

## Helpdesk Report: Community Engagement in Health Service Delivery

Date: 16<sup>th</sup> November 2011

**Query:** What evidence is there to show that community participation and accountability in health service delivery leads to improved access to quality health services and increased government ownership/ responsibility? Do you know of any studies linking community accountability to improved health outcomes?

What evidence is there that community engagement in health service delivery contributes towards stabilisation and peace building/state building efforts?

**Enquirer:** DFID UK

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### 1. Overview

This review gives definitions of the key concepts and a history of community participation and accountability in section 2. Participation in health care was a key principle in the Alma-Ata Declaration. The fourth article of the Declaration stated that, “people have the right and duty to participate individually and collectively in the planning and implementation of their health care”, and the seventh article stated that primary health care “requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care”.

There is evidence to show that community participation and accountability in health service delivery and health care leads to improved health outcomes within that community. The experience of pilot programmes before the Alma-Ata Declaration, and subsequent trial evidence, also suggests that community mobilisation can bring about cost-effective and substantial reductions in mortality and improvements in the health of newborn infants, children, and mothers. This is reviewed in detail in section 3 including studies showing evidence of this link. Section 4 provides some evidence of an improvement in quality due to community participation, especially in providing better services in terms of community need. Action through

civil society is a critical influence on health care quality and access and on the social determinants of health.

Government ownership has been shown to be important; the state can play a role in ensuring its citizens' right to health, while respecting participatory and empowering processes. If marginalised groups and classes organise, they can influence power relations and pressure the state into action. Such popular pressure through organised communities and people's organisations can play an essential role in ensuring the implementation of adequate government policies to address health inequities. This is what is required to assert the right to health. This is presented in detail in section 5.

Section 6 looks at community engagement in health service delivery and how this contributes towards stabilisation and peace building/state building efforts. In the midst of conflict-affected situations worldwide, development projects have the potential to promote reconciliation and build peace. Participatory development projects that involve the input and governance from and implementation by the community maximise that potential. The conclusion of this study implies that development workers and those in the field of peacebuilding must acquire community development approaches, as it is only through developing communities' strengths and capacities that sustainable peace can be achieved.

Section 7 provides comments from specialists in this area and includes further useful references, some of which have not been included in detail in this review due to time limitations.

## 2. Definition and History of Community Participation in Health Service Delivery

### **Community participation: lessons for maternal, newborn, and child health**

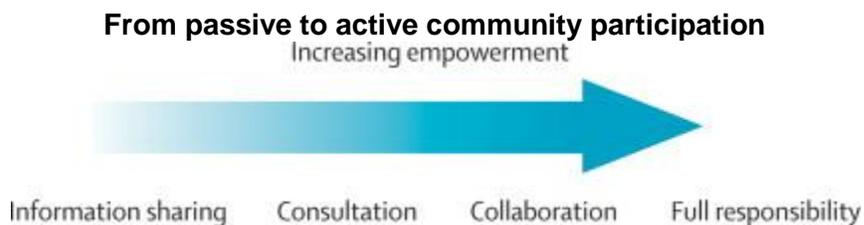
Mikey Rosato MSc, Prof Glenn Laverack PhD, Lisa Howard Grabman, Prasanta Tripathy, Nirjala Nair, Charles Mwansambo, Prof Kishwar Azad, Joanna Morrison, Prof Zulfiqar Bhutta, Henry Perry, Susan Rifkin, Prof Anthony Costello, *The Lancet*, Volume 372, Issue 9642, Pages 962 - 971, 13 September 2008

[http://www.lancet.com/journals/lancet/article/PIIS0140-6736\(08\)61406-3/fulltext#aff3](http://www.lancet.com/journals/lancet/article/PIIS0140-6736(08)61406-3/fulltext#aff3)

### **Definition**

The closely related concepts of participation, mobilisation, and empowerment require definition. Participation has been used to indicate active or passive community involvement. In the past, mobilisation consisted of communities responding to directions given by professionals to improve their health. This process usually took the form of mass campaigns for immunisations where communities were passively involved as the setting where the interventions were implemented or the target of the specific intervention. More recently, health and development workers have begun to act as facilitators focusing on the process of health improvements as well as the outcomes. In this approach the facilitators support local communities to become actively involved—to participate—in both activities and decisions that affect their own health, either as a resource that can provide assets to address a health problem or an agent of change that uses its own supportive and developmental capacities to address its needs. This paper discusses this more recent form of community mobilisation, which is defined as “a capacity-building process through which community individuals, groups, or organisations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others”.

Health programmes today often identify empowerment rather than participation as an objective. Empowerment can be defined as the process and outcome of those without power gaining information, skills, and confidence and thus control over decisions about their own lives, and can take place on an individual, organisational, and community level. Community mobilisation is a way to support this empowerment process and reach this empowerment outcome.



### **Background**

Primary health care was ratified as the health policy of WHO member states in 1978. Participation in health care was a key principle in the Alma-Ata Declaration. The fourth article of the Declaration stated that, “people have the right and duty to participate individually and collectively in the planning and implementation of their health care”, and the seventh article stated that primary health care “requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care”. But is community participation an essential prerequisite for better health outcomes or simply a useful but non-essential companion to the delivery of treatments and preventive health education? Might it be essential only as a transitional strategy: crucial for the poorest and most deprived populations but largely irrelevant once health care systems are established? Or is the failure to incorporate community participation into large-scale primary health care programmes a major reason for why we are failing to achieve MDGs 4 and 5 for reduction of maternal and child mortality?

More recently, the lack of progress with the MDGs and primary health care in many poor countries has encouraged those in favour of comprehensive primary health care to question whether the failure to address community care and participation effectively within health programmes is a major reason for poor sustainability and ineffective scaling-up of selective interventions of proven efficacy. The review of the WHO Integrated Management of Childhood Illness strategy reinforced these questions: “Delivery systems that rely solely on government health facilities must be expanded to include the full range of potential channels in a setting and strong community-based approaches. The focus on process within child health programmes must change to include greater accountability for intervention coverage at population level.”

The background evidence for the Alma-Ata revealed the successes of national health programmes in China, Cuba, Sri Lanka, Tanzania, and Venezuela as well as in subnational programmes in Guatemala, India, Indonesia, Iran, Kenya, and Niger, which all used community participation as a fundamental component of primary health care.

### **Transforming Medical Education: Lessons Learned from THEnet**

Björg Pálsdóttir, MPA and André-Jacques Neusy, MD, DTM&H, Training for Health Equity Network

<http://www.healthprofessionals21.org/docs/TransformingMedEd.pdf>

Social accountability is the obligation to orient education, research and service activities towards priority health concerns of the communities and the regions schools have a mandate to serve. These priorities are jointly defined by government, health service organisations and the public.

### **Women's health groups to improve perinatal care in rural Nepal**

Joanna Morrison, Suresh Tamang, Natasha Mesko, David Osrin, Bhim Shrestha, Madan Manandhar, Dharma Manandhar, Hilary Standing and Anthony Costello, *BMC Pregnancy and Childbirth*, 2005, 5:6

<http://www.biomedcentral.com/1471-2393/5/6>

The vision of Alma Ata was that increasing community participation in planning and implementation would lead to more cost-effective delivery of health care and increases in service utilisation. As communities took greater ownership of services they would become more culturally acceptable and responsive to local needs. Community participation also aimed to increase self-reliance and social awareness, which would lead to better health outcomes. Opinions differ about the extent to which participation can achieve these results, and to what degree governments and agencies have facilitated participation, but the appeal of participatory approaches remains strong. Participation may be considered as a continuum. In fully participatory approaches, needs are identified by the community themselves, who then may seek external support. At the other end of the continuum, superficial participation of community representatives is sought to validate the aims of programme planners, usually already decided.

### **Alma-Ata Declaration**

John H. Bryant, Encyclopaedia of Public Health

<http://www.enotes.com/public-health-encyclopedia/alma-ata-declaration>

The International Conference on Primary Health Care was convened in Alma-Ata, Kazakhstan, in 1978, and was attended by virtually all the member nations of the World Health Organization (WHO) and UNICEF. The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care (PHC) as the key to the attainment of the goal of Health for All (HFA).

People have a right and duty to participate individually and collectively in the planning and implementation of their health care.

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.

At the twentieth-anniversary meeting in Almaty, those present recognised that the principles and actions that characterise PHC at a global level include the strengthening of equity, health gain, quality of care, gender sensitivity, acceptability, participation, cost-effectiveness, and other HFA values.

### **Community participation in rural primary health care: intervention or approach?**

Robyn Preston, Hilary Waugh, Sarah Larkins, and Judy Taylor, *Australian Journal of Primary Health*, 2010, 16, 4–16

<http://www.healthissuescentre.org.au/documents/items/2011/03/366615-upload-00001.pdf>

The term 'community participation' is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs (Zakus and Lysack 1998). The importance of community participation in rural health service development is uncontested. The rural health policy framework Healthy Horizons Outlook (National Rural Health Alliance 2000) includes the principle, "participation by individuals, communities and special groups in determining their health priorities should be pursued as a basis for successful programmes and services to maintain and improve their health". The document also states that "social capability and the physical capacity to plan and implement local programmes are required for communities to improve and maintain their health" (National Rural Health Alliance 2000, p. 7). This is not an isolated pronouncement. The origins of the concept of community participation in rural health lie in its application by international organisations, such as the WHO (1991) in developing countries in an attempt to improve health, social and economic conditions. Rifkin was a major contributor to the conceptualisation of community participation as 'bottom up' or 'top down' and promoted 'bottom up' participation as fundamental to community health development (Rifkin 1986; Rifkin *et al.* 1988)

**A Community Development Approach to Raising Health Standards in Central Java, Indonesia**, Gunawan Nugroho, Chapter in: **In Health By The People**, Edited by Kenneth W. Newell, WHO, Geneva, 1975

[http://whqlibdoc.who.int/publications/1975/9241560428\\_eng.pdf](http://whqlibdoc.who.int/publications/1975/9241560428_eng.pdf)

This chapter reports on example projects from Indonesia prior to 1975. A village development committee was set up which was responsible for the development of the village and it was agreed that the community should be involved in the process of decision-making through meetings where the community was free to express its opinion. The programme was thus developed from below with guidance from above. Development from below was the involvement, from the very beginning of the planning and programming, of the community that was being served in determining needs, decision-making, and taking responsibility for the activities. Providing guidance meant helping people to develop the will and the competence to manage their own affairs and, where necessary, helping in the technical implementation.

The results of the community programmes were that the community was proud of its achievement and had regained its dignity. It was on its way to a better life. The infant mortality rate fell from 153 to 43 per 1,000 live births over a period of 2 years.

The input or contribution from the community itself is a crucial factor determining the outcome of a community health programme as described above. Community awareness and a sense of responsibility, expressed in the involvement of the people in the community health programme, gives the programme an impetus that results in continuing and accelerating movement. In this way a community health programme that may require considerable input initially will in the long run become a progressively less expensive activity that can finally be borne completely by the community itself.

A simple, quick survey was carried out covering primarily physical environment and health. The results, illustrated with maps, were presented at a meeting of the RT (a block of approximately 50-100 families) attended by the heads of all the families in the RT. It was as if the people

looked into a mirror and suddenly became aware of the situation and saw the interrelating factors causing the increase in the number of patients. The clumps of bamboo, the stagnant water, the flooded latrines, and the crowded housing were all responsible-it was the community's responsibility, not the doctor's, not the RT chairman's. All agreed that rapid action would be taken to clean up the environment; this was started a week after the meeting and completed a month later. No dollars were involved, no experts, no outstanding leadership, not even dedication; what was needed was common sense, patience, honesty, and some imagination. Indeed, it seemed too good to be true.

A community health programme is one form of care that can possibly provide the ideal answer to the problem of raising community health standards in particular and the quality of life in general. A community development programme "is aimed at creating possibilities for the poor and the suffering to live a life worthy of man, with a reinstatement of their human dignity and pride. This dignity and pride cannot be purchased with dollars from outside; man has to create them himself by his own actions".

### 3. Community Participation and Improved Health Outcomes

#### Key Paper

#### **Community participation: lessons for maternal, newborn, and child health**

Mikey Rosato MSc, Prof Glenn Laverack PhD, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Prof Kishwar Azad, Joanna Morrison, Prof Zulfiqar Bhutta, Henry Perry, Susan Rifkin, Prof Anthony Costello, *The Lancet*, Volume 372, Issue 9642, Pages 962 - 971, 13 September 2008

[http://www.lancet.com/journals/lancet/article/PIIS0140-6736\(08\)61406-3/fulltext#aff3](http://www.lancet.com/journals/lancet/article/PIIS0140-6736(08)61406-3/fulltext#aff3)

The Jamkhed Project in the state of Maharashtra in India and the Kakamega Project in Western Kenya are examples of successful smaller-scale subnational pilot programmes where community mobilisation was a key intervention. Communities were assisted to identify their own problems, collect their own data, and implement their own solutions. These demonstration projects provided clear evidence of a dramatic effect on health but could not be easily replicated by governments on a larger scale. Once part of a national programme, bureaucratic rules and top-down directives changed the nature of community participation and heavy donor support emphasised performance targets rather than the unhurried process necessary for engagement with communities.

#### **Jamkhed Project (1970 to date)**

Over the first 20 years (1972-92) the project showed a reduction in infant mortality rate from 176 to 19 per 1,000, and a birth rate decline from 40 to 20 per 1,000. Additionally, rates of antenatal care, safe delivery, and immunisation are nearly universal and rates of malnutrition have declined from 40% to less than 5%. In parallel, the women's groups have developed a greater sense of their potential for agency, and caste barriers among women have gradually diminished.

#### **Kakamega Project (1974 to 1982)**

The project achieved improvements in primary care, immunisation, water supplies, family planning, and malaria control. It also increased community support and self-reliance. As the women became empowered, the visits from outside facilitators became less frequent.

The failure to scale-up Jamkhed, Kakamega, and other similar projects through national governments contributed to a move away from participatory approaches to primary health care.

This report also includes a review of studies on community mobilisation and examples of community mobilisation projects in Ethiopia, Nepal, Bolivia, India, Malawi, Pakistan and Bangladesh.

### **What are the mechanisms through which community mobilisation brings about improved health outcomes?**

Some observers feel that community mobilisation works simply by bringing about changes in behavioural risk factors such as home care practices and decisions about care seeking. Women's groups in Malawi and Nepal are increasing the important capacities within communities, such as the ability to identify maternal and neonatal health problems and their root causes; the ability to mobilise resources necessary for improving the health of mothers and newborn infants; the internal and external social networks they can draw on when needed; and the development of strong local leaders who have the motivation and drive to improve maternal and neonatal health in the community. There is evidence that community mobilisation is an effective method for promoting participation and empowering communities among a wide range of other non-health benefits. The experience of pilot programmes before the Alma-Ata Declaration, and subsequent trial evidence, also suggests that community mobilisation can bring about cost-effective and substantial reductions in mortality and improvements in the health of newborn infants, children, and mothers.

### **'Trial of the year' award for UCL study, 1 April 2011**

<http://www.ucl.ac.uk/news/news-articles/1104/11040103>

A UCL study aiming to reduce neonatal mortality rates and maternal depression in very poor communities in eastern India has been awarded 'Trial of the Year' by the Society for Clinical Trials (SCT).

The Society deemed that the Ekjut trial in Jharkhand and Orissa was an "extraordinary randomised clinical trial, conducted with high quality in a very difficult setting, and achieving dramatic results of great public health importance."

The investigators successfully randomised 36 districts to a community intervention (vs. none) which involved using or organising village women's groups, who engaged in participatory learning and action through play, stories and games. Group members themselves identified newborn health problems within the community and selected their own strategies to address the problems, which they then implemented.

Published in *The Lancet* in March 2010, the trial results showed that after three years of the intervention, neonatal mortality was reduced by 45% and maternal depression by 57%. Professor Anthony Costello (UCL Institute for Global Health), was a co-investigator on this study. Explaining the value of such a trial in the developing world, he said: "The trial was designed as a community effectiveness trial rather than an efficacy trial of a perfectly implemented intervention which would be difficult to scale up in the real and resource-limited world in which these tribal populations live. Such trials are essential in the developing world so that we can really estimate the impact and cost-effectiveness of what we do."

**Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial**

Dharma S Manandhar, David Osrin, Bhim Prasad Shrestha, Natasha Mesko, Joanna Morrison, Kirti Man Tambahangphe, Suresh Tamang, Sushma Thapa, Dej Shrestha, Bidur Thapa, Jyoti Raj Shrestha, Angie Wade, Josephine Borghi, Hilary Standing, Madan Manandhar, Anthony M de L Costello and members of the MIRA Makwanpur trial team, *The Lancet*, Volume 364, Issue 9438, 11-17 September 2004, Pages 970-979,

<http://www.sciencedirect.com/science/article/pii/S0140673604170219>

**Methods:** The authors pair-matched 42 geopolitical clusters in Makwanpur district, Nepal, selected 12 pairs randomly, and randomly assigned one of each pair to intervention or control. In each intervention cluster (average population 7,000), a female facilitator convened nine women's group meetings every month. The facilitator supported groups through an action-learning cycle in which they identified local perinatal problems and formulated strategies to address them. They monitored birth outcomes in a cohort of 28,931 women, of whom 8% joined the groups. The primary outcome was neonatal mortality rate. Other outcomes included stillbirths and maternal deaths, uptake of antenatal and delivery services, home care practices, infant morbidity, and health-care seeking. Analysis was by intention to treat. The study is registered as an International Standard Randomised Controlled Trial, number ISRCTN31137309.

**Findings:** From 2001 to 2003, the neonatal mortality rate was 26.2 per 1,000 (76 deaths per 2,899 livebirths) in intervention clusters compared with 36.9 per 1,000 (119 deaths per 3,226 livebirths) in controls (adjusted odds ratio 0.70 [95% CI 0.53–0.94]). Stillbirth rates were similar in both groups. The maternal mortality ratio was 69 per 100,000 (two deaths per 2,899 livebirths) in intervention clusters compared with 341 per 100,000 (11 deaths per 3,226 livebirths) in control clusters (0.22 [0.05–0.90]). Women in intervention clusters were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than were controls.

**Interpretation:** Birth outcomes in a poor rural population improved greatly through a low cost, potentially sustainable and scalable, participatory intervention with women's groups.

**The effect of participatory women's groups on birth outcomes in Bangladesh: Does coverage matter? Study protocol for a randomised controlled trial**

Houweling, T.A.J. , Azad, K., Younes, L., Kuddus, A. , Shaha, S., Haq, B., Nahar, T., Beard, J., Fottrell, E.F., Prost, A., Costello, A., Study Protocol

<http://www.trialsjournal.com/content/12/1/208>

Cluster randomised trials have shown strong reductions in neonatal mortality using community mobilisation with women's groups in rural Nepal and India. A similar trial in Bangladesh showed no impact. A main hypothesis is that this negative finding is due to the much lower coverage of women's groups in the intervention population in Bangladesh compared to India and Nepal.

The study aims to test the effect on newborn and maternal health outcomes of a participatory women's group intervention with a high population coverage of women's groups.

**Methods:** A cluster randomised trial of a participatory women's group intervention will be conducted in 3 districts of rural Bangladesh.

**Community mobilisation and health management committee strengthening to increase birth attendance by trained health workers in rural Makwanpur, Nepal: Study protocol for a cluster randomised controlled trial**

Morrison, J., Tumbahangphe, K.M., Budhathoki, B., Neupane, R., Sen, A., Dahal, K., Thapa, R.<sup>b</sup>, Manandhar, R., Manandhar, D., Costello, A., Osrin, D., *Trials*, Volume 12, 19 May 2011, Article number 128

[http://www.scopus.com/record/display.url?origin=recordpage&zone=relatedDocuments&eid=2-s2.0-79959523084&noHighlight=false&sort=plf-f&cite=2-s2.0-51249095708&src=s&imp=t&sid=Y\\_V\\_4ZigsCEtDUlqh3mwoGI%3a30&sot=cite&sdt=a&sl=0&relpos=1](http://www.scopus.com/record/display.url?origin=recordpage&zone=relatedDocuments&eid=2-s2.0-79959523084&noHighlight=false&sort=plf-f&cite=2-s2.0-51249095708&src=s&imp=t&sid=Y_V_4ZigsCEtDUlqh3mwoGI%3a30&sot=cite&sdt=a&sl=0&relpos=1)

This study will test the effect of community mobilisation through women's groups, and health management committee strengthening, on institutional deliveries and home deliveries attended by trained health workers in Makwanpur District.

**Design:** Cluster randomised controlled trial involving 43 village development committee clusters. 21 clusters will receive the intervention and 22 clusters will serve as control areas. In intervention areas, Female Community Health Volunteers are supported in convening monthly women's groups. The groups work through an action research cycle in which they consider barriers to institutional delivery, plan and implement strategies to address these barriers with their communities, and evaluate their progress.

**Community interventions to reduce child mortality in Dhanusha, Nepal: Study protocol for a cluster randomised controlled trial**

Shrestha, B.P., Bhandari, B., Manandhar, D.S., Osrin, D., Costello, A., Saville, N., *Trials*, Volume 12, 3 June 2011, Article number 136

[http://www.scopus.com/record/display.url?origin=recordpage&zone=relatedDocuments&eid=2-s2.0-79957820516&noHighlight=false&sort=plf-f&cite=2-s2.0-51249095708&src=s&imp=t&sid=Y\\_V\\_4ZigsCEtDUlqh3mwoGI%3a30&sot=cite&sdt=a&sl=0&relpos=0](http://www.scopus.com/record/display.url?origin=recordpage&zone=relatedDocuments&eid=2-s2.0-79957820516&noHighlight=false&sort=plf-f&cite=2-s2.0-51249095708&src=s&imp=t&sid=Y_V_4ZigsCEtDUlqh3mwoGI%3a30&sot=cite&sdt=a&sl=0&relpos=0)

Neonatal mortality remains high in rural Nepal. Previous work suggests that local women's groups can effect significant improvement through community mobilisation. The possibility of identification and management of newborn infections by community-based workers has also arisen.

**Methods/Design:** The objective of this trial is to evaluate the effects on newborn health of two community-based interventions involving Female Community Health Volunteers (FCHVs):

- MIRA Dhanusha community groups: a participatory intervention with women's groups
- MIRA Dhanusha sepsis management: training of community volunteers in the recognition and management of neonatal sepsis.

The study design is a cluster randomised controlled trial involving 60 village development committee clusters allocated 1:1 to two interventions in a factorial design. MIRA Dhanusha community groups: FCHVs are supported in convening monthly women's groups. Nine groups per cluster (270 in total) work through two action research cycles.

### **Explaining the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes: The Ekjut trial process evaluation**

Rath, S., Nair, N., Tripathy, P.K., Barnett, S., Rath, S., Mahapatra, R., Gope, R., Bajpai, A., Sinha, R., Costello, A., Prost, A., *BMC International Health and Human Rights*, Volume 10, Issue 1, 2010, Article number 25

[http://www.scopus.com/record/display.url?eid=2-s2.0-77958056248&origin=resultslist&sort=plf-f&cite=2-s2.0-51249095708&src=s&imp=t&sid=Y\\_V\\_4ZigsCEtDUlqh3mwoG1%3a30&sot=cite&sdt=a&sl=0&relpos=8&relpos=8&searchTerm](http://www.scopus.com/record/display.url?eid=2-s2.0-77958056248&origin=resultslist&sort=plf-f&cite=2-s2.0-51249095708&src=s&imp=t&sid=Y_V_4ZigsCEtDUlqh3mwoG1%3a30&sot=cite&sdt=a&sl=0&relpos=8&relpos=8&searchTerm)

Few large and rigorous evaluations of participatory interventions systematically describe their context and implementation, or attempt to explain the mechanisms behind their impact. This study reports process evaluation data from the Ekjut cluster-randomised controlled trial of a participatory learning and action cycle with women's groups to improve maternal and newborn health outcomes in Jharkhand and Orissa, eastern India (2005-08). The study demonstrated a 45% reduction in neonatal mortality in the last two years of the intervention, largely driven by improvements in safe practices for home deliveries.

**Methods:** A participatory learning and action cycle with 244 women's groups was implemented in 18 intervention clusters covering an estimated population of 114,141. They describe the context, content, and implementation of this intervention, identify potential mechanisms behind its impact, and report challenges experienced in the field. Methods included a review of intervention documents, qualitative structured discussions with group members and non-group members, meeting observations, as well as descriptive statistical analysis of data on meeting attendance, activities, and characteristics of group attendees.

**Results:** Six broad, interrelated factors influenced the intervention's impact: (1) acceptability; (2) a participatory approach to the development of knowledge, skills and 'critical consciousness'; (3) community involvement beyond the groups; (4) a focus on marginalised communities; (5) the active recruitment of newly pregnant women into groups; (6) high population coverage. They hypothesise that these factors were responsible for the increase in safe delivery and care practices that led to the reduction in neonatal mortality demonstrated in the Ekjut trial.

**Conclusions:** Participatory interventions with community groups can influence maternal and child health outcomes if key intervention characteristics are preserved and tailored to local contexts. Scaling up such interventions requires (1) a detailed understanding of the way in which context affects the acceptability and delivery of the intervention; (2) planned but flexible replication of key content and implementation features; (3) strong support for participatory methods from implementing agencies.

### **Community participation in rural primary health care: intervention or approach?**

Robyn Preston, Hilary Waugh, Sarah Larkins and Judy Taylor, *Australian Journal of Primary Health*, 2010, 16, 4–16

<http://www.healthissuescentre.org.au/documents/items/2011/03/366615-upload-00001.pdf>

Community participation is considered important in primary health care development and there is some evidence to suggest it results in positive health outcomes. Through a process of synthesising existing evidence for the effectiveness of community participation in terms of health outcomes they identified several conceptual areas of confusion. This paper builds on earlier work to disentangle the conceptual gaps in this area, and clarify common understanding of community participation. The authors conducted a research synthesis of 689 empirical studies

in the literature linking rural community participation and health outcomes. The 37 final papers were grouped and analysed according to: contextual factors; the conceptual approach to community participation (using a modification of an existing typology); community participation process; level of evidence; and outcomes reported. Although there is some evidence of benefit of community participation in terms of health outcomes, they found only a few studies demonstrating higher levels of evidence. However, it is clear that absence of evidence of effect is not necessarily the same as absence of an effect. They focus on areas of debate and lack of clarity in the literature. Improving understanding of community participation and its role in rural primary health care service design and delivery will increase the likelihood of genuine community–health sector partnerships and more responsive health services for rural communities.

From their review, they have evidence that community participation can result in beneficial health outcomes and increased uptake of services. Fourteen (38%) of the studies presented reported improved health outcomes associated with community participation providing evidence at level 4 or above. In some cases, the health improvements were profound. For example, Manandhar *et al.* (2004) used an empowerment and developmental approach to community participation through a cluster randomised trial to demonstrate significant improvement in birth outcomes in a poor rural population.

They also have evidence that community participation can result in other outcomes that may be related to achieving health improvements. Outcomes such as better access to health services (Adatu *et al.* 2003; Sirivong *et al.* 2003; Braun *et al.* 2006; Jacobs and Price 2006; Bedelu *et al.* 2007; Kilpatrick *et al.* 2009), more relevant and culturally appropriate services (Wilson 2001; Kironde and Kahirimbanyi 2002; Hodgson 2003; George *et al.* 2007; Kilpatrick *et al.* 2009), or just maintaining a service in the face of a threat to remove it (O'Meara and Houge 2003) have been achieved through community participation. Sixty-five percent ( $n = 24$ ) of studies reported achieved this type of outcome from community participation. However, the level of evidence presented in these studies is low, often in the form of a single descriptive case study or satisfaction survey.

While there is some evidence to establish the benefits of community participation in producing health and health related outcomes, only a few good quality higher level studies have been conducted. Few, if any, studies have definitively demonstrated that community participation provides better health outcomes than no community participation in the same circumstances. However, further attention to the analysis and reporting of the community participation aspect of primary health care and public health interventions is warranted, as absence of evidence of an effect is not the same as absence of an effect. Improved analysis of community participation could be achieved by comparative studies, longitudinal studies as well as randomised controlled trials.

**Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial**

Prasanta Tripathy, Nirmala Nair, Sarah Barnett, Rajendra Mahapatra, Josephine Borghi, Shibanand Rath, Suchitra Rath, Rajkumar Gope, Dipnath Mahto, Rajesh Sinha, Rashmi Lakshminarayana, Vikram Patel, Christina Pagel, Audrey Prost, Anthony Costello, *Lancet*, 2010; 375: 1182–92

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)62042-0/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)62042-0/abstract)

In this research, 18 clusters each were assigned to intervention or control using stratified randomisation. Women were eligible to participate if they were aged 15–49 years, residing in the project area, and had given birth during the study. In intervention clusters, a facilitator convened groups every month to support participatory action and learning for women, and facilitated the development and implementation of strategies to address maternal and newborn health problems. The primary outcome was a 32% reduction in neonatal mortality rate and a 45% reduction in years 2 and 3. Although there was not a significant effect on maternal depression overall, reduction in moderate depression was 57% in year 3.

This intervention could be used with or as a potential alternative to health worker led interventions, and presents new opportunities for policy makers to improve maternal and newborn health outcomes in poor populations.

### **Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: a cluster-randomised controlled trial**

Kishwar Azad, Sarah Barnett, Biplob Banerjee, Sanjit Shaha, Kasmin Khan, Arati Roselyn Rego, Shampa Barua, Dorothy Flatman, Christina Pagel, Audrey Prost, Matthew Ellis, Anthony Costello, *Lancet* 2010; 375: 1193–202

<http://www.wcf-uk.org/attachments/article/308/Effect%20of%20scaling%20up%20women%E2%80%99s%20groups%20on%20birth%20outcomes.pdf>

Two recent trials have shown that women's groups can reduce neonatal mortality in poor communities. This study assessed the effectiveness of a scaled-up development programme with women's groups to address maternal and neonatal care in three rural districts of Bangladesh. The study population was divided into clusters. All clusters received health services strengthening and basic training of traditional birth attendants. In intervention clusters, a facilitator convened 18 groups every month to support participatory action and learning for women, and to develop and implement strategies to address maternal and neonatal health problems. Women were eligible to participate if they were aged 15–49 years, residing in the project area, and had given birth during the study period.

The primary outcome was neonatal mortality rate (NMR). Cluster-level mean NMR (adjusted for stratification and clustering) was 33.9 deaths per 1000 livebirths in the intervention clusters compared with 36.5 per 1000 in the control clusters (risk ratio 0.93, 95% CI 0.80–1.09). The study concluded that for participatory women's groups to have a significant effect on neonatal mortality in rural Bangladesh, detailed attention to programme design and contextual factors, enhanced population coverage, and increased enrolment of newly pregnant women might be needed.

### **Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial**

Dharma S Manandhar, David Osrin, Bhim Prasad Shrestha, Natasha Mesko, Joanna Morrison, Kirti Man Tambahangphe, Suresh Tamang, Sushma Thapa, Dej Shrestha, Bidur Thapa, Jyoti Raj Shrestha, Angie Wade, Josephine Borghi, Hilary Standing, Madan Manandhar, Anthony M de L Costello, and members of the MIRA Makwanpur trial team, *Lancet*, 2004; 364: 970–79

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(04\)17021-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)17021-9/abstract)

Neonatal deaths in developing countries make the largest contribution to global mortality in children younger than 5 years. 90% of deliveries in the poorest quintile of households happen at

home. This study investigates whether a community-based participatory intervention could significantly reduce neonatal mortality rates.

This study pair-matched geopolitical clusters in Nepal, and randomly assigned one of each pair to intervention or control. In each intervention cluster, a female facilitator convened nine women's group meetings every month. The facilitator supported groups through an action-learning cycle in which they identified local perinatal problems and formulated strategies to address them. The primary outcome was neonatal mortality rate. Other outcomes included stillbirths and maternal deaths, uptake of antenatal and delivery services, home care practices, infant morbidity, and health-care seeking.

From 2001 to 2003, the neonatal mortality rate was 26.2 per 1000 in intervention clusters compared with 36.9 per 1000 in controls (adjusted odds ratio 0.70 [95% CI 0.53–0.94]). Stillbirth rates were similar in both groups. The maternal mortality ratio was 69 per 100 000 in intervention clusters compared with 341 per 100 000 in control clusters (0.22 [0.05–0.90]). Women in intervention clusters were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than were controls. The study concludes that birth outcomes in a poor rural population improved greatly through a low cost, potentially sustainable and scalable, participatory intervention with women's groups.

### **Improving Maternal and Newborn Survival Through Community Intervention**

Tanja AJ Houweling, Anthony Costello, David Osrin, 2010 (Not Available Online)

On one hand, it is argued that substantial reductions in maternal mortality will not be brought about by community-based interventions: what we require are skilled birth attendance and care for obstetric emergencies. On the other, it is argued that skilled attendance is uncommon in many places and the idea of achieving universal coverage is ambitious in the short or medium term. At current rates and without extra financial resources, coverage in Africa will still be below 50 per cent by 2015 (Knippenberg, et al., 2005). Could maternal and newborn survival be improved through simultaneous interventions in health services and communities?

Improving global health in the twenty-first century requires us to address key implementation issues: how to achieve effective coverage, how to balance community-based and health systems-based approaches, how to address health inequalities in addition to improving averages, and how to monitor progress, even in the poorest settings.

## **3. Community Participation and Quality**

### **Community participation: lessons for maternal, newborn, and child health**

Mikey Rosato MSc, Prof Glenn Laverack PhD, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Prof Kishwar Azad, Joanna Morrison, Prof Zulfiqar Bhutta, Henry Perry, Susan Rifkin, Prof Anthony Costello, *The Lancet*, Volume 372, Issue 9642, Pages 962 - 971, 13 September 2008

[http://www.lancet.com/journals/lancet/article/PIIS0140-6736\(08\)61406-3/fulltext#aff3](http://www.lancet.com/journals/lancet/article/PIIS0140-6736(08)61406-3/fulltext#aff3)

Although maternal survival requires improvements in comprehensive and basic obstetric care at hospitals and health centres, community mobilisation has an important role in improving care practices, increasing the use of safer motherhood services, promoting timely referral when problems arise, and reducing social disadvantage.

Case studies, trials, and large-scale programmes have shown that, when given the opportunity, communities can develop effective strategies to address their needs and reduce mortality and morbidity. These strategies are often highly innovative, practical, and culturally acceptable.

### **Closing the gap in a generation: Health equity through action on the social determinants of health**

WHO, 2008

[http://whqlibdoc.who.int/publications/2008/9789241563703\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)

In the early 1990s, the All India Institute of Hygiene and Public Health (AIIPH) initiated a conventional STI treatment and prevention programme in a red-light district in north Kolkata. The Sonagachi HIV/AIDS International Project (SHIP) was implemented through an intersectoral partnership of WHO, AIIPH, the British Council, and a number of ministries and local NGOs. Sex workers in the area were poor and marginalised. The project quickly moved beyond traditional treatment and education modalities to focus on the empowerment of the sex workers. Key interventions during the first five years included vaccination and treatment services for the sex workers' children, literacy classes for the women, political activism and advocacy, micro-credit schemes, and cultural programmes.

The sex workers created their own membership organisation, the Durbar Mahila Samanwaya Committee (DMSC), that successfully negotiated for better treatment by madams, landlords, and local authorities. In 1999, the DMSC took over management of SHIP, and has since expanded to include 40 red-light districts across West Bengal. It has an active membership of 2,000 sex workers and has established a financial cooperative. The strong occupational health focus and the emphasis on giving sex workers more control over their bodies and living and working conditions has resulted in low rates of HIV infection and STIs in Sonagachi relative to the rest of the country.

### **Review of Matantala Rural Integrated Enterprise and the Community Development with Traditional Leaders Programme**

Norad Report 24/2009 Discussion, Norwegian Agency for Development Cooperation, Oslo, Jul-Larsen, E., Munachonga, M. and Chileche, P., 2009

<http://www.cmi.no/publications/file/?3460=review-of-matantala-rural-integrated-enterprise>

This paper reviews the community development project with traditional leaders, funded by the Norwegian Embassy and implemented by Matantala Rural Integrated Development Enterprise ('Matantala'). Its main development objectives are to contribute to reduction of poverty and improvement of living conditions in three chiefdoms in Zambia's Southern Province, through support to: social services provision; diversified economic activities and increased market production; and changes, attitudes, norms and behaviour among the population, related to empowerment, health, youth and domestic issues and gender balance. More generally, the project aims to explore the extent to which chiefs and headmen can function as drivers for the type of change expressed in the project objectives. Development committees are established at Chiefs and zone level, and each committee disposes of its own budget allocations. Committees comprise traditional leaders and ordinary members of the communities (including a minimum 30 per cent participation by women).

**Outputs:** With the limited staff of Matantala, the project has achieved an impressive list of outputs according to project documents, in terms of education and health infrastructure, income-generation and micro-credit support, establishment of clubs, and workshops and sensitisation

meetings. Local participation was high due in large part to Matantala's close relations to the target population and good mobilisation strategies.

**Effects:** Unlike the production of outputs, it was found that effects in the sense of how the outputs are used or put in practice vary a lot. Concerning the use of community service outputs, the picture remains relatively positive. Problems were identified, however, with maintenance of facilities in some communities. Economic and production activities also suffered from poor maintenance of equipment. In addition, there was often confusion as to what overall objectives the support to alternative income generating activities were supposed to address.

The effects of activities aiming at cultural and normative change are the most difficult to assess, as this is a time-consuming long-term process. Still, the work on sensitisation of the population on health and gender issues has demonstrated some promising results. There is still limited progress in the development of views among the target population of empowerment and belief in their own abilities to combat poverty and hunger. Instead, Matantala and the project were still seen as the main factors that could solve their problems. In addition, committees are still absorbed in their separate mandates and none seem willing to take on an overall function with regards to monitoring and assistance.

The paper provides the following recommendations:

**Institutionalisation:** instead of considering the development committees as temporary, they should be developed into more permanent structures and integrated into the existing traditional leadership structure. As part of this effort, the project should contact the appropriate authority in central government to have their views and recommendations about the development of permanent development structures related to the traditional leadership.

**Greater sensitisation for general civic responsibility:** more emphasis needs to be put in the sensitisation of the development committees on their overall and long term responsibilities in development.

**Clarity on objectives:** support to economic activities aiming at diversification of production and increase of the general social resilience in the communities should be more clearly distinguished from support aiming at increased and improved production for the market. Separate training and sensitisation courses must be developed.

**Empowerment of women:** a study should be undertaken to see how project activities related to the empowerment of women can be better adapted to the needs of an increasing number of women-headed households.

**Inclusion of women:** affirmative action (or targeted service delivery activities) should be adopted to address gender differences/inequalities where these are pronounced – e.g. in relation to extreme poverty levels and access to resources (land, agricultural labour, education, decision making power).

**Coordination and shared lessons on gender:** efforts should be made to identify and learn from government institutions and civil society organisations implementing gender related activities.

**Developing a primary health care management information system that supports the pursuit of equity, effectiveness and affordability.**

Husein K, Adeyi O, Bryant J, Cara NB, *Social Science and Medicine*. 1993 Mar;36(5):585-96.

[http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed&cmd=Search&term=Soc Med\[Jour\]+AND+36\[Volume\]+AND+585\[page\]](http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed&cmd=Search&term=Soc+Med[Jour]+AND+36[Volume]+AND+585[page])

Aga Khan University has developed a series of community-based, urban PHC systems, each serving a population of about 10,000, in the *katchi abadis* (squatter settlements) of Karachi. These communities are severely deprived, with high infant, child and maternal mortality rates. The PHC systems are designed to achieve equity, effectiveness and affordability, and within 3-5 years have advanced substantially toward those goals. A key factor in those developments has been the management information system (MIS), which has served as a basis for planning, managing and evaluating the PHC systems.

### **Training for Health Equity Network**

<http://www.thenetcommunity.org/>

THEnet is a group of innovative schools in Africa, Asia, Europe, Australia and the Americas working with and for disadvantaged communities. They seek to change how academic institutions achieve and measure their impact. THEnet schools define success by how well institutions meet the needs of the societies and communities they serve. They work together to develop evidence on what works and how as well as support other education institutions wanting to improve their impact on health and health systems.

### **Addressing inequities in access to primary health care: lessons for the training of health care professionals from a regional medical school**

Sarah Larkins, Tarun, Sen Gupta, Rebecca Evans, Richard Murray and Robyn Preston, *Australian Journal of Primary Health*

To address inequities in health globally, there is a fundamental need for reform in health professional education. This reform needs to be embedded as part of a broader physical and attitudinal transformation of the health system into a combined teaching, research and service system, focusing on the priority health needs of local communities. General practitioners, educators and researchers are well placed to drive the agenda in terms of educational reform and advocating for change, in partnership with a range of other primary health care professionals and the generalist specialties. In particular, they demonstrate that it is possible to have a positive impact on health workforce inequities through attention to student and staff recruitment, developing a geographically distributed teaching network and providing a curriculum with a strong focus on the health needs of local underserved populations.

### **Community Action for Health: the Role of Comprehensive Primary Health Care**

<http://www.iphu.org/en/cah>

The purpose of this project is to identify and document contemporary episodes of community action for health (including large scale social movement activism as well as local community action) and to reflect upon the circumstances and transactions of these episodes and to reflect upon the implications for PHC practice and for health activist education.

#### **Goals**

- to promote wider appreciation that support for popular mobilisation around the right to health care and action on the social determinants of health are core principles of PHC;
- to document contemporary episodes of community action for health and reflect upon the principles which might guide PHC agencies and practitioners in supporting it.

#### **Background**

The active involvement of communities in the struggle for health (access to health care and action on the determinants of health) was an important part of the vision of Alma-Ata but has been ignored in the various versions of selective PHC (in particular, UNICEF's GOBI FFF and the World Bank's packages of cost effective interventions) which have overshadowed PHC since 1978. PHM sees action through civil society as a critical influence on health care quality and access and on the social determinants of health. The People's Charter for Health calls for popular mobilisation to "demand transformation of the World Trade Organization and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South." The need for such a transformation is illustrated by the current financial crisis which underlines the weaknesses of the current regime of global governance.

The IPHU has been established within the PHM as a focus for activist education and research into activist practice. This project is directed to promoting wider understanding of popular mobilisation and how to support it.

**This project will:**

- identify a range of contemporary episodes of community (and civil society) action on health (including both access and quality of health care and action on the social determinants of health) looking in particular for episodes which have been supported, at least in part, through agencies and practitioners based in primary health care settings;
- document these episodes in a systematic way: including the context, the issues at stake, how the engagement unfolded, how PHC agencies and practitioners were involved and the outcomes;
- analyse and reflect upon the collection of case studies with a view to describing and analysing the problems communities are facing; describing the dynamics of struggle; describing the role of PHC agencies and practitioners; drawing lessons for practice from the case studies;
- bring together the experience of PHC activists in different parts of the world;
- promote the ongoing collection of such case studies across the PHM including the systematic documentation, analysis, reflection and learning.

#### 4. Community Participation and Government Ownership

**Health through people's empowerment: A rights-based approach to participation**

de Vos, P, de Ceukelaire, W, Malaise, G, Pérez, D, Lefèvre, P, van der Stuyft, P, *Health and Human Rights*, Volume 11, Issue 1, 2009, Pages 23-35

<http://www.jstor.org/stable/pdfplus/40285215.pdf?acceptTC=true>

**Abstract**

Analysis of the academic discourse on participation, empowerment, and the right to health since the 1978 Alma-Ata International Conference on Primary Health Care and the subsequent Alma-Ata Declaration shows that each phase of the evolution of these concepts added important new aspects to the discussion. This article focuses on three crucial issues that relate to these additions: the importance of social class when analysing the essentials of community participation, the pivotal role of power highlighted in the discussion on empowerment, and the role of the state, which refers to the concepts of claim holders and duty bearers included in a rights-based approach to health. The authors compare these literature findings with their own

experiences over the past 20 years in the Philippines, Palestine, and Cuba, and they offer some lessons learned. The concept of "health through people's empowerment" is proposed to identify and describe the core aspects of participation and empowerment from a human rights perspective and to put forward common strategies. If marginalised groups and classes organise, they can influence power relations and pressure the state into action. Such popular pressure through organised communities and people's organisations can play an essential role in ensuring adequate government policies to address health inequities and in asserting the right to health.

**The role of the state:** Frequently in discussions of participation or empowerment and their relation to health, focus is placed on individuals and their relations within the community. State and international relations are all too often kept out of the picture. As many root causes of health problems are to be found at levels beyond what is usually described as a community, broadening the horizon of the empowerment discourse and its context to include wider society is mandatory. The human rights framework effectively provides this broader perspective, giving the state a clear role and responsibility for the people's right to health. Cuba's recent history illustrates the role that the state can play in ensuring its citizens' right to health, while respecting participatory and empowering processes, if the necessary political will is present. Empowering processes are not linear. If marginalised groups and classes organise, they can influence power relations and pressure the state into action. Such popular pressure through organised communities and people's organisations can play an essential role in ensuring the implementation of adequate government policies to address health inequities. This is what is required to assert the right to health.

Laverack and Labonte see community empowerment as a continuum consisting of five stages: empowerment, the development of small mutual aid groups, the development or strengthening of community organisations, the development or strengthening of inter-organisational networks, and political action. Ultimately, this process ends with a challenge to state power. Ruby Greene took the argument even further, putting forth that, although community action is essential in defining health needs and needs in other areas related to health promotion, only government action can provide the framework within which substantive improvements can be made. This comment was made in relation to Cuba's experience with community health participation. Cuba is indeed an example of the potential synergy between people's empowerment and the state in realising the right to health.

### **Community-based Approaches to Peacebuilding in Conflict-affected and Fragile Contexts Issues Paper**

Huma Haider, GSDRC, November 2009

<http://www.gsdrc.org/docs/open/EIRS8.pdf>

Community-based projects cross over a number of sectors. This may create tensions if line ministries see community-based approaches as competing with their responsibilities and sector budgets shares. Linking community-based activities to line ministries in government, for example through an inter-ministerial council that oversees the project, may help to mitigate such tensions and contribute to 'buy-in'. (Cliffe, Guggenheim and Kostner, 2003)

The involvement of relevant line ministries is also important for the sustainability of community projects, particular ones that require upkeep and entail recurrent costs. As noted, recurrent costs can impose an immense burden on communities, particularly in conflict contexts. Proper coordination with line ministry's recurrent budget can alleviate this burden by sharing the costs and specifying expected contributions (Cliffe, Guggenheim and Kostner) In addition, the full

range of sectoral services, for example health services, usually cannot be provided by community members alone. Without continuing support for inputs, personnel and training, the sustainability of projects may be limited (Slaymaker, Christiansen and Hemming, 2005; Strand et al., 2003).

Engaging with line ministries also allows for the replication of best practice in community-based approaches. If line ministry staff are familiar with community processes and procedures and have concrete roles to play, a community approach can be adopted on a wider-scale as an effective way of delivering development. (Cliffe, Guggenheim and Kostner, 2003)

### **Community participation: lessons for maternal, newborn, and child health**

Mikey Rosato MSc, Prof Glenn Laverack PhD, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Prof Kishwar Azad, Joanna Morrison, Prof Zulfiqar Bhutta, Henry Perry, Susan Rifkin, Prof Anthony Costello, *The Lancet*, Volume 372, Issue 9642, Pages 962 - 971, 13 September 2008

[http://www.lancet.com/journals/lancet/article/PIIS0140-6736\(08\)61406-3/fulltext#aff3](http://www.lancet.com/journals/lancet/article/PIIS0140-6736(08)61406-3/fulltext#aff3)

What is not known is to what extent peoples' involvement can actually increase resources to support health care, whether participation can create a genuine social learning partnership between people and professionals, whether community mobilisation can really change a commitment to social justice and democracy, and whether community mobilisation can actually accelerate progress at scale toward achievement of MDGs 4 and 5 in high-mortality, resource-poor settings.

Partnerships of government, non-governmental organisations, private sector, and community-based organisations are essential, but can face differences in organisational cultures and values, competition for resources, and varying levels of capacity. Successful programmes define roles and responsibilities clearly, allocate resources fairly, and establish operational guidelines, communication systems, parameters for implementation, and mechanisms for dealing with problems or disputes.

### **Closing the gap in a generation: Health equity through action on the social determinants of health**

WHO, 2008

[http://whqlibdoc.who.int/publications/2008/9789241563703\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)

While highest-level government oversight is needed to push and coordinate ISA and to ensure sustainability, local-level government and community ownership is a prerequisite to sustained results. Government-NGO collaboration can increase the reach of action and win early results. There are many existing intersectoral programmes and frameworks, such as Healthy Cities, Municipalities, Villages and Islands, that take a social determinants approach to health and health equity, that may be explored for their applicability in different contexts.

Following the principles of primary health care as expressed in the Alma Ata Declaration, in 1986, Indonesia launched the integrated health posts (Posyandus). While these achieved impressive coverage, with 254,154 Posyandus operating in 2004, the quality and general performance is varied and has deteriorated considerably. One contributing reason has been drop-out of the health volunteers associated with economic and ideological transition, reducing voluntarism, and collectivism. To redress the situation, the District Health Office initiated and spearheaded a mechanism to coordinate multi-sectoral interventions to rejuvenate community health development. It mobilised support from the highest political authority in the district and

enrolled an NGO as partner. In January 2005, the elected head of Lumajang district launched GERBANGMAS as a strategy of community empowerment and the local government defined three functions of the Posyandus: community education, community empowerment, and community service.

The multi-sectoral village GERBANGMAS teams are provided with a general budget allocation from the local government, which is matched by the community and used for activities as well as to provide incentives for health workers. To guide investment and development, 21 indicators have been defined. Only about one third of these are traditional health indicators, such as use of family planning. The rest address determinants of health, including poverty reduction, literacy, waste management, housing, and mobilisation of youth and the elderly. One proof of the functioning of the village team is that 12 sectoral bodies, including fisheries, public works, labour and transmigration, agriculture, and religious offices, provide budget support through the village team. All indicators have improved both the health-specific and the upstream determinants of health.

## 5. Community Based Approaches and Peacebuilding

### **Building Peace: Post-Conflict Peacebuilding Through Community Development Projects**

Kristellys Zobridek, Eastern University Thesis, 2010

[http://eastern.academia.edu/KristellysZolondek/Papers/273354/Building\\_Peace\\_Post-Conflict\\_Peacebuilding\\_Through\\_Community\\_Development\\_Projects](http://eastern.academia.edu/KristellysZolondek/Papers/273354/Building_Peace_Post-Conflict_Peacebuilding_Through_Community_Development_Projects)

In the midst of conflict-ridden situations worldwide, development projects have the potential to promote reconciliation and build peace. Participatory development projects that involve the input and governance from and implementation by the community maximise that potential. Although there has been a good amount of literature on the subject of development and peacebuilding, the case for community development strategies has to be mainstreamed. This paper demonstrates that community development is essential to the success of peacebuilding through development projects as it captures the necessary aspect of a participatory, community-centred strategy. The conclusion of this study implies that development workers and those in the field of peacebuilding must acquire community development approaches, as it is only through developing communities' strengths and capacities that sustainable peace can be achieved. Furthermore, this paper argues that community development can be understood as synonymous to peacebuilding.

### **Weak State, Strong Community? Promoting Community Participation in Post-Conflict Countries**

Dana Burde, Teachers College, Columbia University, 2004

[http://www.iiep.unesco.org/fileadmin/user\\_upload/Research\\_Highlights\\_Emergencies/62burde.pdf](http://www.iiep.unesco.org/fileadmin/user_upload/Research_Highlights_Emergencies/62burde.pdf)

Despite the different contexts, early evidence indicates that community participation in education in emergencies is fraught with some of the same difficulties that plague education development projects: lack of empowerment among participants, unchanged or increased social divisions, and a restructuring of the role of the state. In addition, in an emergency, INGOs and bilateral donors often conceive (understandably) of an education programme begun during a conflict as a stop-gap measure. Lack of long-term vision, and confusion over the role that an emergency education programme plays in long term social planning, contribute to the

breakdown in services and blurred responsibilities between states and communities after the programme ends.

Putnam argues that "social capital, as embodied in horizontal networks of civic engagement, bolsters the performance of the polity and the economy, rather than the reverse: Strong society, strong economy; strong society, strong state" (Putnam, cited in Foley & Edwards, 1996, p. 40). But in the data described here, and in many places where external actors intervene to support social services and a fledgling civil society, the state is weak and the international organisations are strong. In fact, the communities that participated in the Bosnia programme seemed to gain strength only temporarily. A layer of competent local advocates ("national staff"), hired, trained and paid by INGOs, facilitated and maintained community participation. When the INGO stopped funding the programme, the hired advocates took their skills, social and political capital and sought jobs elsewhere. The PTAs' links to political power were lost.

Finally, community participation is crucial in administering aid and services during and after a conflict. Cultivating ties among professionals across ethnicities may be a particularly productive part of the process. But strong communities and strong states need one another. The groups described here were left with neither. International organisations that replace the state (albeit partially) during a complex emergency by providing social services, or by assisting communities to do so, should not abandon government ministries during social reconstruction. Otherwise, states become accustomed to relying on NGOs (international or local) to provide social services, and abdicate responsibility for providing these services themselves. Thus the emphasis placed on community participation may become a Trojan horse for restructuring the state, fundamentally altering the provision of public education.

### **Community Participatory Methods in Disease Surveillance and Public Health in War-Affected Camps, and Its Potential Contribution to Peace Building**

Kolitha Wickramage, Prakash Nellapalli, *International Electronic Journal of Health Education*, 2008; 11:95-108

<http://www.aahperd.org/aahe/publications/iejhe/loader.cfm?csModule=security/getfile&pageid=27475>

Using a combination of observational, operational data records, case-study narratives, and KAP survey methods, this paper explored how a district health system with the support of a Humanitarian Medical Relief agency sought to meaningfully engage members of a war displaced community in enhancing public health service provision through active disease surveillance and health promotion interventions. Results showed that participatory programming approaches led to the development of beneficiary driven health events that promoted community harmony and capacity building elements within conflicting communities. It is concluded that community participation, if meaningfully applied within humanitarian programming, can contribute to positive public health outcomes, ensure equitable coverage and encourage refugees to be agents of change within their own communities.

### **Health and Peace-building: Securing the Future**

The University of New South Wales Health and Conflict Project, December 2004

[http://www.med.unsw.edu.au/SPHCMWeb.nsf/resources/AUSCAN\\_Issue\\_Paper\\_1.pdf/\\$file/AUSCAN\\_Issue\\_Paper\\_1.pdf](http://www.med.unsw.edu.au/SPHCMWeb.nsf/resources/AUSCAN_Issue_Paper_1.pdf/$file/AUSCAN_Issue_Paper_1.pdf)

Health is valued by all members of a community; therefore the pursuit of health can act as a uniting force. Social stability is enhanced when high quality health care is provided in an accessible and equitable manner. Thus, health systems can be a rallying point for community

action and empowerment, especially with regard to women; they may encourage communal ownership, participation, action and consultation. These principles can be translated into more general empowerment of the community in other spheres of social life.

### **Community-based Approaches to Peacebuilding in Conflict-affected and Fragile Contexts Issues Paper**

Huma Haider, GSDRC, November 2009

<http://www.gsdrc.org/docs/open/EIRS8.pdf>

Community-based approaches have been adopted to provide for services (health and education, in particular), infrastructure, natural resource and environmental management, livelihoods and employment generation – for example through the formation of cooperatives. Many of these initiatives have been designed and implemented with particular attention to fostering social capital, cooperation across divides, and the foundation for reintegration and reconciliatory processes.

The impacts of violent conflict and fragility are extensive and far-reaching. The pursuit of multiple aims concurrently through community-based approaches can be an efficient and effective way to contribute to peacebuilding. Many projects seek to incorporate for example the aims of fulfilling socioeconomic needs, (re)building relationships and social renewal, and the development of participatory governance. This view acknowledges the holistic nature of peacebuilding and the ways in which various elements are connected. In contrast, promoting infrastructure or a health care system without addressing inter-community tensions, for example, fails to fully restore communities and promote sustainable peace (Longley, Christopolos and Slaymaker, 2006; Haider, 2009).

There are concerns, however, that community-based approaches are increasingly being seen as a panacea to resolve all conflict and development issues. While, such programmes and projects can be effective in meeting some aims, they are unlikely to meet all aims with the same level of success. Trying to achieve a plethora of high level goals may end up diluting each specific aim. Objectives are often conflated with the belief that the fulfilment of one aim will automatically result in the other.

There are limitations to the needs that can be met through an isolated community-based approach. Infrastructure, such as roads for example, can spill over defined community areas and require the cooperation of other communities. In Afghanistan for example, a village road project in Upper Nawach ran into trouble after construction reached Lower Nawach and villagers there would not allow the road to be continued through their land. (Zakhilwal and Thomas, 2005) In addition, there are important needs in conflict-affected and fragile contexts that communities may not prioritise as their decisions may not incorporate the prospect of external benefits, e.g. environmental and health issues. (Cliffe, Guggenheim and Kostner, 2003)

### **Building Peace through Participatory Health Promotion Training— A Case from Cambodia 2011**

[http://www.ahi-japan.jp/english/training/intl\\_workshop2011/Case\\_AHI.pdf](http://www.ahi-japan.jp/english/training/intl_workshop2011/Case_AHI.pdf)

## **8. Additional information**

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