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Effect of Community Mobilisation on Maternal and Child Health

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ABSTRACT

There is indication that community mobilisation is an effective method for promoting participation and empowering communities among a wide range of other non-health benefits. Since 1990 the focus of child survival efforts has been on increasing the coverage of health commodities with proven effectiveness such as oral rehydration solution for diarrhea, cotrimoxazole for childhood pneumonia, vitamin A supplementation, insecticide-treated bednets, and vaccinations. The experience of pilot programmes and subsequent trial evidence, also suggests that community mobilisation can bring about cost-effective and substantial reductions in mortality and improvements in the health of newborn infants, children, and mothers. Nonetheless community mobilisation is not a feature of most large-scale primary health care programmes, because it is characterised by several fundamental controversies. Hence, further researches are needed to address these controversies.

Keywords: Community mobilisation, Empowerment, Participation, New-born and Maternal health

INTRODUCTION

Recently the lack of progress with the Millennium Development Goals (MDG) and primary health care in many poor countries has encouraged those in favour of comprehensive primary health care to question whether the failure to address community care and participation effectively within health programmes is a major reason for poor sustainability and ineffective scaling-up of selective interventions of proven efficacy [1]. The review of the WHO Integrated Management of Childhood Illness strategy reinforced these questions; thus, delivery systems that rely solely on government health facilities must be expanded to include the full range of potential channels in a setting and strong community-based approaches. The focus on process within child health programmes must change to include greater accountability for intervention coverage at population level. A crucial policy question is whether specific community participation interventions aimed at women and their families have a direct effect on maternal and child health? [2]. If so, how do these interventions work most effectively, and how can they be taken to scale? This paper therefore examined the effect of community mobilisation on maternal and child health.

Concept of Participation, Mobilisation, and Empowerment

Participation has been used to indicate active or passive community involvement. In the past, mobilisation consisted of communities responding to directions given by professionals to improve their health. This process usually took the form of mass campaigns for immunisations where communities were passively involved as the setting where the interventions were implemented or the target of the specific intervention. More recently, health and development workers have begun to act as facilitators focusing on the process of health improvements as well as the outcomes. In this approach, the facilitators support local communities to become actively involved—to participate—in both activities and decisions that affect their own health, either as a resource that can provide assets to address a health problem or an agent of change that uses its own supportive and developmental capacities to address its needs. Thus, community mobilization is "a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health

and other needs, either on their own initiative or stimulated by others" [2] Health programmes today often identify empowerment rather than participation as an objective. Community mobilisation is a way to support this empowerment process and reach the empowerment outcome. Since 1990 the focus of child survival efforts has been on increasing the coverage of health commodities with proven effectiveness—such as oral rehydration solution for diarrhea, cotrimoxazole for childhood pneumonia, vitamin A supplementation, insecticide-treated bednets, and vaccinations. At the same time, maternal survival efforts also moved away from community approaches focusing on traditional birth attendants, which lacked clear evidence of effectiveness, to efforts entirely focused on strengthening district hospital midwifery and obstetric care services and health systems [4]. These approaches to the diseases of poverty proved more saleable to policy makers for two main reasons: firstly, the clear-cut and rapid public health gains shown by these approaches fitted well within the new culture of evidence-based medicine. Secondly, the scalability of distribution of these approaches seemed intrinsically easier and less expensive than more long-term comprehensive primary health care approaches involving community mobilisation despite strong evidence supporting their effectiveness and affordability [5].

Effect of Community Mobilisation on Maternal, Newborn, and Child Health

Progress towards MDGs 4 and 5 in the poorest countries has remained slow in high-mortality settings. Between 1990 and 2005 there was no substantial change in maternal mortality in sub-Saharan Africa, and of the 68 priority countries targeted for child survival improvements, 41% were deemed to have made insufficient progress and 38% made no progress [6]. Additionally, in 11 African countries there were reversals in under-5 mortality rates in the same period [6]. The evident ineffectiveness of existing programmes and conclusion that this may in part be due to the lack of community involvement has led to a renewed focus on community mobilisation strategies for maternal, newborn, and child survival [1]. Most studies of community mobilisation interventions have investigated the effectiveness of specific interventions targeted at a passive recipient community— the old style of community mobilisation (for example, breastfeeding promotion, diarrhoea prevention and treatment, growth promotion [7], promotion of complementary feeding after 6 months of age, treatment of severe acute malnutrition, and pneumonia prevention and treatment. Far fewer studies have investigated the effectiveness of community mobilisation interventions, either on their own or in combined packages with other interventions, where the community provides the resources and is the active agent of change. In Ethiopia, a cluster randomised controlled trial (cRCT) showed that mobilising women's groups to effectively recognise and treat malaria at home led to a 40% reduction in under-5 mortality. For newborn care, the SEARCH Project in India showed the value of a complex home-based newborn care package (which included community delivery of injectable antibiotics, health promotion, training of traditional birth attendants, and physician visits) within a programme where communities had been mobilised over an extended period [38]. Bang and colleagues [9] ascribe 36% of the reduction in neonatal mortality rate to sepsis management; assessing the contribution of community mobilisation within the intervention compared with control villages is more difficult, although important. In Makwanpur district, Nepal, women's groups, led by a locally recruited woman facilitator, were supported through a community mobilisation action cycle where they discussed maternal and newborn health problems, developed strategies to address them, and then implemented and assessed the strategies in co-operation with local leaders, men, and health workers [10].

The mobilisation intervention had been developed in Bolivia under the Warmi programme [11]. The Warmi programme had seen a large reduction in perinatal mortality rate using before and after analysis of a small population, and the larger Makwanpur cRCT showed a 30% reduction in neonatal mortality rate, as well as significantly fewer maternal deaths (although the numbers of maternal deaths were few and maternal mortality ratio had not been a primary outcome for the trial). Two more recently published studies are the Hala and Projahnmo community effectiveness trials in Pakistan and Bangladesh, which combine demand and supply-side interventions, with different results [12]. The Hala trial was a pilot non-randomised controlled trial in which Lady Health Workers (government health workers responsible for about 200 families each) received training in home-based neonatal care and local traditional midwives (dais) received voluntary training. In addition, village health committees were established for maternal and newborn health. Compared with baseline rates the trial showed a 35% decline in perinatal mortality rate and a 28% decline in the neonatal mortality rate in the intervention villages. The control villages showed no decline [12]. The Projahnmo cRCT assessed the effectiveness of specially trained community health workers, who provided a home-care package including assessment of newborn infants on the first, third, and seventh days after birth, and referral or treatment of sick neonates. The study showed a 34% reduction in neonatal mortality rate in the final 6 months of the trial compared with the comparison group [13]. However, unlike the studies outlined above, the third community care arm, in which community mobilisers held community meetings with women in villages, showed no effect on neonatal mortality compared with the control arm [13].

Arguments Surrounding Community Mobilisation Interventions

Community Mobilisation vs. Home Care Visits

Although increasing evidence favours the effectiveness of community mobilisation interventions, a comparison of the Makwanpur and Projahnmo trials is central to this policy dilemma. The Makwanpur trial suggests that community mobilisation through women's groups is a cost-effective approach to reduce neonatal mortality rate in remote villages where developing and maintaining a programme of home visits by outreach workers has been impossible [14]. Projahnmo, by contrast, suggests that community mobilisation is less effective than a homecare strategy in reducing neonatal mortality rate in communities with a weak health system and low healthcare use. The interpretation of the findings of these trials must be considered carefully to guide policy makers. For example, the community mobilisation component of Projahnmo was less intensive than in Makwanpur. Thus, an important question to ask of these trials might be, what is the necessary level of intensity and coverage of community mobilisation and home-care interventions, to produce the most cost-effective effect? Other important questions include which are the most effective models of these interventions, can they be scaled up in the poorest communities, and what are the institutional and financial barriers to scale-up?

Community Health Workers

The use of so-called barefoot doctors in China inspired primary health care. This model involved local community residents—community health workers—liberating communities by providing first line health care and facilitating others to embrace changes brought about by the new government [15]. This model was adopted by many governments and non-governmental organisations after the Alma-Ata Declaration and in many cases became the definition of primary health care. However, by the 1990s many government programmes for community health workers had vanished because of problems in integrating them into national programmes. People also questioned whether community health workers actually empowered or oppressed as a result of the existing, socioeconomic political structures, bureaucracies, and lack of support from health professionals [16]. Furthermore, the evidence suggests that community health workers are most effective when they also facilitate change at the community level, and participatory approaches promoted by the online journal Participatory Learning and Action have provided structures and frameworks that support this role [3].

Role of Community Mobilisation in Addressing Socio-environmental Causes of Ill-health

Health, particularly in marginalised groups, is indirectly but powerfully affected by the social environment in which personal behaviours are embedded. Risk factors (such as isolation, lack of social support, low self-esteem) and risk conditions (such as poverty, discrimination, steep power hierarchies) can impair control or capacity and the respectful relationships that enable good maternal and child health [17]. Community mobilisation initiatives reported to improve the socio-environmental causes of ill health have addressed a range of concerns including alcohol related violence, breast cancer treatment, and safety in public environments [18]. Different forms of community mobilisation might simply mobilise communities to initiate localised actions based on their immediate needs rather than broader social and political actions. What is not known is to what extent peoples' involvement can actually increase resources to support health care, whether participation can create a genuine social learning partnership between people and professionals, whether community mobilisation can really change a commitment to social justice and democracy, and whether community mobilisation can actually accelerate progress at scale toward achievement of MDGs 4 and 5 in high-mortality, resource-poor settings.

Community Mobilisation and Improved Health

Some observers feel that community mobilisation works simply by bringing about changes in behavioural risk factors such as home care practices and decisions about care seeking. Although undoubtedly one important mechanism through which community mobilisation works, studies of health education suggest that simply providing key messages to improve maternal and newborn care cannot possibly account for all the effect these approaches have on morbidity and mortality [19]. A large proportion of this effect is thought to be due to community mobilisation bringing about changes in socio-environmental risk factors by developing the capacities of communities, the choices they make, and their ultimate empowerment. This mechanism is enshrined in the Ottawa Charter (1986) and the Jakarta Declaration (1997), which equated health promotion with goals of empowerment and a more long term and fundamental shift in village, family, and gender power relations. Women's groups in Malawi and Nepal are increasing the important capacities within communities, such as the ability to identify maternal and neonatal health problems and their root causes; the ability to mobilise resources necessary for improving the health of mothers and newborn infants; the internal and external social networks they can draw on when needed; and the development of strong local leaders who have the motivation and drive to improve maternal and neonatal health in the community [20]. The women's groups are also drawing on these social capacities to make fundamental choices to improve their health, such as about the equitable sharing of resources needed for better maternal and neonatal health; about

planning feasible strategies to address maternal and neonatal health problems; about planning, implementation, evaluation, finances and reporting of programmes; and about which people and organisations to approach to address problems.

CONCLUSION/RECOMMENDATION

There is indication that community mobilisation is an effective method for promoting participation and empowering communities among a wide range of other non-health benefits. The experience of pilot programmes and subsequent trial evidence, also suggests that community mobilisation can bring about cost-effective and substantial reductions in mortality and improvements in the health of newborn infants, children, and mothers. Nonetheless community mobilisation is not a feature of most large-scale primary health care programmes, because it is characterised by several fundamental controversies. Hence, further researches are needed to address these controversies.

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