Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health

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ABBREVIATIONS

CBO	Community-based organization
CHW	Community health worker
CM	Community mobilization
FP	Family planning
HBLSS	Home Based Life Saving Skills
ICDS	Integrated Child Development Services (program in India)
MDG	Millennium Development Goal
MIRA	Mother and Infant Research Activities (NGO in Nepal)
MOH	Ministry of Health
NGO	Nongovernmental organization
PVO	Private voluntary organization
STI	Sexually transmitted infection
UN	United Nations
USAID	United States Agency for International Development
VDC	Village development committee
WHO	World Health Organization

EXECUTIVE SUMMARY

A rapidly growing number of the poorest, most vulnerable communities with the highest newborn and maternal mortality are demonstrating that they can successfully lead efforts to develop and implement culturally appropriate solutions to improve the health of mothers and newborns. In a number of countries these communities have reduced maternal and newborn mortality by 30 percent to over 60 percent in periods of two to three years. Just as important, they are also actively engaged in building civil society by strengthening their capacity to achieve and sustain positive health and other development results. To achieve these results, health programs are using community mobilization as a primary strategy, expanding their efforts to reach multiple districts and, in a few instances, national scale.

In spite of the growing evidence of encouraging results from such programs, some donors and policymakers who do not have experience with the transformational power of community mobilization are skeptical of the process, confused by the range of definitions and approaches, and they have raised a number of legitimate concerns: community mobilization is too messy; takes too long; is too time intensive; costs too much; and cannot achieve large-scale impact.

The purpose of this publication is to address these concerns and present evidence from the field to make the case for including community mobilization as part of broader national health plans to achieve the Millennium Development Goals of reducing maternal and child mortality and improving maternal and child health.

Achieving high-quality, sustainable programming on a large scale is a challenge regardless of what strategy is used—and the community mobilization approach is no exception. It can be done most effectively when it is integrated into a broader national health plan; when there is political, financial, and technical commitment and support; and when there is a clear vision and implementation strategy that respects and builds on local structures, relationships, and resources. It will take time, usually from two to three years, to begin to see a decrease in mortality, especially among newborns, and several more years to strengthen community capacity to sustain improvements.

We call on national policymakers and donors to support a longer-term, more sustainable and equitable vision of partnership with communities, using proven community mobilization approaches that produce impressive health results for mothers and newborns and strengthen civil society by building greater community participation, commitment, and capacity.

INTRODUCTION

Each year more than 500,000 women in the world die from complications and conditions during pregnancy and childbirth. All but one percent of these deaths occur in developing countries, with the highest percentage occurring in sub-Saharan Africa and the highest number occurring in Southeast Asia. For every woman who dies, more than 30 women suffer complications and conditions that compromise their health over the long term.[1] Over four million newborns die in their first month of life, with 25–45 percent (depending on the location) dying in the first 24 hours after birth. Many of these maternal and newborn deaths can be prevented.

In September 2000, 189 member countries of the United Nations endorsed and committed themselves to eight Millennium Development Goals (MDGs).[2] Two of these goals relate specifically to maternal and newborn health: Goal #4—"To reduce by two thirds the mortality rate among children under five" and Goal #5—"To reduce by three quarters the maternal mortality ratio." Other goals are closely related, particularly Goal #3: "To eliminate gender disparity in primary and secondary education, preferably by 2005 and at all levels by 2015."[3]

To address this nearly universal mandate for action at a time when donor and government resources are becoming more and more limited, international donors and implementing agencies are increasingly driven to identify program solutions that are cost-effective and produce sustainable results. Progress is being made through integrated strategies and approaches that take into account the complexity of this challenge, but there is no magic bullet. Maternal and newborn survival and good health are ultimately the result of a society that values women and children regardless of their race and social, economic, and political status, and provides unimpeded access to information and health services from the household to the hospital.

Communities have a critical role as central players in this process. This paper will describe how community mobilization, as part of a broader health strategy, has already contributed greatly to improving maternal and newborn health and how it can continue to support families, communities, and health services in jointly achieving the Millennium Development Goals.

This publication, commissioned by a working group on community mobilization for maternal and newborn health within the USAID-funded ACCESS Program, presents the results of an extensive review of articles in peer-reviewed publications, journals, and books on community mobilization, maternal and newborn health, and related subjects. The author also reviewed relevant gray literature and project documents from organizations working in community mobilization in the field, conducted interviews with program implementers and donors, and has added observations based on her own field experience as appropriate.

Success Stories from Three Countries

There are many examples of community mobilization strategies that have been successful in improving maternal and newborn health throughout the world, but only a few projects have had the necessary resources to measure their effect on mortality reduction. Three such projects are profiled in the boxes appearing at various points in this paper. It is noteworthy that these projects, which have demonstrated reductions of 30 to over 50 percent in mortality, included only minimal health service-strengthening components. We can only imagine how much more progress could be achieved if health service strengthening had been integrated into these initiatives.*

WHAT IS COMMUNITY MOBILIZATION?

GHANA

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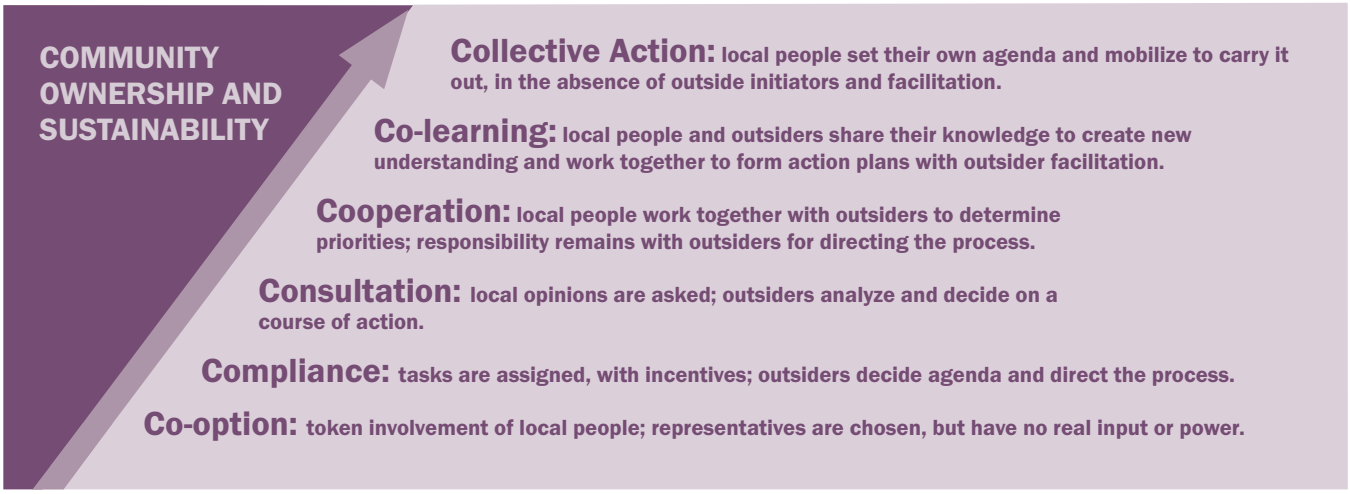
There are nearly as many definitions of community mobilization today as there are communities and organizations using it as a strategy. For the purposes of this publication, community mobilization is: *"a capacity-building process through which community members, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others."*[4]

Although this strategy can be applied to any aspect of community development, in this paper we focus on community mobilization to improve maternal and newborn health. Its primary actors include community members (particularly women of reproductive age), families, households, neighborhoods, and community organizations with their respective links to external resources.

Participation is the essential element of community mobilization, but it is important to recognize that all participation is not equal. Figure 1 shows increasing degrees of community participation, from the low end of co-option to the high end of collective action. As community participation increases, community ownership and capacity increase, with the result that community action and continuous improvement in the quality of community life are more likely to be sustained over time.

** A fourth project, a randomized, controlled trial in Hala, Pakistan, that used community mobilization as one of its primary strategies, demonstrated a 50 percent reduction in neonatal mortality. A description of this program and its results has been submitted to "The Lancet" and should be available later this year.*

FIGURE 1 | Degrees of Community Participation



When carried out at the higher levels of participation, community mobilization:

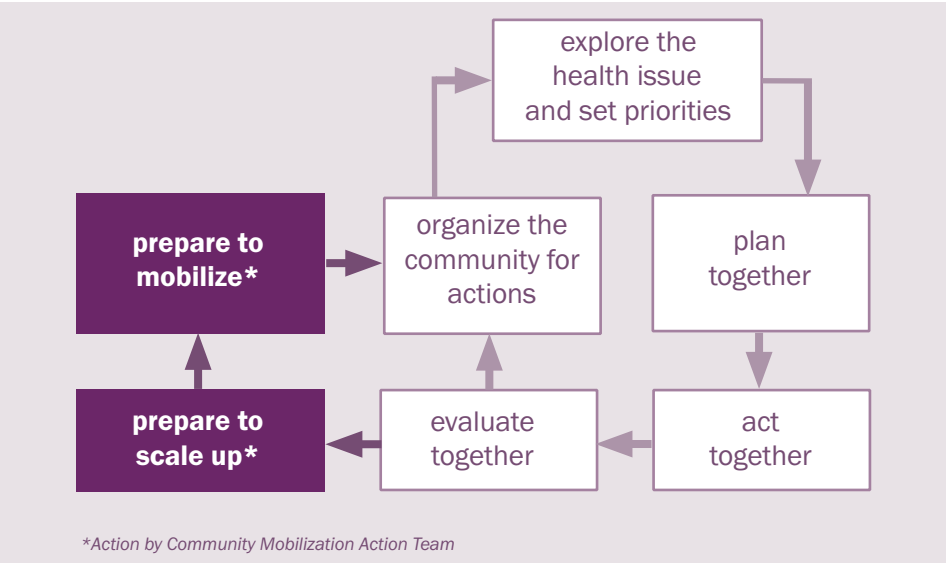
- Builds on social networks to spread support, commitment, and changes in social norms and behaviors.
- Builds local capacity to identify and address community needs.
- Through organizing and capacity strengthening, helps to shift the balance of power so that disenfranchised populations have a voice in decision-making and increased access to information and services while addressing many of the underlying social causes of poor health (discrimination, poverty, low self-esteem and self-efficacy, low social status, etc.).
- Mobilizes local and external resources to address the issue and establishes coordination and monitoring systems to ensure transparency, accountability, and effective management of these resources (in decentralized government, this is evolving as an important issue as health services depend more on local government funding to support them).
- Motivates communities to advocate for policy changes to respond better to their real needs.
- Plays a key role in linking communities to health services, helping to define, improve on, and monitor quality of care from the joint perspectives of community members and service providers, thereby improving availability of, access to, and satisfaction with health services.

True community mobilization incorporates values and principles that empower people to develop and implement their own solutions to health and other challenges. Programs that carry out all of the community mobilization steps but do not embrace these values and principles will not empower communities to achieve lasting results. They may also run the risk of setting poor precedents that leave communities feeling co-opted, manipulated, and reluctant to work with external organizations in the future.

How Does Community Mobilization Work?

Community mobilization at its best does not merely raise community awareness about an issue or persuade people to participate in activities that have been prioritized and planned by others. Rather, it is a comprehensive strategy that includes the following activities: carrying out careful formative research to understand the community context and design the process; entering the community (if externally facilitated) and establishing credibility and trust; raising community awareness about the maternal and newborn health situation; working with community leaders and others to invite and organize participation of those most affected by and interested in maternal and newborn health; exploring the issue to understand what is currently being done and why (helpful, harmful, and benign practices, beliefs, and attitudes) so that they can set priorities; planning; implementing the community plan; and monitoring and evaluating progress. These activities are summarized in the phases of what is known as the Community Action Cycle (see Figure 2).

FIGURE 2 | The Community Action Cycle



Community members who are most affected by and interested in maternal and newborn health are involved from the very beginning and throughout the action cycle. Other individuals and organizations from inside and outside the community who may provide technical and resource support are invited to participate at appropriate points along the way.

The Role of Donors, Policymakers, and External Organizations

The role of donors and policymakers in community mobilization for maternal and newborn health is to ensure that programs:

- Integrate community mobilization into the broader national or regional health plan.
- Prioritize communities with the highest mortality and that could benefit most.
- Hire implementing organizations with proven experience and expertise in community mobilization and maternal and newborn health.
- Engage communities as full partners in planning, implementation, and evaluation.
- Have sufficient financial support; have realistic timelines; are supported by policies that promote community participation.
- Establish links to external assistance within the health and other sectors.
- Establish mechanisms to coordinate the work of all implementing agencies and communities to ensure that perspectives at all levels are taken into account as strategies and materials are developed, to maximize program learning and use of resources.

External assistance is most effective when it starts from where people are and facilitates a process through which interested community members, especially the most vulnerable, identify and implement strategies and approaches that will reduce mortality within their local context. Additionally, external facilitators may share valuable information with community members on effective strategies, practices, and experiences to complement local knowledge, making for better informed community decision-making and planning. To play these roles successfully, external organizations must establish relationships with communities built on respect and trust, with faith in the ability of community members to identify and resolve their challenges in the most appropriate way in the local cultural setting.

Ideally, community mobilization will work together with other, complementary program strategies (mass media, services strengthening, policy advocacy) rather than on its own. For example, Home Based Life Saving Skills (HBLSS) training[5] may be offered to interested communities that have limited access to health services; community members may participate in the development and dissemination of educational messages and materials; and community members may help design health facilities and health protocols that take into account their perspectives on quality care.

BOX 1 | One Size Does Not Fit All

Program designers have developed a variety of approaches to mobilize communities. Two examples are described below.

In Egypt and Pakistan, "positive deviance inquiry" was used so that community members could see how pregnant mothers who gave birth to healthy weight newborns and their families thought and acted differently from those families living in the same community with similar socio-demographic characteristics whose infants were born with low birth weight. Their findings were shared at community and women's group meetings as well as with other community members through community social networks. The findings served as the basis for dialogue and action about prenatal care and nutrition with pregnant women, families, community groups, NGOs, and health providers, leading to positive results. Since the program began in Saft El Sharqeya in November 2004, medically-assisted deliveries increased from 10 percent to 67 percent, with 67 percent of these women practicing family planning within 40 days after delivery. In addition, anemia among pregnant women decreased from 94 percent to 50 percent. [6]

In Nepal, Peru, and Uganda a "Partnership Defined Quality" (PDQ) process entailed working with citizen groups and health provider groups separately at first to explore what "quality" means to each group in the context of health care from the household to the health center and hospital, using a variety of methods including group discussion, role plays, video, and/or audio tapes. The groups envision what high-quality health care looks like and then compare their current situation to their ideal. Both groups are then brought together to share their findings and plan together how to strengthen health care by combining their ideas and resources and leveraging additional resources as needed. They establish a coordination mechanism that usually takes the form of a joint coordination committee to monitor and oversee forward action on their joint action plan. Subsequently, the coordination committee meets regularly to review progress, adjust strategies as necessary, inform the rest of the stakeholders of progress made, and solicit support as needed. In Nepal, this approach resulted in increased use of health services by families, especially from the lower castes, and improved clinic management and services, including better sterilization techniques, waste disposal, and patient flow due to increased awareness in the community, presence of community volunteers in the facility, and the establishment of a joint monitoring system. The approach is now being expanded to 21 districts in Nepal with the assistance of 10 NGOs.[7]

Design Questions

There are some critical questions about the community mobilization strategy that need to be answered (based on the results of the formative research) before proceeding with a mobilization effort. These include:

- What is the goal? (described in terms that motivate citizens)
- Who is the community? (those most affected by and interested in the issue)
- Who is stimulating the process? (outside of or inside the community)
- Who will be facilitating the process? (community member? CBO staff/ volunteer? health system worker? local NGO staff? international PVO staff? government worker outside health system?)

- What support structure exists for facilitators? (training, facilitation materials, monitoring/supervision, logistics and transport)
- What external and internal resources are potentially available to contribute to the effort?
- What laws, policies, and governance structures are in place to support or limit CM efforts?
- To what extent do people have experience participating in community action? Who is included? Who is left out? Why?
- If the effort is externally supported, how long is the donor's timeframe? Is it realistic? What is the potential for longer-term community ownership and sustainability?

Success Factors

A review of the programs that have been implemented to date suggests that the primary ingredients of a successful community mobilization program for maternal and newborn health consist of:

- program staff including: a program manager, team of facilitators (one or two selected from a community, or, more likely, a team of two to cover approximately 10 communities);
- trainer(s);
- transport budget, depending on where facilitators and managers are based and may include means of transport (e.g., bicycles or motorcycles) if facilitators need to travel longer distances;
- budget for developing training and educational materials (e.g., training manuals, picture cards, booklets, audio-video aids);
- media budget (for radio shows, street drama, and other media);
- training budget (depends on distance to training site, number of days, and number of participants and existing skills/knowledge of trainees); and
- other direct costs associated with office expenses.

Some programs budget for grants to communities to implement their plans; a portion of these require some kind of community "match." In some very resource-poor countries, this may be appropriate, but program planners should be aware that any additional resources that an external program contributes are not likely to be sustained after program assistance has ended. There is a lot of pressure to produce results, and programs may justify an infusion of resources by arguing that it will save lives now. The problem comes later when citizens refuse to work on their own behalf because future programs cannot or will not meet the established expectations, and communities did not develop the skills necessary to

leverage their own resources. It is a lot harder to mobilize communities to help themselves when they have a history of handouts and co-option.

The programs that do try to limit their role to providing technical assistance with the development of a methodology, materials, monitoring, and evaluation are sometimes the subject of scrutiny by their peers and donors who ask why they have such a heavy personnel line item and no "program costs." In fact, the personnel line is the major program input. The most important personnel decision a program can make is who will facilitate the process in the community. Programs need to take into account existing organizations and their relationships with the community and the health system. Community members, especially women of reproductive age, must respect, trust, and feel comfortable communicating with the facilitator.

Most programs have developed criteria for the selection of facilitators. Some have asked communities to select someone from within the community who is then trained in facilitation skills and basic maternal and newborn health topics, some have employed NGO staff as facilitators, and others have enlisted government health workers. There have also been examples of pairs of facilitators in a mentoring relationship of an NGO staff person with a person selected by the community.

Ideally, programs would develop the skills of community members to facilitate the process so that this capacity remains in the community, and increasingly more programs are moving in this direction. For this approach to be successful, however, programs need to think about the implications of working in many communities and how these facilitators will be supported. In countries such as the Philippines, there are community volunteer health workers who are provided a small stipend by local governments and who participate in an annual training program offered by the Department of Health; such people are ideal for the role of facilitator. In India where Anganwadi workers already have a full job description, program designers would need to consider carefully the potential challenges that adding an additional role would pose. Another possibility is government health workers, but experience has shown that in many situations these individuals are not able to effectively play the facilitation role; their health service responsibilities, their direct ties to the health system, and their frequent job transfers (especially those who work in rural areas) may make it difficult for them to act as facilitators.

Regardless of who facilitates the process, it is important to develop or adapt and document in a user-friendly way a methodology that any facilitator can pick up and use. Manuals that provide guidance about how to facilitate each phase of the action cycle are widely available.

BOX 2 | Success in Bolivia: The Warmi Project

The Warmi Project (warmi means woman in the local languages of Aymara and Quechua) was first developed and field-tested by Save the Children in Bolivia from 1990 through 1993 in 50 communities of Inquisivi province to demonstrate what could be done to reduce maternal and perinatal mortality at the community level in isolated rural areas with limited access to health services.

A gender-sensitive participatory methodology now known as the Community Action Cycle and briefly described earlier on page 7, was developed to work with women's groups and other community members to improve maternal and newborn health in their communities. The role of the external NGO was to facilitate the process and act as a resource for information. Community members determined how they would reduce mortality, and they then implemented these strategies, at times in collaboration with local organizations.

The project achieved many noteworthy results including a reduction in perinatal and newborn mortality of 67 percent, a reduction in maternal mortality (although the numbers were too small to determine significance), and many significant changes in knowledge and practices related to prenatal care, breastfeeding, immunization, care of the newborn, and increased use of family planning methods.[8] In addition, women increased their participation in community planning and decision-making processes, initiated and participated in a literacy program, and started micro-enterprises to earn income. The 50 demonstration communities assessed their own participation and capacity every year using a five-factor assessment tool[9] and used the results to celebrate successes and identify and plan for areas they wanted to improve.

The Warmi methodology was integrated into the Bolivian National Health Plan ("Plan Vida") in 1994 and was expanded to reach over 500 communities in eight of the country's nine departments, facilitated by a combination of government health workers and members of a network of NGOs. Unfortunately, there were insufficient program resources to measure changes in mortality during the national phase. However, the implementing agencies did document numerous examples of individual and collective action that resulted in significant positive changes in behavior, including increased use of a skilled birth attendant.

Measuring Results

Community mobilization is successful in maternal and newborn health programs when two things happen: when a community achieves its goal of reducing maternal and newborn mortality and morbidity and when a community strengthens its capacity to identify and address its needs including and beyond maternal and newborn health. Through their participation in the process, communities establish necessary organizational structures and relationships, and people develop their knowledge, skills, social support networks, and ability to access and manage resources, which help them to sustain health improvements and improve other aspects of their lives. Over the last few years, some implementing organizations have provided support to communities to mobilize around specific activities to achieve intermediate objectives, such as developing a transport system or establishing an emergency fund, losing sight of the larger goal of improving maternal and newborn health. Several factors drive this approach, including the desires of donor and implementing agencies to:

- Reduce the time necessary for the community to take action.
- Address the challenge of measuring changes in mortality by using more easily measured intermediate program indicators of community action.
- Simplify the process by standardizing action so that it is easier to work at a larger scale.
- Alleviate the underlying fear that communities will not come up with the types of strategies that external planners believe need to be in place.

When programs mobilize around specific activities, communities may be successful in achieving these objectives, but may continue to experience high mortality. The desire to accelerate, simplify, and extend the impact of the process to more communities is understandable. However, in trying to take shortcuts by omitting some of the most critical work (raising community awareness and building commitment, affording citizens the opportunity to explore their current beliefs, attitudes, and practices, setting priorities, planning how best to meet their challenges, implement their plans and monitor their progress), communities will not own the process, will not be committed to working on the issue long term, and will lose the opportunity to strengthen their capacity to identify and address this and other issues. The program also loses the opportunity for communities to create new and elegant solutions that best suit their situation.

Despite the programmatic challenges of measuring significant changes in mortality in smaller community populations, community members do notice changes in the number of funerals they attend and the number of mothers and babies they lose to pregnancy and childbirth-related causes.

Measuring community capacity to sustain health improvements and successfully address other issues is equally important. Maternal and newborn health programs have generally limited their documentation of strengthened capacity to measuring changes in health knowledge, attitudes, and practices of individuals and health service providers and to changes in the quality of care at the level of health facilities. Reasons for not measuring community capacity include: difficulty in determining which indicators to use, limited financial and technical resources to devote to this activity, pressures to rapidly produce results that may compromise the capacity strengthening process, and failure at the beginning of a program to specify capacity strengthening as an important outcome that deserves its own monitoring and evaluation component.

Many other programs, however, in health, agriculture, environment, education, AIDS, and other sectors have more systematically measured

and documented improvements in community capacity resulting from community mobilization approaches. For example, programs have reported improved local governance including more equitable participation of women in decision-making; increased linkages and coordination with social services; better ability to leverage and manage local and external resources; increased CBO participation in networks and coalitions around specific issues to influence policies and resource allocation; greater leadership; and improved ability to plan, implement, monitor, and evaluate collective action

BOX 3 | Success in Nepal: The Makwanpur Project

In rural Nepal, where neonatal mortality is high and 90 percent of babies are born at home, MIRA, a local NGO originally established for the purposes of realizing this study, implemented a randomized, controlled trial from 2001 through 2003 using community mobilization through women's groups as its primary strategy to reduce maternal and neonatal mortality. MIRA adapted the Warmi Project methodology from Bolivia to suit the local Nepalese context. The trial involved 24 village development committees (VDCs) in rural Makwanpur District with an average of 7,000 people per VDC. Half of the VDCs participated in the intervention and half served as control VDCs.

As part of the program, both control and intervention sites benefited from improved equipment and training provided at all levels of the health care system in essential newborn care. Intervention sites differed from control sites in program implementation only due to the community participation component. Results of the 30-month trial showed a 30 percent reduction in neonatal mortality and a significant reduction of the maternal mortality ratio of 69/100,000 live births in intervention areas as compared with 341/100,000 live births in control clusters. Nearly all (95 percent) of the participating women's groups remained active at the end of the trial despite no financial incentives and opportunity costs involved with spending time away from other activities.

The trial did not specifically set out to measure changes in community capacity. However, the project reported that community groups implemented a range of strategies such as: establishing mother and child health funds to reduce cost barriers to care; producing, selling, and using clean home delivery kits; making or purchasing stretchers to help with transport; raising awareness through home and community video shows; fostering participatory health education; improving health facilities (furniture, curtains for privacy); and improving links between community members and health services. More than two years after the project ended, some of the principal investigators returned to communities to share the findings of the study and inquire as to the current state of the program following the withdrawal of funding and the recently ended Maoist insurgency that had made many of the villages inaccessible for periods during the program. Of 111 women's groups that were initially organized during the project, 105 were still meeting regularly, with no external incentives or financial support provided. Women from an unspecified number of the groups had taken on the role of facilitator of the group and/or had counseled pregnant women in their homes using project materials.[10]

There are randomized, controlled trials using a similar approach adapted to the local context now under way in Malawi, Bangladesh, India, and another site in Nepal. The Malawi trial has added a qualitative research component to document changes in community capacity from the beginning of the intervention.

to achieve agreed-upon goals. Indicators of and instruments to measure capacity gains must be adapted locally in light of specific community and program needs in an ongoing process of dialogue with all key stakeholders who will be collecting and using the information.

There are clearly challenges to measuring community capacity, as there are challenges to measuring the capacity of any group or organization. However, it is possible and advisable to do so. To wait until practitioners have a complete and perfect set of indicators and tools before programs begin to document changes in their capacity would be a missed opportunity for communities and programs to learn more about and improve upon the capacity strengthening process.

WHY INVEST IN COMMUNITY MOBILIZATION?

To Raise Awareness and Foster Commitment

When community mobilization is implemented effectively, it raises people's awareness of a real need that they may or may not have perceived before, and it presents an opportunity to achieve a goal that is of clear benefit to the community. When the goal (in this case, reducing maternal and neonatal mortality) resonates with people and they are offered the opportunity to address it in a meaningful way, they become engaged.

To Address the Underlying Causes of Inequitable Access and Care

High maternal and newborn mortality are often the result of physical, social, cultural, and political factors that are beyond an individual's control. Beneath these factors we often find discrimination, power imbalances, and marginalization of women and minority groups that contribute directly and indirectly to poor health by limiting access to information and services, by reinforcing low self- and collective efficacy and esteem, and by inducing a chronic level of stress.

Community mobilization aims to address these underlying issues through collective consciousness and action. Communities—and women in particular—that previously recognized the need to address poor health outcomes but felt helpless to do anything on their own, gain strength in the knowledge that they are not alone and that there is something they can do. They are encouraged as they learn what is already working, and they become increasingly determined to address the challenges that remain.

As women build their understanding, increase their skills, and develop relationships with men, community leaders, and organizations, they often become more valued and respected in the community, and they start to play a more active role in the community decision-making process, inserting maternal and newborn health into the public agenda and inviting others to help support their goal. As they gain access to decision-making processes, women's status and value in the home and community increase, and power imbalances that underlie their ability to access information, services, and other resources become more equitable, enabling them to better identify and meet their needs. As the perceived value of women increases, they become more equal partners in making key household decisions such as whether or not to spend scarce family resources to save the life of a pregnant woman.

BOX 4 | Success in India: The Shivgarh Project

In a cluster-randomized control trial in a population of 104,000 people in Shivgarh, Uttar Pradesh, in northern India, a community mobilization strategy reduced neonatal mortality by 50 percent over the first 12 months of program implementation. The program involved pregnant mothers, their families, and key influential community members, as well as community health workers (CHWs), and increasingly, community volunteers who visited the homes of pregnant women twice during their pregnancy and once within three days of delivery. The program documented marked changes in practices, including an increase in use of Kangaroo Mother Care from 2 percent to universal acceptance. Breastfeeding initiation on day zero increased from 21 to 75 percent in intervention areas versus 19 to 25 percent in the control areas.[11]

The program began by doing initial formative and participatory research on existing attitudes, practices, and beliefs about maternity and newborn care. Program staff engaged community members in mapping the community's households, resources, structures, and stakeholders in newborn care to understand how the community functions—its roles, power structures, and processes.

Based on the formative research, program staff worked with communities to develop very simple messages appropriate to the local context, using words and concepts that communicated important meaning to the local population. Program staff and community members established a pregnancy surveillance system to identify pregnant women. They also held community meetings in the neighborhoods with families and pregnant women so that neighbors and support people could learn about program progress and would work as a team. Program field workers, including CHWs, negotiated new practices with families during those meetings and during prenatal care visits. During these prenatal visits, families rehearsed the new practices in the room in which the birth would take place.

The community took over the communication process by turning the newly negotiated practices into songs. They saw from personal experience that the new practices worked, and once that happened these practices—for example, skin-to-skin contact of mother and baby immediately following birth and immediate breastfeeding—became almost universal in the community.

Although there have been very few published studies comparing higher level community participation with more externally driven, top-down approaches and their effects on health outcomes, the studies that have been published have indicated that community participation approaches resulted in better health outcomes, improved health knowledge and practices, and greater community involvement in health activities.[12, 13] More comparative research needs to be carried out to better understand the complex direct and indirect links between participation, strengthened community capacity, empowerment, and improved health outcomes.

To Strengthen Community Capacity

Several conceptual frameworks have been developed to illustrate the challenges involved in improving maternal and newborn health, such as the "Pathway to Survival,"[14] which describes the possible delays to resolving life-threatening complications: the delay in recognizing a life-threatening problem, the delay in deciding to seek care, the delay in reaching a health facility or service, and the delay in providing adequate treatment.[15, 16] This framework describes a number of decision-making locations and players—from the individual household at one end to the health facility at the other—and the actions that occur prior to and during a life threatening event, helping program planners determine where "the system breaks down," leading to the death of the mother or baby.

Over the last several decades, international and country-level funding for maternal and newborn health programs has been aimed primarily at strengthening the health services component of the pathway, while the household and community components have received significantly less financial support and attention in national plans. The assumption was that if adequate services were available and the community knew about them, families would use them. However, there are many factors that determine whether families will make use of a particular service, including physical access (distance, availability of transport), community and social norms and beliefs, economic access, quality of care (e.g., personnel, hours of service, interpersonal communication and relationship, birth attendance practices), family knowledge (danger signs), and others. More recently, some program planners have recognized the importance of working along the full "Household-to-Hospital"[17] continuum from the home and community to the peripheral health service to the district hospital.

Figure 3 illustrates how communities have addressed challenges along the pathway to survival when engaged in highly participatory community mobilization processes. These examples are not a blueprint for what all communities should do, but merely illustrations of what communities have done when they have analyzed their situation and developed their own strategies.

FIGURE 3 | The Added Value of Community Mobilization along the Pathway to Maternal and Newborn Survival

STEP ALONG THE PATHWAY TO SURVIVAL	EXAMPLES OF WHAT COMMUNITY MOBILIZATION HAS CONTRIBUTED
Prior to pregnancy:	
Ensuring good nutrition	Understanding beliefs about diet, discovering local diets and practices that support good nutrition, and helping community members increase availability and access to nutritious, foods through home and community production of crops, increased income from microcredit programs for women, better food storage techniques, and learning how to prepare foods (recipes, demonstration cooking classes).
Preventing unwanted pregnancy	Women recognize that preventing unwanted pregnancy is one of the most important ways to reduce mortality of mother and baby. Women have successfully rallied their communities to support greater access to and utilization of FP information and services.
Preventing STIs	The CM process raises awareness of STIs and helps community members develop and implement a variety of strategies to prevent them such as addressing alcohol consumption, domestic violence, and negotiating the use of condoms.
During pregnancy:	
Antenatal care	CM raises awareness about the importance of antenatal care and recognizing danger signs during pregnancy, and helps communities develop strategies to help families ad dress problems. In poorly served areas, for example, communities may identify the need for adequate care and explore options such as negotiating with the MOH to staff someone in the community if the community builds a facility, or determine how to get providers to come to the community on a regular basis, or reduce barriers to women getting to a service that is far away (transport, money/cost, dealing with fear of traveling, cross-cultural communication issues, improving attitudes of providers toward serving rural women, or child care concerns).
When a life-threatening event occurs:	
Recognizing that there is a problem that cannot be handled at home	CM raises awareness of danger signs and the importance of immediate action.
Deciding to seek appropriate care	CM aimed at improving women's status changes social norms about the perceived value of women, increases the feasibility of taking action to save lives, helps to define what appropriate care is in that context, and identifies and reduces barriers to seeking care.
Reaching appropriate care	CM processes help communities identify barriers and generate solutions to reaching care through collective action such as establishing emergency funds/loans, developing transport agreements with truckers or making other arrangements, repairing roads, establishing norms that hold families accountable if they don't take action, and applying community pressure on the MOH to advocate for round-the-clock availability of care (some communities have provided housing for providers so that they can stay in the community day and night).

FIGURE 3 | continued

STEP ALONG THE PATHWAY TO SURVIVAL	EXAMPLES OF WHAT COMMUNITY MOBILIZATION HAS CONTRIBUTED
When a life-threatening event occurs: (continued)	
Receiving adequate care	Communities have participated in ensuring adequate care in various ways such as: working with providers to jointly define "quality care." They have contributed community resources (time, labor, transport, money) to help complement government resources. Community members have participated in district health committees that review progress on health indicators, they may do maternal or newborn death audits, and they may establish an ombudsman system to deal with complaints and suggestions for improvement. Local governments in some countries are responsible for hiring, firing, and paying public health service providers, as well as for budgeting health expenses. In other countries where budgets are centrally controlled or in the hands of district health officials, communities may advocate for changes in priorities and health service delivery.
Postpartum:	
Healthy care of the newborn	CM processes facilitate dialogue around newborn care practices, starting from where families are, supporting those existing practices that are beneficial or benign, and negotiating and rehearsing new, healthier practices in ways that are meaningful, acceptable, and feasible in that context.
Birth spacing	See "preventing unwanted pregnancy" above.
Taking appropriate steps at home to support recovery	CM processes can help to shift community norms to support new mothers by enlisting the help of family members and neighbors so that mothers do not have to immediately return to heavy physical work, can breastfeed and take care of themselves and their newborn babies, and by improving access to antibiotics in case of sepsis.

CAN COMMUNITY MOBILIZATION BE SUCCESSFULLY SCALED UP?

Inherent in community mobilization is the potential and promise for taking successful projects to a larger scale. But what do we mean by "large scale"? Must countries mobilize every community in order to have a significant impact on mortality? How many communities constitute large scale? How many people?

The NGO community states that extensive coverage alone (more easily achieved in the more accessible, lower mortality areas) is insufficient to ensure that the most vulnerable benefit and that programs and results are sustained in the long term.[18] A definition of "scaling up" that takes into account these points is offered by the International Institute for Rural Reconstruction: "Scaling-up refers to efforts to bring more quality benefits to more people over a wider geographical area more quickly, more equitably, and more lastingly."[19]

It is not always necessary and is often too expensive to reach every community, nor is it necessary to reach every person in every participating community. Social network studies have documented that people who do not directly participate in community initiatives often benefit from the participation of their friends, family, and others with whom they interact.[20] For example, a woman who attends a women's group meeting and discusses how to identify danger signs during pregnancy then returns home and tells her neighbor about the discussion. The neighbor learns about the signs, and when her daughter is pregnant and begins to bleed, she takes her to the health facility immediately. As more and more people become aware of the activities of those directly involved, they may gain knowledge, may decide to participate themselves, and/or may become participants in changing community norms by adopting new beliefs, attitudes, and behaviors.

Four scaling-up strategies described by Peter Uvin and David Miller are referred to in the literature: (1) quantitative scale-up in which the number of beneficiaries increases, often through geographical expansion; (2) functional scale-up in which a program incorporates additional technical interventions to an existing project; (3) political scale-up that seeks to diminish barriers to program implementation through advocacy to change policies, by enacting legal reform, and by using sociopolitical networks to influence decision-making; and, (4) organizational scale-up that strengthens organizations' capacity to support effective programs over time through expanding their linkages to resources, fostering alliances and coalitions, strengthening organizational systems, and learning new technical skills.[21, 22] Ideally, a country program would pursue all four scaling-up strategies to be effective over the long term.

BOX 5 | Scaling-up in Peru

ReproSalud in Peru is an example of a national program that used community mobilization as its primary strategy to improve reproductive health and empower women to participate in decisions that affect their own lives, the lives of their families, and their communities. The project, which focused on the most marginalized and poor communities of the country, has reached over 150,000 women of reproductive age through the implementing agency, Movimiento Manuela Ramos. Through its established partnerships with over 240 community-based organizations (CBOs), Movimiento Manuela Ramos reached over 2,300 neighboring women's CBOs in 91 districts—or nearly 10 percent of all districts in the country.[23]

Community mobilization can spread organically or in a planned manner from one community to others as broader awareness and interest are raised. To encourage more rapid expansion, programs have used radio, TV, or other mass media to communicate the experiences and results from participating communities to others[24] and have developed "centers of learning"[25, 26] or "living universities"[27] to provide training and support to new communities interested in participating.

By targeting only those areas of highest mortality in hard-to-reach (geographically, socially, linguistically) areas of the country with a well-designed methodology and with well-supported technical assistance, training, and monitoring systems in place, countries can rapidly (within one to two years) begin to see declines in newborn mortality. And in cases where there are links to emergency obstetric care, there will often be reductions in maternal mortality as well. It is helpful to begin scaling up in communities that are most interested and that have some previous positive history of collective action and participation. "Piggy-backing" in this manner on existing positive NGO relationships and programs with communities helps to reduce the cost and initial lead time needed to develop trust and credibility. Choosing scale-up sites carefully like this builds momentum, and momentum is a key element of successful expansion.

How Much Does It Cost?

There is limited information available on the cost of community mobilization programs. The Makwanpur, Nepal, trial did an analysis that found that the cost per newborn life-year saved was $111 ($142 including health systems strengthening costs), a result that falls within the World Bank's standard that interventions of less than $127 are considered cost-effective. The Nepal analysis did not attempt to estimate costs "saved" by the many other longer-term benefits of participation in the intervention within and beyond added health benefits.

The Warmi Project in Bolivia built on existing relationships and infrastructure, thereby keeping costs down. The cost of the initial demonstration project in 50 communities—including development of the methodology, materials, facilitators (a team of two facilitators usually

covered 10 communities), and other program expenses—was approximately $100,000 per year. The national Warmi program, which reached over 200,000 women in eight out of nine departments, had a program budget for implementing partners and the five-member national training, technical assistance, and coordination team of less than 5 million dollars for a four-year period.

The Hala and Shivgarh trials in India and Pakistan have also stated that they are low-cost.[28] Cost will vary according to country, geography, length of program, and the extent to which programs build on existing capacity of implementing organizations and communities. The cost will also depend on decisions made about the role of external assistance, such as whether to provide access to resources other than technical assistance and materials associated with training/capacity strengthening and health communication. The initial cost of developing methods and materials to support CM processes may distort the per beneficiary cost when calculated for pilot or demonstration programs in smaller populations since these are not recurring costs, and the per beneficiary cost will usually be significantly lower as program coverage expands.

The responsibility of the state for meeting the needs of its citizens must also be taken into account when considering the costs of community mobilization. Some countries are cost-sharing between the public and private sectors or across various branches of government, with the national government supporting items such as health service staff salaries, essential medicine, or health insurance, and the local government contributing stipends to CHWs and providing funds to improve health facilities, roads, gasoline, and other resources.

Do the Results Last?

There are few published studies that follow up on community mobilization initiatives (or most other programs, for that matter) to capture what happened after outside assistance ended. But if the jury is still out on sustainability, some valuable lessons have been learned. In evaluating sustainability, it is important to remember that successful community mobilization embraces a broad range of indicators within two equally important areas: health benefits (lower mortality rates, improved health indicators) and capacity (individual, group, organizational, institutional, and/or community). Experience has shown that programs that receive less than three years of assistance may not show sustainable results, especially if the people involved had not worked together before the program began or if their initial organizational capacity was very limited. Programs that receive five to 10 years of assistance are more likely to produce results that last.

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Capacity-building results are sometimes overlooked or even misjudged by standard sustainability indicators. Let's say a program organizes women's groups to give women a voice in the community. After some time, women are invited to participate in community decision-making meetings as equal partners with men, and the women determine that they have achieved the objective of their group and choose to disband. In this case, the fact that there is no longer a women's group is surely not an indicator of failure. PVOs and NGOs working in the field with communities have a lot of experience with capacity strengthening, and a growing number are now measuring more systematically changes that contribute to greater likelihood of sustained improvements over time.[29]

Finally, in rapidly changing environments it may be more appropriate not to speak so much of sustainability but of adaptability, resilience, and organizational learning—all of which keep families and communities on a path to continuous improvement.

RECOMMENDATIONS FOR DONORS AND POLICYMAKERS

The following are recommendations for donors and policymakers as you consider appropriate roles for communities in reducing maternal and newborn mortality:

- Make every effort to integrate community mobilization into broader national health strategies to complement and work with other components, such as service strengthening, policy, training, communication, and logistics.
- Support community mobilization processes that aim for higher levels of community participation using community development approaches that treat community members as full partners in improving maternal and newborn health rather than as passive recipients or consumers of health services. This shared responsibility

between communities and health services promotes greater community ownership and more sustainable improvements over the long term.

- Provide appropriate funding levels, taking into account that most funding will go toward personnel costs for facilitation and capacity-strengthening roles. Determine roles and responsibilities regarding funding and consider requiring some kind of match from communities, even in-kind contributions such as volunteer time, local materials, etc. However, be aware of the potential pitfalls of enlisting NGOs, communities, and volunteers to contribute resources and perform functions for which national and local government should be responsible.
- Hold programs accountable for achieving improved health outcomes and strengthened community capacity to sustain these results, and be flexible about how they get there. Don't prescribe or dictate how communities must act; they need to be the protagonists in their own development and in finding solutions that are feasible and culturally appropriate to their settings.
- Set realistic timelines based on the context. Well-organized communities will not need as long to demonstrate results as communities that do not have a long history of community participation and local governance. Build in at least three to five years to better support community capacity strengthening that will enable communities to sustain results and continue to improve their health.
- Provide the necessary resources for implementing agencies and communities to adequately monitor, evaluate, and document results in both community capacity and health outcomes. There are effective tools available that can be adapted locally. Additionally, support documention of these efforts several years after program support has ended to learn more about real program sustainability that can inform future program design.
- Hire experienced organizations to help train facilitators and provide technical assistance to the programs. Just as health providers can do harm if they do not have adequate skills to provide services, community facilitators can also set bad precedents and create challenging situations if they are not properly trained. External organizations (to the community) can play a valuable role in catalyzing action and in helping to strengthen local community capacity when they have a good mix of technical health and organizational development skills. Many NGOs are particularly well-suited to and experienced in this work.

- Encourage the involvement and leverage the resources of sectors outside of health to contribute to improvements in maternal and newborn health. Programs should be designed to acknowledge and maximize these linkages and resources.

CONCLUSION

There are an increasing number of proven, successful examples of community mobilization that have reduced maternal and newborn mortality in communities with limited access to health services and information. As important, the participation of community members as full partners in these programs helps to strengthen civil society through greater community commitment, ownership, and capacity to achieve and sustain improvements in health and other areas of community life over the long term.

To achieve the Millennium Development Goals by 2015, we call on donors and policymakers to adopt and support a longer-term, more comprehensive vision of community mobilization. This comprehensive community mobilization is integrated into national health plans and conceived of at strategically large scale, addressing inequity by prioritizing the most vulnerable communities with the highest mortality and engaging these communities as full partners in identifying, implementing, and evaluating culturally appropriate solutions to improve maternal and newborn health.

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The ACCESS Program is the U.S. Agency for International Development's global program to improve maternal and newborn health. The ACCESS Program works to expand coverage, access and use of key maternal and newborn health services across a continuum of care from the household to the hospital—with the aim of making quality health services accessible as close to the home as possible. JHPIEGO implements the program in partnership with Save the Children, Constella Futures, the Academy for Educational Development, the American College of Nurse-Midwives and Interchurch Medical Assistance.

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Adapted from Cornwall, A. (1996). "Participatory Research Methods: First Steps in a Participatory Process," Chapter 9 in *Participatory Research in Health: Issues and Experiences* (de Koning, K. and Martin, M., eds.), London and New Jersey: Zed Books, Ltd.

CREDIT FOR FIGURE 2

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