Social mobilisation guide - a community mobilisation approach

An example of salt reduction and stroke prevention in Sierra Leone from the RUHF programme[1]

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Introduction

Social mobilisation in this context means sharing knowledge and bringing about action to improve health. It involves a technical working group who initiate and guide the process. It involves village or urban area community leaders and stakeholders – such as traditional and other leaders, priests, imams or other faith group leaders, community health workers, pupils and students teachers etc.

The technical working group work with the initial 'pilot' site stakeholders to develop the approaches and materials, e.g. messages and posters. Learning from this pilot site the approaches and materials are refined. They are then replicated, working with the new community stakeholders. In each community the stakeholder group may adjust the materials and methods to their local situation.

An example of this was salt reduction to reduce high blood pressure (and to reduce strokes and heart disease) in Sierra Leone, where there were activities such as community meetings and schools outreach activities. In addition, there was a successful local radio intervention where stakeholders heard the opportunity to share their stories and inspired many to reduce their salt intake.

1 https://www.qmu.ac.uk/research-and-knowledge-exchange/research-centres-institutes-and-knowledge-exchange-centres/institute-for-global-health-and-development/nihr-research-unit-on-health-in-situations-of-fragility-ruhf/

How to use the guide

This is a concise guide on how to develop social mobilisation interventions with a community mobilisation approach. Guidance is given from known principles in social mobilisation and our experience in Sierra Leone, examples of which are given in the text boxes. Suggestions are then made for scale up.

We refer to pages in the WHO guide on social mobilisation for health promotion in places if the reader would like more in depth information: https://iris.wpro.who.int/handle/10665.1/6735. Page numbers are indicated in brackets.

This WHO guide includes a wider scope, including 'Political', 'Government', 'Corporate' 'Community' and 'Beneficiary' mobilisation. In this guide, social mobilisation is equivalent to the 'Community' mobilisation. Principles of social mobilisation

Social mobilisation is a method used to solve a specific problem in a community by the participation or engagement of community themselves. They have ownership and control over the process and are empowered with the knowledge and skills to carry out the specific actions in the community to achieve change. They will help to create change in the community (becoming 'ambassadors for change'). There a several approaches; our guide is based on community mobilisation, whereby the community leaders ('stakeholders') spread their messages via their networks in which they hold influence, and also via local media to reach the wider population (p5).

Social mobilisation is about community leaders/people taking action towards a common good.

Salt reduction as an example

We developed a social mobilisation intervention in a village in Bombali District Sierra Leone, working with community leaders in 2020-21. The villages typically have structures, such as village development committees and the facility management committees, which were useful in organising the stakeholder task force. Community meetings and actions such as local radio shows were effective in promoting behaviour change with respect to salt reduction and other behaviours to reduce hypertension and stroke in the community. In-depth consultation was done with the community and wider stakeholders on non-communicable disease[2], which lead to the decision of a social mobilisation approach and concentration on salt reduction to tackle hypertension and stroke. The WHO document suggests a method to undergo a situational analysis prior to undertaking the intervention (p7-12). Health programme staff act as 'catalysts', helping with information, and 'facilitate' i.e. mobilise change, building partnership links between community leaders who can make things happen. Successful behaviour change through social mobilisation can add confidence for community members to change other aspects that affect their health and wellbeing.

2 https://www.qmu.ac.uk/media/10279/strengthening-ncd-services-at-primary-care-level-brief.pdf

The process

Phase 1 Intervention and materials development

Developing a TWG

The technical working group (TWG) should consist of people who have an invested interest in tackling the problem identified. Specifically, it is important to have members of the team who are knowledgeable about the social mobilisation approach, while all should be committed to an intervention that is community owned and lead. It may involve people from governmental and non-governmental organisations. A facilitator should be chosen who will be trusted by the community, able to build bridges between community stakeholders, help them play to their strengths and guide them on the delivery of the intervention. WHO describe this person as the catalyst for change (p13).

A budget should be developed, aiming for as limited resources as possible to ensure sustainability and replicability are possible. The group members should have defined roles and activities assigned, with a clear workplan.

The Sierra Leone TWG members included:
- *Intervention facilitator*
- *District social mobilisation lead*
- *Research assistants*
- *Local/village Clinical Officer*
- *Researchers from medical school in Sierra Leone*

The technical working group can help with:

- Focus group discussions in framing the problem clearly within the community
    - This is important to understand the root causes of the problem and the perceived best ways of tackling it
    - Information can be relayed to the local leader stakeholders delivering the intervention
- Knowledge transfer of the problems root causes, and evidence-based solutions
    - This will be initially to the stakeholders, who can adapt this more to the local context e.g. shaping messages according to language, literacy, media that are used and trusted by community members
- Choosing the most appropriate intervention community area to start the work
    - There should be active community structures
    - Consideration should be given to social capital that will aid success of the intervention
    - The problem should be relevant and of interest to community members
    - It will be easier to implement if there has been or is some current activity to tackle the problem
    - Ideally there should be a community health centre or relevant institution that is trusted by the community and wanting to engage in the activities

- Choosing the community stakeholders (described as health promotion champions, p17) who will co-develop and deliver the intervention
    - These people should want to actively participate
    - They should be influential in their community and have activities in which they can already spread messages, e.. school teacher to pupils
    - They will have some broad ideas of how to tackle the problem
    - They will be good communicators and able to work together with different sections of the community with cultural and gender differences, varied literacy levels and socioeconomic status
    - The range should be representative of the whole community impacted by the issue e.g. youth, adults, different religions and occupations
    - Representatives of the locally relevant organisations should be considered, e.g. community health workers, district health management team social mobilisation lead, health centre worker, Village Development Committee member, Facility Management Committee member
    - Include those who may already be active in the area of concern
    - Participant should be agreeable and available to attend meetings, and devote a set amount of time per month to the activities on a voluntary basis, with costs covered.

Choosing the correct stakeholders was key to the success of the Sierra Leone intervention. 20 members were chosen. They included religious leaders, teachers and youth leaders. Some were illiterate. The stakeholders were chosen by the local community health officer and the facilitator based on their social capital and involvement in the village development committee. These people were therefore already expected to be working on developing and improving the health and wellbeing of their community. Face to face discussions were held with each to explore their interest and motivation for involvement, with the knowledge of the time required for commitment and that this is not paid work.

- Develop a broad outline for a pilot intervention in a community
    - This is important to have as a starting point for the stakeholders to plan around
- Develop a budget for the stakeholders to:
    - cover expenses, participation should be otherwise voluntary
    - facilitate meetings
    - cover costs of activities e.g. radio airtime
    - pay for materials required e.g. posters
- Develop outline of options for community mobilisation actions
    - Initially the stakeholders should be consulted on the best way they know to transfer knowledge to the community to create behaviour change
    - Common evidence-based activity options for behaviour change can be offered
- Co-develop materials for actions
    - Materials may be produced by the community; if so, the accuracy of content can be checked by the health workers in the TWG
- Pilot and assess the intervention and adapt/refine the details before replicating the process with these materials in the next community

- problem solving when a barrier exists, for example coronavirus restrictions; the TWG can help the facilitator to think of other ways to carry out activities

The Sierra Leone TWG met every 2 weeks to discuss progress, barriers and solutions. Each member had roles and tasks that were shared at the end of each meeting with clear timelines. This allowed easy monitoring of the intervention to ensure goals are reached or were adapted to changes in circumstances.

The community stakeholder meetings

The following is a guide on content for each meeting. Meetings can happen as a group or may be split into smaller meetings amongst team members once activities are allocated. As far as possible, the community stakeholders are encouraged to be involved in setting up meetings and organising themselves. This would include ensuring timings are a convenient to all members. Ensure the meetings are as brief as possible, and no more than half a day to ensure people are not kept away from their daily tasks for too long and increase the likelihood of participation of otherwise busy people. Ensure the meetings are kept as low cost as possible.

Stakeholders met at the local community health centre which is on the main road, this ensured it was a recognised place, and easy to access. It is near the local market and other conveniences to making it a more attractive place to meet. It meant the busy clinical officer was also able to easily attend, who was instrumental to the meetings.

The technical working group considers the strategies (based on their situational analysis and knowledge of the community) and then meets with the community stakeholders. Such knowledge may have come from initial discussions with the stakeholders, e.g. from talking to the priest they may discuss ways they can help influence behaviour amongst the worshipers that come to the church. These discussions identify the strengths and weaknesses in the community stakeholder group and play to their strengths. It is also important to quickly recognise where consensus lies on specific activities, even if you do not think it is the best idea yourself; trust the stakeholders as they are likely to know best. If there are challenges within your own TWG or organisation that may impact on the intervention, then be honest about this also. Transparency is key (P31-36).

There were unforeseeable issues leading to a delay in some resources, e.g. posters. The facilitator was transparent about issues, and the stakeholders were motivated to continue and adapt and moved on with their mobilisation efforts. Managing resource constraints is a common problem in social mobilisation efforts (p40).

Meeting 1 (p27)

- Discuss to achieve a shared understanding of the health problem
- Be transparent about the budget available (if this is coming from outside of the community, e.g. government funds). People can then be realistic about the activities and the resources required, plus their own expenses that can be covered.
- Share an outline of the plan and example activities, while discovering those important to the community stakeholders
- Agree on roles and responsibilities of the stakeholders

Meeting 2

- Facilitate the development of clear action plans for each activity e.g. material development (e.g. translating/ adapting a national material), production and how to deliver the materials to the community

- TWG members and stakeholders to agree on who will who develop materials, who will attend radio discussion programme, who will create/ put up posters

- Begin to co-develop the materials required

  - Consider the feasibility criteria for what is proposed: gender/cultural feasibility, organizational feasibility, financial feasibility – and so how sustainable and replicable the activities are.

  - Materials should be developed with the technical working group, with some specialist support for the accuracy of content. This should be in line with national or WHO guidelines.

- Check with stakeholders, what they want to learn from the project e.g. the number of people engaged through each activity? Can the stakeholders monitor/evaluate their activity?

Meeting 3

- Review actions and outcomes (p 28)
- Reflect on challenges and successes (29)
- Refine materials if necessary

Meeting 4

- Plan for replication to other communities (beyond the initial site)

Replication Process

Example materials – produced from RUHF salt reduction project in Sierra Leone

Local radio debates and jingles

1 Through the workshop identify common misconceptions and barriers to salt reduction and high blood pressure prevention
2 Turn these into catchy jingles with support from local popular radio stations
3 Approach influential speakers, knowledgeable around salt and high blood pressure for radio debates and discussions

The main local radio stations were contacted and commissioned to make a jingle in the two main languages of the community. The jingle was based on key messages that were co-developed by the TWG and community stakeholders. This was aired for several months. 6 radio show panel discussions were held also with speakers including the district nutritionist, the facilitator, stakeholders and the clinical officer.

Radio show discussion with experts

Community awareness raising activities

1 This was through community stakeholders utilising their roles to spread messages in the community e.g. community health workers or traditional birth attendants
2 Stakeholders that carry out meetings with other community members may wish to spend a minute raising awareness about the problem e.g. village leader or imam
3 General messages can be discussed, and questions answered
4 Posters and stickers can be distributed and put in key areas

Stakeholders split up into teams of social mobilizers and took a specific day and part of the village to walk around and opportunistically talk to groups of people about salt reduction, hypertension and stroke. They supplied stickers and posters and wore T-shirts with key messages on them. They also carried out meetings in the community with up to 30 participants, which the clinical officer also attended and where he opportunistically offered to check blood pressures. This resulted in new identified cases of high blood pressure.

Community awareness raising

School outreach activities

1 Organise the message with the local experts
2 Meet with the head teacher to decide on how best to organise the meeting
3 Keep the meeting short and the messages brief and simple
4 Try not to take away from their regular education
5 Get the pupils to reflect on how they might spread this knowledge further and how they could change their health behaviours

Community stakeholders, including teachers, discussed hypertension and salt reduction at schools with their students. The community stakeholders developed the messages with the clinical officer who also attended to answer questions. This resulted in school going pupils educating their family members, and also requesting street sellers to put less salt in their food.

School outreach activity

Conclusion

Social mobilisation is a way of sharing knowledge and bringing about action to improve health. It involves a technical working group and stakeholders developing the approaches and materials to use. We learn from this initial 'pilot' site and refine the approaches and materials. Then they are replicated, working with the new community stakeholders (local/religious leaders, health workers, teachers etc.). In each community the stakeholder group may adjust the details to their local situation.

An example of this was salt reduction to reduce high blood pressure (and so reduce strokes and heart disease) in Sierra Leone, where there were activities in the community meetings and schools' activities etc. In addition, there was a successful local radio intervention. We have also carried out a review of this pilot to learn lessons on its effectiveness and design.

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