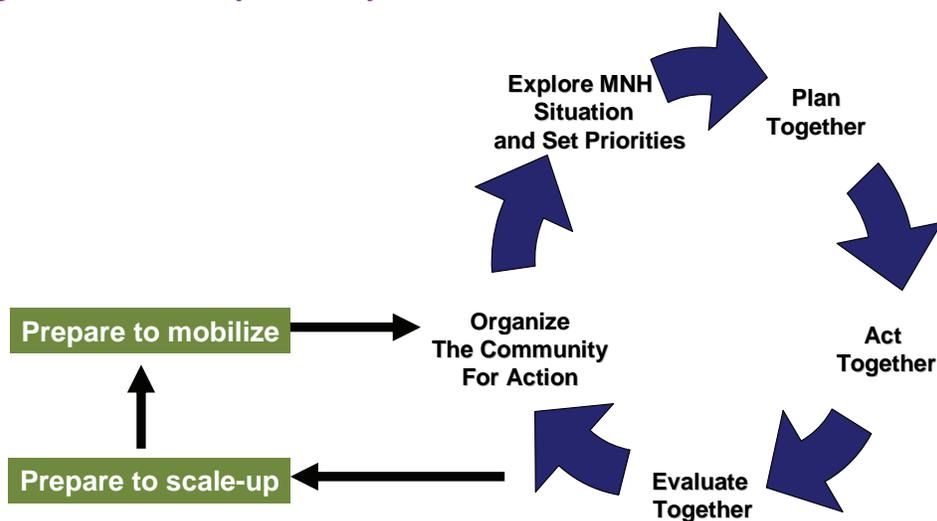
- Carrying out careful, formative research in order to design a locally-appropriate, context specific community mobilization strategy;
- Selecting and training individuals who will facilitate the community mobilization process within communities;
- Raising community awareness about the local MNH situation;

³⁵ Otchere, S. and Ransom, E. 2006 Bringing Care Closer to Mothers and Newborns: Using the Gap Analysis Tool to Develop a Household to Hospital Continuum of Care. Save the Children. Washington, DC: 2006.

- Working with community leaders and others to invite and organize participation of those most affected by and interested in MNH;
- Exploring with community members the local practices, beliefs and attitudes that affect MNH;
- Supporting communities to set local priorities for action;
- Helping community members develop and implement their own community action plans; and
- Working with communities to build their capacity to independently monitor and evaluate their progress towards achieving improved health outcomes for mothers and newborns.

These activities are summarized in the phases of what is known as the Community Action Cycle (CAC) (see Figure 11). The CAC is the common framework that ACCESS used in all programming contexts.

Figure 11: Community Action Cycle



The Program’s primary role in supporting community mobilization for MNH included:

- Facilitating the integration of community mobilization into the broader national, regional or district health plan;
- Supporting implementing organizations (MOHs, local government or NGOs) to develop community mobilization technical skills and expertise through training, targeted technical assistance and joint development of guidelines, manuals and supportive communication materials; and
- Monitoring progress of community mobilization efforts to refine strategies, energize stakeholders and contribute to community mobilization expansion/scale-up planning.

From Dr. Sani Musa, Kano State, Nigeria

“Since the commencement of the ACCESS community mobilization program in my village a year and a half ago, particularly with the introduction of the Community Core Groups, no single woman has died of pregnancy related problems. We have also experienced a significant reduction in neonatal deaths over the same period. The program has raised community awareness about maternal and newborn health, and gained participatory involvement of religious and traditional leaders in the roll out of the community mobilization process.”



RESULTS

The tables below highlight community mobilization interventions ACCESS implemented in Bangladesh, Malawi and Nigeria, respectively. Each intervention was uniquely designed to respond to the specific context in which the MNH program operated. As such, the Bangladesh program represents an NGO-led model, the Malawi program an MOH-led program, and the Nigeria program a model led jointly by MOH and civil society.

The CAC framework was common to each intervention—whether facilitated by MOH staff (as in the case of Malawi) or by NGO staff (as in case of Bangladesh)—and the development of skilled community mobilization facilitators was essential in all three programs. None of the programs provided monetary incentives to community members to organize, analyze and address the local barriers to MNH in their communities. Those community members with heightened awareness of the problems faced by families acted collectively out of a desire to make a difference.

Table 4: Bangladesh: NGO-led Model

CONTEXT	INPUTS	RESULTS
<ul style="list-style-type: none"> • Population covered by the intervention: approximately 795,000 • Most CHWs inactive and many vacant posts • Severely limited access to public, facility-based MNH services • No funding to strengthen public service delivery • Active NGO environment • Neonatal mortality rate: 37/1,000 • Skilled attendance at birth: 11% • Total fertility rate: 3.7 • Modern contraceptive prevalence rate: 32% 	<ul style="list-style-type: none"> • Community mobilization training manual, tools and communication materials developed • 125 NGO staff trained and supported to facilitate community mobilization • Over 2,500 local leaders instructed on how to lead community mobilization efforts • 1,904 Community Action Groups (CAGs) received monthly facilitation support. CAGs were composed of 21,875 men and women who participated to track pregnancies in their communities, and create and implement plans to encourage healthy home practices and remove barriers to use of services • 56% of CAGs included MOH health and FP staff 	<ul style="list-style-type: none"> • 61% of CAGs generated community emergency funds (to date used by 619 families for transportation or doctors fees, drug purchase or food). • 83% of CAGs organized emergency transport systems (to date used by 436 mothers and 247 newborns) for cases of obstructed labor, retained placenta, convulsions and (in the newborn) pneumonia, convulsions and jaundice, among others. • CAGs re-opened 69 inactive clinics and Expanded Program on Immunization Centers, and opened 12 new satellite clinics and 2 Expanded Program on Immunization Centers, working closely with local government and NGO representatives.

Table 5: Malawi: MOH-led Model

CONTEXT	INPUTS	RESULTS
<ul style="list-style-type: none"> Population covered by the intervention: 178,000 in communities linked to nine targeted health centers in three focus districts Program support to strengthen public health services along the full HHCC Health Surveillance Assistants (HSAs) have a mandate to engage community members in addressing local health challenges Neonatal mortality rate: 33/1,000 Infant mortality rate: 72/1,000 Skilled attendance at birth: 54% Contraceptive prevalence rate: 41% 	<ul style="list-style-type: none"> Facilitated national stakeholder review of community mobilization experiences to agree on a common framework and process National Community Mobilization Training Manual and tools developed in partnership with MOH/Reproductive Health Unit (RHU) 10 MOH staff trained as national (master) trainers 30 district MOH staff trained as trainers 120 HSAs and 18 Supervisors trained HSAs are supporting 675 villages to develop MNH CAGs that are linked with existing village development committees 	<ul style="list-style-type: none"> MOH/RHU owns community mobilization guidelines and training materials and plans to use them in training HSAs to facilitate community mobilization. Levels of community participation are high, especially among men. Deliveries by a skilled birth attendant increased to 71.7%, based on data collected by HSAs during their home visits between January and September 2009. USAID will continue catalytic support to MOH for expansion of community mobilization coverage under MCHIP.



Community Meeting

Table 6: Nigeria: Jointly Led MOH and Civil Society Model

CONTEXT	INPUTS	RESULTS
<ul style="list-style-type: none"> Community mobilization inputs provided in 17 Local Government Authorities (LGAs) in Kano, Katsina and Zamfara states in North West Zone HHCC framework; inputs at all levels National recognition of community engagement's importance (policies and structures in place, but not operational) Many civil society actors at all levels, including NGOs, associations, CBOs and unions) Neonatal mortality rate: 55/1,000 Modern contraceptive prevalence rate: 3.3% 	<ul style="list-style-type: none"> 17 Community Mobilization Teams (CMTs) at the LGA level formed and trained 37 CMTs at the Primary Health Centers (PHC) level formed and trained PHC CMTs supported formation and training of community core groups composed of 338 volunteer representatives from existing civil society groups in PHC catchment areas 	<ul style="list-style-type: none"> Transportation agreements negotiated with transport unions in all 17 LGAs to allow emergency transport to health facilities at a fixed low cost (to date, 6,500 women have used the transport system). Advocacy efforts resulted in new resources, such as an ambulance purchased to transport patients from PHC to hospital; ANC drugs and long-lasting insecticide-impregnated nets; a doctor and midwife posted to facility and paid shift-duty allowances so the facility is now open 24 hours a day, seven days a week. Increased ANC visits and facility deliveries based on program monitoring data.³⁶

WAY FORWARD

Challenge 1: MOH staff who are closest to the community (i.e., the CHWs) are already overworked.

Lessons Learned:

- Simplify and shorten community mobilization training curricula and processes as much as possible.
- Examine whether CHWs should lead or only support community mobilization efforts. There may be other options for community mobilization facilitation—such as existing community leaders, volunteers or members of civil society organizations, who can engage and feed input from communities to the health system.

Challenge 2: Community mobilization competes with many other priorities (clinical training, infrastructure development) within a resource limited environment.

Lessons Learned:

- Technical experts need to make every effort to integrate community mobilization into broader national health strategies, especially when existing MOH policy calls for strong community engagement.
- When communities, CHWs and program managers experience results, the relative value of community mobilization is compelling and support is more likely.



Community meeting, India

³⁶ Improvements in service utilization are likely due to a combination of community mobilization inputs, as well as improved quality of care at the facility and volunteer female counselors in the community.

Challenge 3: Ensuring stakeholder ownership of community mobilization is a time-consuming process.

Lessons Learned:

- Recognize this reality and plan accordingly. Stakeholder engagement cannot be over-emphasized.
- Develop solid partnerships with existing organizations at all levels. Community mobilization efforts have limited potential to expand and receive continued support without MOH buy-in.
- Seek greater flexibility in donor timelines.

Challenge 4: Community mobilization takes time.

Lessons Learned:

- Simplify the processes as much as possible before you start, and refine further as you rollout.
- As staff becomes more confident and skilled, community mobilization processes speed up. Good training is essential.
- Community mobilization successes build momentum and can lead to organic expansion.
- Communities and groups with prior experience organizing to solve problems can move more quickly.



Men's group, Afghanistan

Challenge 5: There is generally inadequate supportive supervision and mentoring available for community groups.

Lessons Learned:

- Factor supervision needs into human resource planning and program timelines. More supervision is needed in the beginning.
- Link communities so they learn from each other.
- Develop and provide communities with easy-to-use tools and learning materials.
- Consider working with existing groups in the community that are interested in supporting MNH, such as women's groups or agriculture groups. Existing groups need less support than newly-formed groups because they already have experience working together.

Recommendations for Future Community Mobilization Programming

1. Advocate with donors and program managers to include a community mobilization component in all comprehensive MNH programs. Community mobilization is an essential component of the HHCC approach, and is effective in increasing demand for and use of services.
2. Analyze the programming context carefully to identify existing systems, resources, policies, community structures and cultural factors. A community mobilization initiative that fits with and builds on local resources is more likely to be sustained and scaled up.
3. Continue to simplify community mobilization processes and tools—without losing the empowering, capacity building foundation.
4. Disseminate guidance on community mobilization indicators and monitoring systems so that program managers will be confident in tracking and reporting community mobilization outputs.

5. Budget sufficient resources to document and share community mobilization results—especially in peer review journals, because these are powerful advocacy tools.
6. Conduct cost-effectiveness studies to quantify the added-value of community mobilization.
7. Test variations of the community mobilization model for peri-urban and urban contexts.

