

Review Article

Community Mobilisation: A Concept Analysis

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ABSTRACT

Background: Community mobilization is a process for reaching out to different sectors of a community and creating partnerships in order to focus on, and ultimately address, a pressing issue such as child morbidity and mortality. This process empowers community members and groups to take action to facilitate positive change. The concept of community mobilisation continues to be one of the most contested concepts yet characterized by ambiguities in its definition and meaning. However, various players are in agreement that it entails the following processes, mobilizing necessary resources, disseminating information, generating support, and fostering cooperation across public and private sectors in the community. Mobilization efforts are described in the literature as “building community or collaborative partnerships,” “community engagement or involvement,” or “coalition building.” Though some of these terms refer to specific structures, the underlying goal of engaging a wide-range of community members to create and implement a shared vision is the same. When this process is effectively explored it results in improved health outcomes and full empowerment of a targeted community.

Materials and Methods: Walker and Avant’s framework was used to analyze the concept and the related literature published between 2010 and 2015. A total of 66 papers were analyzed.

Results: Review of the literature showed that community mobilisation is a complex process. Moreover, to occur successfully, it requires some necessary antecedents like identification of community needs and community mapping (Formative research), contextual participatory approaches integrating all stakeholders in all steps of the process. The main consequence is ‘social learning’ for both health promoters and local people leading to mutual understanding and better health outcomes. In addition, this study revealed some empirical referents which are helpful to evaluate the process.

Conclusion: By aiming to bring out a clear picture on the concept of community mobilisation, this paper highlighted its attributes, antecedents, consequences and empirical referents. Identifying the characteristics of this concept may resolve the existing ambiguities in its definition and boundaries thereby facilitate distinction from similar concepts. Similarly, these findings can be used in effective community mobilisation for better health outcomes in various health disciplines and in the development of useful theories, models and tools for assessing and evaluating health programs.

Key words: Community mobilisation, Concept analysis, participatory approaches.

INTRODUCTION

Community mobilisation is a concept that has been used and defined in various disciplines and contexts but with a diffuse and heterogeneous meaning. Community mobilization is a frequently

used term in developmental sector. It has been proved to be a valuable and effective concept which has various implications in dealing with basic problems like health and hygiene, population, pollution and gender bias. The concept encompasses a wide range

of interventions and approaches that include community meetings; training or sensitization sessions with traditional authorities, community or religious leaders; street theatre and other cultural activities, marches and demonstrations. It also entails the process of building community capacity to self-identify priorities, resources, needs and solutions in such a way as to promote representative participation, good governance, accountability and peaceful change (Mercy corps, 2011).

Community mobilisation occurs along a continuum and exists in different levels but the ultimate goal is full empowerment and ownership of processes and outcomes by a given community or society. Most of the community mobilisation approaches tap on the innate and inherent community capabilities by making use of 'positive deviance' that always exist in any given community for a recommended practice. This paper seeks to unpack the concept of community mobilisation in the context of health, outlining what it is and the key features and attributes of true community mobilisation in the realm of health programming. A full comprehension and utilisation of the concept of community mobilisation will result in effective community health systems strengthening and ultimately improve health outcomes for all groups of people in any society especially the most vulnerable groups. Walker and Avant's, 2004 model of concept analysis will be employed to guide the process of concept analysis.

Step 1: Identify the aim/purpose of the analysis

Aim: To explore and clarify the characteristics of community mobilisation and distinguish between the ordinary and holistic usage of the concept.

MATERIALS AND METHODS

Walker and Avant's eight-step concept analysis method was used. The iterative steps are Selecting a concept, Determining the purposes of analysis,

Identifying all uses of the concept, Determining the defining attributes, Identifying a model case, Identifying additional cases, Identifying antecedents and consequences, and Defining empirical referents. This paper reviewed existing literature to fully substantiate the concept and holistically comprehend its usage in various contexts. The key words used in literature searches were community mobilisation, mobilisation approaches and social mobilisation. The inclusion criteria for papers was as follows (i) papers from the health field and community development (ii) English language (iii) Concept analysis papers (iv) Studies on efficiency and effectiveness of community mobilisation approaches. A total of 66 articles were initially identified. These were scaled down to 7 papers through screening by relevance. Thematic and content analysis was employed to merge codes in line with the 8 iterative steps in Walker and Avant's model for 2004.

RESULTS

Step 2: Significance and uses of the concept

Community mobilisation in health is a critical pillar for community empowerment. Through community mobilisation one facilitates sustainable community development through capacity enhancement. This entails fostering skills and knowledge, developing commitment to better health outcomes in the local people and enhancing partnership with health workers. Community mobilisation approaches are used as a conduit for the decentralisation of health services and education to the grass roots to attain saturation coverage. This is in line with the dictates of the Primary Health Care approach that services should reach the most vulnerable groups (accessibility) and should be affordable.

Community mobilisation has a lot of significance in the promotion of positive health seeking behaviours as it promotes change at the societal level, beyond the

individual. It also makes use of the available social capital and existing social ties to foster positive behaviour change. Through community mobilisation, social advocacy for policy change is achieved and engagement of communities from grassroots always results in inclusive and comprehensive approaches informed by facts and reality on the ground. It is only through effective community mobilisation that communities can dream of equity and equality in access to and utilisation of health services.

Step 3: Defining attributes

Community mobilization is resource intensive; it is a process that requires stakeholders to engage in authentic power sharing. It requires mastery of several skill sets, and demands intensive saturation. Community mobilisation is a system that catalyses' the development of community specific interventions as well as a paradigm shift from social service to social change. Community mobilization is a process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve the health, hygiene and education levels so as to enhance the overall standard of living in the community.

A community is a group of people, based on common values and norms, who live within a geographically defined area and who share a common language, culture or values (David Werner and Bill Bower, 1996). It can also be defined as an area or a village with families who are dependent on one another in their day-to-day transactions, enjoying mutual benefits. From this background it is logical that community mobilisation encompasses holistic engagement and active participation of community members to the highest extent possible in bring solutions to their own health-related problems. The genesis to community mobilisation is knowledge of a community since the process of

mobilisation is an active process and meaningful participation is the only recipe to sustainable and cost effective troubleshooting and problem solving (David and Bil, 1982).

The process employs participatory approaches that are contextual and relevant to the target population in problem identification and problem solving. Communities have different amounts of resources and different values and beliefs. The diversity in community dynamics and structures makes some approaches applicable in a one community yet taboo and ineffective in the next community hence the facilitator (s) cannot make an assumption that they know everything basing on previous experiences. It involves community self- assessment and decentralization of power to communities allowing them to take the lead in what they can do hence supports the movement from known to unknown in fostering positive behaviour change. Discussing the results with the community help them learn and appreciate why certain activities in health promotion and diseases prevention failed or succeed. Community health education is appropriate to the extent that it helps the poor and powerless gain control over their health and their lives.

Participatory approaches inclusive of: (I) Story telling (ii) Songs (iii) Playing (iv) Role playing (v) popular theatre (vi) Practical experience (vi) small group discussions (vii) Sketching maps are often used to stimulate learning. These are liberating approaches to educate; transform society to meet people's needs and stem from strength based approaches which employ the concept of positive deviance in mobilizing for behaviour change. Flow of knowledge and ideas is both ways (mutual learning) methods and help the weaker get stronger. Its purpose is not to provide services to communities but to stimulate them to develop strategies to address their own health challenges. Community mobilisation seeks to empower communities to recognize and change the existing

negative norms relating to their own health.

In summary community mobilisation in health involves exploring health issues and set priorities. This is followed by planning with the community, collaborative action and all inclusive evaluation in preparation for scaling up and expansion of recommended practices. The preparation involve mobilisation of more people and community organisation for action and the cycle starts again and again.

Step 4: Identifying a model case

A model case is a pragmatic example of the concept which includes all defining attributes of the concept (Walker and Avant, 2005). It can be a real instance, retrieved from the literature or constructed by analyst (McKenna H, 1997).

Model case

Utilisation of the positive deviance hearth approach in improving nutritional status for children with moderate malnutrition

Positive Deviance/Hearth is a community-based approach to address malnutrition with three connected goals: (i) Rehabilitate malnourished Children (ii) Enable families to sustain the rehabilitation of these children on their own (iii) Prevent malnutrition among the community's other children, current and future. This is a home- and neighborhood-based nutrition program for children who are at risk for protein-energy malnutrition in poor resource settings (Judian, 2005). The program uses the "positive deviance" approach to identify those behaviors practiced by the mothers or caretakers of well-nourished children from poor families and to transfer such positive practices to others in the community with malnourished children. The "Hearth" or home is the location for the nutrition education and rehabilitation sessions. The whole process starts with the community diagnosing itself with regards to the nutritional status of children. Screening of children for malnutrition brings about facts and figures with regards on the prevalence of moderate malnutrition. All the stakeholders then agree to fight malnutrition

by assessing local resources and troubleshooting on the causes of malnutrition in their setting. Some implied causes fall off along the way as the community members compare the nutritional status of different children from households which have similar traits such as poverty levels, social status etc. As the households honestly reflect on the differences in nutritional status amongst similar families they come up with effective ways of addressing malnutrition through local recipes. The positive deviants (those people who are poor yet their children maintain good nutritional status) take the lead in demonstrating how they feed their children and how often and others learn from them. The external facilitators' role is very minimal in the whole process and facilitators are not dominators but rather equal participants giving very little input and building upon to the existing knowledge. The community takes part in monitoring progress during the rehabilitation phase and determining whether the outcome has been met and support each other in preventing relapses.

Evaluation of the model case

Community mobilization should impact on all levels of health promotion and prevention as outlined of the social-ecological model, though the community level will be the designated or primary focus. Effective mobilization efforts, impact on the individual and relationship levels by changing individual perceptions and beliefs and then community norms and values with regards to their own health. Community norms and societal norms regarding health are deeply intertwined; as community norms shift the larger societal norms will also shift. The model case above meets these requirements. There is meaningful and active engagement and participation of all relevant stakeholders starting from grassroots level with the utilisation of the bottom up approach in the whole program cycle from inception to evaluation and the cycle is continuous.

The model case employs a low cost

high impact approach and acknowledges the availability of indigenous knowledge and ways which it effectively utilizes to solve the existing health problem of malnutrition in a contextual and sustainable way using simple technology. The approach takes on the available capabilities through the use of positive deviants to motivate critiques who always think maintaining good nutritional status for children is an expensive exercise hence peers learn from each other and support each other for better health outcomes. The social cohesion and competitiveness that the approach brings provides a sustainable platform for innovation and a true sense of achievement amongst community members. In this case malnutrition is now viewed a community challenge as opposed to being a problem for a particular household and every community member actively participates in fighting malnutrition by monitoring each other's behaviours and practices.

Step 5: Identifying additional cases

Introducing additional cases, borderline, related and contrary, is another way to gain deeper insight about the concept. They provide examples of what the concept is not and help us to differentiate that from related or similar concepts (Mckenna H, 1997).

A contrary case

Improving water and sanitation in community X by an NGO to reduce prevalence of diarrhoeal diseases

An NGO that specializes in water and sanitation visits a district A and gets statistics on the water and sanitation coverage. The available statistics reveal that community X has the lowest water and sanitation coverage and as a result there is high prevalence of diarrhoeal diseases especially among the under-fives and this is the leading cause of morbidity and mortality. The NGO collects information on the size of community X from the district office and all the necessary demographics including average household size. This information allows them to develop a 2 year project to address the problem. The NGO

liaises with the local leadership for community X and construct a two hole Blair toilet for each household and drill sufficient bush pump boreholes for easy access to portable water basing on the calculations they have made from the available statistics. The NGO also trains pump-minders as part of their exit strategy and give them kits to use for their job. The NGO exits community X and returns a year later to evaluate the impact of the project on water and sanitation coverage and also collects data on prevalence of diarrhoeal diseases. It is worrisome that they discover that despite the investments done in community X, the prevalence of diarrhoeal diseases remains high, 60% of the boreholes are non-functional and some of the Blair toilets are being used for other purposes. There is still a significant proportion of households that practice open defaecation.

Evaluation of the contrary case

In the case above the process used a top down approach and the community was not actively involved in the process of change. The change facilitators did not do needs assessment and a proper situation analysis hence the prescriptive process failed to address the root causes of the problems at hand. The mobilisation process should have started with the establishment of positive relationships and a proper stakeholder analysis to ascertain the power dynamics in the community. A formal mobilisation structure should have then been established with the community. The NGO made an assumption that supplying what is lacking in their own perspective would result in positive health outcomes, probably basing on their previous experiences from other similar projects elsewhere. Prescriptive structures using a top to bottom approach lacks sustainability as it places limitations on some of the strategies, which a community can realistically implement. In this case the community did not learn on how to effectively utilise the Blair toilets and to effectively use and protect water sources in a sustainable manner. Power to change

health outcomes wasn't decentralized to the communities hence they did not take full responsibility and accountability for their own health. The greatest improvement in people's health will be as a result of what they do to and for themselves. It is not the result of external interventions.

Step 6: Identifying antecedents and consequences

Identifying antecedents and consequences are important steps in the analysis of a concept because they can refine the concept's attributes and highlight the common social context of applying the concept. Antecedents are those events and circumstances which happen before occurrence of the concept and may be associated with the occurrence or necessary condition for its occurrence (Walker and Avant, 2005). Following thematic analysis of the literature, the following steps/processes were identified as antecedents of the community mobilisation process

Antecedents

- Existence of a health problem affecting the whole community
- Availability of scale free social capital (Establishing positive relationships)
- Identification of community needs and community mapping (Formative research)
- Effective awareness creation
- According to the Theory of Reasoned Action developed by Martin Fishbein and Icek Ajzen, there should be positive individual perception and influential people regarding the expected outcome since the perceptions of the significant others greatly influence their behavioral intention.
- Identification of the right people (strong leadership) in the community who can explain norms, taboos and rules of the community since it's important to respect indigenous knowledge. These can be religious and traditional leaders custodians/ gate-keepers of customs and culture), opinion leaders and natural leaders. Diffusion of Innovation Theory

by Everett Rogers proposes that opinion leaders-trusted trendsetters-through their actions, attitudes and views influence those of other members via social relationships.

- Determine community mobilisation theories and approaches to use to understand how individuals change
- Establish a formal mobilisation structure
- Engage Diverse Organizations, Community Leaders, and Residents
- Develop a Shared Vision
- Create a Strategic Plan
- Develop an action plan
- Authentic Participation and Shared Decision Making
- Establish Effective Channels for Internal Communication
- Determine the most effective and relevant channels to reach the target audience (UNAIDS, 2007)
- Establishment of process and Outcome Evaluations systems
- Good facilitation skills, community mobilization theory and a true affinity for the communities you are attempting to mobilize.

Consequences

- Mobilisation promotes change at the societal level, beyond the individual
- Effective community mobilisation contributes to the success of any health intervention and health outcomes.
- Involving local people in planning increases their commitment to the programme and helps them to develop appropriate skills and knowledge to identify and solve their problems on their own.
- Active participation of local people helps to increase the resources available for a health programme, promotes self-help and self-reliance, and improves trust and partnership between the community and health workers.
- Community mobilisation brings about 'social learning' for both health workers and local people leading to mutual

understanding and better health outcomes.

- Community mobilization encourages stakeholders to develop and implement strategies that reflect the culture of the given community. When this happens, community mobilization initiatives become powerful tools in developing strategies that are culturally competent, relevant and compelling for historically marginalized communities.
- If the community owns its health activity, then this is more likely to be sustainable. By being involved they will also be empowered, partly by advocating for health policy changes.
- Addresses underlying causes of inequitable access to health care
- Strengthen community capacity
- Community mobilization can also leverage the rich history of culturally-specific strengths and assets.

A pilot randomized controlled cluster trial with Lady Health Workers in Sindh Province, Pakistan sought to demonstrate the effective use of community-based evidence for health promotion (Omer et al. 178-85). A baseline study on mothers and children provided local evidence for risk communication tools designed and tested by LHWs. The communities were randomized to intervention and control. LHWs visited women before and after childbirth to discuss safe practices in pregnancy, in the intervention group LHW using the new tools and in the control group using their standard procedures. A household survey and focus groups permitted assessment of the impact of the intervention. Women in the intervention communities were more likely to attend prenatal checkups, to stop routine heavy work during pregnancy, to give colostrums to newborn babies, and to maintain exclusive breastfeeding for four months. Discussion by lay health workers of local evidence underlying safe motherhood messages improved uptake of protective health practices. It was revealed that door-to-door health promotion based on

culturally appropriate interaction around relevant evidence can have a positive impact on health practices. Engaging health workers from the onset builds capacities, improves dialogue within the health system and performance of frontline health workers (Omer et al. 178-85).

Step 7: Define empirical referents

Empirical referents are indicators that show the occurrence of the concept by their existence (Walker and Avant, 2005). In fact defining attributes of the concepts of interest can play the role of empirical referents to show occurrence of them.

Empirical referents for effective community mobilisation

- Active and meaningful participation of the whole community in health programs
- Community accountability
- Positive health outcomes (reduction in morbidity and mortality)
- Good participatory community governance
- Peaceful change and sustainable development
- Community empowerment and innovation
- long-term commitment to a community change movement and motivation of communities to advocate for policy changes to respond better to their health needs

DISCUSSION

Based on the findings, the defining attributes of community mobilisation encompasses holistic engagement and active participation of community members to the highest extent possible in bring solutions to their own health-related problems. The process employs participatory approaches that are contextual and relevant to the target population in problem identification and problem solving. It is critical that community mobilisers know their community well, and understand their problems and their needs. Introducing new interventions that slightly deviate from local practices and beliefs may need gradual

processes. It is also prudent to understand existing health beliefs and practices in a given community. Effective community mobilisation involves listening to community members carefully and handing over the stick to them to lead the process of their own change. Several authors have tried to describe and quantify degree of community participation and its potential impact in health outcomes. The lowest level of participation is co-option whereby local representatives are chosen, but have no real input or power. Compliance involves assignment of tasks with incentives but outsiders decide the agenda and direct the process. The third level is consultation whereby local opinions are asked for, and outsiders analyse and decide on a course of action. With cooperation, local people work together with outsiders to determine realities but the responsibility remains with outsiders for directing the process. Collective action involves local people setting their own agenda and mobilizing each other to carry it out, in the absence of outside initiators and facilitators. The highest level is co-learning whereby local people and outsiders share their knowledge to create a new understanding and work together to form action plans, with outsiders facilitating. From this background, it then becomes important in community mobilisation at design stage to determine the most appropriate mobilisation models and relevant participatory approaches for the best health outcomes. More often than not, what is termed community mobilisation is actually community manipulation for a desired outcome and at the end the process fails to yield sustainable results. Support from influential people inclusive of opinion leaders eases the process of community mobilisation and the social marketing process. Community relations (methods and activities that you undertake to establish and promote a setting that is conducive to good relationships), create a strong bond with the community and are a critical ingredient to successful community mobilisation. The ultimate goal of community mobilisation

according to Lao Tsu is that “when you finish your job, the people will say we did it all by ourselves”.

CONCLUSION

This analysis has revealed that to work effectively with the community, one need to understand who holds the power in the community and how they influence community decisions. The community has an important role to help identify health problems and use the available resources in the community to plan activities and then act to improve the community's health. For successful, effective and sustainable implementation of community mobilisation activities, one needs to involve everyone in a community network, especially those with power (the decision makers in the community), as early and as often as possible and across all stages of community mobilisation. When everything has been, the ultimate measure of successful community mobilisation is sustainable improved health outcomes for the community and this emanates from a strong will, social cohesion and community empowerment. Effective community mobilisation will enable government to meet the dictates of the primary health care approach and in the long run meet the sustainable development goals leading to an improved quality of life.

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