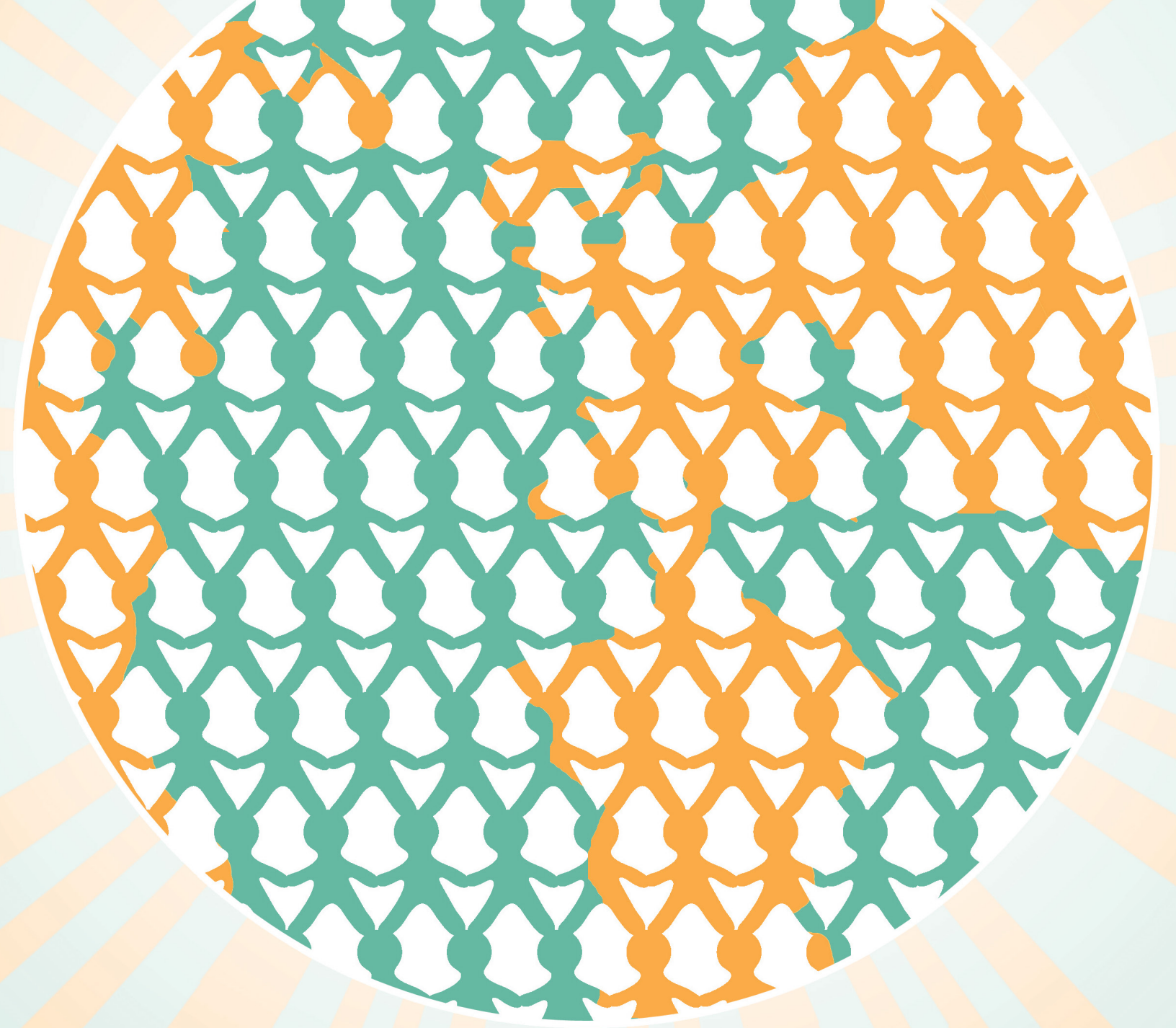

ARTIST
Annie Zhu

CRITICAL REVIEW

Community-based Interventions

INTERNATIONAL DEVELOPMENT, GOVERNMENT, AND COMMUNITY

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ABSTRACT

Non-governmental organizations (NGOs) are often criticized for their work in the healthcare sectors of developing countries. Recently, they have been moving from a projectized to sectoral support approach in an attempt to respond to this critique. Community-based intervention is a sectoral technique that can be used to exploit the community as a resource to provide the community itself with support in ways that the limited human resources in the healthcare sectors of developing countries currently cannot. The peer group intervention and community health worker are both tested strategies that have resulted in positive outcomes in the healthcare sectors of disadvantaged areas. Although community support systems may be limited in technical skill, a new body of research indicates that this intervention can nonetheless be a predictor of improved management of chronic illnesses that present high disease burden. By working with local stakeholders, NGOs may be able to effectively facilitate this intervention to promote sustainable positive health outcomes. By evaluating the effectiveness of the community-based intervention in Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) management in Malawi, a greater understanding of its role can be gained in a more tangible manner.

INTRODUCTION

The role of the non-governmental organization (NGO) in the healthcare sector of developing countries is a highly debated subject because of controversial and potentially harmful interventions implemented in the past.[1] Developed areas predominantly use a health care strategy in which highly skilled and specialized physicians deliver healthcare with sophisticated technology. Although international NGOs often try to apply this same approach to international development, severe human resource deficiencies in disadvantaged communities render such a strategy ineffective.[3] Community-based intervention is one way in which human resource deficiencies can be overcome. Malawi is a country representative of many of the issues which developing countries face. Thus, the model of community-based intervention in the management of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) within Malawi can be utilized to understand how healthcare initiatives can be better implemented by NGOs in developing countries.

CASE STUDY BACKGROUND – MALAWI'S CONTEXT

Human resources in Malawi's healthcare sector are scarce, particularly due to low salaries and poor working conditions provided by the Ministry of Health (MOH). In Malawi, 50% of all healthcare posts in the MOH are unfilled.[4] Qualified healthcare professionals are inclined to work abroad or with NGOs and aid organizations.[5] This internal brain drain contributes to the MOH's low capacity to manage diseases such as HIV/AIDS. In Malawi, it is estimated that there are 7435 people living with HIV/AIDS per physician.[6] In sub-Saharan Africa, 1.5% of adults receive HIV testing and counselling, and 5% of pregnant women have access to Mother-to-Child Transmission Prevention programmes.[3]

While the healthcare sector is unable to manage the HIV/AIDS epidemic, the general population continues to engage in behaviours which lead to the spread of HIV. Factors such as gender inequality, conservative culture, and economic issues contribute to these behaviours. With respect to gender inequality and cultural values, male dominance over sexuality makes it difficult for females to negotiate safe and/or protected sex. Double standards also allow and in some cases, encourage men to have multiple partners.[7] Moreover, when families pass through important events such as births or deaths, women are not allowed to have sex. While the women remain abstinent, men may seek sex elsewhere and later infect their monogamous partners.[8] Some parents may even advise their daughters to buy their own personal items even though they are aware that their daughters' only possible source of income is sexual intercourse.[9] Economic issues, such as men traveling to urban centres to find work, increase the likelihood of divorce, multiple partners, and casual sex.[7] Even if couples are together, they may not be able to afford or access protection.[8]

PEER GROUPS

There are many types of community-based interventions, all with the goal of taking advantage of the community as a resource to improve health outcomes. The first of these interventions is the peer group in which participants discuss a certain healthcare issue by which they may be affected.[10] This intervention is based on Albert Bandura's social-cognitive learning theory model, which describes an improvement in self-efficacy or self-confidence as a means to promote behavioural change.[11] Promoting behavioural change is instrumental in disease prevention in developing countries where HIV/AIDS is endemic.

ONE IN TWENTY PREGNANT WOMEN IN SUB-SAHARAN AFRICA HAVE ACCESS TO MOTHER-TO-CHILD TRANSMISSION PREVENTION PROGRAMMES.[3]

Peer group intervention is a technique in which a natural community leader is trained to facilitate group discussion about a certain topic with affected or interested individuals in the community. These interventions increase the peer group leaders' as well as the participants' understanding of their personal control, decision-making, and critical awareness of social and political environments. Participants are also able to increase their community engagement to accomplish

their own goals. These outcomes are referred to as psychological empowerment and allow people to challenge cultural norms that cause stigmatization of HIV/AIDS discussion. Peer group leaders also report an increase in their own knowledge of HIV and HIV-prevention behaviour. This allows leaders to see themselves as change agents in order to ultimately reduce the high-risk behaviours of the people in their communities, neighbourhoods and workplaces.

The relationship between foreigners and local citizens when imparting healthcare services and knowledge is often unstable due to the history of colonialism in many developing countries, especially in sub-Saharan Africa. Thus, locally chosen peer group leaders enable residents to build trust and disseminate knowledge more efficiently.[11] The native status of the peer group leaders also allows them to address HIV/AIDS prevention by connecting the training they receive with their cultural context. For example, prior to training, leaders express that they are often exposed to HIV-prevention messages from sources such as the radio. However, these messages are discounted due to certain cultural beliefs. For example, the words "sexual intercourse" are often considered to be foul language.[11] By integrating cultural context into their training, local leaders can easily address these stigmas in group discussions. Furthermore, they can readily identify effective strategies to provide HIV/AIDS education, such as through plays, dramas, poems, and group teaching methods.[11] In the past, leaders found that discussing HIV/AIDS was also extremely effective at church organizations,[11] in a context where low-HIV-risk behaviours, such as abstinence and monogamous relationships, were promoted.[8] In fact, instead of trying to form new peer groups, it is often beneficial to approach spiritual groups that already exist in churches to provide support.[4]

IN MALAWI, ALTHOUGH 50% OF WOMEN WITH HIV RECEIVE MOTHER-TO-CHILD TRANSMISSION PREVENTION, ONLY 6-15% OF HIV-EXPOSED INFANTS RECEIVE AN HIV TEST.[14]

The outcomes of this combination of cultural context and HIV/AIDS education in peer group discussions are mainly positive. Peer group discussions help participants with infection combat loneliness and share knowledge about ways in which they can adopt a lifestyle that includes adherence to antiretroviral therapy (ART) – therapy which targets retroviruses such as HIV.[2] Additionally, these sessions give participants increased self-efficacy and hope, by providing them with the tools necessary to grapple with a condition as daunting as HIV/AIDS. Participants understand that they can avoid infection if they decrease high-HIV-risk behaviours and increase preventative measures such as condom use.[7]

COMMUNITY HEALTH WORKERS

Healthcare professionals in Malawi are overburdened, limited to their technical roles, and cannot provide much emotional support or medical follow-up to their patients. Thus, a type of valuable community support used extensively in Malawi is the community health worker (CHW) – a layperson who is trained in certain niche healthcare work. CHWs can extend healthcare services by providing emotional support, counselling, adherence support, and home-based care.[2] CHWs are managed by healthcare professionals such as nurses, who provide them with support and instructions.[12] This kind of task shifting helps healthcare professionals take on leadership roles to manage CHWs, perform the technical aspects of their jobs more effectively, and decentralize healthcare operations to reach remote areas.[13]

One of the major benefits of CHWs is their provision of longitudinal care. In Malawi, although 50% of women with HIV receive Mother-to-Child Transmission Prevention, only 6-15% of HIV-exposed infants receive an HIV test. HIV-infected babies then experience fast immune system deterioration and disease progression, as well as high mortality without early ART. This demonstrates that low retention and loss to follow-up are significant issues in Malawian healthcare. Community support can offer a solution to these problems by allowing for continuity of healthcare support in areas where healthcare is usually very discontinuous, reducing the loss to follow-up.[14] For example, when women are pregnant, CHWs can act as case coordinators from the time of HIV/AIDS diagnosis of the mother at antenatal care, to early infant diagnosis, to infant treatment. Thus, CHWs can serve as stable positive role models and resources in high-prevalence communities.[10]

If formalized, the creation of a separate cadre of CHWs specifically trained to provide healthcare services may be a cost-effective solution to inadequate healthcare in developing regions. In a study assessing health literacy using patient characteristics and community support as predictors of two-year positive health outcomes, the latter yielded the strongest positive effect on health outcomes. Physical outcomes in HIV/AIDS patients such as CD4+ T-cell counts and maintenance of viral suppression were also most improved by community support.[2]

LIMITATIONS OF COMMUNITY-BASED INTERVENTIONS

The community-based intervention in general can be an effective way to enhance the capacity of public health operations. In the Thyolo district in Malawi for example, health provision centres have a maximum of only 400 hospital beds. In contrast, decentralized community care supports over 5000 people, 2000 of whom are affected by advanced HIV/AIDS.[13]

However, the CHW model still requires development, as CHWs have identified some systemic barriers that limit their effectiveness. An example of a barrier is the lack of continuing education regarding government policy changes

and treatment guidelines recommended by health centres. It is thus essential for CHWs to understand the guidelines that encompass their roles through continual training by governmental entities.[15] Additionally, most of the community-based interventions currently under research are run at least partially by NGOs. Thus, when feedback is collected, people tend to emphasize the positive aspects of the program for fear of NGOs pulling back funds. To avoid this, capacity development and feedback mechanisms originating from the government are essential to further assess intervention effectiveness.[11] Therefore, government involvement in CHW and peer group leader recruitment, selection, training protocol standardization, and provision of continuous retention incentives is critical to sustainably extend community-based interventions.[16]

Although volunteer CHWs and peer group leaders have expressed a strong willingness to continue juggling many roles,[10] it is unrealistic to expect them to do so forever. Volunteers receive incentives such as rain boots, rain coats, bicycles, seed grain, and fertilizer for private or community farms.[4] Such unsustainable payment methods will not facilitate long-term community support in the healthcare sector. Also, while the community is a good resource that is currently untapped, it will ultimately reach a threshold. Ideally, these responsibilities should be taken on by the Ministry of Health (MOH), since community-based interventions may cause policy-makers to disengage from taking on these responsibilities. Thus, it is important to cultivate a collective sense of responsibility between community leaders, health representatives, NGOs, and the ministry through a forum for discussion to ensure continuous progress towards effective healthcare delivery.[13]

THE ROLE OF THE NGO

NGOs are often criticized for their work in the healthcare sector because of their short-term projectized approach, lack of cultural context, and implementation of policies inconsistent with the needs of the people. It is a common misconception that any type of healthcare policy is better than what is currently in place. However, studies demonstrate that many healthcare services already exist and are underutilized in developing areas because they do not meet the needs of the people.[1] It is essential for NGOs to understand that their practices may not necessarily benefit the target country, despite their humanitarian intentions. Usage of community-based approaches is rare as NGOs usually focus on approaches that excessively rely on foreigners. In some cases, this may compromise independence of the country's own activities and promote dependence on the NGOs.[17]

That being said, NGOs can fill many gaps in regards to human and financial resource deficiencies in developing countries through their experience working with various stakeholders such as the MOH.[5] Thus, the NGO can do meaningful work if it works with local stakeholders to implement community-based interventions in response to the community's specific strengths, weaknesses, and needs. For example, Malawi has comprehensive record-keeping systems at its hospitals and health centres. Summaries are sent to district hospitals, which are then entered into electronic databases at the national level. This efficient feedback and information system can be used by NGOs to implement community-based interventions.[3]

FUTURE PUBLIC HEALTH INTERVENTIONS

Working with local stakeholders can increase their ownership and accountability. This collaboration also allows the NGO to align its work with the goals identified by the target country and use pre-existing structures to improve health outcomes.[1] This is important to avoid undermining or competing with local work. Hence, the role of the NGO is one of mediation – to take advantage of the community as a resource and thereby manage chronic illnesses such as HIV/AIDS. Consequently, community-based intervention may allow communities to take control of their own healthcare. It is only through promotion of such community-focused behavioural changes can the NGO contribute to sustainable positive health outcomes and ultimately ensure an effective exit strategy, enabling disadvantaged communities to develop effective healthcare delivery infrastructure. ■

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