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WHO document review: “Working with individuals, families and communities to improve maternal and newborn health”

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WHO document summary

The complicated aspect of behaviour change and sustainability can be brought about through empowering individuals, families and community (IFC) in the true sense. Increase in awareness & knowledge, positive attitude and requisite skills lead to change in practices. Actually making people realize the importance and benefits of certain public health interventions and empowering them and providing them with support within their community and through service delivery will lead to sustainable behaviour change. Once a critical mass of people start adopting healthy behaviour which benefits the mother and the child, then it will definitely improve overall health and quality of life.

The WHO document "Working with Individuals, Families and Communities to Improve Maternal and Newborn Health" gives a very clear understanding of what Countries need to adopt in order to empower IFC and make a difference to maternal and newborn health.

Over the last hundred years, innovations in medicine, science and technology have resulted in improved health, quality of life and a rise in life expectancy worldwide. In light of this impressive record it is disheartening that the benefits of scientific medicine continue to elude millions of people in the poorer parts of the world. Children and adults are undernourished, live in poor housing and die from illnesses that are often preventable in the prime of their lives. India, with its wealth of scientific researchers and medical professionals, has made impressive gains in scientific medicine, but the health needs of the majority of the population continue to be unmet.

In developing countries death due to pregnancy and childbirth are common and reduction in maternal and infant mortality a real challenge. Thus this has been an area of concern and governments across the globe have set time bound targets to try and achieve the Millennium Development Goals (MDG).

In 2003 the World Health Organization (WHO) published a strategic framework entitled "Working with individuals, families and communities to improve maternal and newborn health" (WHO, 2003), commonly referred to as the IFC framework. Based on the Health Promotion approach of the Ottawa Charter (WHO, 1986), the framework asserts that working with individuals, families and communities is a critical link in ensuring the recommended continuum of care throughout pregnancy, childbirth and the postnatal periods for women and newborn.

The IFC strategic framework is proposed by WHO as a key component of maternal and newborn health (MNH) strategies in developing countries, recognizing that these programs cannot achieve the desired reductions in maternal and neonatal morbidity and mortality if women and their families have no possibility to be healthy, to make healthy decisions, and to act on these decisions.

The framework emphasizes the positive and active role that individuals and groups can play to improve health, as well as the wide array of influences on health, including social, cultural and economic influences. It is designed to be integrated into national MNH strategies, to compliment the health service and policy components.

The integration of the IFC framework within national health programs has two principal objectives:

- Aims to contribute to the empowerment of women, men, families and communities to improve and increase their control over maternal and newborn health. Empowerment for MNH is a means and an end, and occurs both at the individual level, and also at the

collective level, through a process that actively involves people in analyzing their situation and in finding solutions.

- Increase access to and utilization of quality health services, particularly those of the skilled attendant at birth.

The framework identifies key interventions and strategies (based on expert opinion and a review of experiences in different countries) to achieve these aims. The interventions are categorized into four priority areas/pillars, namely:

- Developing **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
- Strengthening **linkages** for social support between women, men, families and communities and with the health-care delivery system
- Improving the **quality** of care of health services and their interactions with women, men, families and communities.

The multiple determinants of maternal and newborn health and the proposed objectives of the IFC component require an integrated approach, with consideration to interventions from each of the four priority areas. An inter-sectoral approach is also needed, in particular looking to collaboration with education, transport, sanitation and income-generating programs. Since establishing the performance of IFC interventions and what it has achieved is critical, this document also provides a succulent monitoring and evaluation framework. An outcome model for the Making Pregnancy safer framework for the development of IFC interventions is provided in the document. This model will help Governments adopt this strategy with ease and make changes as required in the policies and programs to ensure that the demand –side of implementation is strengthened.

Since there is a need to get a buy-in and ownership from various Governments to ensure that this strategic framework is adopted appropriately, the document gives a detailed outline of the 'Role of WHO' and how it plans to support efforts of Member States, their Ministries of Health and other sectors that play a role in improving the health of mothers and infants and saving lives.

Literature search

The WHO document "Working with Individuals, Families and Communities to Improve Maternal and Newborn Health" gives a very clear understanding of what Countries need to adopt in order to empower IFC and make a difference to maternal and newborn health. [1]

"We need to focus more on the most vulnerable children: the newborns. Many conditions that result in a newborn dying can easily be prevented or treated. We need a combined approach to the mother and her baby during her pregnancy, to have someone with knowledge and skills with her during childbirth, and effective care for both after birth." —Gro Harlem Brundtland, Director-General, World Health Organization [2]

Many governments and nongovernmental organizations (NGOs) are working with communities to identify gender constraints and develop culturally sensitive programs to help people make better decisions about their health and the health of their newborns. For example, the Bayalu Seeme Rural Development Society, which carries out community-based projects

with farm families in the Indian state of Karnataka, has developed new activities to address gender-based constraints identified by local women. Women's groups have selected traditional birth attendants for training and have pressured health authorities to provide gynecological services and regular visits by an auxiliary midwife. A project evaluation showed that participants were more likely to have at least three antenatal visits and to have trained personnel attend them during childbirth than nonparticipants were. The evaluation also found that participants were more likely to say that they had the right to make decisions and move freely outside the home, participated in politics and public protests, and were willing to act against domestic violence. [3]

Roughly 60 percent of births in less developed countries occur at home, so parents need to be educated about what they can do to save their newborns' lives. [4]

Families need to adopt better nutritional practices, including breastfeeding; learn how to dry and warm their newborns; and better understand the danger signs of maternal and neonatal complications. Saving newborn lives depends on a broad based coalition that includes donors and international organizations that can provide policy focus and funding, governments that are willing expand their commitment to national and local health care services, and NGOs and grassroots organizations that can work with communities to pass on information on saving newborns.[5]

A cluster- randomized control trial in a population of 104,000 people in Shivgarh, Uttar Pradesh, in northern India, a community mobilization strategy reduced neonatal mortality by 50 percent over the first 12 months of program implementation. The program involved pregnant mothers, their families and key influential community members, as well as community health workers and increasingly, community volunteers who visited the homes of pregnant women twice during their pregnancy and once within three days of delivery. The community took over the communication process by turning the newly negotiated practices into songs. They saw from personal experience that the new practices worked, and once that happened, these practices- for example skin-to-skin contact of mother and baby immediately following birth and immediate breastfeeding- became almost universal in the community. [6,7]

Consequent to the adoption of NPP 2000, the village panchayats (local self governing agencies) have become important stakeholders in the field of health and for FW. One of the promotional and motivational measures is to reward the panchayats and the Zila Parishads for exemplary performance. Panchyants can play an important role in the universalization of the small family norm, and thereby achieving reduction in IMR, birth rate and promoting literacy for completion of primary school, for achieving the goal of Health for All by 2010. [8]

Every year, thousands of women and babies in India die due to complications of pregnancy and delivery—most of them preventable. Sure Start works consistently toward creating awareness of maternal and newborn health in the wider community and focuses in particular on helping women and their families make individual decisions which will make motherhood safe and give babies the best possible start in life. The essence of Sure Start's endeavor is to work in close partnership with families and community groups through collaborative and creative initiatives, encouraging them to become agents of lasting change in urban and rural societies. [9]

Bringing together women, families and communities with health care providers is not an easy process. However, sufficient evidence exists to demonstrate that, unless they begin to work more closely together, the goals for maternal and newborn health, including the reduction in morbidity and mortality cannot be achieved. [10]

Cultural attitudes and behaviors, such as machismo and paternalism, can have a particularly negative impact when food and feeding is seen as the purview of women only and therefore considered relatively unimportant. A father in Guatemala noted that, "Our young children aren't malnourished. The older children are the same and they are alive and well." Careful and culturally-appropriate methods of convincing fathers to participate and to allow their wives to participate must be developed and implemented. The process of community entry and sensitization must therefore go beyond the community at large, or even the community leaders, to specifically include husbands of participating women. The men of the family should be considered as actual participants in the process and not as just another element of the community at large. The women and men must be jointly engaged in the search for high potential solutions. [11]

A large proportion of women each year deliver with no skilled birth attendants, and many more mothers and newborns go without any post-natal care during the most vulnerable days and weeks after birth. Children born to unhealthy mothers are also more likely to be under weight and to have difficulty combating illness. They face an environment that is less able to provide safe and nurturing conditions that are necessary for their healthy growth and development. The Member States of the South-East Asia Region expressed their concern and adopted a resolution at the 53rd Session of the Regional Committee for South-East Asia held in New Delhi in September 2000. The resolution emphasizes among others, the need to incorporate the national strategy for reduction of maternal mortality and morbidity as an important element of health sector reform. [12]

An assessment done of MCH programs in India suggested the following; 'Interventions recommended for optimal community-based newborn care (Short Term Package – During the Next Five Years); early and exclusive breastfeeding, prevention and management of hypothermia (including 'kangaroo' mother care at home), clean delivery, tetanus toxoid immunization, community-based pneumonia case management, intermittent presumptive treatment of malaria in endemic areas* and community-based resuscitation of newborns*(* There was consensus among experts on interventions 1 to 5. For interventions 6 and 7, although the majority of experts recommended their inclusion, there was no consensus on these interventions for the short term package.)'

They also mentioned that more information is needed about how to engage Panchayati Raj Institutions and about how Village Health Committees can contribute to newborn survival and focus on equity. Although NGOs and community-based organizations such as Village Health Committees and women's groups are often used for community mobilization and health education efforts, there is little information on how to sustain their work and the feasibility of similar efforts supported through Government systems and programs. Many interventions have been successful at small scale, but more information is needed about how to implement similar efforts at large scale and which factors are most important to the successful scale up of an intervention. [13]

WHO document appraisal

1. Scope and purpose of the WHO document

1.1. The objectives of the guideline are specifically defined?

A: In my opinion the document I reviewed had a very clearly articulated scope and purpose. This document had a very specific scope i.e. how working with individual, families and

communities would make a big difference in improving maternal and newborn health outcomes.

1.2. The questions covered by the guideline are specifically described?

A: The various components covered by the guideline document are clearly mentioned and various steps on how to operationalize the concepts and strategies are described in detail using models and conceptual framework.

1.3. The patient/community/group of people (women, men, children, adolescents...) to which the guideline is meant to apply is specifically described?

A: This is a document and not a guideline. But yes the various stakeholders were considered while putting together this document.

2. Stakeholder involvement

2.1. The guideline was developed with the involvement of different relevant professional group?

A: Various International Organization representatives and Making Pregnancy safer Department of WHO were closely involved in the development of its document and its review.

2.2. Patients and target groups views and preference have been sought?

A: The target groups views were not sought i.e. the various individual Governments (Dept. of health and Family Welfare) and policy makers.

2.3. Who are the users of this guideline (doctors, nurses, midwives, health workers etc.)?

A: Governments (Department of Health and Family Welfare) and NGOs who work in the field of maternal and neonatal health.

2.4. Has the guideline been piloted among target users?

A: The Secretary General of Enfants du Monde (EdM), Carlo Santarelli, under a mandate by WHO, was responsible for the elaboration of the framework. EdM subsequently adopted the IFC framework in Bangladesh, Burkina Faso, El Salvador, Guatemala & Haiti. Also made contacts in Niger and Rwanda.

3. Document development

3.1. Systematic methods were used to search for evidence?

A: The document based its main conceptual approach on the Health Promotion Approach as outlined in the Ottawa Charter, 1986. The maternal mortality estimates were then developed by WHO, UNICEF and UNFPA. Hence this document is based on evidence available globally.

3.2. Criteria for selecting the evidence are clearly described?

A: The source of the evidence and why it will work is described briefly. But in my opinion the practical aspects of actually making a difference when implemented through Governments and Departments of health at the grassroots level is missing. It seems more theoretical than practical and doable.

3.3. Methods used for formulating the recommendations are clearly described?

A: This document has operationalizing strategies and roles but no specific recommendations.

3.4. The health benefits, side effects and risks have been considered in formulating the recommendations?

A: Not applicable to this document.

3.5. There is an explicit link between the recommendations and the supporting evidence?

A: Not applicable to this document.

3.6. Procedure for upgrading the guideline is provided?

A: Since this is a strategy document no guideline for upgrading is provided.

3.7. The recommendations are specific and unambiguous (clear)?

A: Not applicable to this document.

3.8. Key recommendations are easily identifiable, practical and strong?

A: The operational concept and strategies are easily identifiable but not very practical since constraints in working with Governments On the demand –side issues have not been addressed very concretely.

3.9. Guideline is supported with tools for application?

A: Yes, tools for designing National IFC strategies have been provided and for evaluating the impact.

3.10. Has the guideline had peer review and testing?

A: Not apparent from reading this document.

4. Applicability

4.1. Is this guideline known in your professional environment?

A: Not really. But similar concepts are frequently discussed by INGOs and NGOs.

4.2. Are the recommendations applicable to your professional practice, are they applied in your country?

A: As mentioned above, the concept of IFC is practiced by INGOs and NGOs in pilot projects. The Govt. of India through its National Rural Health Mission (NRHM) put in place to involve communities at the grassroots level by giving provision for forming Village Health and Sanitation Committees, Self-help groups and Local self-Governments (Panchayati Raj). But in reality these groups have been partially formed and where formed not very clear about their roles and responsibilities. Overall the Govt. programs are more services (supply) related rather than demand generation. It does not have the necessary human resources within the system to truly involve IFC. If the health systems strengthening efforts, accountability and actual implementation of District Action plans happen then perhaps this IFC model would be really applicable and can make a definite difference not just to improve maternal and newborn health but also the overall quality of life of the marginalized people.

If not:

4.2.1. What are the barriers to implement this guideline in your professional practice?

Some factors, which limit the applicability of guideline:

- Financial factors: Not an issue----a lot of resources are unspent
- Organizational (lack of human resource, skills, material and equipment) : is an issue

- Peer group (difference between local standards and desired practice)
- Individual factors (lack of knowledge and skills)

A: Same as mentioned above.

4.2.2. What are the guidelines used in your institution/country (please provide references or documents)

A: The main guidelines used in my Country are based on the NRHM policy documents and the State Implementation Plans which talk about committees at the village level to involve communities (Ministry of Health & Family Welfare, India).

4.3. Would you recommend this guideline in your professional practice or in your country?

A: Yes, definitely. In fact as mentioned above to some extent many pilot projects have worked on the IFC strategy but scalability and sustainability is an issue. The real challenge is to get the Govt. to adopt this approach.

Conclusions

The IFC document based on the Health Promotion approach is really a strategy that I think is very relevant in public health today. The main challenge is to convince Governments and show them simple ways of actually doing it. India has a Planning Commission and a representative for Health who is a great champion of proactive policies. Similarly, (as I have very oft mentioned in high level meetings) the Country needs an Implementing Commission too which will ensure that the wonderful policies and strategies that are developed in my Country and by the global Organizations, are actually implemented at the ground level even in the remote villages.

Many factors contribute to poor quality of implementation and health care: lack of necessary supplies or equipment, lack of awareness of standards, low provider competence, poor organization of care, and lack of motivation or rewards for quality. Inefficient organization of care is common in many settings, resulting in poor health care quality and waste. Culturally inappropriate care or poor interpersonal treatment also contributes to poor quality care and negatively affects acceptance and utilization of health services, especially by disadvantaged and underserved groups.

The system needs stewardship at all levels: strong policies and institutions that foster public-private partnerships encourage the private sector to invest in rural areas, and strengthen the resource pool so that flagship programs (such as the National Rural Health Mission) can succeed. The WHO document “Working with Individuals, Families and Communities: To improve Maternal and Newborn Health” is a good document to base a National IFC strategy on for any Country. Detailing out the practical implementation steps and ensuring buy-in and commitment at all levels of the Govt. will achieve sustainable behaviour change and improve health seeking behaviour by proactively involving individuals, families and communities.

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