



# How to Mobilize Communities for Improved Maternal and Newborn Health



**USAID**  
FROM THE AMERICAN PEOPLE

**a<sup>o</sup>ccess**

Access to clinical and community  
maternal, neonatal and women's health services



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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, the Futures Group, the Academy for Educational Development, the American College of Nurse-Midwives and IMA World Health.  
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## ABBREVIATIONS

ANC	Antenatal care
ART	Antiretroviral therapy
BEOC	Basic essential obstetric care
BP/CR	Birth preparedness/complication readiness
CEONC	Comprehensive essential obstetric and newborn care
CHW	Community health worker
CM	Community mobilization
EMNC	Essential maternal and newborn care
EOC	Essential obstetric care
HHCC	Household-to-hospital continuum of care
HIV	Human immunodeficiency virus
IPT	Intermittent preventive treatment of malaria
ITN	Insecticide-treated net
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MNH	Maternal and neonatal/newborn health
MOH	Ministry of Health
NGO	Nongovernmental organization
PD	Positive deviance
PMTCT	Prevention of mother-to-child transmission of HIV
PVO	Private voluntary organization
SC	Save the Children
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
WHO	World Health Organization

## ACKNOWLEDGMENTS

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## INTRODUCTION

For millions of women who lack access to skilled care during pregnancy, childbirth, and their babies' first month of life, the special joy that mothers and their families feel at childbirth is often overshadowed by the life-threatening risks both mother and child face. Too often, the miracle of new life is transformed into a painful struggle for survival.

*Household-to-Hospital Continuum of  
Maternal and Newborn Care, ACCESS 2005*

This guide is intended for individuals who will work with communities as they mobilize to improve maternal and newborn health (MNH). These “facilitators,” as they are called throughout, may be from inside or outside the community; they may know a great deal about community mobilization (CM) or very little; they may be catalysts for improving essential maternal and newborn care (EMNC) or merely responding to requests from the community; they may be directly involved in facilitating community mobilization or may train others to do so. The idea to mobilize for EMNC may be their own or a mandate received from the organization they work for. Typically, they belong to an organization already working in the community or in the local area, and they will be reading this guide to better understand community mobilization in the context of improving maternal and newborn health.

This guide has deliberately been created to supplement the existing *How to Mobilize Communities for Health and Social Change* (Health Communication Partnership), and as far as possible it does not repeat material from that source. Both guides use the same organizing framework—the community action cycle—and have some steps in common, but otherwise they are different entities. The present guide applies the principles and steps of community mobilization as outlined in *How to Mobilize* to the field of maternal and neonatal health. While it might—*just*—be possible to facilitate a successful community mobilization (CM) initiative using the present volume alone, it is not recommended. At the very least, would-be facilitators should use the two guides in tandem, referring to the earlier guide for the details of the CM methodology and to the present guide for the details of maternal and newborn health.

### HOW THIS GUIDE IS ORGANIZED

This guide has two parts:

- I. Chapter One is a general overview of maternal and newborn health. While many readers will already be working on EMNC projects or may even be EMNC professionals, others may have more limited experience in the field. Community mobilization facilitators do not have to be experts in this content area, of course, but they should have a general familiarity with the main components of EMNC. This chapter should help them in this regard.
- II. Chapters Two through Seven take the reader step by step through the mobilization process, following the phases of the community action cycle. This is the “how-to” portion of the guide, containing all of the essential instructions for carrying out a community mobilization initiative to improve the health of pregnant women and newborns.

The Annex contains a series of 19 tools that readers will find useful for carrying out various steps described in the guide.

## AN OVERVIEW OF MATERNAL AND NEWBORN HEALTH

Together stakeholders can plan for the care that women and newborns need during pregnancy, childbirth, and the postpartum/newborn period, prepare to take action in emergencies, and build an enabling environment for maternal and newborn survival.

*Birth Preparedness and Complication Readiness:  
A Matrix of Shared Responsibility,  
Maternal and Neonatal Health Program 2004*

This introductory chapter, a brief overview of the fundamentals of essential maternal and newborn health, is divided into three sections:

- The first section describes what a comprehensive EMNC program or set of services would consist of.
- The second section describes the most common obstacles many families face to accessing and receiving these services.
- The third section proposes a variety of interventions that would enable more women and newborns to have access to and receive the services they need.

This opening chapter, in other words, is *not* about community mobilization; it is about maternal and newborn health. While community mobilization facilitators do not have to be experts in maternal and newborn health, they do need to have a basic understanding of the fundamentals so they can offer useful guidance and advice to community members and to the community team.

We begin with a few statistics describing the scale of maternal and newborn mortality worldwide.

### **MATERNAL MORTALITY AND MORBIDITY**

- Over 60 million women a year deliver without a skilled provider in attendance:
  - 2 out of 5 births in Asia occur without a skilled provider
  - 3 out of 5 births in Africa occur without a skilled provider
- 529,000 women die each year from complications related to pregnancy and/or birth:
  - 1 out of 2 of these deaths occurs within 1 day of delivery
  - 2 out of 3 occur within the first week after delivery
  - 4 out of 5 occur within the first 2 weeks after delivery

For every 1 woman who dies, 30–50 suffer a childbirth-related injury, infection or disease

### **NEWBORN MORTALITY**

- 2 out of every 5 under-five deaths occur in the newborn period (the 1<sup>st</sup> 28 days after birth)
- Four million infants die each year in the first 28 days after birth; of these:
  - 3 out of 4 die within the first week of life
  - 1–2 out of 4 die within the first 24 hours of life

As these numbers suggest, death and illness among pregnant women and their newborns are still everyday occurrences in communities and villages around the world, despite more than two decades of effort to combat these conditions.

## COMPREHENSIVE MATERNAL AND NEWBORN HEALTH CARE

This chapter begins with a description of the ideal package of health services for mothers and newborns. If your community could offer complete and comprehensive health care for these two groups, what would such care look like? In offering this list we do not mean to suggest that your community needs or is in a position to offer all of these services; our intention, rather, is to offer a complete list of the health needs of pregnant women and newborns to help the community: 1) identify local needs; and 2) select priority areas for possible interventions.

As listed below, the health needs of pregnant women and newborns fall into four categories: before pregnancy, during pregnancy, during labor and childbirth, and during the immediate postnatal period and the first 28 days of life.

### *Maternal Health Needs before Pregnancy*

Good maternal health begins before pregnancy by educating and counseling girls, young women, and family members about a number of important women's health and health-related issues, including:

- Reproductive health
- Safer sex
- Benefits of delayed marriage and childbirth
- Consequences of early pregnancy
- Avoidance of unintended pregnancy
- Prevention of domestic and gender-based violence
- Good non-maternal nutrition
- Importance of formal education
- Income generation/employment opportunities
- Gender equity

### *Maternal Health Needs during Pregnancy*

In addition to those topics already mentioned above, a comprehensive maternal and newborn health program during pregnancy would address and/or provide for the following needs:

- Birth spacing and family planning counseling
- Safer sex
- HIV counseling, testing and treatment using antiretroviral drugs
- Pregnancy registration and monitoring (including identifying due date)
- Four visits to a skilled antenatal health provider
- Knowledge of danger signs
- Good maternal nutrition including micronutrient supplementation

### **Road Map to the MDGs**

The African Regional Reproductive Health Task Force (Dakar 2003) developed a Road Map to help African countries meet the Millennium Development Goals for maternal and newborn care. The Road Map proposed the following interventions:

- Define the minimum package of MNH services at each level
- Review/revise national policies using international evidence-based MNH standards
- Upgrade health services to ensure accessible, acceptable, quality essential MNH care
- Establish essential obstetric care (EOC) standards
- Assess/update pre-service training in EOC
- Procure communication equipment (e.g., two-way radios) and emergency transport
- Build the capacity of district health mgmt. teams to integrate MNH into sector-wide approach plans and Poverty Reduction Strategy papers
- Strengthen health information
- Promote male involvement

African Regional Reproductive  
Health Task Force 2004

- Reduced workload
- Malaria prevention and treatment
- Prevention and treatment of sexually transmitted infections
- Diagnosis and treatment of tuberculosis
- Tetanus toxoid immunization
- Counseling on infant feeding
- Birth planning (for normal birth and for complications, including obstetric emergency)
- Community emergency transportation and financing scheme
- Good personal and household hygiene

### ***Maternal and Newborn Health Needs during Labor and Delivery***

A comprehensive maternal and newborn health program for this period would address and/or provide for the following needs:

- Knowledge of danger signs and complications on the part of all family members
- Knowledge on the part of all family members of where to take the mother and/or newborn in the case of complications
- Childbirth attended by a skilled provider
- Community emergency plan including transportation to health facilities for emergency obstetric and newborn care
- Community funds to pay for needed maternal and newborn clinical care
- Traveling and delivery companion
- Clean and safe delivery (including avoiding infection and contact with maternal blood)
- Emergency obstetric care
- Blood transfusion
- Functioning referral system between community and health centers
- Appropriate inter-health facility referral system including radio/telephone communication and ambulances
- Health centers/posts with basic emergency obstetric and newborn care capability
- District hospital with comprehensive obstetric and newborn care capacity
- Antiretroviral therapy

### ***Maternal and Newborn Health Needs Postpartum and for the First 28 Days***

A comprehensive maternal and newborn health program for this period would address and/or provide for the following needs:

- Resuscitation and suctioning
- Drying and warming of the baby
- Clean cord cutting
- Skin-to-skin contact
- Immediate and exclusive breastfeeding
- Prevention of hyper- and hypothermia
- Vaccinations
- Eye care
- Education about breast care/recognition of breast problems
- Treatment of breast problems and oral thrush
- Referral system and transportation plan for maternal and newborn emergencies as described above
- HIV counseling, informed testing, and treatment using antiretroviral drugs
- Safer sex
- Birth spacing and family planning counseling
- Diagnosis and treatment of any infections in mother (including sexually transmitted infections [STIs], TB, malaria, pneumonia)
- Malaria and STI prevention
- Diagnosis and treatment of any infections in the newborn (including sepsis, and acute respiratory infections)
- Increased food intake for the mother
- Knowledge of newborn danger signs and postpartum maternal complications
- Good hygiene for mother, newborn and household
- Early postpartum and newborn care visit (first visit within three days after childbirth)
- Mother-to-mother support groups

These are the elements of a complete and comprehensive maternal and newborn health care system. Communities must start from where they are in addressing these needs, but it is important for those who facilitate community mobilization for EMNC to have the big picture in mind, to be aware of the entire range of maternal and newborn health care needs, so they can guide community members in identifying and meeting local needs.

### **COMMON OBSTACLES TO MATERNAL AND NEWBORN HEALTH CARE**

Many communities will not be able to meet many of the needs listed above, and even in those communities where certain services are available; some families may not be aware of the services, have access to them or seek them out. There are many reasons why this is the case, many obstacles that prevent mothers and newborns from asking for and/or receiving the care they need, and these will be

described below. These obstacles to receiving care are often presented in a form known as the Three Delays—delays in deciding to seek care, delays in reaching care, and delays in receiving care—and they can occur during the antenatal period, at the time of labor and delivery, and during the postnatal period. In the end, mobilizing the community to improve maternal and newborn health will almost always involve eliminating one or more of these obstacles to receiving care.

### **Delays in Deciding to Seek Care**

There are many reasons—some general and some more specific—why pregnant women and family members do not seek health care for themselves or their newborn, or why they hesitate to seek such care. These include:

- Failure to recognize signs of complications during pregnancy and labor or danger signs for newborns
- A particular kind of care or service is not available
- Necessary medicines or supplies are widely known to be unavailable
- Lack of awareness that certain services are available
- Limited contact with the health system
- The cost of care
- Previous negative experience with the health system
- Perceived poor quality of the health system (from stories from other women)
- Inadequate screening programs
- Untrained attendants or community health workers who do not refer
- Low perceived risk/failure to perceive severity of the problem
- Lack of transportation
- Lack of a reliable due date
- No birth planning
- Traditional beliefs
- Preference for traditional healers/remedies
- Stigma associated with certain kinds of care, such as STI and HIV testing and treatment
- Gender violence
- Women’s low status and lack of economic independence and decision-making power

#### **Due Date**

In Kenya, one of the most common reasons women did not seek skilled care in time was because they did not have a reliable due date. Many women stated that a reliable estimated date would help them prepare for seeking skilled care.

CHANGE 2005

#### **Juana’s Story**

One week before the delivery, Juana began to swell up, and traditional birth attendant (TBA) Berta said she should go to the hospital. But Juana’s husband refused, saying they would treat her badly or not treat her at all because she was a “natural” (indigenous). Berta told him not to be afraid and that she would not attend Juana any longer if he did not agree to take Juana to the hospital. She said she did not want her patient to die in her care, and this convinced Juana’s husband.

They had to make many arrangements because they had seven children at home and neither grandmother was living. Juana’s sister agreed to stay with the children, and three days before the birth, when Juana was very ill, she, Berta and the husband went to the hospital via public transportation. Juana was admitted, told she needed to stay, and spent three days before giving birth without complications.

“We never said anything about [a plan],” Juana explained later, “since nothing had ever happened before. We didn’t prepare things.” Her husband added: “No, I didn’t think there would be a problem. Juana had already had other births, and she knew how to help so the child would come out all right.”

National Reproductive Health Program/Guatemala 2004

### ***Delays in Reaching Care***

Even when women or family members overcome the obstacles listed above and decide to seek care, they do not always reach the care they seek, or reach it in time. The most common reasons are:

- Distance to the facility or health care provider
- Lack of emergency transportation
- Lack of money to pay for transportation
- Poor condition of the roads
- No skilled attendant to accompany mother or child

### ***Delays in Receiving Care***

In some cases, women and newborns do not receive the care they need even after they reach the health facility or health care provider. The most common reasons include:

- A particular kind of care or service is not available
- Lack of skilled providers
- Poorly trained providers
- Services not available 24 hours/seven days a week
- Negative attitude of providers
- Cumbersome or confusing administrative procedures
- Shortage of supplies, medicine or blood
- Family asked to go out and purchase supplies and medicines
- Lack of equipment or beds
- Lack of an adequate referral system (to next level of care)
- No transportation to referral location
- Costs of care
- Lack of outreach and follow-up

In addition to receiving care for which the three delays were conceptualized, there are individual and household behaviors that, when adopted, will improve maternal and newborn health. Behaviors such as seeking antenatal care (ANC), using a skilled birth attendant, sleeping under insecticide-treated nets (ITNs), putting the baby skin-to-skin with the mother, drying and wrapping newborns, require facilitated negotiations with mothers and their families through interpersonal communication, group discussion and other proven behavior change interventions.

### **INTERVENTIONS TO IMPROVE MATERNAL AND NEWBORN HEALTH**

In this third section, we examine what communities can do to help families overcome the obstacles to health care for mothers and newborns, as well as what they can do to add to or improve the services that are presently available. These interventions are arranged according to the four key locations where good EMNC practices need to occur and by antenatal, delivery and postpartum care. This particular framework, known as the household-to-hospital continuum of care (HHCC), is an integrated approach to community- and facility-based maternal and newborn programming developed by the ACCESS Program.

## ANTENATAL CARE INTERVENTIONS

These interventions would address the following needs:

Household	Type 1 Health Facility	Type 2 Health Facility	Hospital
Improve antenatal preventive practices: <ul style="list-style-type: none"> <li>• Malaria prevention</li> <li>• Safer sex</li> <li>• Adequate nutrition</li> <li>• Tetanus immunization</li> </ul>	Provide focused ANC services: <ul style="list-style-type: none"> <li>• Intermittent preventive treatment (IPT)</li> <li>• Tetanus toxoid, STI prevention and detection</li> <li>• Prevention of mother-to-child transmission of HIV (PMTCT)</li> <li>• Iron/folate</li> <li>• Birth preparedness/ complication readiness (BP/CR)</li> </ul>	Same as for type 1 facility plus: <ul style="list-style-type: none"> <li>• Laboratory service to screen for anemia, STI and HIV</li> <li>• Provide blood transfusion</li> </ul>	Same as type 2 facility plus: <ul style="list-style-type: none"> <li>• Ensure in-house blood bank</li> <li>• Provide comprehensive laboratory service</li> </ul>
Ensure at least four ANC visits starting at 12 weeks	Recognize and manage danger signs		
Improve birth planning and complication readiness	Provide basic essential obstetric care (BEOC) 24 hours a day		
Improve recognition of maternal and newborn danger signs by mothers and families	Improve participation of community in managing the facility		
Ensure families and community health workers (CHWs) have skills to perform obstetric first aid	Improve referral system, including communication with/transportation to next level of care		
Promote testing and counseling for HIV	Provide ANC outreach services		
	Support and supervise interventions at household level		

## DELIVERY AND NEWBORN CARE INTERVENTIONS

These interventions would address the following needs:

Household	Type 1 Health Facility	Type 2 Health Facility	Hospital
<p>For mother:</p> <ul style="list-style-type: none"> <li>• Promote delivery by skilled provider (including use of partograph and active mgmt. of 3<sup>rd</sup> stage of labor in the home)</li> <li>• Ensure clean and safe delivery where skilled providers are not available, including use of misoprostol after birth</li> <li>• Ensure adequate hydration and nutrition for mother during labor</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct clean and safe childbirth including use of partograph and active mgmt. of 3<sup>rd</sup> stage of labor</li> <li>• Recognize and manage maternal and newborn danger signs</li> <li>• Provide BEOC 24 hours a day</li> <li>• Improve referral system including communication with/transport to next level of care</li> <li>• Support and supervise interventions at the household level</li> <li>• Provide PMTCT services, including the use of nevirapine</li> </ul>	<p>Same services as type 1 plus:</p> <ul style="list-style-type: none"> <li>• Blood transfusion</li> <li>• Basic laboratory service</li> </ul>	<p>Same services as type 2 plus:</p> <ul style="list-style-type: none"> <li>• Manage pregnancy-related complications and treatment for the sick newborn including associated obstetric/surgical procedures</li> <li>• Comprehensive laboratory services: all basic lab tests, blood sugar, bilirubin, STI, HIV</li> <li>• In-house blood bank</li> <li>• Provide comprehensive essential obstetric and newborn care (CEONC) 24 hours a day</li> </ul>
<p>For newborn (At all levels):</p> <ul style="list-style-type: none"> <li>• Initiate/promote immediate and exclusive breastfeeding within 1 hour</li> <li>• Maintain baby's warmth: dry and wrap immediately or dry and put skin-to-skin with mother and cloth over baby</li> <li>• Delay bathing</li> <li>• Recognize and resuscitate asphyxiated newborns</li> </ul>			
<p>For mother and newborn (At all levels):</p> <ul style="list-style-type: none"> <li>• Improve recognition of maternal and newborn danger signs and care seeking by mothers and families</li> <li>• Ensure families and CHWs have knowledge and skills to perform obstetric first aid</li> </ul>			

## POSTPARTUM CARE INTERVENTIONS

These interventions would address the following needs:

Household	Type 1 Health Facility	Type 2 Health Facility	Hospital
<p>For mother:</p> <ul style="list-style-type: none"> <li>• Improve preventive practices, such as:               <ul style="list-style-type: none"> <li>– ITN use for malaria</li> <li>– Safer sex</li> <li>– Adequate nutrition</li> <li>– Basic hygiene</li> <li>– Basic breast care</li> </ul> </li> <li>• Initiate family planning</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Recognize and manage maternal and newborn danger signs</li> <li>• Provide BEOC 24 hours a day</li> <li>• Improve referral system including communication with/transportation to next level of care</li> <li>• Support and supervise interventions at the household level</li> <li>• Provide PMTCT services, including the use of nevirapine for the baby</li> <li>• Provide postnatal care outreach services</li> </ul>	<p>Same services as type 1 plus:</p> <ul style="list-style-type: none"> <li>• Blood transfusion</li> <li>• Basic laboratory service</li> </ul>	<p>Same services as type 2 plus:</p> <ul style="list-style-type: none"> <li>• Manage pregnancy-related complications and treatment for the sick newborn including associated obstetric/surgical procedures</li> <li>• Comprehensive laboratory services: all basic lab tests, blood sugar, bilirubin, STI, HIV</li> <li>• In-house blood bank</li> <li>• Provide CEONC 24 hours a day</li> </ul>
<p>For newborn (Household and all levels):</p> <ul style="list-style-type: none"> <li>• Continue exclusive breastfeeding</li> <li>• Maintain baby's warmth</li> <li>• Keep cord clean and dry</li> <li>• Provide recommended immunizations</li> <li>• Sleep with mother under ITN</li> </ul>			
<p>For mother and newborn (Household and all levels):</p> <ul style="list-style-type: none"> <li>• Ensure early postnatal visit, within 3 days, with skilled provider</li> <li>• Improve recognition of maternal and newborn danger signs and care-seeking by mothers and families</li> <li>• Ensure families and CHWs have knowledge and skills to perform obstetric first aid</li> </ul>			

A few additional interventions, implied in the preceding list but not specifically stated, are as follows:

- Training for community-based providers (TBAs, CHWs, midwives)
- Training for facility-based providers
- Establishing an emergency transportation system
- Supporting adherence for antiretroviral therapy (ART)
- Providing financial assistance to poor families
- Improving household hygiene
- Improving gender equity/the status of women
- Improving access to and education for young girls
- Mother-to-mother, father-to-father, and teen support groups

These interventions run the gamut from relatively limited and specific, such as “promot[ing] testing and counseling for HIV” or “recogniz[ing] and resuscitating asphyxiated newborns,” to broader and more complex, such as “provid[ing] BEOC 24 hours a day.” Implementing any of these interventions will involve carrying out various activities and drawing on a number of resources, and the more complex the intervention, the more activities and resources required.

In the case of a more complicated, multi-faceted intervention, a community can decide to carry out only certain elements of that intervention and not others. Or it may be that the community is already carrying out certain aspects of that intervention (providing a particular care or service, for example) and only needs to implement other aspects. Or, most commonly, communities will combine various elements of various interventions to create their own hybrid EMNC program.

In this chapter, then, we have outlined the most common health care needs of pregnant women and newborns, examined the obstacles that many families face in meeting these needs, and described interventions to improve maternal and newborn care and reduce mortality. With this information as background, we can now begin our discussion of how to mobilize the community to improve maternal and neonatal care.

#### **Referrals**

The ability and readiness of caregivers to refer to the next level of care when the need arises is critical to the success of the HHCC approach—and to saving the lives of mothers and newborns.

ACCESS Program 2005

## PREPARE TO MOBILIZE

Any approach to improve essential maternal and newborn care services must address the issues of the community and the health system together, systematically, and in close collaboration among all stakeholders if it is to be successful.

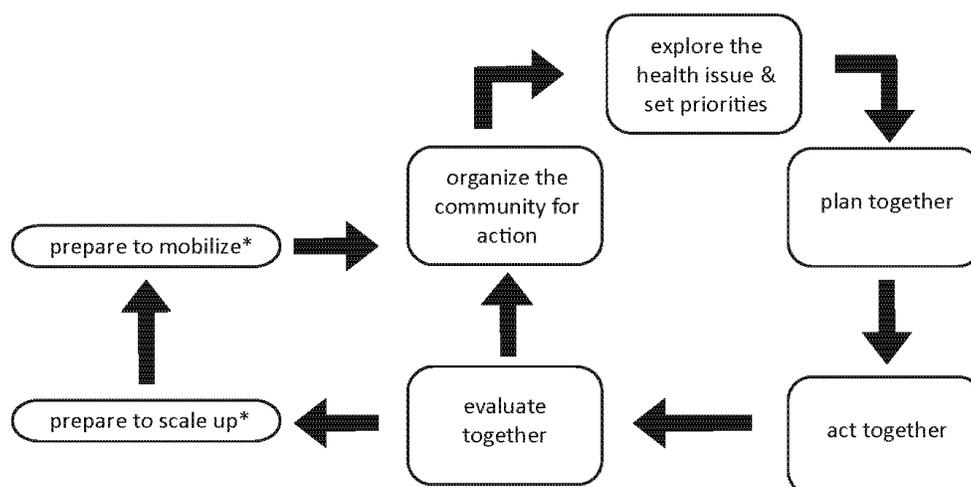
*Household-to-Hospital Continuum of Maternal and Newborn Care, ACCESS Program 2005*

- Step 1. Identify stakeholders for maternal and neonatal health
- Step 2. Meet with stakeholders to discuss EMNC needs
- Step 3. Assemble a committee mobilization team
- Step 4. Gather information about the community and local EMNC issues
- Step 5. Develop a community mobilization plan
- Step 6. Strengthen the capacity of the CM team

## THE COMMUNITY ACTION CYCLE

The theoretical basis for the community mobilization approach is a model known as the community action cycle. The stages of community mobilization (the next six chapters in this guide) are structured in accordance with and closely follow the phases of this cycle, which describes in a general way how community members work together to identify and address local problems and evaluate the results.

# Community Action Cycle



\*Action by Community Mobilization Technical Assistance Team

While there is a logical sequence to the cycle, local circumstances may dictate starting at some phase other than preparing to mobilize and even going back to an earlier phase after completing a later one. After planning together, for example, the mobilization team may need to go back and further explore the health issue. And evaluation, the last phase, often leads to additional planning. Communities that

have already mobilized around one EMNC issue may be able to skip the preparation, organization and exploration phases and begin directly with the planning phase; it is important, however, in taking up any “new” EMNC issue to be sure to explore the underlying causes, as these can differ from one issue to the next. (Note that this guide does not address the scaling-up phase.)

The sequence of steps under each phase is likewise not hard and fast. In preparing to mobilize, for example, some projects might begin with Step 4 above (Gather information about...) and only as part of that process identify stakeholders (Step 1).

This chapter—Prepare to Mobilize—describes the preliminary work that has to be done prior to the first phase of the action cycle (organizing the community). It assumes that the reader/facilitator is from an organization, located in the community or not, which has been charged with helping the community mobilize to improve maternal and newborn health. The decision to mobilize for EMNC may have come from the facilitator’s own or another organization, from the Ministry of Health (MOH) or some other government entity, from members of the community or from any combination of sources. But at this point in the process, the facilitator and his/her team are leading the effort and assuming primary responsibility for the activities described in this chapter. There will be considerable contact between the facilitator’s team and various community members and groups during this period, but there will not yet be significant community involvement.

### **STEP ONE: IDENTIFY STAKEHOLDERS FOR MATERNAL AND NEONATAL HEALTH**

Typically, the first step in preparing to mobilize is to identify key stakeholders for EMNC in the community. These are individuals and groups who have an interest in or may already be working to improve EMNC and/or who will be the main beneficiaries of improved maternal and neonatal care. Possible stakeholders typically include:

- Pregnant women and recent mothers (mothers with babies under one month of age)
- Family members including husbands and mothers-in-law
- Community leaders (business, political, religious and educational)
- Community-based health care providers (TBAs, midwives, CHWs, traditional healers)
- Facility-based providers (at peripheral facilities and district/local hospitals, including public, private and faith-based facilities)
- Pre-existing community groups (such as women’s groups, faith-based groups, service organizations, youth groups)
- Nongovernmental organizations [NGOs/private voluntary organizations (PVOs), local, national, or international]
- Government officials (MOH, other ministries, and provincial, regional and district officials)
- Donors and development agencies
- Policymakers

One of the first things facilitators should do is identify individuals from these populations, meet with them to discuss EMNC needs in the community and determine their interest in participating in or supporting the community mobilization effort. Not all of these individuals or groups will become active in your community mobilization activities, but it is important to get their perspective and advice as you lay the groundwork for addressing EMNC issues in the community.

## STEP TWO: MEET WITH STAKEHOLDERS TO DISCUSS EMNC NEEDS

After you have identified those who are interested in, affected by or working on EMNC issues in the community, you should meet with them to get their perspective on the current state of care/services in the community and what they see as priority health needs for pregnant women, mothers and newborns. As preparation for these meetings, you may want to gather statistics on maternal and neonatal morbidity and mortality in the local area or region, which you can usually get from records kept by local facilities. These statistics could include information such as the number of women and newborns who died during or after delivery, the number of women who bled or had other complications during delivery, the number of women referred to a higher level of care, and the number of newborns who needed resuscitation or who were admitted for health problems during the first 28 days after delivery.

Generally, the objectives of your initial meetings with stakeholders will be to:

1. Introduce yourself and your organization to the stakeholders
2. Solicit their views on local EMNC care and priority needs
3. Discuss the capacity of the community to improve EMNC
4. Solicit their support in moving forward with the CM initiative

If you or your organization already works in the community, it may not be necessary to introduce yourself to all of the stakeholders, but if you come from outside or if you are known to some but not all of these individuals, you should identify who you are and what your organization does.

### *The Household-to-Hospital Continuum of Care and the Three Delays*

In identifying and discussing EMNC services and priority needs with stakeholders, you may find it helpful to identify and analyze EMNC issues in terms of the household-to-hospital continuum of care (HHCC) and the three delays as presented in Chapter 1:

- Delays in deciding to seek care
- Delays in reaching care
- Delays in receiving care

Thinking about EMNC needs in terms of the continuum of care and the delays—and in particular in terms of what *causes* each delay—will help stakeholders identify the key EMNC needs in their community.

**See Tool #1: “Questions for Stakeholders about the Three Delays” for more details.**

### *A Question of Timing*

As part of your initial meetings with stakeholders, you may want to ask them if they think the community is ready to address EMNC needs at this time. You will be doing a much more thorough assessment of community capacity later in the action cycle, but it is important at this early stage to determine whether this is the right time and the right place to mobilize for EMNC. The community may already be mobilizing around other issues, for example, and not in a position to add EMNC to its agenda, or the community may have just finished a major CM initiative and need time to regroup, or EMNC may not be regarded as a high priority at a time when the community is fighting HIV/AIDS, for example, or going through a drought. The timing of a community mobilization effort is crucial to its success, so it is important at this stage to see if the time is right.

### STEP THREE: ASSEMBLE A COMMUNITY MOBILIZATION TEAM

If most of the stakeholders agree that the time is right for mobilization, you will need to put together a team of people (which may include stakeholders) who will work with you in guiding and supporting the community to improve EMNC. This CM team, which is to be distinguished from the “Core Team” of community members who will actually design and carry out the mobilization effort (see Chapter 3, Step 3), will usually consist of staff members from your organization and/or from other external organizations who may be your partners in this endeavor, as well as one or more respected individuals from the community. This team will serve as a kind of advisory board to the Core Team, as well as a source of important contacts and even certain skills that the Core Team may not possess. In assembling this team, you should look for people with the following expertise:

- Experience in maternal and newborn health services
- Knowledge of the local political, socio-economic and cultural context
- Knowledge of or experience in community mobilization
- Community mobilization skills (communication and facilitation skills, program design, management skills, organizational behavior/group dynamics skills, capacity-building skills, planning and evaluation skills, knowledge of participatory methods)
- Personal attributes such as tactfulness, flexibility, patience and listening skills
- Links to other organizations or entities with resources that may be needed by the community

Some examples of possible team members would be community-based health workers, midwives, the local hospital director, representatives from women’s groups, and civil or religious leaders.

#### ***A New Team or an Old Team?***

It is possible, of course, that such a team—or something very close to it—already exists. That is, there may already be a village health committee or a local health council that is responsible for health activities in the community. While this committee was probably not designed with community mobilization in mind, and while its members may not have the expertise you are looking for, it would be very important to consult and work closely with any existing entities of this kind. You might want to include several members of this committee on your CM team, for example, or even formally align yourself with this group—and its network of contacts and resources and reservoir of trust—by making your CM team a subcommittee of this pre-existing organization. The bottom line is that if there are existing health groups working in the community, sooner or later you are going to need their cooperation, or at least their blessing, as you go about your mobilization efforts.

#### **Gathering Information**

In preparing the MNH Community Mobilization and Behavior Change program in Guatemala, program organizers gathered information from the following sources/by the following means:

- A baseline study done in the target region in 2001
- Questionnaires for households, women, men, community leaders and health committees
- In-depth interviews with women and husbands
- In-depth interviews with family members
- Household observation guide
- Visits to the health committee
- Visits to the local hospital
- Dialogue with TBAs
- Dialogue with the head of the health center
- Dialogue with members of the health committee
- Dialogue with the director of the local hospital
- Dialogue with the director of the local health zone

National Reproductive Health Program/Guatemala 2004

### ***Choosing a Team Leader***

Once you have assembled your team and before you undertake the remaining steps in this preparation phase, which require some coordination and supervision, you should choose a team leader. The group should make the decision, of course, and should also agree on the criteria. Here are some possible criteria for a good CM team leader:

- Trusted and respected in the community
- Previous management/leadership experience
- Understanding of the local context
- Background in or awareness of basic tenets of community mobilization
- Knowledge of or familiarity with local EMNC issues, such as deliveries in the home, or someone who works at a local clinic
- Contacts outside the community, with donors and NGOs, and with various levels of government

It is not likely you will find someone with all of these attributes, so your group might want to prioritize these (and also add other attributes that apply in the local circumstances). Even as you assemble your team, you should keep these attributes in mind and think about who would make a good leader.

### **STEP FOUR: GATHER INFORMATION ABOUT THE COMMUNITY AND LOCAL EMNC ISSUES**

Before you approach the community to invite their participation in the mobilization effort, you and your team will need to gather information about the community and about local EMNC issues. You have already learned a great deal from your meetings with stakeholders, of course, so you may not need to spend much time on this step; moreover, you will also be conducting a much more in-depth assessment of EMNC later in the action cycle. Nevertheless, learning more about some of the topics listed below will help you understand the community better and make you more informed about EMNC care and needs.

In gathering information about the community, you will want to learn about some or all of the following:

- Existing maternal and newborn health care services, including community- and facility-based services
- Local leaders (business, political, religious, educational)
- Pre-existing community groups (women's groups, church groups, youth groups, civic organizations, Rotary Club, etc.)
- NGOs and their programs, especially those working in maternal and child health programs
- Socio-economic status—source of income, level of education, employment type, etc.
- Social and cultural norms
- Gender roles and relations
- Previous and/or ongoing community mobilization activities in health or other sectors
- Channels of communication

### ***Identifying Resources: Finding What Works and Looking for Positive Deviants***

As part of this step, you and your CM team also should determine what resources are available in the community that could be applied to the health issue. Resources for carrying out EMNC activities will be of three types:

**Human:** Existing groups, community members willing to work on the project, staff of your organization and of any partner groups, facility and community-based health care providers, people outside the community.

**Financial:** Money from all sources, including your organization, other donors, the national or regional government, and money raised by the community itself, in-kind contributions.

**Material:** Equipment, medical and other supplies, office space, furniture, vehicles and petrol, medicines (including antiretrovirals), donated blood, vaccines, vitamins and food, clothes and other household items, seeds for kitchen gardens.

### Building on Strengths

Special attention needs to be given to mobilizing existing resources. The key principle is to start with what exists and build on it.

Making Pregnancy Safer  
Initiative/WHO 2003

As you identify local resources, it is important to remember that every community already has a certain amount of “capacity,” a number of existing activities, programs, groups, individuals, and skills that can be applied to any mobilization initiative. There will of course be things that need fixing in any community—and one or more of these will be the focus of a mobilization effort—but there are also many things that are not broken and work quite well, and it is essential to identify and exploit these community strengths. Identifying and emphasizing what the community does well—looking at the positive side of community capacity—not only makes your assessment more balanced, it can also build confidence, inspire civic pride, and generally add momentum and energy to the mobilization effort.

Another key resource in any community exists in the form of its “positive deviants.” These are individual women and families who are at risk but are *not* experiencing the common EMNC problems affecting their neighbors because they engage in certain “deviant” (unusual) activities that offer them protection from maternal and newborn morbidity and mortality. If these positive activities can be identified, they become a very valuable resource that can be shared with (i.e., taught to) other women and families. (For more information about positive deviance, readers should consult: [www.positivedeviance.org](http://www.positivedeviance.org) or contact [monique.sternin@tufts.edu](mailto:monique.sternin@tufts.edu).)

### Identifying Obstacles

Obstacles to carrying out a mobilization effort for EMNC could include the following:

- Lack of human, financial and material resources as listed above
- Lack of or poor transportation infrastructure, such as roads and bridges
- Lack of running water and electricity
- Lack of or distant medical facilities
- Unemployment and poverty
- Political unrest or war
- Natural phenomena such as drought or flooding
- Competing health priorities
- Gender inequities

**Tool #2: “Assessing Assets and Barriers” may help the group at this stage.**

## Learning about Maternal and Newborn Health Issues

With regard to the health issue, you may want to ask the following questions (taken from *How to Mobilize Communities for Health and Social Change, HCP*), or you may want to ask these questions later, when you and the Core Team explore the health issue with the community (see Chapter 4, Step 1).

- Which community members and/or groups are the most affected by the issue?
- How many people are directly affected? Indirectly? (The answer to this will help determine your coverage.)
- Where do the people most affected live? Do those most affected live close together? Are there health and other services nearby?
- What are the socio-demographic characteristics? Do those most affected share similar characteristics?
- Why are these people most affected? (Answering this question includes exploring the aspects of the key issue that makes people more likely to be affected, such as risk factors and specific practices.) Is there limited access to information? Services? Resources? Why? (Geography or discrimination?)
- To what extent do those most affected decide what they do, or do others decide for them? Who influences their decisions and practices at the household level?
- What are the current beliefs and practices (at household and facility levels) related to the issue? Who decides or influences what will be done and how at the community level?
- What positive deviance practices exist in the community?
- Are the people in the community organized around this or any other issue? Is there a history of community mobilization in the past?
- What is the level of capacity/skills in the community? Previous participation in/experience with collective assessment, planning, action, monitoring/evaluation, decision-making, negotiation?

### Root Causes

Be sure to determine the true cause of a problem. In a clinic in East Africa clients complained they had to wait too long for services. At first staff felt this delay was caused by a shortage of nurses. But an analysis revealed that no clients were being seen during the lunch and tea breaks because all the staff took these breaks together. The staff solved the problem by staggering the times for their breaks.

EngenderHealth 2002

## STEP FIVE: DEVELOP A COMMUNITY MOBILIZATION PLAN

This is **not** the plan the community will develop later (see Chapter 5) to improve maternal and neonatal health (which is called the Community Action Plan and will be developed by the Core Team). Rather, this is the plan for how your organization and the CM team will guide, support and otherwise assist the community in designing and carrying out its action plan. While this mobilization plan can and should be developed at this phase, it will necessarily be quite general; many of the specifics and details will have to be added later (see Chapter 6) after the community has designed its own action plan.

The elements of a community mobilization plan for EMNC are as follows:

1. **Program objective.** The objective or outcome of the CM initiative should be stated simply and in terms of how the mobilization activities will benefit the community. Sample objectives for an EMNC effort include:
  - Improve the quality of antenatal care
  - Increase antenatal care attendance

- Reduce mother-to-child transmission of HIV
- Reduce the incidence of STIs (or TB, malaria, etc.) among pregnant women
- Improve the quality of facility-based maternal and neonatal care
- Improve the quality of emergency obstetric care in the community
- Increase the percentage of births attended by a skilled provider
- Increase utilization of maternal and newborn services (or of a specific service)
- Improve postpartum care for mothers and newborns

The overall objective **for the CM team** should be to maximize the capacity of the Core Team and community members to design and carry out their action plan.

2. **Program strategies.** The strategies of this CM plan are all those activities that will result in your CM team achieving its objective of maximizing the community’s capacity. These would typically include activities such as:
  - Developing and coaching Core Team members
  - Facilitating community participation
  - Providing technical advice and support
  - Supporting various activities in the community action plan
  - Helping the Core Team mediate conflicts
  - Helping community members problem solve and trouble-shoot

Remember: These are strategies/activities for your CM team, not for carrying out the actual community action plan that will be designed later by the Core Team (Chapter 5, “Plan Together”) and executed with help from the community (Chapter 6, “Act Together”).

3. **The community mobilization process.** In this, the heart of your plan, you will identify in a general way the role the CM team will play and the actions they will take during each phase of the community action cycle. The responsibilities of the CM team are summarized in the steps that are used to organize Chapters 2–6. The team should look closely at each of these steps and plan in a general way what it will do to execute each one.

**Tool #3: “Planning the Role of the CM Team” will be useful here.**

4. **Monitoring and evaluation plan.** You will need to select and measure indicators to determine how well you are doing as a team in developing community capacity during each phase of the community action cycle. The best way to do this would be to look again at all the actions you have outlined immediately above (in element No. 3). The community mobilization process) and determine as a group how you would measure whether or not those actions were successful. You may also find the table below helpful as a way to structure your discussions about the monitoring and evaluation (M&E) plan.

## TEMPLATE FOR MONITORING THE CM TEAM

CM Team Action	Indicator	How to Measure the Indicator	By Whom	By When
1. Gather information about the health issue	1. Data collected analyzed and report produced	1. Availability of report		
2. Develop a core group from the community	2. Core group selected and functioning	2. Minutes from core group meeting		

5. **Project management plan.** This plan outlines who the various members of the CM team are, what their respective roles and responsibilities are, how they will interact with each other and how they will interact with the Core Team and the community as a whole. This careful division of responsibility and clarification of roles is essential not only for the smooth running of the team but also so as not to confuse the community as they work with the team.
6. **Budget.** You will need to estimate your costs based in part on the activities you foresee for the team as envisioned in the earlier parts of this plan. The most common costs would be: salaries, equipment, materials, travel and per diem, administration and training.

### STEP SIX: STRENGTHEN THE CAPACITY OF THE COMMUNITY MOBILIZATION TEAM

The last step in this preparation phase is to develop key skills and qualities in the CM team. As the team has executed the previous two steps in this chapter, it has had to work together and cooperate in a number of ways. This has given team members a chance to see each other's strengths and weaknesses and the different skills and expertise each member brings to the team. As part of this step, you can sit down with the team and identify individual strengths and skills, and make a list of skills the team does not have and needs to find (outside the group) or develop. Some of the core competencies for a successful team are the ability to:

- Develop an ongoing dialogue between community members regarding maternal and neonatal health issues.
- Create or strengthen community organizations aimed at improving EMNC.
- Assist in creating an environment where individuals can empower themselves to address their own and the community's EMNC needs.
- Promote community members' participation in ways that recognize diversity and equity, particularly for those who are most affected by the EMNC issue.
- Work in partnership with community members in all phases of the community action cycle to create locally appropriate responses to EMNC needs.
- Identify and support the potential of communities to develop a variety of strategies and approaches to improve EMNC (even interventions that may not have been recommended by donors and other external actors).
- Assist in linking communities with external resources (organizations, funding, technical assistance, etc.) to aid them in improving EMNC.

## ORGANIZE THE COMMUNITY FOR ACTION

Working with individuals, families, and communities is the critical link to ensure the recommended continuum of care throughout pregnancy, childbirth, and the postpartum periods.

*Working with Individuals, Families and Communities  
to Improve Maternal and Newborn Health,  
Making Pregnancy Safer Initiative/WHO 2003*

Step 1. Orient the community

Step 2. Build community support for improving maternal and newborn health

Step 3. Select a Core Team and decide roles and responsibilities

Up to this point in the mobilization effort, you and the team have interacted primarily among yourselves, with limited participation or involvement from the community, although you have certainly had contact with various sectors of the community in carrying out some of the steps described in the previous chapter. Now it is time to formally approach the community at large and invite them to participate.

### STEP ONE: ORIENT THE COMMUNITY

One of the first things the team should do at this point is meet with the community to make them aware of the mobilization effort and to introduce the CM team. While you will no doubt need to hold one or more general meetings open to the entire community, you may also want to hold a series of one-on-one meetings with key individuals who need to be informed about your intentions and whose cooperation and support will be necessary for your success. These one-on-one meetings should precede the general community meetings. (Many of these people, of course, will be stakeholders with whom you may already have met.) In mobilizing for maternal and neonatal health, you would typically need to meet with some or all of the following:

- Community leaders such as traditional chiefs
- Community-based EMNC providers (TBAs, midwives, CHWs and traditional healers)
- Facility-based EMNC providers (nurses, midwives, doctors, administrative staff at peripheral health facilities and the district hospital and at any other hospital nearby)
- Any other health providers (outside of EMNC)
- Leaders of local women's groups, church groups and youth groups
- Local business, political, religious and educational leaders
- NGO/PVO groups working on EMNC or other health issues in the community or surrounding area
- Government officials (of health and other ministries) at local, regional or provincial level
- Media representatives

These individuals may also come to the open community meetings (and you should encourage them to), but if they do not it is important that you contact them separately to inform them of your plans and solicit their input and support.

Some of the most common objectives for these initial orientation sessions are:

- To introduce yourself and your CM team to the community
- To present the information you have gathered about local EMNC care and needs
- To explain the reason(s) why your team would like to work with the community
- To describe the three delays and the household-to-hospital continuum of care
- To explain the community action cycle and how your team proposes to work with the community
- To invite participation by interested community members

The initial orientations are designed to raise awareness throughout the community of the EMNC needs and of the planned mobilization effort and to plant the seed for eventual individual and group participation. After these meetings, the community will at least be talking about EMNC issues, and some people will be inspired to become more involved.

## **STEP TWO: BUILD COMMUNITY SUPPORT FOR IMPROVING MATERNAL AND NEWBORN HEALTH**

Once there is general awareness in the community of the need to improve maternal and neonatal health and of the mobilization plan, it is important to allow some time for the community to embrace the need and assume responsibility for addressing it. *Remember: You cannot mobilize the community to improve EMNC, but you can help the community mobilize itself.* Once the CM team has done its part, by helping raise EMNC issues in the community and by offering to help the community address maternal and newborn care, the team should then concentrate its efforts on building momentum in the community. This will not only ensure wider participation in the eventual mobilization effort, it will also help ensure sustainability after various improvements are put in place.

With regard to EMNC, there are a number of things the CM team can do at this critical juncture between raising community awareness and creating community support:

- Follow up with community leaders to solicit their support and to encourage them to speak out on EMNC.
- Visit health care facilities, meet with staff, discuss their needs and concerns vis-à-vis your plans, and solicit their input.
- Meet with community-based EMNC providers to discuss their needs and concerns (such as questions about integrating CM activities into what they're already doing, the role such providers may play in the CM effort, and any other concerns about the impact of CM activities on their work).
- Reach out to (attend the meetings of) various community groups (women's groups, church or other faith-based groups, service organizations) to answer questions and solicit input about your proposed initiative.
- Meet with pregnant women, recent mothers and family members, including husbands (at their homes or at meetings set up for this purpose).
- Meet with traditional midwives/birth attendants and traditional healers.
- Meet with organizations already working on EMNC in the community, solicit their input and identify their concerns.

- Sponsor or support additional awareness-raising events in the community, especially around birth preparedness and complication readiness, the three delays, and the household-to-hospital continuum of care (for example, at a health fair, street theatre, school plays or church events).
- Encourage local media to publicize EMNC issues.
- Identify potential Core Team members (see Step 3 below) and encourage them to become more involved.
- Advocate at higher levels and with donors for more support for community-based EMNC initiatives (e.g., more staff for facilities, more EMNC-friendly policies at facilities, subsidized deliveries for most vulnerable or poorest populations).

### **Nepali Women Organize to Fight Newborn Mortality**

Inspired in part by the *Warmi* project in Bolivia, the Mother and Infant Research Activities (MIRA) group sponsored an intervention in rural Nepal to determine whether village women could be organized to successfully fight neonatal mortality. A series of meetings were held “with members of the Makwanpur District Development Committee, the Chief District Officer, and local stakeholders.” A baseline service audit identified weaknesses in antenatal, delivery, and newborn care.

The gist of the intervention was to identify and train a cadre of locally resident female facilitators whose job was to organize and then support women’s groups to reduce neonatal mortality. “The intervention needed a facilitator rather than a teacher, with abilities and training in participatory communication techniques. She needed to have a grasp of perinatal health issues and some knowledge of interventions so she could act as a broker of information and a catalyst for change.

“The first step of the intervention was to discuss issues around childbirth and care behaviors in the community, which allowed facilitators to develop participatory learning skills and generated information on pregnancy and childbirth, covering beliefs and practices in both uncomplicated and complicated pregnancies. The facilitators then supported the women’s groups through monthly meetings” for a year.

In the next phase the groups implemented and assessed their own strategies. “Some typical strategies were community-generated funds for maternal and infant care, stretcher schemes, production and distribution of clean delivery kits, home visits by group members to newly pregnant mothers, and awareness raising with a locally made film to create a forum for discussion.”

Indicator outcomes showed that “women in the [intervention areas] were more likely to have had antenatal care [than those in control areas], to have given birth in a health facility with a trained attendant or government health worker, to have used a clean home delivery kit or a boiled blade to cut the umbilical cord, and for the birth attendant to have washed her hands.”

At the end of the project, neonatal mortality in the intervention areas had been cut by 30 percent, and “maternal mortality, although not a primary outcome of the trial, was also significantly lower in interventions areas.”

Manandhar et al. 2004

It is not possible to specify how long it will take to build support for improving EMNC or all the forms that support will take, but it is important to give the community time to get comfortable with the idea of taking action on its own in this area. It is highly unlikely that at your orientation meetings you have told the community anything it does not already know about local EMNC issues. But what you **have** done is to make the community aware of the fact that there is a group of people who want to work with them on these issues; all that is needed now is for the community to decide that it is **interested in and capable of** taking on this challenge.

And this is what must happen during this crucial period after you have oriented the community to your team and announced your willingness to work with them. Through increased awareness, the community comes to the realization that it can take effective action on EMNC, that it is ready to do so at this time and that it already has a great deal of capacity in this area. This realization will occur to some people before it occurs to others—and will not occur at all to still others. But it is not necessary for everyone in the community to be convinced about the possibility of doing something about the problem; there just needs to be a critical mass of people whom you can depend on to support the initiative, directly or indirectly, until the results of the effort begin to speak for themselves.

Waiting for the community to get on the CM bandwagon can be very frustrating, but it is important not to rush this process however tempted you may be. If you try to begin the CM effort before there is any real momentum in the community—if you get ahead of where the community is—then you may end up with the community assisting you with your project rather than you helping them with theirs.

### **STEP THREE: SELECT A CORE TEAM AND DECIDE ROLES AND RESPONSIBILITIES**

As the community inches closer to taking ownership for improving EMNC, it will be time for the CM team to assemble what this guide calls the “Core Team.” The Core Team is a group of community members who will take primary responsibility for designing and implementing the community action plan (the heart of the mobilization initiative), with the guidance and support of the CM team and with the active participation of various groups and individuals from the community.

All Core Team members, regardless of their other qualifications, should meet two key criteria:

- The person has expressed an interest in working on the CM initiative.
- The person has time to devote to working on the CM initiative.

Beyond that, you should look for team members who come from a cross-section of populations and interest groups in the community, including:

- Women
- Men
- Different generations
- Someone from the group(s) most affected by EMNC issues
- Community-based health care providers
- Facility-based health care providers
- Community leaders

Finally, in terms of characteristics and skills, look for people with a good reputation in the community and, as far as possible, those who have:

- Good communication and listening skills
- Knowledge of/experience with community mobilization
- Knowledge of EMNC
- A good reputation in the community
- Good facilitation skills

#### **Keeping Track of the Teams**

Hereafter, this manual will refer to two teams: the CM team, which is the original advisory/support group that initiated and will continue to guide the mobilization effort; and the Core Team (always with initial capital letters), which is the group of committed individuals from the community who will be responsible for designing the actual mobilization plan and, with other community members, carrying out all the associated activities.

### **Reaching out to Those Most Affected**

It should be noted that getting the participation of those most affected is not always easy. They may be members of marginalized groups; they may not have time for “volunteer” work; they may believe they have nothing to offer; or they are not reached through the regular channels by which people learn about the CM effort. For these reasons, the CM team may have to be very proactive in finding and involving such people. Here are a few questions to ask in thinking about how to reach such people:

- What services in the community do these people already avail themselves of (such as a health post or a clinic or something unrelated to health, such as a credit bureau)? Can they be reached through those services?
- What groups in the community do such people belong to? Church groups? Women’s groups? Can they be reached through these groups?
- Who in the community is in contact with such people? CHWs? TBAs? Religious leaders? Can they be reached through these people?
- Is any other group, such as NGOs, already working with marginalized people? Can they be reached through the NGO?
- For people living in rural areas, when do they come into the community? To do what? Can they be reached on these occasions?
- What adjustments could the team make to make it easier for such people to become more involved? (meeting times, meeting place, timing of activities, etc.)

### **Roles and Responsibilities**

After you have assembled your Core Team, you should work with them to decide the roles and responsibilities for each team member, including who will be the team leader. The roles and responsibilities will probably have to change somewhat as you move through the community action cycle, the process the team will be following as they mobilize the community, because each phase of the cycle involves a different set of tasks. So the best way to approach this issue is to have the team review roles and responsibilities at the start of each phase of the cycle, looking at the roles needed for that phase and deciding who the best person would be for each role. As you go through this process, you may also decide that you need to add new people to the Core Team at different phases (or seek the expertise from an outside consultant).

#### **A Good Leader...**

- Is a good facilitator
- Has time to devote to the issue
- Is committed to the issue
- Is dynamic but not bossy
- Can admit and learn from mistakes
- Can bring out the best in team members
- Is able to “lead from behind”
- Is visionary
- Takes calculated risks
- Is diplomatic

Adapted from CEDPA 2000

**See Tool #4: “Assigning Roles and Responsibilities of Core Team Members” for guidance.**

## EXPLORE THE HEALTH ISSUES AND SET PRIORITIES

The process of gathering information...should be conducted in partnership with the different actors and stakeholders and, in particular, with community representatives....

*Working with Individuals, Families and Communities  
to Improve Maternal and Newborn Health,  
Making Pregnancy Safer Initiative/WHO 2003*

Step 1. Explore EMNC issues with the community and gather information

Step 2. Analyze the information and choose priorities

Now that you have helped develop a certain amount of community support for and commitment to working on EMNC, it is time to work with the Core Team to explore in depth the issues in the community, gathering the information needed to design the community action plan (described in the next chapter) and choose a priority health need (or needs). In addition to providing important information to the Core Team, exploring EMNC issues in a participatory way with the wider community also has a number of other benefits:

- It keeps the conversation about EMNC alive and builds additional awareness and support.
- It brings more of the community into the mobilization effort and develops community capacity in the area of information gathering.
- It provides crucial information on EMNC care that can be used to establish a baseline for eventual monitoring and evaluation.
- It may encourage community- and facility-based EMNC providers to think more strategically about how to address EMNC needs.
- It develops the Core Team as they work together in their first major joint undertaking.
- It builds interest in and momentum for the community action plan.

### Birth Narratives

The [team conducted] interviews to gather narratives [about birth complications]. This involved talking with all the people who had participated in making decisions for a woman who had experienced life-threatening obstetric complications, including the women themselves, other family members, community and religious leaders, TBAs, and skilled providers. In many emergency cases the narratives revealed that women spent considerable time going to traditional healers and following other cultural and religious practices before seeking medical treatment.

CHANGE 2005

### STEP ONE: EXPLORE THE EMNC ISSUE WITH THE COMMUNITY AND GATHER INFORMATION

Facilitators should take note that the CM team has already gathered some information about the community and EMNC issues back in Chapter 2, Step 4, but this was done by your team, not the Core Team, and it involved minimal contact with the community. The purpose of this earlier effort was to collect enough information to: 1) be able to design the community mobilization plan (for the CM team); and 2) be able to raise awareness in the community (through community meetings) about EMNC issues and the need to address them.

The exploration and information gathering envisioned in this step will be much more in depth, systematic and participatory. The overall goals, as noted above, are to provide the Core Team and the CM team with a complete understanding of the state of EMNC care in the community, enable the teams to choose one or more priority EMNC needs, give the teams the information needed to design an effective intervention and provide baseline data to monitor and evaluate results.

### **Key Topics**

In this exploration/information gathering step, the Core Team will be trying to answer some or all of the following questions about the current state of prenatal, labor and delivery, and postnatal care for mothers and newborns:

- What is the degree of maternal and neonatal morbidity and mortality in the community?
- What are the primary causes (social and medical) of maternal and neonatal morbidity and mortality in the community?
- What kinds of EMNC care are currently available in the community?
- What groups, organizations, facilities and individuals are currently offering this care? Who provides the care?
- Who decides if a woman or newborn can seek care (husband, mother-in-law, grandmother)?
- What kinds of care are **not** available?
- What are the main reasons women and newborns do not receive the care they need (financial, lack of transport, lack of caregivers, mother not empowered to make decisions)?
- What are prevailing beliefs and attitudes associated with prenatal, labor/delivery, and postnatal care for women and newborns?
- What are the common household practices associated with prenatal, labor, and postnatal care for women and newborns?
- What are the practices of positive deviants?
- What financial aid and human resources exist in the community to improve EMNC?
- What are the biggest obstacles in the community to improving EMNC?
- What has been done in the community in the past five years, 10 years to improve EMNC?
- What are the relevant policies, regulations or laws—local, national or facility-specific—that affect EMNC?

#### **Sources of Existing Information on the Three Delays**

- Peripheral health facility patient/coverage records
- Hospital patient/coverage records
- Facility and hospital client surveys
- Demographic and health surveys
- PVO/NGO and donor data
- National monitoring and evaluation surveys/reports
- Qualitative and quantitative research studies

Information on these topics can be gathered in three main ways: 1) from existing documents (see box); 2) by conducting interviews and/or focus groups in the community; and 3) through various “participatory research” activities (see below). Collecting data from existing documents is relatively straightforward and does not usually require a great deal of preparation, although you will have to locate the various documents and may have to comb through considerable data to find the information that is relevant to EMNC.

## Conducting Interviews

Conducting interviews and focus groups, on the other hand, which is especially important for the community mobilization approach, takes considerable preparation. Your main task here will be to design interview/focus group questionnaires on EMNC for the various people you will be interviewing. At a minimum, you will probably need to interview representatives from the following groups:

- Women and family members of the most affected group(s), including husbands, mothers-in-law, and grandmothers
- Community-based EMNC providers
- Facility-based EMNC providers
- Other health providers
- NGO/PVO staff working in EMNC
- Religious leaders
- Community leaders
- MOH/government officials

You do not have to ask all of these groups about all of the topics listed above, but you should get input on the health issue from a variety of sources. For details, see Tool #5: “Designing Questionnaires for Interviewing the Community.”

In many ways the most important group you will need to interview is women and family members. These are the clients or customers of maternal and newborn care, the people on whose behalf the community is being mobilized, so you should give a lot of thought and care to what questions you want to ask them. Any mobilization effort that does not seek out the views of this group and take their experiences into account will be successful only by accident.

At the same time, interviewers should realize that many of the topics they are inquiring about are quite personal and sensitive; these are not issues that many people are comfortable talking about, even to other family members, let alone to people they don’t know. You should try to allow for as much privacy as possible, separate women from men, husbands from wives, daughters-in-law from mothers-in-law, etc.

Below you will find three lists (organized around the three delays) you can use in designing your own questionnaire for gathering information from this important group. These lists have some general

### Maria’s Story

The child was born normally but half an hour later the placenta had not come out and there was heavy bleeding. The TBA Ana said they would have to take Maria to the hospital, but Maria’s mother-in-law disagreed; she said the TBA could get the placenta to come out, that it wasn’t “good to move a woman when the child has just been born,” that “you only go to the hospital to die,” and “if it’s someone’s time to die, it’s a sin to go against their fate.” But Maria’s brothers persuaded their mother to let the family take Maria to the hospital, and Maria’s husband, who trusted the midwife, agreed.

The first doctor who came to see Maria was very rude. “You have the strength and yet do nothing,” he said. “You want us to operate on you so you can lie in bed for several days. That’s how women are; they make no effort and they want you to do everything for them.”

“[But] the placenta was not coming out,” Maria said, “and I had no more strength.” Then a second doctor came and was very kind. “My pretty daughter,” he said. “I know you’re very tired. But you still have a little bit of strength left. The operation is very difficult and it’s hard for the wound to heal afterwards. It’s better if we try a little bit longer to get the placenta to come out by itself.” The doctor massaged Maria’s belly and told her when to push while he pulled on the cord, and little by little the placenta came out.

At 6:00 a.m. they told Maria to go home, because it was a holiday and they had no place for her to stay. As she was leaving the hospital, she fainted and had to be given an IV. The midwife, Ana, complained about the poor care, but after the IV was taken out the doctors again told Maria she had to leave, and the family had to hire a car (for \$31) to transport her home.

National Reproductive Health Program/  
Guatemala 2004

questions and some very specific ones, and there is some repetition—within and between the three lists—as certain questions inquire about the same issue from different angles.

### **Questions about Delays in Deciding to Seek Care**

1. What EMNC services are you aware of in the community?
2. Have you ever used any of these services? If not, why?
3. What services are available that you have not used? Why have you not used them?
4. What is your opinion of the quality of EMNC services—antenatal, delivery, postnatal—available in the community? Is this opinion based on your own experience or stories you have heard from other people? Please explain.
5. Have you ever had an unpleasant or negative experience in using any of these services?
6. Have you ever sought antenatal, labor/deliver or postnatal care for yourself or your newborn? If not, why (for each type)? If yes, what did you think of the service you received?
7. Who decides if you seek care or take your infant for care?
8. Have you ever decided not to seek care because you could not afford it?
9. Have you ever been screened for TB, STIs, HIV or malaria? If not, why not?
10. Do you receive any care from a traditional healer? What kind of care? Are you more comfortable receiving care from this person or from a health facility? Why?
11. Do you sleep under a bed net (for malarial areas)?
12. Are you aware of the signs of complication during labor and delivery?
13. Do you/your family have a birth plan for labor and delivery?
14. Are you aware of the danger signs for newborns?
15. Do you know your due date/Did you know your last due date?
16. Was your last delivery attended by a skilled provider? What kind of provider?
17. Have you been tested for HIV/AIDS? Would you be comfortable going for such a test? Would you tell your family?
18. Can you spend money on health care without getting permission from your husband or other family members?
19. Do you have any income of your own?

#### **A Family Decision**

There are families that do want to [take women in labor to the hospital], and there are others that don't, even when the midwife insists that they take the patient to the hospital. If those involved don't want to, it doesn't happen.

Group of Women,  
Totnicapan Guatemala  
Tapia et al. 2004

### **Questions about Delays in Reaching Care**

1. How far do you live from the nearest health facility with trained providers?
2. How far do you live from the nearest hospital?
3. How long would it take you to walk to the nearest facility?
4. How long would it take you to reach this facility in a car?

5. What is the condition of the roads between your home and the nearest facility? Would a vehicle be able to move quickly along these roads?
6. In an emergency, is there any local transportation (car, motorcycle, bus) you could take to get to this facility quickly?
7. How much does this transportation cost?
8. Can you afford this transportation?
9. Is there a trained health care provider who could accompany you to the nearest health facility in case of an emergency?
10. Have you ever experienced a delay in reaching care for a maternal or neonatal health problem/emergency? For each episode, what was the cause of the delay?
11. Do you know other people who have experienced a delay? What was the cause?

#### **The Pure Grace of God**

They came to look for me since I have a car. The husband came to tell us, but only when his wife was at the point of death. And he said: "Do me a favor; take my wife to the hospital." We left at 11 at night and arrived at one in the morning. And the doctor said: "It is by the pure grace of God that your wife did not die. Why did you wait until now to bring her in?"

Group of Midwives,  
Quiche, Guatemala  
Tapia et al. 2004

#### **Questions about Delays in Receiving Care**

1. Have you ever been denied or unable to receive the kind of care you needed at a health facility? What was the reason?
2. Has anyone you know ever been denied or was unable to receive the kind of care she needed at a health facility? Why?
3. Have you ever had an unpleasant or negative experience with health care providers at a health facility? Please explain.
4. Has anyone you know ever had an unpleasant or negative experience with health care providers at a health facility? Please explain.
5. How long do you have to wait for care when you arrive at the health facility?
6. Do you believe this health facility has enough staff? If not, why?
7. Have you ever been unable to receive the medicine/drugs/blood transfusion you needed at the health facility?
8. Have you or anyone you know ever not received care at the health facility because of a lack of certain equipment? Which equipment?
9. Do you feel the staff at this facility are well trained? If not, why?
10. In general do you feel comfortable using this health facility? If not, why?
11. Does the health facility you go to have a referral system if they cannot treat you/your newborn for your problem? Is there transportation available to get to this facility?
12. Did you ever decide not to go to a referral facility after you were referred there? Why?
13. Can you/your family generally afford the care provided at the health facility?

**Tool #6: "Questionnaire for Interviewing Women" is an example of a questionnaire.**

After you and the Core Team have developed questionnaires for the various interest groups you will be interviewing, you will need to design some kind of mechanism for recording the answers. Whatever mechanism you decide on, it should be easy to use during the interview or focus group, and it should also be easy to use later when you want to aggregate and analyze the information.

**See Tool #7: “Form for Recording Interview Responses.”**

### **Participatory Research**

In addition to conducting focus groups and interviews, other effective ways to explore the health issue and gather information come under the category of participatory research. As the name suggests, this kind of research requires the active participation and involvement of the “subjects,” the people with whom you are exploring the health issues and whose views and practices you are trying to learn more about. In conventional research, the agenda is driven by the researchers, who select the topics and devise the questions, and the relatively passive subjects merely respond. In participatory research, the agenda is driven more by the subjects.

**See Tool #8: “How To Conduct Video Discussion Group,” Tool #9: “The Problem Tree,” and Tool #10: “Community Mapping” for examples of participatory research activities.**

### **Aggregating the Information**

After you have collected information about EMNC in the community—from documents, interviews and participatory research—and before you begin to analyze it, you and the Core Team have to organize all of the information you collected into a form that will permit easy analysis. You will need to aggregate or group together the responses from the various interview questionnaires and participatory activities, separating the responses out by topic or question in such a way that you will be able to identify the most common or frequent responses. This will give you a picture of how the various groups in the community perceive the current state of EMNC and help you identify priority needs.

**See Tool #11: “Aggregating Information about the Health Issue.”**

## **STEP TWO: ANALYZE THE INFORMATION AND SET PRIORITIES**

This is a crucial moment in the mobilization process, for it is at this point that the CM team and the Core Team will decide what they are going to do to improve EMNC in the community. Or, ideally, it is the point where the two teams will meet with interested community members, report to them on what has been learned, and jointly make this key decision. And if the previous step has been done properly, you should now have in front of you all the information you and the community need to do this. That is, you should have information that tells you what the most common EMNC needs are in the community, and all you have to do now is decide which of those needs are priorities.

### **Criteria for Choosing an Issue**

- Does it affect a large number of people?
- Do your data show that addressing this issue will result in real improvements in people’s lives?
- Does the issue have a clear individual or institutional target?
- Does the issue address an historic imbalance or injustice in society?
- Is addressing this issue feasible in the current context?
- Is addressing this issue consistent with your organization’s values/mission?

Adapted from CEDPA 2000

In identifying priorities from among the list of most common needs, you will require some selection criteria. Some of the most common criteria for selecting a health need are:

- Severity of the problem. How severe are the consequences of this condition or problem?
- Current frequency. How common or widespread is this problem at the present time?
- Future frequency. Is this problem likely to become even more widespread in the future?
- Impact on the community. What are the effects of this problem on the community?
- Community capacity. Is it realistic for the community to try to address this problem at this time? Is there a reasonable chance the community could be successful in addressing this problem?

Once all those involved in this decision-making process have agreed on the criteria and weighed the various needs against the criteria, one or more priorities should begin to emerge. The CM team and the Core Team members should work hard to make sure this process is as participatory as possible; it may require more than one meeting (or meetings in more than one location) to make sure all interested and affected parties can have their input and/or to allow time for a consensus to emerge. If there is not community buy-in to this crucial decision, then there may be limited support for the initiative going forward and problems with sustaining the effort over the long term.

You have, incidentally, collected much more information than you need in order to select a priority EMNC issue. While that information has not been needed to complete this phase of the community action cycle, it will be very important in the three remaining phases.

## PLAN TOGETHER

Our most urgent need is not for a master plan for all communities but for plans that are based on the views and needs of the people, developed with the people, and subject to modification by the people.

Patrick Boyle in *How to Mobilize Communities for Health and Social Change*, Howard-Grabman and Snetro 2003

- Step 1. Select the planning team
- Step 2. Design the planning session
- Step 3. Conduct the planning session and design the Community Action Plan
- Step 4. Share the plan with the community at large, solicit feedback and make changes

Now that the Core Team has selected an EMNC issue, it is time to design the actual intervention that will address the health issue. The details of this intervention will be decided on during this phase of the community action cycle and spelled out in the core document known as the Community Action Plan. This action plan should specify the following six things:

1. The goals of the intervention
2. The activities necessary to achieve the goals
3. Who will be responsible for carrying out the activities
4. The resources needed to carry out the activities and how they will be obtained
5. A timeline for implementing the activities
6. A plan to monitor and evaluate the results of the intervention

As the Core Team (with the advice and support of the CM team) enters into this design phase of the action cycle, now is the time for CM team members to step back and begin transferring more responsibility and decision-making—hence more ownership—for the action plan to the Core Team. While it is obvious that the CM team cannot and should not carry out the action plan, that they will clearly need to let go during the **next** phase of the action cycle (Chapter 6: Act Together), this process of letting go should actually begin here in the planning phase.

This is not to say that the CM team's work is now finished, but only that what has been essentially a relationship of co-equals now becomes one wherein the CM team supports the efforts of the Core Team. As CM team members go through the following steps then, they should be careful to begin acting more as advisors and less as decision-makers. They should be more reactive than proactive, waiting to be approached for advice rather than just offering it, turning questions from the planning team back on the questioners. They also have to be willing to let the Core Team make mistakes and learn from trial and error. If they think something the Core Team proposes will not work or is not a good idea, they might want to confine themselves to asking questions rather than giving their own opinions.

## STEP ONE: SELECT THE PLANNING TEAM

The first step in this planning process is to determine who should make up the planning team. Typically this would include some or all of the CM team and all of the Core Team. But now that you have selected the health issue, you may also want to consider adding members to either of these teams and/or to this planning group; in particular, you may want to consider adding members of any constituency whose support or cooperation—whose buy-in—it is now apparent will be crucial to the success of your intervention.

You may not have had any TBAs involved in your effort up to this point, for example, but now that you have identified increasing skilled attendance at birth as a priority need, you will certainly want to have TBAs involved in this planning phase. If you know of people in the community with project planning experience, you might also want to invite them to be on the team. Finally, if you do not have any members of the group most affected by the health issue on the CM or Core Team, you might invite one or more of these individuals to be part of the planning process. Remember here that people who may not have previously been available to serve on the Core Team, because it was a long-term commitment, might be available to take part in the planning sessions.

## STEP TWO: DESIGN THE PLANNING SESSION

This planning session, which in reality is more likely to be a series of sessions, is a pivotal moment in the life of the CM initiative. While the plan that emerges at the end of this session can—and almost certainly will—be altered from time to time, it is important to design as sound a plan as possible from the beginning. If the plan stumbles in its early activities, then the Core Team or community members can become discouraged, partners may become alienated and support may wither. The plan does not have to be perfect—and you should stress this during the planning sessions—but neither is it a good idea to rush the planning process.

### Health Committees in Guatemala

The first community mobilization activity was to introduce the idea of a community emergency plan to health care providers—at the health facility in the district center, at the Technical Center for Rural Health, and to the auxiliary nurse at the local health post in Las Canoas. The next step was to form a local health committee through holding a community assembly where local leaders explained the process and the objectives and shared statistics on maternal death. In later meetings the maternal and neonatal needs were analyzed in more detail and solutions were discussed.

Based on this the health committee (including a TBA and other leaders) designed a community emergency plan, taking into account the local transportation options, economic resources, and existing prenatal and delivery care arrangements at the health post. A central component of the plan was the training of TBAs (by the health center nurse) as key liaisons between pregnant women and the health system. Participating TBAs agreed to prepare a list of pregnant women under their care so that a health committee member could visit these women, explain about the importance of prenatal care, describe danger signs, and explain about the emergency plan.

Further community assemblies were held from time to time to acquaint newly recruited members of the health committee about the initiative. The link between the local health post providers and the committee was also stressed, as committee members urged local women to visit the health post. One problem that emerged was that the health post was not always open during its “hours of operation.”

The community mobilization/health committee approach was supported by those responsible for health promotion in rural areas, and they advocated for it at higher levels. [For lessons learned from the Guatemala program, see box on page 46.]

National Reproductive Health Program/  
Guatemala 2004

In order to design the planning session, you will need to know what is going to take place during this event. Generally a session for designing a community action plan consists of the following steps:

1. Introductions of team members
2. Review of the community action cycle
3. Overview of this planning process and the elements of a community action plan
4. General discussion of the EMNC issue and presentation of relevant data and interview findings
5. Identification of the goals of the intervention/action plan
6. Identification of specific strategies for reaching the goals
7. Decision about what activities will need to be carried out to achieve the goals
8. For each activity, specifying:
  - Resources needed and how they will be obtained
  - Person responsible for overseeing/implementing the activity
  - Timeline for when the activity will be carried out
  - Indicators to monitor and measure results
9. Development of an M&E plan (this can also be done at the beginning of the “Evaluate Together” phase in Chapter 7)
10. Creation of a draft copy of the action plan
11. Decision about how the group will coordinate its activities once the plan is set in motion
12. Decision about any other next steps

Whoever is responsible for planning this session must take care of all logistics, provide all necessary materials, and either chair the meeting or select and notify the chairperson.

### **STEP THREE: CONDUCT THE PLANNING SESSION AND DESIGN THE COMMUNITY ACTION PLAN**

This is the moment that everything you have done so far has been leading up to. After completing Steps 1–4 above, which should be relatively straightforward (since the group is in familiar territory), you will arrive at the heart of this planning phase: Steps 5, 6, 7 and 8. This is where the team will actually design the intervention and specify the means by which it will achieve the intended result.

The specifics of every community action plan are different, depending on the health issue(s) that have been chosen and on local circumstances. So it is not possible to provide in-depth guidance to facilitators at this point. At the same time, in order to make this guide as useful as possible and to provide a model for program planners, we have selected three common maternal and neonatal health issues—one each for the antenatal, labor and delivery, and postnatal periods—and presented a sample community action plan. The three EMNC issues we have chosen are:

1. Improving ANC skills of community-based EMNC providers
2. Developing a birth preparedness and complication readiness plan
3. Improving home-based postpartum care of newborns

For each of these issues, we will specify the overall goal and then list the typical activities that would be involved to achieve this goal. For each activity, a Core Team would need to decide what resources would be needed and where they would be obtained, who would be responsible for carrying out the activity, and the timetable. When your planning team designs its own action plan, it may want to use a matrix like this:

Activity and/or Strategy	Resources Needed and How Obtained	Person(s) Responsible	Timetable

**Sample Action Plan I: Improving Antenatal Care Skills of Community-based EMNC Providers**

In many communities and for many families, the primary—and in some cases the **only**—health care provider for pregnant women is a local community or village health worker. The care and support this person can provide is only as good as her/his experience and training. In some cases, CHWs have little or no formal training, and in others they have limited training in certain areas. Accordingly, many communities need to improve the ANC offered by local providers.

Goal: To improve the skills of CHWs to provide antenatal care to pregnant women. (The goal could also be more limited, identifying specific types of ANC.)

Activities: A community action plan to upgrade local provider skills would normally include the following activities; many of these activities have sub-steps for which you will need to specify resources, persons responsible and a timetable.

1. Meet with stakeholders to discuss details of the action plan, solicit their input and make any needed changes.
2. Identify individuals (CHWs, etc.) to be trained and/or mentored.
3. Design a plan to assess skill needs of CHWs.
4. Develop interview/focus group questionnaire.
5. Interview CHWs to determine level of skills and skill gaps.
6. Interview women, family members and other health care providers to determine CHW skills and skill gaps.
7. Aggregate information and identify skills that need to be improved.
8. For each skill, design a training and/or mentoring plan.
9. For each skill, identify a trainer and/or mentor to work with CHWs.
10. For each training event, organize a location and all logistics.
11. Oversee/facilitate the training event(s).
12. For mentoring activities, pair each CHW with a mentor and design a schedule.
13. Monitor the mentoring process on a regular basis.
14. Design a plan to monitor the results of training/mentoring activities.
15. Design a questionnaire or skills checklist to use with CHWs, trainers, mentors and women/family members to determine results of training.
16. Survey all parties using the questionnaire.
17. Review survey results and adjust training and mentoring activities as necessary.

**Tool #12: “Skills Required for Skilled Attendants” and Tool #13: “Maternal Danger Signs” may be useful in the context of this plan and this topic in general.**

## ***Sample Action Plan II: Developing a Birth Preparedness and Complication Readiness Plan***

One of the most common causes of maternal and neonatal morbidity and mortality is lack of preparation for an emergency during or immediately after labor and delivery. Accordingly, one of the most pressing EMNC issues in many communities is to help women and families develop an emergency birth plan. If a community chooses to mobilize around this issue, its emergency action plan should probably contain the following elements:

**Goal:** To increase the number of families who have developed an emergency birth plan.

**Activities:** Your community action plan would normally have the following general activities; some of these activities will have sub-steps for which you will need to specify resources needed, persons responsible and timetable.

1. Meet with stakeholders to review the action plan, solicit input and make necessary changes.
2. Design interview and/or focus group questionnaire to determine current household beliefs/practices about birth planning.
3. Conduct interviews/focus groups with key groups: women/family members, TBAs, CHWs, facility-based health providers, etc.
4. With stakeholders (as appropriate), review interview data and identify key elements needed in an ideal birth preparation/complication readiness (BP/CR) plan for this community. These usually include:
  - Pregnancy identification
  - Knowledge of due date
  - Location chosen for the delivery
  - Arrangements for a skilled birth attendant
  - Way to contact skilled provider and health facility
  - Supplies needed for clean delivery
  - Supplies needed in immediate postpartum period for mother and newborn
  - Awareness of emergency signs for mother
  - Designated person to make decisions for the mother
  - Name/location of nearest facility offering essential obstetric care (EOC)
  - Emergency transportation
  - Blood donors
  - Awareness of newborn danger signs
5. Design a plan (or separate plans) to make these elements available to mothers and/or family members in the community. For each item on the list, the planning team should specify the actions that will be needed to provide mothers and family members with that item, which will either be:
  - Information (due date, way to contact provider and facility, location of nearest EOC, awareness of emergency signs for mother and danger signs for newborns),
  - Supplies (for clean delivery and postpartum care), or
  - Services (skilled attendant, emergency transportation, blood).

For the actions that are needed to provide each item, the plan, as usual, should specify resources needed, persons responsible and a timetable.

6. Ensure that responsible persons implement the plan(s) for providing the various elements.

7. Design a plan for coordinating the various activities and for monitoring whether or not they are being carried out.
8. Conduct the monitoring activities according to the plan.
9. Develop a follow-up scheme for visiting households and determining whether they have a complete BP/CR plan. If they do not, identify the reasons they do not have a complete plan and adjust your action plan accordingly.

Instead of undertaking to provide for all the elements of a complete BP/CR plan, the Core Team may decide (or may need) to provide only for certain elements and not others, such as an emergency transportation system or a system of blood donors.

**See Tool #14: “The Birth Plan and Complication Readiness Matrix,” Tool # 15: “Questions for Learning about Local BP/CR Practices,” and Tool #16: “Birth Preparedness Card” for more information about this topic.**

### ***Sample Action Plan III: Improving Home-based Postpartum Care of Newborns***

It is well known that the newborn period—the first 28 days after birth—is the most dangerous period for infants, so many communities may want to address this issue in their action plan.

**Goal:** To improve the quality of care given to newborns by mothers and family members in the home.

**Activities:** A typical action plan for this health need would normally have the following general activities.

1. Review the action plan with stakeholders for their input and make changes as necessary.
2. Identify target population(s) for the mobilization effort. This would normally be mothers and family members but could also include primary health providers.
3. For the target population(s), design a needs assessment questionnaire to determine present knowledge of good postpartum care and to identify current postpartum care practices. This questionnaire would cover such topics as:
  - Cord care
  - Household hygiene
  - Knowledge of newborn danger signs
  - Current practices associated with common newborn health problems
  - Plan for newborn emergency
  - Breastfeeding practices
  - Knowledge of Kangaroo Mother Care/baby warming
4. Conduct interviews/focus groups with the target population using the questionnaire.
5. Analyze the interview data and determine newborn care priorities.
6. For each priority, develop an action plan to address this problem. If a common problem is feeding difficulties, for example, the action plan might consist of:
  - Develop/locate materials on newborn feeding practices.
  - Identify providers (e.g., CHWs, facility-based staff) to provide counseling in newborn feeding practices.
  - Train providers as necessary.
  - Plan home-, facility-, and community-based counseling sessions.

7. Or the action plan could take a mass-media approach and might proceed as follows:

- Determine key messages about newborn feeding.
- Prepare sample education material: flyers, posters, banners, health cards, visual aids for presentations, radio and TV spots.
- Pretest and refine messages/materials.
- Organize and conduct education/awareness raising activities

8. For each activity in the action plan, specify the sub-steps, resources needed, persons responsible, and a timetable.

9. Design a plan to monitor activities.

10. Carry out the monitoring plan.

#### The Best Messages

- Attract immediate attention (so be daring, original)
- Stir the emotions
- Are very simple
- Communicate a benefit
- Create trust
- Encourage a specific action
- Need to be repeated

Adapted from CEDPA 2000

**See Tool# 17: “Newborn Danger Signs” for useful information.**

#### **STEP FOUR: SHARE THE PLAN WITH THE COMMUNITY AT LARGE, SOLICIT FEEDBACK AND MAKE CHANGES**

After the team has finished designing its action plan, which may take several meetings, it should show the plan to the wider community for feedback. In the end, many of the activities proposed in a typical community action plan will require the cooperation or even the active participation of many members of the community. So it is important at this stage, when the specifics of the plan have been worked out, to solicit the buy-in of as many stakeholders, groups and individuals as possible.

The CM team and the Core Team should be prepared to receive conflicting feedback at this stage and to have to reconcile conflicting agendas; this is all part of the sometimes messy process of getting participation. Once the teams have gotten the feedback, then they should fine-tune adjust the plan as necessary.

## ACT TOGETHER

Community ownership over the strategies is fostered by engaging those most affected to plan and carry out appropriate health actions.

*Household-to Hospital Continuum of Maternal and Newborn Care, ACCESS 2005*

Step 1: Redefine the roles and responsibilities of the CM team and the Core Team

Step 2: Support the implementation of the community action plan

We noted earlier that during the design/planning phase, the CM team should begin the process of letting go and turning over increasing responsibility for the action plan to the Core Team. This transition will be greatly accelerated during this “act together” phase, and this shift in roles and responsibilities is in fact something the two groups need to examine deliberately as this phase begins.

### STEP 1: REDEFINE THE ROLES AND RESPONSIBILITIES OF THE CM TEAM AND THE CORE TEAM

It is not always easy for the CM team to fade into the background. It was this team, after all, that provided the initial impetus and leadership of this undertaking and who are in large part responsible for its success up to this point. But if the mobilization initiative is to achieve its key goal—developing community capacity—and if its accomplishments are to be truly sustainable, then increasingly the initiative has to become the responsibility of the Core Team.

But any shift of this magnitude must be gradual, not abrupt. At the beginning of this act together phase, it is likely the Core Team has not yet worked together extensively, except to create the action plan, and may not even have become a real team yet. This is particularly true if the team recently added any new members in light of the health issue it has chosen and the action plan it has developed. For this reason, the CM team may have to be more active and provide more guidance in the early stages of rolling out the action plan. Even so, they should continually be on the lookout for opportunities to hand various tasks over to the Core Team and others, to work *with* Core Team members on certain tasks rather than continuing to do those things *for* them.

Here are five important questions the CM team might want to discuss and answer in this context:

- What are some of the things CM team members have done (out of necessity) that have made the Core Team/other members of the community come to need and depend on them? What happens if the CM team stops doing these things?
- How does the CM team now encourage independence in people who have come to depend and rely on it?
- What are some of the **less** important/less critical things the CM team has done in the past that could now be turned over to the Core Team/others (tasks they stand a good chance of succeeding at and which would therefore give them confidence in themselves)?
- What are some **medium difficulty**/somewhat sophisticated tasks the CM team could start grooming the Core Team to get ready for?

- What are the **most difficult**, complex tasks that would eventually need to be taken over by the community? What can the CM team start doing now to prepare for the day when the Core Team takes over these responsibilities?

The shift in roles and responsibilities will evolve naturally in some respects, but it is also important to be systematic about the process, to discuss it and plan for it. In this regard, a useful activity at this point is for CM and Core Team members to sit down together with the action plan and discuss the role each team should play in carrying out the various activities and sub-steps. In this discussion, both groups should keep in mind that increasingly the role of the CM team should be to support activities and the role of the Core Team is to conceive, design and carry them out.

## **STEP TWO: SUPPORT THE IMPLEMENTATION OF THE COMMUNITY ACTION PLAN**

Once the two teams have had the discussions and made the decisions described immediately above, they only need to be true to the agreements they have made. For their part, the members of the CM team need to resist the instinct to do things for the Core Team (especially when they think they know a better way, when the Core Team is struggling, or when the CM and/or Core Team feels pressured by time), and the Core Team needs to resist the temptation to rely too much on the CM team for support.

In addition to any specific tasks or activities decided under Step 2 above, the members of the CM team can provide general support to the action plan in the following ways:

- Locating resources with the Core Team for various activities
- Providing (or finding) technical advice as needed
- Advocating with contacts outside the community (or with the community) for support for the action plan
- Mentoring/coaching Core Team leaders and team members
- Identifying skill gaps/training needs for Core Team members and locating resources to address these needs
- Monitoring the implementation of various activities
- Mediating conflicts (among team members or between the Core Team and the community)
- Staying in touch with stakeholders
- Providing administrative backup

## EVALUATE TOGETHER

Participatory approaches at the community and district levels in monitoring and evaluation should extend from design to data gathering to analysis and sharing of results. Evaluation is intended to be a part of empowerment.

*Working with Individuals, Families and Communities to Improve Maternal and Newborn Health, Making Pregnancy Safer Initiative/WHO 2003*

- Step 1. Assemble a monitoring and evaluation (M&E) team
- Step 2. Select indicators
- Step 3. Design an M&E plan
- Step 4. Implement the M&E plan
- Step 5. Analyze the results and make necessary changes to the action plan

Regular M&E are essential to the success of any development project. We need to monitor and evaluate for at least three reasons:

- To determine whether activities are proceeding as planned
- To determine whether these activities are making a difference, i.e., having an impact on the health problem
- To make adjustments or changes if the activities are not producing the desired results

In some ways this may prove to be the most difficult part of the mobilization initiative, largely because while the Core Team and members of the community will be on familiar ground in carrying out many other aspects of the action plan, they are less likely to have had experience with monitoring and evaluation. Accordingly, while the CM team has retreated to a less direct and more supportive role vis-à-vis other aspects of the action plan, they may have to become more directly involved, especially in the design stages, of this phase of the initiative. At the same time, it should be remembered that developing community capacity in M&E is an underlying objective of this phase.

### Why Measure Results?

- To measure/demonstrate change in short and long term
- To discover trends and patterns
- To identify problem or areas that need more support
- To identify organizations or activities that need support
- To identify and understand successes
- To monitor progress towards goals
- To increase accountability

CEDPA 2000

### STEP ONE: ASSEMBLE A MONITORING AND EVALUATION TEAM

While members of the CM and the Core Team will be involved in M&E, it is generally a good idea to have a separate M&E team, at least for designing the evaluation plan (as opposed to actually carrying out the activities, which can and should involve the wider community). In assembling this team, you should think in terms of what background people should have to be on the team and also in terms of involving individuals or constituencies who should be but are not yet part of the initiative. At a minimum, you should try to get the following expertise on the team:

- Those most affected by the EMNC issue (the target population(s) of the intervention)
- People who have been involved in implementing the action plan

- People with previous M&E experience
- People working in EMNC programs

## STEP TWO: SELECT INDICATORS

Probably the most important step in M&E is selecting indicators. Indicators are anything you measure in order to determine whether your activities are being carried out (known as process or input indicators) and whether they are producing results (output indicators). The former, of course, are very closely tied to the activities of the community action plan, and the latter are a function of the overall goal of your plan. A third type, impact indicator, measures whether the outputs actually reduced maternal or newborn mortality.

In selecting indicators, the M&E team should keep three general criteria in mind:

- The indicators should be related to what you are trying to measure.
- To the extent possible, they should be quantifiable (although qualitative indicators are also valuable).
- They should be easy to measure.

**Tool #18: “Sample Indicators for Measuring EMNC” provides many useful examples of the most common indicators.**

### *Indicators for the Sample Action Plans*

If we return to the three action plans outlined in Chapter 5, we can offer a few examples of process and output indicators.

#### I. IMPROVING ANTENATAL CARE SKILLS OF COMMUNITY-BASED EMNC PROVIDERS

Activity	Sample Process Indicator
Interview CHWs to determine level of skills and skill gaps.	Number of CHWs interviewed Total team time spent on interviewing
Interview women, family members, other health care providers to determine CHW skills and skill gaps.	Number of women, family members, etc. interviewed Total team time spent on interviewing
Aggregate information and identify skills which need to be improved.	Number of skills identified
For each skill, design a training and/or mentoring plan. (Not realistic to develop a plan for each skill)	Number of training/mentoring plans developed Team time spent designing plans
Objective	Sample Output Indicators
To improve the skills of CHWs to provide antenatal care to pregnant women.	Number of CHWs who discussed malaria prevention (for example) in last household visit Number CHWs who encouraged women to seek TB screening during last visit Number of CHWs who could name at least four danger signs during pregnancy Number of CHWs who knew how to calculate a woman’s due date

## II. DEVELOPING A BIRTH PREPAREDNESS AND COMPLICATION READINESS PLAN

Activity	Sample Process Indicator
Meet with stakeholders to review the action plan, solicit input and make necessary changes.	Number of stakeholders visited Time spent meeting with stakeholders
Conduct interviews/focus groups with key groups: women/family members, TBAs, CHWs, facility-based health providers, etc.	Number of women, family members, etc. interviewed
Review interview data and identify key elements needed in an ideal BP/CR plan for this community.	Number of interviews reviewed Number of elements identified
Design a plan (or separate plans) to make these elements available to mothers and/or family members in the community.	Number of plans designed Time spent designing plans
Objective	Sample Output Indicators
To increase the number of families who have developed an emergency birth plan.	Number of families with an emergency birth plan Number of families aware of nearest health facility Number of families with an emergency transportation plan Number of families who have made arrangements for a skilled attendant Number of women who know their due date

## III. IMPROVING HOME-BASED POSTPARTUM NEWBORN CARE

Activity	Sample Input Indicator
Review the action plan with stakeholders for their input and make changes as necessary.	Number of stakeholders who reviewed the plan
Identify target population(s) for the mobilization effort.	List of populations identified
Conduct interviews/focus groups with target population using the questionnaire.	Number of interviews/focus groups conducted Time spent on interviews/focus groups Money spent on interviews/focus groups
Analyze the interview data and determine newborn care priorities.	Number of questionnaires analyzed Number of priorities identified
Goal	Sample Output Indicators
To improve the quality of care given to newborns by mothers and family members in the home.	Number of mothers, family member, providers who can list at least four danger signs Number home visits where provider discussed feeding practices Number of providers trained to give counseling on feeding practices

Using these activities and corresponding indicators as examples, the M&E team should brainstorm possible indicators for the various activities in their action plan. Once again, they should try to select indicators that are quantifiable and easy to measure.

In addition to these indicators, you may also want to identify and measure indicators of increased community capacity. A guide for doing this and a list of generic indicators can be found in *How to*

*Mobilize Communities for Health and Social Change*, pp. 206–208. Finally, if you also wish to measure Core Team capacity, see the tool described below.

**Tool #19: “Indicators for Measuring Core Team Capacity” gives examples of this kind of indicator.**

**STEP THREE: DESIGN A MONITORING AND EVALUATION PLAN**

Once the team has chosen indicators, it is now in a position to design an evaluation plan. A typical M&E plan consists of the following elements:

1. Process and outcome indicators
2. Baseline status or value for each indicator
3. How the indicators will be measured
4. Any resources/materials needed for measuring the indicators
5. Who will be responsible for measuring each indicator
6. How often each indicator will be measured

The baseline information describes the indicator at the start of the community mobilization initiative and allows you to measure progress at various intervals, such as after three months, after six months, after one year. Actually measuring the indicators will usually involve creating some forms that can be used for recording information.

At one or more planning meetings, the M&E team should develop a detailed plan for how items 2-6 will be accomplished. This plan should then be reviewed by the Core Team, the CM team and ideally by others in the community who are familiar with M&E. This simple matrix may help the team design its plan:

Indicator	Baseline Data	How to Measure	Resources Needed	Who Will Measure	Time Table

Team members should keep in mind that M&E are ongoing activities that should take place at regular intervals throughout the life of the CM effort. Accordingly, while they should make their plan as complete as possible, they should be careful not to make it too complex or unwieldy, as it will have to be carried out repeatedly and should not be viewed as burdensome.

**STEP FOUR: IMPLEMENT THE MONITORING AND EVALUATION PLAN**

As mentioned earlier, the M&E team need not feel responsible for actually carrying out the plan; in fact, people from the community should be enlisted in this effort in order to develop local M&E capacity. This would be a good time to involve stakeholders who have not yet shown an interest in or have not had time to participate in the effort.

The role of the CM team during the actual execution of the plan should be limited to oversight. If the plan has been well-designed, with good indicators and a detailed implementation scheme—and it is on the design that the CM team should focus its attention—then carrying out the plan should be relatively straightforward, something that can be done by people with limited experience and with only minimal instruction and supervision. This process in turn allows a much wider range of people to become involved in the evaluation, making it truly participatory.

### **STEP FIVE: ANALYZE THE RESULTS AND MAKE NECESSARY CHANGES TO THE ACTION PLAN**

The purpose of evaluation is to determine whether the plan is working—and if it is not working, to change it.

Once the evaluation data have been collected, the Core Team and the CM team need to sit down and analyze both the process indicators, to see if the planned activities are actually being carried out, and the outcome indicators, to see if the plan is having the intended effects.

If the activities are not being carried out or not being carried out as planned, the group should discover why and move to correct whatever is not working. In the latter instance, if the activity is not being carried out as planned, that may be because the original plan was not workable and has been changed as a result. In these instances, you should look at the outcome indicators to see if this change has produced results; if it has, then you do not need to take any corrective action (because it has already been taken).

If the activities are not having the intended effects, then you will need to discover why and make appropriate changes. There are many reasons why activities may not be producing certain results, and you should try to pinpoint the reason or reasons as best you can before you fix the plan. Some of these reasons are:

- There were not enough resources to carry out the activity.
- There were enough resources but they were not being used efficiently.
- The persons responsible did not have the skills to carry out the activity.
- Not enough time was allowed to carry out the activity.
- There were not enough people to successfully carry out the activity.
- Someone objected to the activity and it had to be stopped.
- The activity was poorly conceived and could not have had the intended impact.

After you collect the evaluation data and before you make changes to the plan, you should conduct a public meeting, report your findings to the community, indicate your proposed changes and solicit input.

#### **Lessons Learned In Guatemala**

An evaluation of the Guatemala Maternal and Neonatal Health Project (see box on page 15) identified several important strategies for mobilizing for EMNC:

- Provide incentives to strengthen local health committees
- Support the local committees as they go about collecting information on pregnant women and educating them about healthy childbirth
- Encourage/support the health committees, health posts, health centers, and hospitals to work together and coordinate their activities
- Advocate for hiring personnel who know the languages spoken in the communities closest to local health care sites
- Support strengthening of TBA training and integration into the health care system
- Allow TBAs to accompany women under their care at the time of delivery in a health facility, so they can offer emotional support and learn to identify emergency cases

National Reproductive Health Program/  
Guatemala 2004

You should also hold meetings with stakeholders for the same purpose and make changes to the plan only after you have obtained everyone's input.

It is important in the early stages of the plan that the community not be discouraged if the plan is not yielding immediate results. You should remind the community that some results will take a long time before they are manifest, and that most plans need to be adjusted several times before they work.

## EPILOGUE

Readers should remember that just as no two communities are alike, neither will any one community mobilization effort be just like any other. The guidance offered in this volume is necessarily general; you may not need to execute all of the steps in this guide, execute them in the order presented or even follow all the phases in the community action cycle. And you may need to carry out steps that are not mentioned here. Readers should seize upon and use what they find relevant to their situation and disregard what does not apply.

There may also be an implicit assumption in what is written here that you will be working alone as you design and execute community mobilization to improve EMNC. But in nearly every community, a number of maternal and newborn health initiatives are already under way, so you will have partners who can advise and assist you in your work. You are not starting from scratch, and you are not working in isolation.

Finally, it bears repeating that community mobilization is almost never a quick fix for any development problem. By its nature, community mobilization depends on the emergence of a critical mass of informed, committed individuals who are motivated and have the capacity to act to improve maternal and newborn health. Even where the needs are great and the solutions obvious, this dynamic cannot be forced. Community mobilization is an organic process that evolves according to its own timetable; it can be facilitated, but it cannot be imposed. As frustrating as this can be, both to outside facilitators and organizations and to members of the community itself, it is a truth that it would be unwise to ignore.

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# TOOLS FOR COMMUNITY MOBILIZATION FOR MATERNAL AND NEWBORN HEALTH

- TOOL #1—Questions for Stakeholders about the Three Delays
- TOOL #2—Assessing Assets and Barriers
- TOOL #3—Planning the Role of the CM Team
- TOOL #4—Assigning Roles and Responsibilities of Core Team Members
- TOOL #5—Designing Questionnaires for Interviewing the Community about the Health Issue
- TOOL #6—Questionnaire for Interviewing Women
- TOOL #7—Form for Recording Interview Responses
- TOOL #8—How to Conduct Video Discussion Groups
- TOOL #9—The Problem Tree
- TOOL #10—Community Mapping
- TOOL #11—Aggregating Information about the Health Issue
- TOOL #12—Skills Required for Skilled Attendants
- TOOL #13—Maternal Danger Signs (Signs of Obstetric Emergency)
- TOOL #14—The Birth Plan and Complication Readiness Matrix
- TOOL #15—Questions for Learning about Local BP/CR Practices
- TOOL #16—Birth Preparedness Card
- TOOL #17—Newborn Danger Signs
- TOOL #18—Sample Impact Indicators for Measuring ENMC
- TOOL #19—Indicators for Measuring Core Team Capacity



## **TOOL #1—QUESTIONS FOR STAKEHOLDERS ABOUT THE THREE DELAYS**

As part of an initial meeting or in one-on-one discussions with stakeholders, facilitators may want to organize the conversation in terms of the three delays. Here are some questions you can ask about each delay.

### 1. Delays in Deciding to Seek Care

Do most pregnant women/family members recognize maternal and newborn danger signs?  
Do pregnant women/family members actively seek MNH care when they need it?  
Are certain women/categories of women less likely to seek care than others? Which ones?  
Can you think of any examples of women/do you know any women who did not seek this kind of care when they needed it? Why not?  
What prevents women/family members from seeking this kind of care in your community?

### 2. Delays in Reaching Care

When women/family members seek MNH care, do they always reach it or reach it in time?  
Do you know any women who did not reach care?  
What prevents women in your community from reaching care when they decide to seek it?  
Are some women less likely to reach care than others? Which ones? Why?

### 3. Delays in Receiving Care

Do women who reach care always receive the care they are seeking?  
What kind(s) of care do women most frequently not receive?  
When women reach a care facility, what prevents them from receiving the care they have come for?  
Are certain kinds of women less likely to receive care than others? Which ones? Why?  
Do you have any stories about women who did not receive care?

## TOOL #2—ASSESSING ASSETS AND BARRIERS

At a safe motherhood workshop in Zambia, participants identified local and national assets and barriers to improving maternal health. This table could be used to stimulate a similar process with the core team as part of gathering information.

### ASSETS

National Policymakers	Health Care Providers	Health Facility	Community	Family	Individual Woman
Knowledge of govt. policies and operations	Clinical knowledge	Building	Supportive networks	Supportive of woman during pregnancy	Willpower
Links to various ministries	Willingness to improve health, help community	Providers	Local knowledge	Family knowledge	Confidence
Resources	Relationships with other providers, policymakers	Medicines	Resources	Share resources	Health
Power and influence	Influence	Links to MOH and other providers	Facilities		Knowledge of body

### BARRIERS

National Policymakers	Health Care Providers	Health Facility	Community	Family	Individual Woman
Inequitable distribution of resources	Negative attitudes due to frustrating conditions	Inadequate equipment, resources	Inadequate BP/CR knowledge	Lack of BP/CR knowledge, especially danger signs	Inadequate BP/CR knowledge
Lack of political commitment to safe motherhood	Inadequate motivation	Inadequate funding	Limited transport	Distance to clinic	Marginalized decision-making
Limited capacity to articulate and implement policies	Lack of resources	Critical shortage of providers	Inadequate skilled attendance	Poverty	Traditional norms
Inadequate communication resources	Critical shortage of staff	Lack of transport	Poverty	Gender imbalance in decision making	Low level of education for women
Lack of defined policy on SM	Gaps in skills, knowledge	Lack of inter-sector collaboration	Excessive beer drinking	Socialization during adolescence	

## TOOL #3—PLANNING THE ROLE OF THE CM TEAM

Step of the CM Process	Role(s) of the CM Team
<b>Prepare To Mobilize</b>	
Step 1. Identify stakeholders for maternal and neonatal health	
Step 2. Meet with stakeholders to discuss EMNC needs	
Step 3. Assemble a community mobilization team	
Step 4. Gather information about the community and local EMNC issues	
Step 5. Develop a community mobilization plan	
Step 6. Strengthen the capacity of the community mobilization team	
<b>Organize the Community</b>	
Step 1. Orient the community	
Step 2. Build community support for improving maternal and newborn health	
Step 3. Select a core team and decide roles and responsibilities	
<b>Explore the Health Issues and Set Priorities</b>	
Step 1. Gather information on EMNC issues with the community	
Step 2. Analyze the information and choose priorities	
<b>Plan Together</b>	
Step 1. Select the planning team	
Step 2. Design the planning session	
Step 3. Conduct the planning session and design the community action plan	
Step 4. Share the plan with the community at large, solicit feedback, and make changes	
<b>Act Together</b>	
Step 1: Redefine the roles and responsibilities of the CM team and the core team	
Step 2: Support the implementation of the community action plan	
<b>Evaluate Together</b>	
Step 1. Assemble a monitoring and evaluation team	
Step 2. Select indicators	
Step 3. Design a monitoring and evaluation plan	
Step 4. Implement the monitoring and evaluation plan	
Step 5. Analyze the results and make necessary changes to the action plan	

**TOOL #4—ASSIGNING ROLES AND RESPONSIBILITIES OF CORE TEAM MEMBERS**

Photocopy the matrix below and use it at the beginning of each stage of the community action cycle to decide who the best people are on the core team for each role.

**NAME OF STAGE** \_\_\_\_\_

<b>Major Tasks for This Stage</b>	<b>Roles Needed on the Core Team</b>	<b>Skills Needed for Each Role</b>	<b>Core Team Member with These Skills</b>

## TOOL #5—DESIGNING QUESTIONNAIRES FOR INTERVIEWING THE COMMUNITY ABOUT THE HEALTH ISSUE

For each group you decide to interview, you will probably need to design a separate questionnaire, although many of the questions may be the same on all of the questionnaires. Here is a partial list of the groups you may have to interview; delete any that are not relevant to your community and add any other groups that are important.

- Women and family members of the most affected group(s)
- Community-based EMNC providers
- Facility-based EMNC providers
- Other health providers
- NGO/PVO staff working in EMNC
- Community leaders
- MOH/government officials
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Take the first group and enter its name on the form provided on the next page. Then look at the list of topics below and decide which topics (add others if necessary) you should ask this group about and enter that topic in left hand column of the form. Then enter in the right hand column the specific questions you should ask this group. Now do the same for the remaining groups on your list.

- The magnitude of the problem
- Who is most affected by the particular delay
- How people are affected by the delay
- Any beliefs or attitudes associated with the delay
- Local household practices vis-à-vis the delay
- Primary causes of the delay (and causes of the causes)
- Which groups, organizations, individuals in the community are providing services/care related to the delay
- Which services/care are being offered by these groups, etc.
- Which services/care are currently not being offered
- Which resources there are in the community to address the delay and improve services/care
- Which resources are not available
- Which obstacles there are to addressing the delay
- The history of anything done in the community about the delay
- Any policies, regulations or laws—local or national or facility-specific—that affect the delay
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## INTERVIEW QUESTIONNAIRE

NAME OF GROUP \_\_\_\_\_

Interview Topic	Questions to Ask About this Topic
1.	
2.	
3.	
4.	
5.	

**TOOL #6—QUESTIONNAIRE FOR INTERVIEWING WOMEN**

1. How old are you? \_\_\_\_\_
2. When is the last time you visited a health provider? \_\_\_\_\_
3. Why did you visit the health provider? \_\_\_\_\_
4. What kind of health provider did you visit? \_\_\_\_\_  
(Nutritionist, doctor, midwife, community health promoter, health educator, nurse)
5. Do you feel you received the care and information that you needed? YesNo
6. If you answered “No,” what more did you need/want? \_\_\_\_\_  
\_\_\_\_\_

7. In this next group of questions, I will be asking you if you have ever received information about certain topics related specifically to pregnancy. If you have received information on the following, please tell me who provided this information to you?

What foods a pregnant woman needs to eat	No	Yes	From_____
What to do if she develops constipation	No	Yes	From_____
What to do if she has vaginal bleeding	No	Yes	From_____
How to carry heavy loads in a way that protects from back pain	No	Yes	From_____
When it is fine to have sex during pregnancy	No	Yes	From_____
Warning signs of trouble that indicate a need to visit the health provider right away	No	Yes	From_____
How to prepare for the birth regarding baby clothes, supplies for delivery, cost of care	No	Yes	From_____
What are the signs of labor requiring coming for care, or calling your midwife/TBA/etc.	No	Yes	From_____
How a person gets the HIV/AIDS virus	No	Yes	From_____
How to protect yourself and your baby from HIV/AIDS and other STIs	No	Yes	From_____
Which family planning methods you can choose after delivery and their effect on breastfeeding	No	Yes	From_____

8. If you were having a problem with your pregnancy, with whom would you discuss it? (Check all answers that apply.)

- Sexual partner
- Male relative
- Female relative
- Male friend
- Female friend
- Male doctor
- Female doctor
- Midwife
- Traditional birth attendant

- Nurse
- Health promoter
- No one
- Other (specify) \_\_\_\_\_

9. Which of the following tests have you had to check your health? When did you last have these tests?

Blood pressure	No	Yes	Last checked _____
Cholesterol	No	Yes	Last checked _____
Check for anemia	No	Yes	Last checked _____
Test for cancer of the cervix (mouth of the uterus)	No	Yes	Last checked _____
Blood test for diabetes	No	Yes	Last checked _____
Self-exam of breasts	No	Yes	Last checked _____
Provider exam of breasts	No	Yes	Last checked _____
Tuberculosis test	No	Yes	Last checked _____

10. Which of the following conditions can have bad effects on your ability to function sexually?

High blood pressure	No	Yes
Anemia	No	Yes
Severe vomiting	No	Yes
Alcoholism	No	Yes
Sexually transmitted infections (STIs)	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Depression	No	Yes
Pressure at work	No	Yes
Smoking	No	Yes
Stretch marks	No	Yes
Drinking coffee	No	Yes

*(Note to Interviewer: The correct answers are "yes" to all the above choices except the last two.)*

11. What are the places you know about in this community where a woman can go to receive **reproductive health services**? (List all she mentions. Note that you may have to explain a bit about what reproductive health means.)

12. What are the places you know about in this community where a woman can go to receive **reproductive health education**? (*List all she mentions.*)

13. Are there any other thoughts that you would like to share regarding the quality and availability of services for women in your community?

14. In your community, how safe is it for a woman to be pregnant and to have a child? Explain.

15. What can men do to help make motherhood safer?

*Source: Reproductive Health Awareness: A Wellness, Self-Care Approach, CEDPA, 2003.*

**TOOL #7—FORM FOR RECORDING INTERVIEW RESPONSES**

To create a simple form for recording information from the interviews, just list the questions from your questionnaires (designed with Tool 4.1) down the left-hand column of a chart like that below, and then record answers in the right-hand column.

NAME/TYPE OF INTERVIEWEE \_\_\_\_\_

Interview Question	Response

## TOOL #8—HOW TO CONDUCT VIDEO DISCUSSION GROUPS

The Guatemala MNH Program has used a participatory research method that it calls video discussion groups to explore maternal and neonatal health issues in rural areas. “The central theme of participatory research,” the group writes in its manual *“Tying Knots” for Healthy Motherhood*, “is to investigate in partnership with the community the causes of maternal and neonatal deaths, as well as the availability of health services in...case of an obstetric emergency.” This tool will briefly summarize the steps of this approach.

STEP 1: The approach begins with the making of one or more short videos depicting local women and family members in a common problem situation. If you are not in a position to make videos, then you could present the same situations with well-rehearsed role plays; the idea is to give the participants something to watch and then react to. The two situations dramatized in the Guatemala videos were:

Video 1: A woman lies ill at home. The person who is with her explains the woman’s symptoms to another person, but neither of them knows that these are danger signs. The midwife arrives and states that in this case she can’t do anything for the woman. At the same time a health care provider arrives and insists that they take the woman to the nearest health center. The husband is not there and the mother-in-law does not want the woman to be taken to a health center. A heated argument ensues among those who are with the woman about what should be done. You see the woman becoming weaker all the while, on the verge of fainting. And the film cuts off.

Video 2: It has been decided to take the woman in Video 1 to the health center, where this scene takes place. The man on duty receives the group, asking them why they waited so long. He is rude to the family and to the midwife. The medical service provider, a young man, arrives. He does not speak the local language and begins to explain through an interpreter what is wrong with the woman and what he is going to do. The interpreter has difficulty translating because the doctor has used technical terms that do not exist in the local language. The doctor begins to gather the instruments he will need for the intervention, and everyone begins to mobilize. The film cuts off.

STEP 2: Once the videos are made, arrangements are made to show them to groups of women who have been assembled for the purpose of conducting participatory research. A meeting is set up, the proper introductions and explanations given, the purpose and conduct of the meeting described: “Together we are going to watch a short film that has been made for this meeting, and afterwards we will talk about what each person thinks of what he or she saw in the film”). You also explain at this point that you will be recording the reactions—the observations, opinions, discussions—of the women for later use in designing your intervention. (You will have designed a means of recording and later of transcribing what the women say.)

STEP 3: You now show the first video (or conduct the first role play). After the showing, the facilitator conducts a discussion, using questions like the following:

- What do you remember of what you have just seen? Have you experienced anything like this? Have you heard of a case like this in your community?
- What happens in the film? What is wrong with the woman who feels ill? Who is arguing? Why are they arguing?
- In cases like this, what do the people in the community do? What is done with the woman?
- In your opinion, what would happen next? When and how does the family realize that the woman’s condition is serious? Who decides what to do? What do they do (accept that she is going to die, call in a traditional healer, take her to a health center, church-based institution)? What happens to the sick woman at the end (dies, survives)?

- What problems will they have to face in trying to save this woman's life? What do they need to resolve these problems? Who helps them? Who does not help them (family, community, networks outside the community)? How hard is it to resolve these problems?
- If you were in this situation, what would you do?
- What happens when a woman dies in the community? With whom are the children left? Who takes care of them? What happens to the husband?

STEP 4: The second video is shown, followed by a discussion using questions like:

- What did you see in the film? What is happening?
- Has anything like this happened to you or to someone you know? What happened?
- What is it that most draws your attention in this second film? What else do you see? Is it like this in the health services that you know?
- Do you remember that we showed you only one part of the film? What do you think happened at the beginning (in the part of the film that we did not show, when the family arrives at the health center)?  
What did the family do to get to the health center?
  - How was the family received at the health center? How do you think that the health workers treated the family, the woman, the midwife? Did they let them ask questions? How did they answer?
  - What did the health workers say to the midwife?
- And in the film clip that we saw, how do you think the woman and her family feel in the place where she is being treated? How does the place where the woman is being treated seem to them? What is present and what is lacking in the health center? What do they like and what don't they like?
- If it were you in this situation, what would you do?
- At the end of the film (which we haven't seen either because we cut it off before it got there) what do you think happens to the woman? Does she live or die?
- What would be a happy ending to this second film? What would be needed to get to this happy ending?
- How would you like to be treated in the health centers?

The purpose of this discussion is to elicit from participants which qualities they are looking for in the health center and in the people who work there, the list of which, if appropriate, can later be prioritized in another step of this activity.

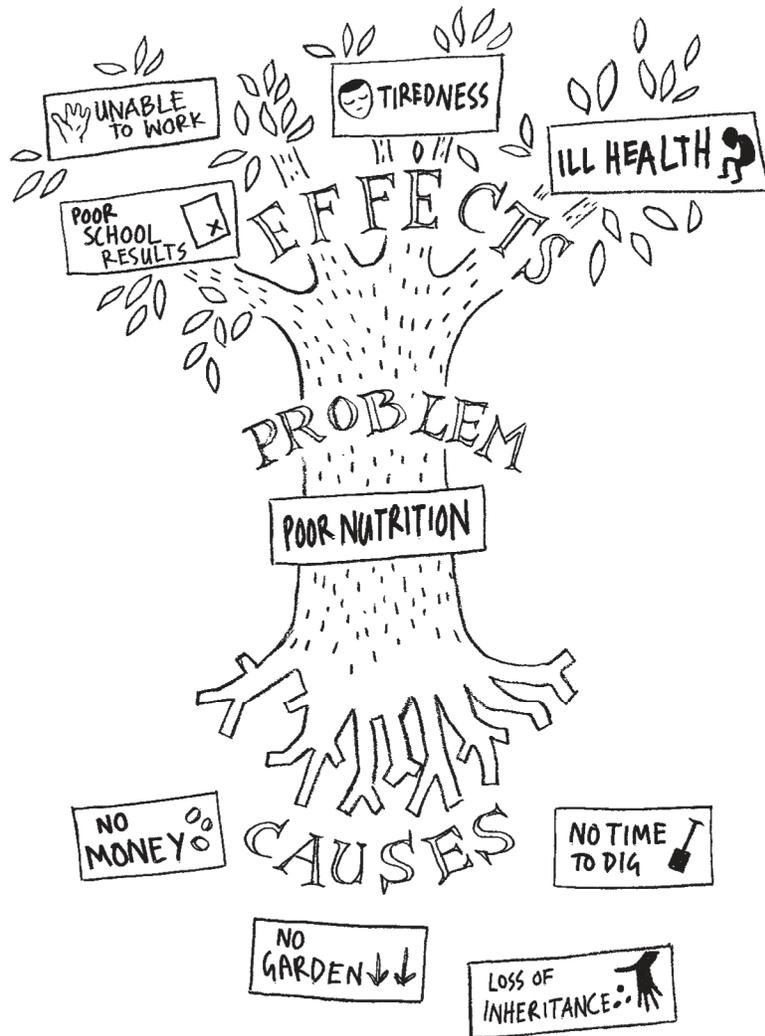
This tool continues with several more steps, which the reader can find in the source cited below.

*Adapted from: "Tying Knots" for Healthy Motherhood: A Method of Participatory Research and Action Using Video Discussion Meetings. MNH Project/Guatemala, 2004.*

## **TOOL #9—THE PROBLEM TREE**

Another commonly used participatory research method is the problem tree. Here is a brief description of how to conduct participatory research using the problem tree.

1. Explain that the focus of this meeting is to describe those things that prevent mothers and newborns from being healthy or from surviving.
2. Ask community members to list as many of these things as they can. Sum up the key points from this discussion and ask community members to choose the main things that prevent mothers and newborn from being healthy.
3. Ask a volunteer to draw a tree on the floor, wall or ground. This should show the three main parts of the tree: the trunk, the roots and the branches.
4. Describe the idea of the tree: the trunk stands for the problem being discussed, the roots stand for the causes of the problem and the branches stand for the effects of the problem.
5. Agree on a symbol for the main problem. Explain that the group will be creating more symbols. Once everyone is clear about this, ask the volunteer to remain in the center and to represent the discussions on the diagram using symbols. Ask community members, “What are the main causes of this problem?” Agree on a symbol for each cause, and show each cause separately on the roots.
6. Take one cause at a time, explaining that people can also look at the secondary causes of a problem by asking the question, “Why?” For example, if the problem on the tree trunk is that mothers are not aware of danger signs, ask, “Why?” And then to that answer, ask, “Why?” again. Continue in this way until community members feel that all the causes have been discussed.
7. Ask for a volunteer to summarize the work so far, from the trunk to the smallest root, so that community members can be sure that nothing has been forgotten and that everything is in the right place.
8. Explain that community members can now consider the effects in the same way. Ask, “What are the main effects of this obstacle?” Agree on a symbol for each effect, and show each effect separately on the branches.
9. Take one effect at a time, explaining that people can also look at the secondary effects of the main? Effects by asking the question, “What is the effect of this?” Continue in this way until community members feel that all the effects have been discussed.
10. Ask for a second volunteer to give an overall description of the tree with all its roots and branches. This allows community members to have an overall view of the problems of mothers and newborns. It also makes sure that there is no confusion between causes and effects.
11. Explain that at this or a future meeting, the community will look in detail at how it can deal with problems such as these.
12. Discuss and agree how those present will find out from community members who have not attended the meeting today whether they agree or disagree with the ideas that were discussed or if they have new ideas to add.



Example of a problem tree (not completed) for an HIV/AIDS orphans and vulnerable children program.

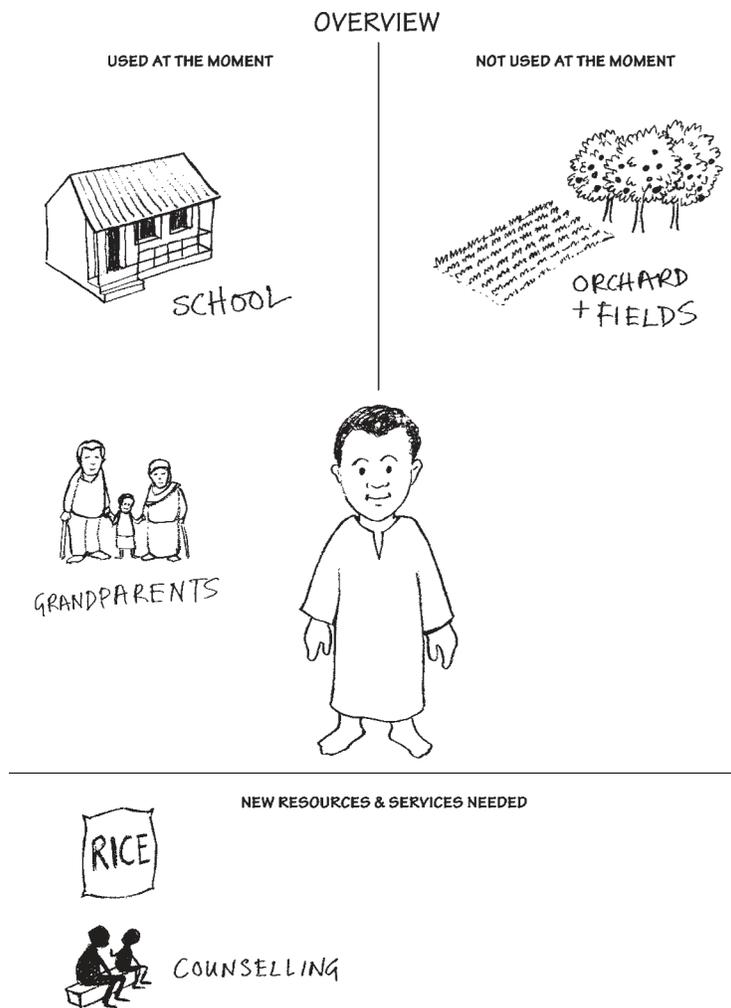
*Adapted from: Building Blocks in Practice: Participatory Tools to Improve the Development of Care and Support for Orphans and Vulnerable Children, International HIV/AIDS Alliance, 2004.*

## **TOOL #10—COMMUNITY MAPPING**

Community mapping is another type of participatory research tool. Here is a brief description of how to gather information using this tool.

Explain that at this meeting, community members will be looking at the different kinds of resources and services available to mothers and newborns. These include land-based resources and services, building-based resources and services, human resources, and other resources and services. For clarification of the resources and services, go through each of the four types asking for examples.

1. Land-based resources: fields, gardens, woods, sources of wild food
2. Building-based resources: clinic, hospital, pharmacy, church, NGO
3. Human resources: grandparents, aunts, uncles
4. Other resources: those resources that do not fit into any of the categories above, such as transportation
5. Divide participants into two groups. Ask one group to draw a pregnant woman in the middle of their paper; ask the other group to draw a newborn.
6. To the left of the pregnant woman or the newborn, the group (using symbols) should draw all of the resources and services that are available and currently being used.
7. To the right of the woman/newborn, each group (using symbols) should draw all of the resources and services that could benefit a pregnant woman/newborn but that are not being used.
8. Below the woman/newborn, each group should draw any new resources or services that may be needed. These can be resources that the community could provide or resources that must come from outside the community.
9. Ask each group to present its drawing to the other group and have a general discussion on the work done. The facilitator should sum up the information that has been gained from all of the drawings created. (If the drawings have been done on the ground, ask a volunteer from each group if he or she can make a paper copy of the drawing.)
10. Discuss and agree how those present will find out from community members who have not attended the meeting today whether they agree or disagree with the ideas that were discussed or if they have new ideas to add.



An uncompleted drawing from an HIV/AIDS project.

*Adapted from: Building Blocks in Practice: Participatory Tools to Improve the Development of Care and Support for Orphans and Vulnerable Children, International HIV/AIDS Alliance, 2004.*

**TOOL #11—AGGREGATING INFORMATION ABOUT THE HEALTH ISSUE**

To aggregate the responses from all of the groups, list the common topics (which appeared on all of the questionnaires) in the left column and responses in the right. List topics asked only of some groups but not others at the end, and specify which groups they are. If many representatives of a particular group were interviewed, then you can adapt this chart to aggregate responses by individual groups.

Topics Discussed with All Groups	Responses from All Groups
How people are affected by the delay	
Local household practices vis-à-vis the delay	
Primary causes of the delay (and causes of the causes)	
Topics Discussed with Some Groups	Responses

## **TOOL #12—SKILLS REQUIRED FOR SKILLED ATTENDANTS**

### ***Antenatal Care***

1. Use appropriate interpersonal communication and counseling skills for all stages of care
2. Take a detailed history and demonstrate cultural sensitivity
3. Provide antenatal care throughout the pregnancy
4. Perform a general exam and identify deviations from normal
5. Screen for prevalent or endemic conditions
6. Take vital signs (temperature, pulse, respiration, blood pressure)
7. Auscultate the fetal heart rate
8. Calculate estimated date of delivery
9. Educate woman and family about danger signs during pregnancy and when/where to seek care
10. Provide appropriate intervention and/or referral for:
  - infection
  - intrauterine fetal death
  - malpresentation and abnormal lies at birth
  - multiple gestation
  - poor nutrition and anemia
  - pre-eclampsia and eclampsia
  - rupture of membranes prior to term
  - severe vaginal bleeding
11. Perform an abdominal exam identifying abnormalities and factors placing woman at risk
12. Prepare woman and family for birth by providing information and support

### ***Labor and Delivery***

13. Time and assess effectiveness of uterine contractions
14. Perform a vaginal exam, noting the vulva, status of membranes and color of amniotic fluid, cervical dilation and presenting part
15. Provide support and psychological care for the woman and family
16. Ensure and explain importance of hydration, nutrition, comfort, cleanliness, elimination and mobility
17. Recognize delay in labor, prioritize care, take appropriate action and evaluate the results of the intervention
18. Use the partograph
19. Recognize the presence of meconium in amniotic fluid
20. Make appropriate referrals in response to level of risk
21. Recognize fetal distress and take appropriate action
22. Conduct vertex deliveries, using appropriate hand maneuvers and aseptic precautions
23. Perform and repair episiotomy to save the life or protect the mother from injury
24. Take appropriate care of the cord at birth

### **Immediate Postpartum and Newborn Care**

25. Clamp and cut the cord using aseptic technique
26. Perform physiologic or active management of third stage of labor, including
  - perform controlled cord traction
  - administer oxytocic agents
  - check the placenta and membrane for completeness
  - check that the uterus is well contracted
27. Manage postpartum hemorrhage
  - administer oxytocic agents
  - perform aortic or bimanual compression
28. Provide a safe and warm environment for mother and infant; dry the infant
29. Ensure that respiration is established; begin newborn resuscitation if indicated
30. Encourage early and exclusive breastfeeding
31. Examine the newborn, noting risk factors from pregnancy and from labor history
32. Assess and monitor the infant in immediate post-birth period for evidence of normal transition to newborn
33. Refer sick newborns to next level of care
34. Monitor postpartum woman for 24 hours and one week, assessing recovery from childbirth and any deviations such as hematoma and infection
35. Educate woman and family about postpartum and newborn care

### **Additional Skills**

36. Perform life-saving skills in cases of: convulsions, obstructed airway, serious infection, shock, unconsciousness, vaginal bleeding, shoulder dystocia, cord presentation and cord prolapse
37. Make appropriate and timely referrals for emergency care, arranging for transport and care during transport
38. Identify breech and other malpresentations and make timely referrals in early labor
39. Anticipate needs for forceps delivery or vacuum extraction; perform vacuum extraction
40. Manage complications of late labor
41. Identify and manage fetal distress and multiple births
42. Perform manual removal of retained placenta
43. Identify and repair cervical lacerations

*Adapted from: Saving Mothers' Lives: What Works, The White Ribbon Alliance for Safe Motherhood/India, 2002.*

## **TOOL #13—MATERNAL DANGER SIGNS (SIGNS OF OBSTETRIC EMERGENCY)**

### ***During Pregnancy***

- Bleeding from the vagina (birth canal)
- Severe headaches, blurred vision
- Convulsions, loss of consciousness
- Severe pain in the abdomen (lower stomach area)
- Fever
- Cough that lasts longer than 3 weeks
- Persistent diarrhea
- Ruptured membranes without labor pains for more than 4 hours
- Foul-smelling or yellow/green/brown discharge from the vagina
- The fetus stops moving

### ***During Labor and Delivery***

- Labor begins before the end of the 8<sup>th</sup> month (37 weeks)
- Labor lasts over 8 hours
- Labor continues more than 4 hours after the membranes rupture
- The baby is in an abnormal position
- There is vaginal bleeding
- The woman has severe headaches, visual disturbances, excessive sweating, dry mouth, convulsions (fits), or loss of consciousness
- The placenta does not come out for 30 minutes after the delivery of the baby and the mother is hemorrhaging
- The placenta does not come out for 30 minutes after the delivery of the baby and the mother is not hemorrhaging

### ***Postpartum***

- Fits and loss of consciousness
- Steady or heavy bleeding for fist-size clots from the vagina
- Fever along with pain and tenderness to touch in the lower abdomen
- Foul-smelling vaginal discharge

*Adapted from: Saving Mothers' Lives: What Works, The White Ribbon Alliance for Safe Motherhood/India, 2002.*

## **TOOL #14—THE BIRTH PLAN AND COMPLICATION READINESS MATRIX**

Developed by The Maternal and Neonatal Health Program, Jhpiego, the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, the Centre for Development and Population Activities, and the Program for Appropriate Technology in Health.

This matrix describes a comprehensive approach to one of the core issues in maternal and neonatal health: death and morbidity of mothers and newborns due to inadequate preparation for labor, delivery, and birth complications. The matrix identifies the actions that need to be taken at various levels by the key players involved in maternal and neonatal health: policymakers, health care facilities, providers, the community, family members, and pregnant women. The matrix “can be used to introduce and reinforce the concept of BP/CR, to demonstrate and support shared responsibility and accountability for safe motherhood, and to plan appropriate safe motherhood interventions and activities.” (*Birth Preparedness and Complication Readiness: A Matrix of Shared Responsibility*, Maternal and Neonatal Health Program, 2004.)

## The BP/CP Matrix: Pregnancy

POLICYMAKER	FACILITY	PROVIDER
<p><i>Creates an environment that supports the survival of pregnant women and newborns.</i></p>	<p><i>Is equipped, staffed and managed to provide skilled care for the pregnant woman and newborn.</i></p>	<p><i>Provides skilled care for normal and complicated pregnancies, births and the postpartum period.</i></p>
<p>Promotes health and survival for pregnant women and newborns</p> <p>Ensures that skilled antenatal care policies are evidence-based, in place and politically endorsed</p> <p>Uses evidence-based information to support systems that routinely update service delivery and cadre-specific guidelines</p> <p>Promotes and facilitates the adoption of evidence-based antenatal care</p> <p>Ensures that adequate levels of resources (financial, material, human) are dedicated to supporting antenatal care and an emergency referral system</p> <p>Encourages and facilitates participation in policy-making and resource allocation for safe childbirth and emergency referral services by communities, families, individuals and advocacy groups</p> <p>Coordinates donor support to integrate birth preparedness and complication readiness into antenatal services</p> <p>Has a national policy document that includes specific objectives for reducing maternal and newborn deaths</p> <p>Ensures that protocols are in place for clinical management, blood donation, anesthesia, surgical interventions, infection prevention and physical infrastructure</p> <p>Advocates birth preparedness and complication readiness through all possible venues (e.g., national campaigns, press conferences, community talks, local coalitions, supportive facilities)</p>	<p>Has essential drugs and equipment</p> <p>Follows infection prevention principles and practices</p> <p>Has a functional emergency system, including:</p> <ul style="list-style-type: none"> <li>• communication</li> <li>• transportation</li> <li>• safe blood supply</li> <li>• emergency funds</li> </ul> <p>Has service delivery guidelines on appropriate management during the antenatal period</p> <p>Has job aids to assist providers in performing appropriate antenatal care</p> <p>Ensures availability of a skilled provider 24 hours a day, 7 days a week</p> <p>Is gender and culturally sensitive, client-centered and friendly</p> <p>Involves community in quality of care</p> <p>Reviews case management of maternal and neonatal morbidity and mortality</p>	<p>Provides skilled antenatal care, including:</p> <ul style="list-style-type: none"> <li>• detecting and managing complications</li> <li>• promoting health and preventing disease, including: <ul style="list-style-type: none"> <li>– provision of iron/folate and tetanus toxoid</li> <li>– vitamin A and iodine in areas with deficiencies</li> <li>– presumptive treatment of malaria and worms in areas of prevalence</li> <li>– encourages use of bed nets</li> </ul> </li> <li>• screening for and managing HIV/AIDS, tuberculosis, STDs</li> <li>• assisting the woman to prepare for birth including: <ul style="list-style-type: none"> <li>– items needed for clean birth</li> <li>– identification of skilled provider for the birth</li> <li>– plan for reaching provider at time of delivery</li> <li>– identification of support people to help with transportation, care of children/household, and accompaniment to health facility</li> <li>– Complication Readiness Plan in case of emergency: emergency funds, transportation, blood donors, and decision-making</li> </ul> </li> <li>• counseling/educating the woman and family on danger signs, nutrition, family planning, breastfeeding, HIV/AIDS</li> <li>• informing woman and family of existence of emergency funds</li> <li>• referring to higher levels of care when appropriate</li> <li>• honoring the pregnant woman's choices</li> </ul> <p>Supports the community s/he serves</p> <p>Respects community's expectations and works within that setting</p> <p>Educates community members about birth preparedness and complication readiness</p> <p>Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness</p>

COMMUNITY	FAMILY	WOMAN
<i>Advocates and facilitates preparedness and readiness actions.</i>	<i>Supports pregnant woman's plans during pregnancy, childbirth and the postpartum period.</i>	<i>Prepares for birth, values and seeks skilled care during pregnancy, childbirth and the postpartum period.</i>
<p>Supports and values the use of antenatal care</p> <p>Supports special treatment for women during pregnancy</p> <p>Recognizes danger signs and supports implementing the Complication Readiness Plan</p> <p>Supports mother- and baby-friendly decision-making for normal births and obstetric emergencies</p> <p>Has a functional transportation infrastructure for woman to reach care when needed</p> <p>Has a functional blood donor system</p> <p>Has community financing plan for obstetric emergencies</p> <p>Can access facility and community emergency funds</p> <p>Conducts dialogue with providers to ensure quality of care</p> <p>Dialogues and works together with provider on expectations</p> <p>Supports the facility that serves the community</p> <p>Educates members of the community about birth preparedness and complication readiness</p> <p>Advocates for policies that support skilled healthcare</p> <p>Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness</p>	<p>Advocates for skilled healthcare for woman</p> <p>Supports and values the woman's use of antenatal care, adjusts responsibilities to allow attendance</p> <p>Makes plan with woman for normal birth and complications</p> <p>Identifies a skilled provider for childbirth and the means to contact or reach the provider</p> <p>Recognizes danger signs and facilitates implementing the Complication Readiness Plan</p> <p>Identifies decision-making process in case of obstetric emergency</p> <p>Knows transportation systems, where to go in case of emergency, and support persons to accompany and stay with family</p> <p>Supports provider and woman in reaching referral site, if needed</p> <p>Knows supplies to bring to facility or have in the home</p> <p>Knows how to access community and facility emergency funds</p> <p>Has personal savings for costs associated with emergency care or normal birth</p> <p>Knows how and when to access community blood donor system</p> <p>Identifies blood donor</p>	<p>Attends at least four antenatal visits (obtains money, transport)</p> <p>Makes a birth plan with provider, husband, family</p> <p>Decides and acts on where she wants to give birth with a skilled provider</p> <p>Identifies a skilled provider for birth and knows how to contact or reach the provider</p> <p>Recognizes danger signs and implements the Complication Readiness Plan</p> <p>Knows transportation systems, where to go in case of emergency, and support persons to accompany and stay with family</p> <p>Speaks out and acts on behalf of her and her child's health, safety and survival</p> <p>Knows that community and facility emergency funds are available</p> <p>Has personal savings and can access in case of need</p> <p>Knows who the blood donor is</p>

## The BP/CP Matrix: Labor and Childbirth

POLICYMAKER	FACILITY	PROVIDER
<i>Creates an environment that supports the survival of pregnant women and newborns.</i>	<i>Is equipped, staffed and managed to provide skilled care for the pregnant woman and newborn.</i>	<i>Provides skilled care for normal and complicated pregnancies, births and the postpartum period.</i>
<p>Promotes improved care during labor and childbirth</p> <p>Ensures that skilled care policies for labor and childbirth are evidence-based, in place and politically endorsed</p> <p>Uses evidence-based information to support systems that routinely update service delivery and cadre-specific guidelines</p> <p>Promotes and facilitates the adoption of evidence-based practices</p> <p>Supports policies for management of complications based on appropriate epidemiological, financial and sociocultural data</p> <p>Ensures that adequate levels of resources (financial, material, human) are dedicated to skilled care at birth and an effective emergency referral system</p> <p>Encourages and facilitates participation in policy-making and resource allocation for safe childbirth and emergency referral services by communities, families, individuals and advocacy groups</p> <p>Coordinates donor support for improved management of labor and childbirth</p> <p>Ensures that protocols are in place for clinical management, blood donation, anesthesia, surgical interventions, infection prevention and physical infrastructure</p> <p>Advocates birth preparedness and complication readiness through all possible venues (e.g., national campaigns, press conferences, community talks, local coalitions, supportive facilities)</p>	<p>Has essential drugs and equipment</p> <p>Follows infection prevention principles and practices</p> <p>Has appropriate space for birthing</p> <p>Has a functional emergency system, including:</p> <ul style="list-style-type: none"> <li>• communication</li> <li>• transportation</li> <li>• safe blood supply</li> <li>• emergency funds</li> </ul> <p>Has service delivery guidelines on appropriate management of labor and childbirth</p> <p>Has job aids to assist providers in performing labor and childbirth procedures</p> <p>Ensures availability of a skilled provider 24 hours a day, 7 days a week</p> <p>Is gender and culturally sensitive, client-centered and friendly</p> <p>Involves community in quality of care</p> <p>Reviews case management of maternal and neonatal morbidity and mortality</p>	<p>Provides skilled care during labor and childbirth, including:</p> <ul style="list-style-type: none"> <li>• assessing and monitoring women during labor using the partograph</li> <li>• providing emotional and physical support through labor and childbirth</li> <li>• conducting a clean and safe delivery including active management of 3rd stage of labor</li> <li>• recognizing complications and providing appropriate management</li> <li>• informing woman and family of existence of emergency funds (if available)</li> <li>• referring to higher levels of care when appropriate</li> </ul> <p>Supports the community s/he serves</p> <p>Respects community's expectations and works within that setting</p> <p>Educates community about birth preparedness and complication readiness</p> <p>Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness</p>

COMMUNITY	FAMILY	WOMAN
<i>Advocates and facilitates preparedness and readiness actions.</i>	<i>Supports pregnant woman's plans during pregnancy, childbirth and the postpartum period.</i>	<i>Prepares for birth, values and seeks skilled care during pregnancy, childbirth and the postpartum period.</i>
<p>Supports and values use of skilled provider at childbirth</p> <p>Supports implementing the woman's Birth Preparedness Plan</p> <p>Makes sure that the woman is not alone during labor, childbirth and immediate postpartum period</p> <p>Supports the woman in reaching place and provider of her choice</p> <p>Has a functional blood donor system</p> <p>Recognizes danger signs and supports implementing the Complication Readiness Plan</p> <p>Supports mother- and baby-friendly decision-making in case of obstetric emergencies</p> <p>Can access facility and community emergency funds</p> <p>Supports timely transportation of woman</p> <p>Promotes community norms that emphasize priority of transportation for pregnant women and obstetric emergencies</p> <p>Dialogues and works together with provider on expectations</p> <p>Supports the facility that serves the community</p> <p>Advocates for policies that support skilled healthcare</p> <p>Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness</p>	<p>Advocates for skilled healthcare for woman</p> <p>Recognizes normal labor and facilitates implementing Birth Preparedness Plan</p> <p>Supports woman in reaching place and provider of choice</p> <p>Supports provider and woman in reaching referral site, if needed</p> <p>Agrees with woman on decision-making process in case of obstetric emergency</p> <p>Recognizes danger signs and facilitates implementing the Complication Readiness Plan</p> <p>Discusses with and supports woman's labor and birthing decisions</p> <p>Knows transportation systems, where to go in case of emergency, and support persons to stay with family</p> <p>Knows how to access community and facility emergency funds</p> <p>Has personal savings for costs associated with emergency care or normal birth</p> <p>Purchases necessary drugs or supplies</p> <p>Knows how and when to access community blood donor system</p> <p>Identifies blood donor</p>	<p>Chooses provider and place of birth in antenatal period</p> <p>Recognizes normal labor and understands Birth Preparedness Plan</p> <p>Recognizes danger signs and understands Complication Readiness Plan</p> <p>Knows transportation systems, where to go in case of emergency, and support persons to stay with family</p> <p>Can access community and facility emergency funds</p> <p>Has personal savings and can access in case of need</p>

## The BP/CP Matrix: Postpartum and Newborn

POLICYMAKER	FACILITY	PROVIDER
<i>Creates an environment that supports the survival of pregnant women and newborns.</i>	<i>Is equipped, staffed and managed to provide skilled care for the pregnant woman and newborn.</i>	<i>Provides skilled care for normal and complicated pregnancies, births and the postpartum period.</i>
<p>Promotes improved postpartum and newborn care</p> <p>Ensures that skilled postpartum and newborn care policies are evidence-based, in place and politically endorsed</p> <p>Uses evidence-based information to support systems that routinely update service delivery and cadre-specific guidelines</p> <p>Promotes and facilitates the adoption of evidence-based practices</p> <p>Supports policies for management of postpartum and newborn complications using appropriate epidemiological, financial and sociocultural data</p> <p>Ensures adequate levels of resources (financial, material, human) are dedicated to supporting the skilled management of postpartum and newborn care and the effectiveness of an emergency referral system</p> <p>Encourages and facilitates participation in policy-making and resource allocation for safe childbirth and emergency referral services by communities, families, individuals and advocacy groups</p> <p>Coordinates donor support for improved postpartum and newborn care</p> <p>Ensures that protocols are in place for clinical management, blood donation, anesthesia, surgical interventions, infection prevention and physical infrastructure</p> <p>Advocates birth preparedness and complication readiness through all possible venues (e.g., national campaigns, press conferences, community talks, local coalitions, supportive facilities)</p>	<p>Has essential drugs and equipment</p> <p>Follows infection prevention principles and practices</p> <p>Has a functional emergency system, including:</p> <ul style="list-style-type: none"> <li>• communication</li> <li>• transportation</li> <li>• safe blood supply</li> <li>• emergency funds</li> </ul> <p>Has service delivery guidelines on care of newborn and mother postpartum</p> <p>Has job aids to assist providers in performing appropriate postpartum and newborn care</p> <p>Ensures availability of a skilled provider 24 hours a day, 7 days a week</p> <p>Is gender and culturally sensitive, client-centered and friendly</p> <p>Involves community in quality of care</p> <p>Reviews case management of maternal and neonatal morbidity and mortality</p>	<p>Provides skilled newborn and postpartum care, including:</p> <ul style="list-style-type: none"> <li>• recognizing complications in the newborn and postpartum woman and providing appropriate management</li> <li>• promoting health and preventing disease in the woman, including: <ul style="list-style-type: none"> <li>– provision of iron/folate and tetanus toxoid</li> <li>– vitamin A and iodine in areas of deficiencies</li> <li>– encouraging use of impregnated bednets for the woman and newborn in areas of malaria prevalence</li> <li>– provision of contraceptive counseling and services</li> </ul> </li> <li>• promoting health and preventing disease in the newborn, including: <ul style="list-style-type: none"> <li>– thermal protection</li> <li>– promotion of breastfeeding</li> <li>– eye care</li> <li>– cord care</li> <li>– vaccinations</li> </ul> </li> <li>• providing appropriate counseling and education for the woman and family about danger signs and self-care for the postpartum woman and newborn</li> <li>• informing woman and family of existence of emergency funds</li> <li>• referring to higher levels of care when appropriate</li> </ul> <p>Supports the community s/he serves</p> <p>Respects community's expectations and works within that setting</p> <p>Educates community about complication readiness</p> <p>Promotes concept of and dispels misconceptions and harmful practices that could prevent complication readiness</p>

COMMUNITY	FAMILY	WOMAN
<i>Advocates and facilitates preparedness and readiness actions.</i>	<i>Supports pregnant woman's plans during pregnancy, childbirth and the postpartum period.</i>	<i>Prepares for birth, values and seeks skilled care during pregnancy, childbirth and the postpartum period.</i>
<p>Supports and values women's use of postpartum and newborn care</p> <p>Supports and values use of skilled provider during postpartum period</p> <p>Supports appropriate and healthy norms for women and newborns during the postpartum period</p> <p>Makes sure that the woman is not alone during the postpartum period</p> <p>Recognizes danger signs and supports implementing the Complication Readiness Plan</p> <p>Supports mother- and baby-friendly decision-making in case of newborn emergencies</p> <p>Supports timely transportation of woman and newborn to referral site, if needed</p> <p>Has a functional blood donor system</p> <p>Can access facility and community emergency funds</p> <p>Dialogues and works together with provider on expectations</p> <p>Supports the facility that serves the community</p> <p>Educates community members about complication readiness</p> <p>Advocates for policies to support skilled healthcare</p> <p>Promotes concept of and dispels misconceptions and harmful practices that could prevent complication readiness</p>	<p>Advocates for skilled healthcare for woman</p> <p>Supports the woman's use of postpartum and newborn care, adjusts responsibilities to allow her attendance</p> <p>Recognizes complication signs and facilitates implementing the Complication Readiness Plan</p> <p>Agrees with woman on decision-making process in case of postpartum or newborn emergency</p> <p>Knows transportation systems, where to go in case of emergency, and support persons to stay with family</p> <p>Supports provider, woman and newborn in reaching referral site, if needed</p> <p>Knows how to access community and facility emergency funds</p> <p>Has personal savings for costs associated with postpartum and newborn care</p> <p>Purchases drugs or supplies needed for normal or emergency postpartum and newborn care</p> <p>Knows how and when to access community blood donor system</p> <p>Identifies blood donor</p>	<p>Seeks postpartum and newborn care at least twice—at 6 days and at 6 weeks postpartum (obtains money, transport)</p> <p>Recognizes danger signs and implements the Complication Readiness Plan</p> <p>Speaks out and acts on behalf of her and her child's health, safety and survival</p> <p>Knows transportation systems, where to go in case of emergency, and support persons to stay with family</p> <p>Can access community and facility emergency funds</p> <p>Has personal savings and can access in case of need</p>

## **TOOL #15—QUESTIONS FOR LEARNING ABOUT LOCAL BP/CR PRACTICES**

1. What does the pregnant woman do to protect her baby's and her own health while pregnant?
2. Where does she get this information?
3. What types of preparations does she make as childbirth approaches?
4. Who helps the woman in her preparations?
5. What types of problems can occur during pregnancy, childbirth and the postpartum period?
6. What can be done if the woman experiences these problems?
7. What are the best actions to take to help a woman who is experiencing complications?
8. Who can help?
9. What problems can happen at the time of seeking help? How can they be addressed?
10. Where does the woman get money/help for emergency transport?
11. Where can she be brought to get help?
12. Is the facility equipped to handle emergencies?
13. What kind of obstacles can be experienced when seeking help?
14. Who is involved in deciding how to find help when a woman is experiencing complications during pregnancy, childbirth or the postpartum period?
15. What if those persons are not home?
16. Who can provide help or advice in their stead?

**TOOL #16—BIRTH PREPAREDNESS CARD**

The information provided below could be made into a simple birth preparedness card that can be given to women and family members to help them plan for birth. A CHW or some other provider should go over the card and help the family complete it.

I want to deliver at: \_\_\_\_\_

I want to be delivered by: \_\_\_\_\_

I want a checkup one week after birth by: \_\_\_\_\_

ESTIMATING BIRTH COSTS

Cost of delivery: \_\_\_\_\_

Cost of transport: \_\_\_\_\_

ITEMS FOR BIRTH

Facility Birth

- Cotton wool
- Gloves

Home Birth

- Clean razor blade
- Plastic sheet
- Clean cord tie
- Cotton wool

Means of transport: \_\_\_\_\_

The person who will escort me to skilled care is: \_\_\_\_\_

For an emergency during childbirth I will go to: \_\_\_\_\_

Nearest emergency contacts: \_\_\_\_\_

\_\_\_\_\_

Compatible blood donors who will help if needed: \_\_\_\_\_

\_\_\_\_\_

## **TOOL #17—NEWBORN DANGER SIGNS**

### ***Breathing problems***

- Breathing is faster than 60 or less than 30 breaths in a minute.
- Breathing is shallow or irregular, with or without pauses.
- There is a noise with each breath (gasping).
- There is in-drawing of the chest with breathing, flaring of the nostrils.
- Tongue and lips or skin color is blue.

### ***Feeding difficulties or not sucking***

- Unable to suck or sucks poorly.
- Cannot be awakened to suck or does not stay awake to suck long enough to empty the breast.
- Sucks but does not seem satisfied.

### ***Feels cold***

- Body (abdomen or back) feels cold or cooler than that of a well person.
- Axillary temperature below 36 °C.

### ***Fever***

- Body (abdomen or back) feels hot compared to that of a well person.
- Axillary temperature above 37 °C.

### ***Red, swollen eyelids and pus discharge from the eyes***

### ***Redness, swelling, pus, or foul odor around the cord or umbilicus***

### ***Convulsions/fits***

- Fits are more than the tremor or jittery movements of normal babies.
- The baby may become rigid or shake.

### ***Jaundice/yellow skin***

- Yellow skin or eye color which begins in the first 24 hours or after 2 weeks is serious.
- Yellow skin color that appears when the baby has any other danger sign is serious.

*Source: Care of the Newborn Reference Guide, Saving Newborn Lives/Save the Children USA, 2004.*

## **TOOL #18—SAMPLE IMPACT INDICATORS FOR MEASURING EMNC**

Indicators are “measurable statements of program objectives and activities. [They] are used to measure program process and progress toward desired program results. This short list of key indicators are the most important indicators to collect as they are standardized, widely used, and can be readily used to compare results among programs.”

### **ANTENATAL**

- Percentage of mothers of children aged 0–23 months in catchment area that saw a skilled provider three or more times during last pregnancy.
- Percentage of mothers with children aged 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child.
- Percentage of health facilities with skilled attendant (doctor, nurse or midwife) available 24 hours per day, seven days a week.

### **LABOR AND DELIVERY**

- Percentage of children aged 0–23 months whose delivery was attended by a skilled health provider.
- Percentage of communities with an emergency transport plan in place.

### **POSTPARTUM**

- Percentage of mothers who received postpartum care at each recommended interval from skilled personnel.
- Percentage of communities that have an emergency transport system.
- Percentage of health facilities with skilled attendant ((doctor, nurse or midwife) available 24 hours per day, seven days a week.

### **NEWBORN CARE**

- Percentage of children aged 0–23 months who were immediately breastfed at birth.
- Percentage of children aged 0–23 months whose delivery involved use of a clean birth kit or whose cord was cut with a new razor.
- Percentage of newborns who receive postnatal care from a skilled provider at each recommended interval.

*Source: Maternal and Newborn Standards and Indicators Compendium, Motherhood and Reproductive Health Working Group, CORE Group, Washington, DC, December 2004, pp. 15, 85–87.*

## **TOOL #19—INDICATORS FOR MEASURING CORE TEAM CAPACITY**

As part of monitoring and evaluation, you may also want to evaluate the success of the core team. Here are some questions to consider:

1. Is there a spirit of cooperation among core team members?
2. Are members regularly sharing experience, ideas and lessons learned?
3. Is there good communication between the members?
4. Do members participate equally in team activities?
5. Do members participate in group decision-making?
6. Is the team eliciting community and health sector perspectives about maternal and neonatal health?
7. Does the team continue to represent the perspectives of diverse members of the community (e.g., gender, age, class, ethnicity, socioeconomic status)?
8. Does the team engage in strategic planning?
9. Does team leadership facilitate coordination and action?
10. Does the team regularly evaluate its activities to determine lessons learned?
11. Is the team achieving its short-term objectives?
12. Has the team raised awareness of maternal and neonatal health?
13. Has the team influenced policy- and decision-makers?
14. Are diverse organizations/sectors involved in promoting MNH?
15. Is mass media used effectively to raise awareness about MNH issues?
16. Has the team been successful in mobilizing additional government resources for MNH?
17. Has the team been successful in mobilizing other external resources?

*Adapted from: Igniting Change: Capacity-Building Tools for Safe Motherhood Alliances, 2004, pp. 63–65.*





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 IMA World Health.