



POLICY BRIEF

COMMUNITY ENGAGEMENT AND REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH



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BACKGROUND

Most causes of maternal, newborn, and childhood mortality are preventable using an evidence-based, cost-effective set of essential interventions. Proven best practices for reproductive health are also widely promoted by global agencies and African governments. Still, poor access to, and utilization of, such interventions are major barriers to RMNCH in Africa. Women and children continue to die from three key delays: seeking care, reaching the health facility, and receiving appropriate case management by health workers. Uptake of reproductive health services remains low.

Improving utilization and eliminating delays requires communities to be empowered and engaged to participate in RMNCH. Communities should help to define and prioritize relevant RMNCH problems, understand the short- and long-term consequences of women and children's health, feel ownership of interventions and outcomes, and participate in planning, implementing, monitoring, and feedback. Not only should African governments make a commitment to engage communities, communities likewise must have mechanisms by which to engage the state.

Community engagement is necessary for gains in equity and sustainability. Many African countries experience regional

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disparities in women and children's health. Equity issues are masked when RMNCH data is aggregated at national level, and centralized planning is prioritized. National RMNCH targets may be reached, yet whole regions left behind. Community engagement helps guarantee a country's RMNCH gains are distributed fairly.

Lastly, many RMNCH initiatives in Africa are financed by external sources and carried out within time-bound project cycles. Community engagement is essential to ensure that achievements are sustainable beyond the duration of projects and programs. Community engagement also can illuminate potential grassroots sources of funding and resource mobilization.

CHALLENGES

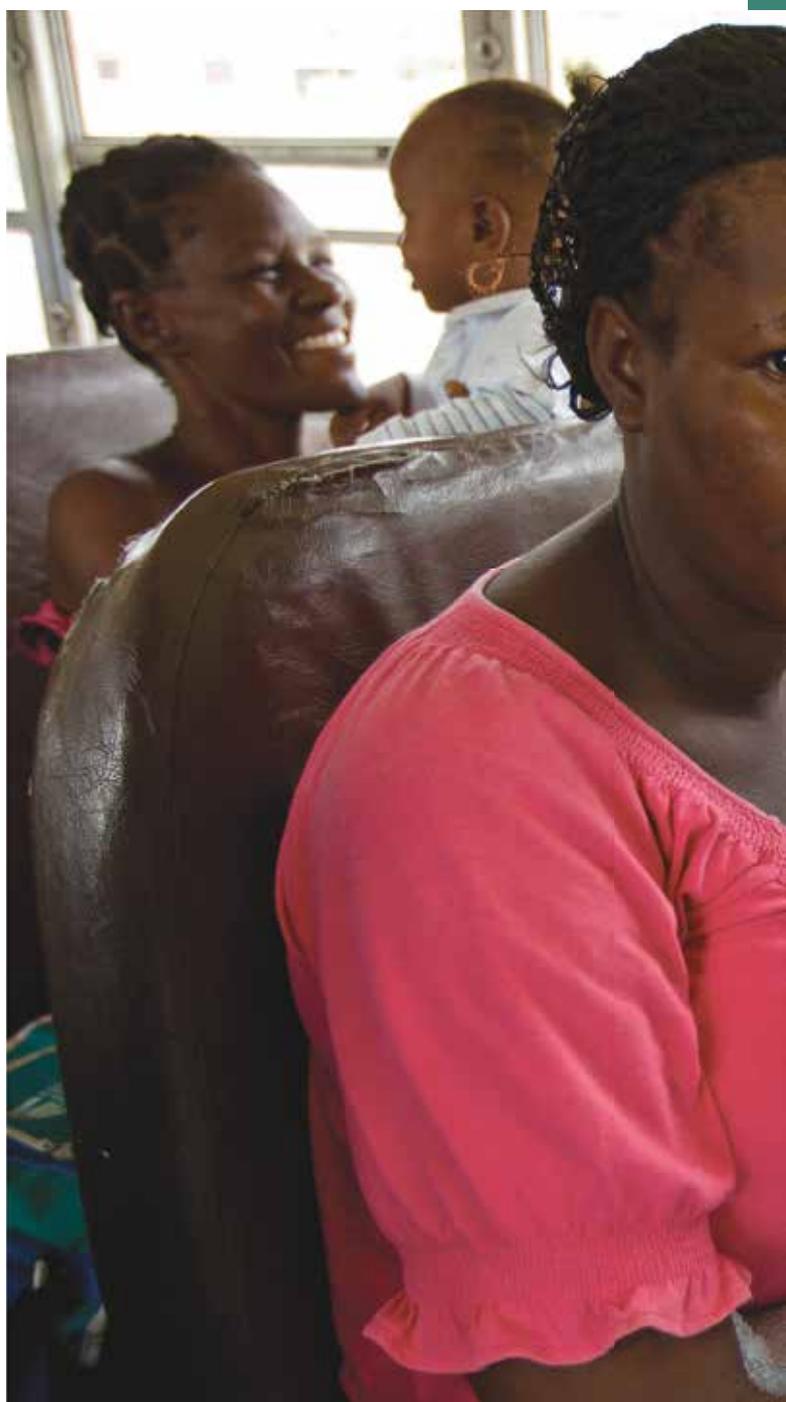
- Social conditions and cultural beliefs contribute to a community's sense of engagement in the health of women and children. Changes to attitudes and behaviors are challenging to implement, incentivize, sustain, and measure. RMNCH interventions must target male change agents and other male community members to succeed.
- A strong advocacy climate is critical to engaging local communities, as community organizations are vital stakeholders in defining and demanding appropriate services, as well as ensuring accountability. Outreach and advocacy to community organizations is still under-funded and under-coordinated in many African countries.
- Indirect costs of care-seeking (e.g. transport costs, loss of income, lack of child care) play a major role in the unwillingness of community members to make use of health facilities. These are key areas around which communities can be mobilized to provide support, but such factors are sometimes given less attention than more easily measured facility-based interventions.
- When successful MNCH projects are chosen for scale-up, the technical components of such interventions may be prioritized for scale up over community engagement components.
- Community health workers (CHWs) have sometimes lacked coordination, clearly defined roles and supervisory structures, and incentivization. Their training may be fragmented and infrequent. CHWs represent the "front line" of the health system, and should be critical agents in community mobilization, health promotion, and referral. In some instances, CHWs are not being utilized efficiently.

STRATEGIES AND BEST PRACTICES

- Involve communities in the identification of RMNCH problems, as well as in the planning, financing and implementation of solutions. Community systems (e.g. community-built maternity waiting homes, community emergency transport, pooled financing mechanisms for emergencies, community-led construction of health worker housing) are activities that can be funded, built, and administered at grassroots levels, creating a degree of community ownership of women and children's health and a potential for sustainability (e.g. Malawi, Nigeria, Zambia).
- Involve communities in the creation of accountability mechanisms and quality assurance. Community scorecards and other social

auditing mechanisms allow communities to provide feedback to health administrators as to the performance of local health facilities (e.g. Ethiopia, Sierra Leone, Tanzania, Rwanda).

- Utilize community- and facility-based maternal and perinatal death reviews and maternal near miss audits to expose any avoidable factors that contributed to a maternal death. Community engagement in identifying community-level gaps, as well as relevant strategies and responses to address those gaps and stimulate action is critical (e.g. Sierra Leone, Malawi, South Africa).
- Support women's participatory learning and action groups. Studies show these groups to be a cost-effective way to improve maternal and neonatal survival in rural, low-resource settings, even when the proportion of pregnant women



participating is only 30 per cent. Interventions can reduce newborn deaths by one third and maternal deaths by 55 per cent, and prevent up to 283,000 neonatal deaths per year. Such groups improve care practices (e.g. hygiene, breastfeeding, bed net use), build social support for mothers, improve decision-making for care seeking, and help women hold health services accountable (e.g. Malawi).

- Leverage new digital technologies to bridge the gap between communities and states. For example, mobile phones, Internet, and social media platforms can be used by citizens to access evidence, hold governments accountable, and carry out RMNCH advocacy. SMS-based alert systems to improve antenatal health visits, phone-based incentivization or information platforms for CHWs, and SMS systems for surveillance and vital event reporting can all improve the flow

of information and resources to/from communities (e.g. Kenya, Nigeria, South Africa, Uganda).

- Focus on change agents, including male change agents. Tap into local leadership networks, existing women's groups, religious institutions, and other forums in which community key opinion leaders congregate (e.g. Egypt, Ghana, Nigeria, South Africa, Zambia).
- Develop, cost, ratify, budget, and implement Roadmaps for Maternal, Newborn and Child Health to ensure strategies for RMNCH advocacy and community engagement are institutionalized at national level. Roadmaps extend Ministry of Health focus beyond facility-level, and guide both government and other stakeholders (e.g. Senegal, Tanzania, Uganda, Zambia).
- Ensure National Health Policies and Strategic Plans build community engagement into their mission or vision statement to enable a policy platform from which to justify and develop community-based activities (e.g. Uganda, Zambia).
- Commit to recruiting, training, and retaining quality human resources for RMNCH at the community- and primary-levels (e.g. Malawi, Nigeria, Uganda, Zambia). For example:
 - CHWs can be taught basic case management and recognition of key danger signs in maternal and child health, to boost referral systems and avoid delay in care-seeking.
 - Community-sponsored mother-shelters or maternity waiting homes can provide a place for women near delivery to reside in order to avoid delays in reaching facilities.
 - Health facility workers can be trained in midwifery skills, including a continuous emphasis on respectful care, to encourage facility-based births and avoid delays in receiving care.

These efforts, however, will go to waste, if health workers cannot be retained.

CASE STUDIES: NIGERIA

The Program for Reviving Routine Immunization in Northern Nigeria-Maternal, Newborn and Child Health (PRRINN-MNCH) is a six-year maternal, newborn, and child health initiative in Northern Nigeria. Originally focused on improving routine immunization uptake, PPRIN now includes demand generation for MNCH services. Political sensitivities in Northern Nigeria previously led to a drop off in service utilization for immunization and facility-based births. Collaboration with the Ministry of Religious Affairs (MoRA) and Islamic scholars helped promote women and children's health services. State ministries include funds for demand-side issues in their budgets, and are active in community engagement activities. Information systems collect information on equity, including gender disaggregated human resources data, to help plan human resources for health. MNCH volunteers are identified by community members and trained in identifying danger signs. Indirect costs of care seeking are addressed through the creation of emergency transportation systems and emergency savings plans. The program has started working on social accountability systems and feedback mechanisms to allow health facility data to flow back to the community. Routine immunization and antenatal clinic visits have improved markedly.



Photo: UN Photo/Logan Abassi

KEY OPPORTUNITIES

- The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an African Union initiative intended to speed up progress on reducing maternal and infant mortality on the continent. CARMMA prioritizes communities by promoting the mobilization of key opinion leaders at community level, and by disseminating community advocacy messages. <http://www.carmma.org>
- The Maputo Plan of Action is an African Union plan that encourages its signatories to promote, strategize, and cost universal access to sexual and reproductive health services. The Maputo Plan, like CARMMA, prioritizes community-based services for sexual and reproductive health, and community engagement and involvement.
- MamaYe! is a public action campaign which engages the wider public in five African countries on maternal and newborn survival (Ghana, Malawi, Nigeria, Sierra Leone, Tanzania). It uses evidence strategically to stimulate and inform advocacy and enable strengthened accountability. <http://www.mamaye.org>
- There is technical support available from WHO, UNFPA, and other agencies to help national governments develop/improve “roadmaps” for maternal, newborn, and child health. These include integrating best practices in community engagement, including advocacy messaging and accountability mechanisms.
- Community-led total sanitation (CLTS) is a model for participatory community engagement in health-related water

and sanitation. Communities targeted by CLTS collectively identify the extent of water and sanitation problems, then generate resources and implement solutions. CLTS addresses women and children's health and safety in terms of proximity of water and toilets to the household (e.g. Kenya, Nigeria, Sierra Leone, Zambia). <http://www.cltsfoundation.org/>

- There is a renewed interest in integrated management of childhood illness. Integrated Community Case Management (iCCM) represents a reboot of older models but strongly emphasizes building on existing initiatives, peer supervision and mentoring of CHWs, use of digital technologies, and improved use of evidence. CCM Central is a product of the iCCM Task Force and includes tools for costing, advocacy, programming, and monitoring. www.CCMCentral.com

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