



Unlocking community capability: key to more responsive, resilient and equitable health systems

Communities are more than a geographic location; they are a site of struggle and also a dynamic engine of change. Unlocking their capabilities to strengthen health systems requires understanding and adapting to local context, engaging a diversity of actors and working with the productive tensions inherent to collective action.



Members of a savings group in Kibuku District, Uganda. Savings groups were formed as part of FHS research in Uganda to help women save for maternal health care.

Key messages

- 1 Health programmes to unlock community capability must be contextually responsive; different settings require different strategies to engage opinion leaders, ensure the involvement of marginalised groups, and manage community incentives and expectations.
- 2 Skilled facilitators can catalyse community action but must have adequate time, training, and support to build community trust and manage relationships.
- 3 Flexible intervention design allows implementers to be sensitive to local realities and to modify plans when needed.
- 4 Indirect financial inputs (e.g. travel support) and strategic linkages to additional resources (e.g. helping communities access government funds) can further enable and sustain community participation.
- 5 Despite many initiatives to engage communities, communities still often are not the ones setting the priorities or agendas for those initiatives. This must change.

Introduction

Communities are groups of people who have common interests, resources, beliefs, needs, occupations or other social conditions that characterise their membership. Although community members share aspects of cohesiveness, they are also divided through poverty, gender and other types of social exclusion. Community based solutions require institutions and processes that transform these power relations, rather than unwittingly further entrench inequalities, despite good intentions to improve health.

In Future Health Systems (FHS), we focussed on communities as active service delivery participants across a wide variety of contexts. In this brief, we draw from a systematic review (George et al 2015) and country case studies to reflect on the **process** of unlocking community capabilities, the **key actors** involved, and the **productive tensions** within community partnerships forged to build more responsive, resilient and equitable health systems.

Unlocking Community Capabilities: country case studies

- **Community score cards in Afghanistan:** Community members, health providers, and local leaders scored health facility performance and developed action plans.
- **Self-help groups in Bangladesh:** Facilitators engaged pre-existing self-help groups to “put health on their agenda” by taking up health education, supporting community health workers, and linking with health facilities.
- **Learning platform in India:** Researchers worked with local stakeholders to facilitate evidence based decision-making on child health in a cyclone and flood-prone region.
- **Community partnerships in Uganda:** Community groups focused on birth preparedness, and partnerships with savings groups and transportation providers to improve women’s access to health facilities.

What have we learnt?

Processes that unlock community capability

Putting communities in the driving seat: While a range of ‘participatory’ methods to engage communities exist, the principle of sharing power to ensure community ownership is less common. In George et al.’s (2015) systematic review assessing health systems interventions that engaged communities, almost all (95%) of the articles involved communities in implementing interventions, 50% in identifying



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and defining interventions, 31% in managing resources for interventions, 24% in monitoring and evaluating interventions, and only 18% in identifying and defining problems. Out of 260 articles assessed, only five discuss power or control of interventions with communities and only four articles involved communities in all five steps of the project cycle.

▲ Women show the effect of flooding on their land in the Indian Sundarbans, West Bengal.

Understanding context: Communities have important pre-existing strengths and resources, which can be harnessed and further strengthened to improve health. Some are tangible such as local transport and informal healthcare providers, others are linked to a history of association and trust that can support broader collective action and social capital. However, communities also have pre-existing structures that make it challenging to harness local resources, such as prior negative experiences with interventions, mistrust among community members and of public structures, and norms that exclude or disadvantage members by gender and class/caste. Change cannot be effected or sustained if local power dynamics and broader contextual factors are not understood or addressed.

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- In Afghanistan, the war set a context of low community trust in the state and community scepticism and fear of evaluating services from public institutions. Overcoming this distrust, scepticism and fear to introduce community score cards required extensive community consultation and engagement.
- In the Indian Sundarbans, rising sea levels and frequent floods linked to climate change downgraded health as a priority. Action research initiatives like Photovoice enabled participants to reflect on their contextual day-to-day survival and its implications for child health. It also gave them a way to discuss their needs with local decision makers.

Interests and incentives matter: Programmes that rely on volunteerism must consider the risks and benefits participation presents to community members, particularly when working in marginalised communities where the majority may have precarious livelihoods. Community expectations regarding indirect incentives (travel allowances, refreshments, bicycles, uniforms, bags, and supplies) must be assessed, and if not met or discussed can be a major deterrent to action.

- In Uganda, community health workers struggled to travel to meetings outside of their villages in the absence of travel allowances.
- In Afghanistan, given that community members travelled long distances to participate, the absence of refreshments during long meetings was a concern with implications for sustainability beyond the project period.

Project flexibility and responsiveness:

Community health interventions must be flexible if they are to respond to emerging and diverse community needs. Health may also not always be the first concern mentioned by communities. Being responsive to community needs and facilitating dialogue across sectors may lead to collaborations that are not as straightforward as initially planned, but they can build an important foundation for more effective health interventions.

- In the Indian Sundarbans, government representatives and the local media were brought together to identify collaborative innovations previously not envisioned, such as maternity waiting homes and strategies to improve health media coverage.
- In Bangladesh, self-help organisations focussed on access to employment and financial resources as a major priority. Not until community members linked health care expenditure and lost time due to illness to home finances, did efforts to prevent illness resonate. However, after two years of health promotion, health outcomes were still poor because of the lack of quality clinical services, which was outside of the project remit. Nonetheless, community demand led project staff to support paramedic and midwife training to staff village health posts established by the initiative.
- In Afghanistan, although community meetings were conducted separately for men and women, in one community, women demanded access to the men's discussions to ensure that their priorities were addressed.

Relationships, trust and time: participatory projects seeking to unlock community capabilities require positive relationships of trust between community members and outside actors, e.g.

programme staff and health providers. Building these relationships takes time.

- In Bangladesh, facilitators spent time in communities informally discussing health issues and attending social events before formally engaging community members through mapping and village transects (walks). Engaging in school-based health activities and remaining unaffiliated to political parties enabled staff to avoid suspicion and develop community trust.
- In Afghanistan, trust increased between community members and health facility staff through better understanding one another's needs and constraints. At first, community members ranked the structural quality of health facilities on the score card much lower than health providers did. However, through discussion and time to understand their different perspectives, both groups came to a consensus ranking.

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Engaging diverse actors: everyone has a role to play

Engaging respected local leaders and peers:

People are more likely to engage in new initiatives if they are encouraged to do so by respected peers or leaders.

- In Uganda, community members preferred educational radio talk shows that featured their local leaders conveying key maternal health messages.
- In Afghanistan, village "white beards", female elders, Mullahs and headmasters participated actively in the community score card programme.

Plan for gender equity: Gender must be carefully considered and actively supported throughout any participatory programme. From a systematic review of 106 articles that engaged communities in health systems interventions, 28% did not mention gender in any way, 35% mentioned gender in one or two sentences and only 28% discussed gender issues substantively (George et al. 2015). Community programmes have the opportunity to further support gender equality, but can also inadvertently cause gender harm.

- In Afghanistan, the project's inability to provide transportation to meetings made it particularly difficult for women to participate.
- In India, analysis of women's social ties for child care identified multiple sources of personal support (friends and relatives) but also highlighted how women were largely excluded from formal support structures (political parties, loan groups).

Mediating inherent tensions in community partnerships

Balancing bottom up and top down

change processes: Resource-poor communities cannot be expected to fix all their own problems. Governments are responsible for strengthening social safety nets and ensuring primary health care in the long run. At the same time, immediate health needs must also be met and communities can change key behaviours, improve aspects of environmental health (such as sanitation behaviour) and mobilise locally relevant and sustainable resources. Striking a balance between government and community action requires deep engagement with local contexts and on-going reflection by programme staff and communities.

- In Afghanistan, filling score cards enabled community members and clinic staff to discuss facility shortcomings. While staff could address issues within their control, such as staff timeliness and small facility repairs, major “upstream” issues such as drug procurement, hiring female doctors, and expensive infrastructure were beyond

their control. Important gains were made when the community score card process was coupled with inputs from higher health system levels to enable the staff to improve services more comprehensively.

- In Uganda, official structures (government support staff) were overburdened, with 80 villages each to support and no financial resources to visit these villages. The project provided government staff with funds for travel to their respective villages, but also set up peer support systems where village health teams (VHT) were supported by a ‘super VHT’.
- **Supporting tangible benefits without creating dependency:** In both Bangladesh and Uganda, programme implementers struggled with community expectations for tangible financial assistance and were concerned about relationships of dependence. In Bangladesh, project staff consistently did not provide direct financial resources for activities and avoided taking the lead in community initiatives, instead encouraging community members to take initiative and invite facilitator inputs.

CREDITS

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Conclusions

Unlocking community capabilities entails identifying local resources, building capacities, and brokering partnerships for service delivery models that advance social equity and strengthen health system resilience. There are complex tensions inherent to community development:

- achieving buy-in from powerful stakeholders while also engaging marginalised groups;
- encouraging self-reliance and the mobilisation of local resources while also demanding structural change; and
- catalysing change from the outside without creating dependency.

Engaging with these tensions to strengthen health systems demands a careful consideration of context, programme flexibility, and on-going efforts to build trust and collaboration across multiple levels.

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