Scaling up community engagement

to improve access to maternal, newborn and child health services

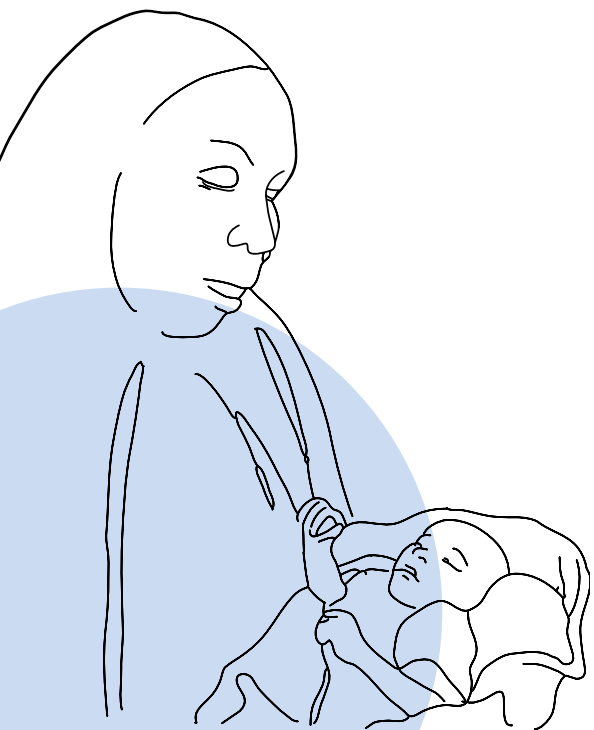
Key messages:

1. **PRRINN-MNCH used a strategy of local dissemination to rapidly scale up a successful community engagement approach. The end results were achieved in a highly cost-effective way.**
2. **Successful local dissemination depends on the quality and sustainability of the MNCH response in 'hub' communities. LGAs need to provide low-key, ongoing support to these communities help maintain motivation and focus.**

The challenge: large populations needed to be reached

When PRRINN-MNCH started working in Katsina, Yobe and Zamfara states, numerous barriers prevented or delayed communities using MNCH services. Baseline studies showed that if health-seeking behaviours were to change, all barriers had to be addressed simultaneously and entire communities had to be mobilised around a MNCH agenda.

A further challenge was to design an approach that could be implemented at scale by local partners. The combined population of the local government areas (LGAs) in which PRRINN-MNCH was working was 9.5 million. Previously all other health-related community engagement (CE) activities in the north of Nigeria had been implemented on a small scale, usually on a pilot basis. PRRINN-MNCH was therefore in new territory.



The response: local dissemination

PRRINN-MNCH and its partners adopted a three-part strategy to achieve scale:

- Test a community engagement approach in pilot intervention sites
- Scale up the approach using government and programme resources
- Use a strategy of local dissemination to roll out on a much greater scale

The CE approach was tested initially in nine LGAs in three states covering a population of approximately 250,000. The pilot sites were particularly remote or hard to reach.

The pilot phase lasted 18 months. Thirty six new LGAs were then added over a 17-month period, increasing population coverage to 1.74 million (a seven-fold increase). Despite the rapid pace of scale-up, only 20% of the potential population of the intervention LGAs was being reached. Hence it was important to find a way to increase coverage.

The programme adopted a strategy of local dissemination to increase coverage. Trained community health volunteers in the PRRINN-MNCH supported intervention sites ('CE complete communities' or hub communities) shared what they knew, and provided ongoing support and encouragement, to neighbouring communities ('CE light communities') with minimal external support.

A key question for PRRINN-MNCH and its partners was whether outcomes and impact in the CE light communities were comparable to those in the sites that received more intensive support from the programme and its partners.

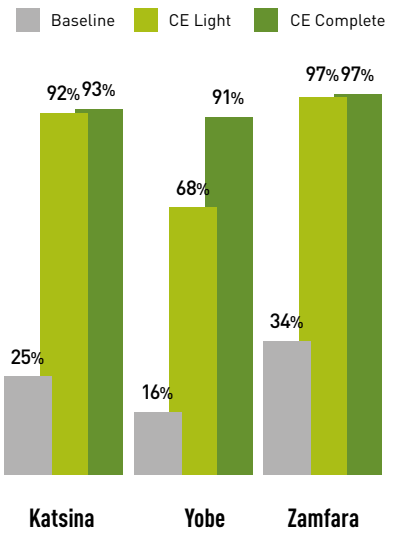
The results: positive changes in CE light communities

A knowledge, attitudes and practices endline survey (KAP) in early 2011 found considerable positive shifts in MNCH attitudes and behaviour in the CE light communities.

All three states showed a dramatic improvement in knowledge of at least four maternal danger signs in both types of community (Fig 1).

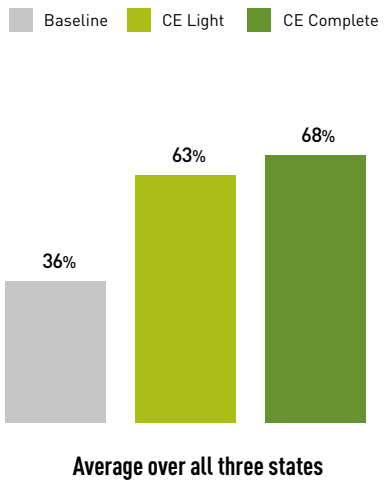
THIS DOCUMENT IS ONE OF A SERIES OF KNOWLEDGE SUMMARIES THAT DRAW ON THE ACTIVITIES, RESULTS AND LESSONS LEARNED FROM THE PRRINN-MNCH PROGRAMME

Fig 1: Knowledge of 4+ maternal danger signs by type of site



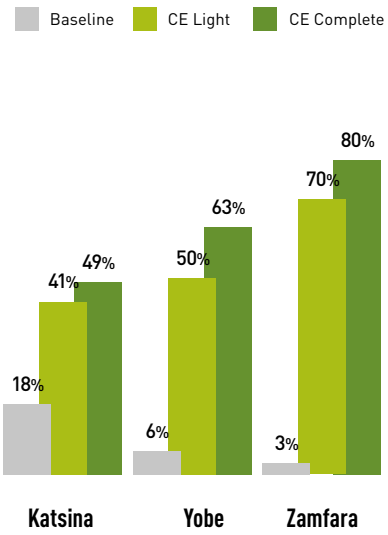
The percentage of respondents who were prepared for a maternal emergency was similar in the CE complete and CE light sites (68% and 63% respectively) compared to a baseline result of 36% (Fig 2).

Fig 2: Preparedness for maternal emergency by type of site



In relation to children with the complete set of vaccinations, both types of site had results that were substantially better than the baseline situation (Fig 3).

Fig 3: Children with 4 vaccinations by type of site



Policy implications

The local dissemination strategy resulted in a three-fold increase in the number of intervention communities across the three states (from 806 to 2,398). Population coverage increased from 1.74 million to 4.3 million people. This translated into 45% coverage of the intervention LGAs. The sites included many of the most remote or hard to reach communities. In future, continued emphasis on providing direct support to hub communities while promoting local dissemination will allow the LGAs and eventually the states to achieve 100% coverage at speed.

Considering the minimal external investments made in the CE light sites, with the results derived from communities' own investments, the changes in MNCH attitudes and behaviour were obtained in a highly cost-effective way.

"The MNCH activities have brought progress to our community... we are now united and we do things together. We have started rolling out to other communities like Afuntuna, Chadi and Kadirawa." Community Health Volunteer, Katsina

The fact that communities drove the process of local dissemination, choosing where and when to support neighbouring communities, also bodes well for long-term sustainable change. The efforts to reach out to and support neighbouring communities point to improved prospects for greater social support and cohesion.

Performance in the CE light communities mirrored closely that of the CE complete communities. Hence, getting the strategy right in the core communities is essential to maximise positive spin-offs from these initial community-based investments.

Conclusion

Taking community-based MNCH interventions to scale where large populations are scattered over huge geographical areas is challenging. PRRINN-MNCH demonstrated that it is possible to design a comprehensive, integrated and inclusive community engagement approach which empowers rural communities to address poor MNCH indicators, while rolling this out at scale.

PRRINN-MNCH

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

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