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Working With Individuals, Families and Communities to Improve Maternal and Newborn Health

Guideline Appraisal of WHO Document

The objective of this appraisal is to evaluate the WHO document on working with individuals, families and communities to improve maternal and newborn health with a view to determining the applicability of its recommendation in Sudan

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Table of Contents

1	Short summary of the Document:	3
2	Literature search	4
3	Guideline Appraisal	6
3.1	Scope and purpose of guideline.....	6
3.2	Stakeholder involvement	6
3.3	Guideline Development	7
3.3.1	Rigour of development	7
3.3.2	Clarity and presentation	8
3.4	Applicability.....	8
4	Conclusion.....	13
5	References:	15

1 Short summary of the Document:

Making Pregnancy Safer initiative has proposed a strategic framework for working with individuals, families and communities to improve maternal and newborn health throughout the life-cycle of the woman, from adolescence through to the birth of her own child, and at all levels of the health system from the household to the first service level, and a higher-level referral service site. By this means women, families and communities will be empowered to increase their control over maternal and newborn health, and create their demand for accessing and utilizing acceptable health care services.

Four priority areas for intervention have been identified; developing capacities, increasing awareness, strengthening linkages, and improving quality of services. Moreover, five strategies were proposed to achieve the goal of this document: Education, Community action for health, Partnerships, Institutional strengthening at the district health level, and Local advocacy. Furthermore: five healthy setting were recognized as physical contexts to provide healthy and supportive environment: Household, Community, Health Care services, Schools, and Workplaces.

A participatory approach is needed throughout and at each level in addition to integrating the following strategies into MPS initiative and maternal and newborn health program: Developing national IFC strategies, Assessment, priority selection and planning at the district level, Implementation Through the district health system, Building on and integrating existing resources, and Monitoring and evaluation.

2 Literature search

“Women are not dying because of diseases we cannot treat ... they are dying because societies have yet to make the decision that their lives are worth saving.” Mahmoud Fathalla [1]

Many single interventions are available, but no single intervention is by itself sufficient to improve maternal and newborn health and decrease morbidity and mortality [2]. There is a need for a continuum of care all the way through pregnancy, childbirth and the postnatal period [3]. Working with individuals, families and communities is considered by Making Pregnancy Safer to be the critical link of continuum of care [4].

Continuum of care has been defined as “all women should have the highest attainable standard of health, through the best possible care before and during pregnancy, childbirth, and postpartum period. This continuum of care encompasses the life-cycle of the woman, from adolescence through to the birth of her own child. Additionally, it includes all levels of the health system from the household to the first service level, and a higher-level referral service site, as appropriate for the needs of each woman or newborn”[5].

Health promotion is defined as “the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being” [6].

Health promotion and community based participatory intervention could significantly reduce maternal and neonatal mortality rates and improve their health.

A cluster randomized controlled trial was conducted in Nepal to study the effect of a participatory intervention with women's groups on birth outcomes. In each intervention cluster a female facilitator convened nine women's group meetings every month and supported them through an action-learning cycle in which they identified local perinatal problems and formulated strategies to address them. They concluded that birth outcomes in a poor rural population improved greatly through a low cost, potentially sustainable and scalable, participatory intervention with women's groups. This was evidenced by their findings of reduced neonatal mortality rate, maternal mortality ratio, more antenatal care, more institutional delivery, more trained birth attendance, and more hygienic care in the intervention groups.[7]

An intervention including initiating and strengthening women's organizations, developing their skills in problem identification and prioritization, and training community members in safe birthing techniques was conducted in a remote Bolivian province to evaluate the potential effect of organizing women's groups on perinatal mortality in a remote, rural area of a developing country. The study concluded that the perinatal mortality decreased significantly. They noticed that there was a significant increase in the number of women participating in women's organizations following the intervention, as well as in the number of organizations. The proportion of women receiving prenatal care and initiating breast-feeding on the first day after birth was also significantly larger. The study demonstrated that community organization can improve maternal and child health in remote areas. [8]

Safe Motherhood and Reproductive Health Working Group and CORE Group published a Maternal and Newborn Standards and Indicators Compendium in five interrelated phases of a woman's reproductive cycle: 1) Pre-Conception/ Inter-Conception; 2) Antenatal; 3) Labor and Delivery; 4) Postpartum Care; and 5) Newborn Care. The settings for these phases are household, community, First-Level Care, and Second-Level Care health care facility. The Compendium provides a single source of information to determine recommended practices and standards of care and to identify which indicators are appropriate to use with the different interventions.[9]

Involving women's groups in problem solving empower them and create demand for better health care services and respect for their rights. Communication and social mobilization efforts that concentrate on violence against women are synergizing efforts to decrease maternal death. Open dialogue with policy makers, political leaders, women's group, community leaders, youth leaders, and health professionals in regard to identifying the problems, developing action plans and activities is encouraging community empowerment.[10]

The objective of this appraisal is to evaluate the WHO document on working with individuals, families and communities to improve maternal and newborn health with a view to determining the applicability of its recommendation in Sudan.

3 Guideline Appraisal

3.1 *Scope and purpose of guideline*

The guideline stated clearly and specifically that its objectives are to empower women, families and communities to improve and increase their control over maternal and newborn health, and increase accessibility and utilization of quality health services that provided by skilled attendants. For that reason this document is written to set up a common vision and approach to identify the role of the WHO at this level of proposed intervention.

Although, it is recommended by AGREE (2001) that a detailed description of the questions covered by the guideline should be provided, particularly for the key recommendations, it is not clear in this document that there is a detailed description of the questions covered. Instead, detailed information were given about the concept and rational of the proposed approach and interventions.

This document specifically described group of peoples to whom the guideline is meant to apply. These include women, families and communities in different settings such as households, communities, health services, schools and workplaces.

3.2 *Stakeholder involvement*

This document was developed as the result of a consultative process with the involvement of participation in the Reproductive Health programme managers' meeting of the African Region and meetings with WHO Reproductive Health Advisers and partners and including visits to Bolivia and Indonesia. However, information about the composition, discipline and relevant expertise of the document development group were not provided.

The primary users of this document are also its main contributors, which their views, perspectives and preference have been sought:

1. The WHO Making Pregnancy Safer global team
2. Other WHO staff involved in maternal and newborn health work
3. Safe Motherhood partners
4. Other technical specialists in related areas

It has been recommended that information about target groups' experiences, expectations and perspectives should inform the development of guidelines. There is no clear evidence that this process has taken place in this document.

It is not clear if the recommended strategies in this document have been piloted among target users or not. Some interventions seem to be piloted as a single intervention by itself. But there is no clear evidence that the proposed continuum of care comprehensive strategies of "working with individuals, families and communities to improve maternal and newborn health" have been piloted.

3.3 Guideline Development

3.3.1 Rigour of development

The process of development this document includes consulting different documents and references mainly: (a) Health Promotion approach as outlined in the Ottawa Charter, 1986, (b) WHO regional and country strategies for working at the community level for maternal and newborn health, (c) Report of an informal consultation on the subject held at WHO Headquarters in October 2001

While the material consulted have been listed, details of the strategy used to search for evidence including search terms used, sources consulted and dates of the literature covered were not provided. Furthermore, criteria for selecting the evidence and the criteria for including /excluding evidence identified by the search were not explicitly described.

There is no clear description of the methods used to formulate the recommended interventions and implementation process and how final decisions were arrived at. Areas of disagreement and methods of resolving them were not specified

The benefits of the recommended strategies, interventions and implantation process have been addressed. But there is no clear evidence that risk, threats and implication on other existing programs which might emerge as a result of implementation of the proposed comprehensive interventions and strategies have been addressed. Even though, the document stressed that further researches are needed support a better understanding of the processes as well as the outcomes of such interventions.

Although, the document has provided a list of references and materials that have been consulted to develop the recommendations, it is not clear that each recommended intervention is linked with a list of references on which it is based.

There is no evidence that this document has been reviewed externally before it is published. The document has not provided clear description of the methodology used to conduct the external review; as well there is no list of the reviewers and their affiliation.

This document clearly stated the process for updating the document through review, documentation, dissemination and evaluation, in addition to systematic review of the current literature and experiences developed worldwide. While it is clear that there is a standing panel receives regularly updated literature searches and makes changes as required, there is no apparent timescale.

3.3.2 Clarity and presentation

The recommended strategies provided an understandable, concrete and precise description of which implementation process is appropriate in different settings and priority areas. However, there may be uncertainty about the outcome of the applications of the proposed approach.

These recommendations are easily identifiable through a strategic framework for the development of interventions. This framework has identified conceptual basis, aim, priority areas, settings for interventions, and strategies.

However, this document to be effective it needs to develop tools and technical guidance to support the implementation and application of the proposed interventions.

3.4 Applicability

This document of “Working with individuals, families and communities to improve maternal and newborn health” is known in our professional environment in the region and in Sudan.

An inter-country meeting on Working with Communities to Improve Maternal and Neonatal Health in the Eastern Mediterranean Region was held in Damascus, Syria, from 9 to 11 April 2007. The meeting was organized by the WHO EMRO and attended by 55 participants from countries in the region including Sudan and international organizations. [11]

The Sudan national reproductive health policy in 2005 and in 2010 in addition to Sudan Road Map for Maternal & Neonatal Mortality Reduction 2010-2015 stressed on the working with individuals, families and communities as an important component to reduce maternal and neonatal mortality. It has been stated that:

“Quality services alone will not produce the desired health outcomes where there is no possibility to be healthy, to make healthy decisions and, moreover, to be able to act on those healthy decisions. WHO’s target: By 2015, in all countries with high MMR, strategies are in place for involving women and communities in maternal and newborn health programming and for strengthening their capacities to improve self-care.” [12]

“Participation with communities is an essential and fundamental tenet which this policy emphasizes to achieve, as without it the reproductive health services required on a continuum over the life span of men and women will not be sustainable” [13]

Sudan Road Map for Maternal & Neonatal Mortality Reduction 2010-2015, stated clearly that one of its main components is Raise awareness towards RH issues among individuals, families & community. And one of its main objectives is *“to strengthen the capacity of individuals, families, and communities to promote, own and practice the minimum package of evidence-based family/community level MNCH care”*. [14]

The strategic approaches of the Roadmap include empowering families and communities, especially the poor and the marginalized, to improve awareness on Sexual and Reproductive Health issues including Maternal & Neonatal Health and HIV, Family Planning, early marriage and Female Genital Mutilation, to improve key community and family practices and to make the treatment of common diseases and injuries available within the community. Promoting education, in particular girls' education, community-based interventions (condom, FP distribution, and education), and media campaigns. [14]

The Logical frame work of the Sudan roadmap to improved awareness and practice of Individuals, families and Community to promote Maternal & Neonatal Health (MNH) includes encouraging communities to practice the home based MNH interventions , enhancing community engagement in community committee, and maximizing the use of multiple media outlets to broadcast messages on maternal and newborn home based care. [14]

The operational plan for the initial phase 2010-2011 of the Sudan road map included in its work plan two main products to raise the awareness among individuals, families and communities toward RH issues: 1) mainstreaming RH communication strategy into RH community interventions, and 2) implementing RH community package. Many activities have been planned to achieve Operationalization of the RH communication strategy and implantation of RH community package by the end of 2011 which include: [15]

1. Finalization of the RH key messages
2. Produce /MNH IEC materials
3. Conduct 4 training courses for media people on RH issues
4. Develop training packages for community RH promotion
5. Printing and distribution of community RH promotion package
6. Conduct 2 TOT courses on community RH promotion package
7. Conduct training of community RH promoters 5 per locality

My reflection is that although it seems that The Sudan national reproductive health policy (2005 & 2010) and Sudan Road Map for Maternal & Neonatal Mortality Reduction 2010-2015 acknowledged the importance of working with individuals, families, and communities to improve maternal & neonatal health”, the proposed strategies, products, and activities don't fully match the strategies and activities proposed by Making Pregnancy Safer (MPS) Department.

Most of the existing / proposed activities in Sudan focus mainly on preparing, distributing and training on RH materials. They believe that this might lead to develop capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies; increasing awareness of the rights, needs and potential problems related to maternal and newborn health, however, more social mobilization strategies are needed in order to achieve this level of awareness and capacity.

Unfortunately, this is not the case usually, in a cluster randomized trial conducted in everyday practice in Wales – UK, they found that evidence based leaflets were not effective in promoting informed choice in women using maternity services [16].

Engaging the individuals, families and communities in maternal and neonatal health activities is a key concept, which is not very clear in the policies, roadmap and proposed activities in Sudan.

It is clear that there is no or limited activities for community dialogue between the community and health services, strengthening linkages for social support between women, men, families and communities and with the health care delivery system.

The Reproductive Health Department in FMOH may argue that (as they stated in their document) *“the initial phase of the road map 2009-2011 will focus on the supply issues of the interventions to make services available first, before fully focusing on a further creation of demand”*[14], I am not sure if postponing demand creation to the next phase is a right decision specially if we know that things at a community level don't move as fast, particularly in Sudan, because of diversity of culture, conflict and post conflict circumstances, different language spoken, limited resources. I am afraid that we are still in the dilemma of focusing on reducing supply barrier and wondering why people don't utilize the services. Strategies that neglect participation of the communities from the first stage in problem identification, prioritization and decision-making will not fully successful in generating demand or increase the awareness and capability to stay healthy.

South Sudan has a special case, While in the North Sudan the first level of health service is the Basic Health Unit, in South Sudan, the first level is Community-Based Health Activities which run by Health Committees (consists of elected community members) and a network of Home Health Promoters (elected by the Health Committee). [17] In my opinion, if this level of care carefully designed and sustained, it will a good potential for to make implementation of working at IFC level a success. As well it prepares a platform - from the bottom up - for any future activities involving the community, and it will facilitate community mobilization and demand generation.

The other issue that I want to discuss here is the applicability of involvement of TBAs in the working at IFC level in Sudan. In spite of the fact that around 20% of deliveries in Sudan are attended by Traditional Birth Attendants (TBAs), a percentage which reaches above 40% in some states [18], and the Sudan Roadmap reconfirmed that TBAs are still attending deliveries even in Khartoum state [14], (although TBAs are now obsolete according to the national policy) they didn't mention any activities linked to TBAs.

In contrast, the document of Basic Package of Health Services for Southern Sudan 2006 stated that:

“Although investment directed at reducing maternal mortality will be made in training midwives and not in training Traditional Birth Attendants (TBAs), co-operation with already trained TBAs can be continued until the uptake of facility-based deliveries, itself conditioned by staffing PHCU/Cs with Community Midwives. TBAs can continue being supported as other Home Health Promoter in roles other than the deliveries, such as IEC activities, iron-folic supplementation, IPT etc”. [17]

Due to the TBAs cultural and social acceptability, knowledge and experience, Making Pregnancy Safer suggested that TBAs can be considered an important ally for health education and social support and a positive link between women, families and communities and the formal health care system, an activity that should be considered by the policy maker and program directors.

A successful story of the community-directed treatment with ivermectin (CDTi) is a good example of engaging the communities in improving their health [19]. In CDTi community members themselves lead the process of drug delivery and treatment to nearly 60 million Africans including Sudanese communities, and significantly ensuring sustained high treatment coverage and advancing the process of disease elimination. Through participation in community directed interventions, Sudan has a good experience in working and involving the communities in improving their health. This is a good potential strength to implement the strategy of “Working with individuals, families and communities to improve maternal and newborn health”.

Other strengths are the Political will, government commitment, and partners' involvement like WHO, UNDP, USAID, UNICEF, IPPF, and many others.

Many barriers and threats may influence the implementation. Socio economic and cultural factors; unclear and under research community contexts, Harmful traditional beliefs and practices which lead to the first delay in the referral system; and poverty particularly among women coupled with low status and poor decision-making power, financial constraints and funding stability, scarce human resources, and attention given

mainly to improve supply side. In addition to that, it is difficult sometimes to convince policy-makers to divert limited and insufficient resources to health promotion interventions.

The effects of conflict, natural disasters, high illiteracy, poverty, diverse environments, vast geographical area, the associated difficulties in transportation and communication represent the major obstacles in the rebuilding the health sector.

The inadequate administrative and organizational capacity, fragile infrastructure and lack of accepted training in capacity building limit success of administration systems in the health sector.

High and quick turnover of health professionals, weak recruitment mechanisms, lack of incentives and insufficient numbers of trained personnel at peripheral levels are constrains for human resources development.

One of the serious factors that might limit the applicability of this document is extensive movement of conflict affected population in repatriation and resettlement.

4 Conclusion

Overall, the guideline of “Working with individuals, families and communities to improve maternal and newborn health” is of high quality and based on the best available evidence. Implementation of the recommended interventions would help to improve maternal and neonatal health.

The scope and purpose of this document including the overall aim of the guideline, the specific questions and the target patient population are clear and fully described. Yet, there is no clear detailed description of the questions covered.

This document relatively represents the views of its intended users and stakeholder involved. However, there is no clear evidence that this document has been informed by the target groups’ experiences, expectations and perspectives, as well as, it is not clear that the recommended strategies have been piloted among target users.

The process used to gather and synthesise the evidence, the methods to formulate the recommendations and to update them are clearly described. However, details of the strategy and criteria used to search for and selecting evidences were not explicitly described. There is no clear description of the methods used to formulate the recommended interventions and how final decisions were arrived at. Moreover, there is no clear evidence that risk, threats and implication on the other existing programs which might emerge as a result of implementation of the proposed comprehensive interventions and strategies have been addressed. It is not clear that each recommended intervention is linked with a list of references on which it is based. There is no evidence that this document has been reviewed externally before it is published. And while it is clear that there is a standing panel receives regularly updated literature searches and makes changes as required, there is no apparent timescale.

The recommended strategies provided an understandable, concrete and precise description of which implementation process is appropriate in different settings and priority areas. These recommendations are easily identifiable through a strategic framework for the development of interventions. However, this document to be effective it needs to develop tools and technical guidance to support the implementation and application of the proposed interventions.

This document is known in our professional environment in the region and in Sudan. The Sudan national reproductive health policies in 2005 and in 2010 in addition to Sudan Road Map for Maternal & Neonatal Mortality Reduction 2010-2015 recommend this strategy as an important component to reduce maternal and neonatal mortality. Most of the existing / proposed activities in Sudan regarding working with the communities focus mainly on preparing, distributing and training on RH materials, with limited activities for community dialogue between the community and health services, strengthening linkages for social support between women, men, families and communities and with the health care delivery system. However, more social mobilization strategies and high level of communities’ engagement are needed in order to achieve the desire level of awareness and capacity.

Although, there are many barriers and threats may influence the applicability of this guideline in Sudan, there are many strengths and potentials for implementation

I strongly recommend these guidelines for use in Sudan to improve maternal and neonatal health. Research is needed to understand the context of our communities in order to be able to work with them to improve their health, particularly maternal and neonatal health.

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