



EVIDENCE-BASED LESSONS LEARNED FROM EVALUATIONS ON COMMUNITY PARTICIPATION AND CIVIL SOCIETY INVOLVEMENT IN HEALTH

INTRODUCTION

Knowledge generated by evaluation reports and impact studies is often insufficiently considered due to the abundance of evaluations of varying quality in the international development health sector. It can be difficult to focus on key relevant information to maximise the use of the available evidence, making institutional learning difficult for future interventions.

This resource aims to be a tool that can facilitate strategic reflection and institutional learning from high-quality, relevant evaluations of community participation and civil society involvement in health that can be generalised beyond their specific context. It brings together evidence from 27 evaluations and impact studies. Over 400 articles and reviews were examined to produce this list. The evidence contained in these articles includes a number of meta-evaluations and systematic reviews. Most of the articles included relate solely to settings in Sub-Saharan Africa, although several relate to developing countries globally. It is not clear if the evidence from Africa will be relevant to Central Asia as the nature of the legacies of colonialism are likely to be different in these settings. The overview excludes literature on specific approaches to reduce exposure to malaria, because much is already known about what is effective in this domain. However some of the approaches cited in this review have also been proven to reduce the impact of malaria as well as having other health benefits. Studies cited in this resource are numbered in square brackets [x].

COMMUNITY PARTICIPATION AND CIVIL SOCIETY INVOLVEMENT

Participation in health care was a key principle of the 1978 Alma Ata Declaration¹. 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, and control of primary health care.'

But is community participation an essential pre-requisite for better health outcomes or simply a useful but non-essential companion to the delivery of treatments and preventative health education? Using the example of community mobilisation on maternal, new born and child health, an extensive review was undertaken to answer this question [18]. It found that the key to success of community empowerment was the moment when the community engaged with the problem-posing, problem-solving process and recognised that they could collectively change their circumstances. However, effect can vary greatly depending on decisions about the goal, who constitutes the community, who is facilitating the support process, the social and political context, the duration of external or donor support, and the cost effectiveness of the programme.

Although this tool aims to guide donors, policy makers and practitioners to select evidence-based interventions, a number of authors [9, 26, 27] caution that there are no 'magic bullet' solutions that work in every context. There is a real danger when replicating models and projects that certain factors may not be taken into account. The literature warns that what has proven to be successful in one setting should be used as a learning resource and inspiration rather than a simple activity to be transplanted, because it cannot necessarily be transferred directly, in the same form, to a new context, without a thorough and locally-informed analysis of the new environment. What is important for successful replication is to adopt successful process and understanding. Therefore it is the learning that should be transferred from one situation to another.

1 Declaration of Alma Ata: International conference on primary health care, Alma Ata, USSR, September 6 – 12, 1978. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

OVERVIEW OF APPROACHES/INTERVENTION TYPES

Table 1 provides an overview of approaches and intervention types across a range of domains and an assessment of their effectiveness. Approaches are coded green where there is strong evidence of effectiveness; yellow indicates equivocal or conflicting evidence.

Health promotion domain	Approach	Evidence of effectiveness
Health systems at the community level	1. Community-directed intervention	Green
	2. Village Health Committees	Green
	3. Health facility committees	Yellow
	4. Community-based monitoring of health services	Green
	5. Community health nurses/officers	Green
	6. Community health volunteers	Yellow
	7. Community-promoters/agents	Green
Financial approaches	8. Pricing health-promoting products	Yellow
	9. Cash transfers	Green
	10. Conditional cash transfers	Yellow
Communication	11. Finance for non-profit health care providers	Green
	12. Community-level mass media exposure	Green
	13. Investment in communications	Green
	14. Peer approaches	Yellow

Health systems at the community level

1 Community-directed intervention (CDIs)

CDIs are undertaken under the direction of the community itself. Local health services and their partners introduce a range of possible interventions in a participatory manner and explain the CDI approach and how it can ensure community ownership from the outset. The community takes charge of the process through a series of community meetings where the roles and responsibilities are discussed and the community decides how, when and where the intervention will be implemented and by whom; how implementation will be monitored, and what support (financial or otherwise) if any, will be provided to the implementers. The community then collectively selects the implementers. Health workers train and monitor the latter, but the community directs the intervention process.

CDIs have been found to be more effective than other delivery approaches for a range of interventions to treat intestinal worms, give vitamin A supplements, distribute insecticide treated nets, and home management of malaria [21]. When given the necessary training and support, community implementers were able to implement and sustain the strategy. No

financial incentives were given. Community implementers perceived intrinsic incentives as being more decisive in the delivery of the CDI approach. Constraints included shortage of supplies and reluctance of health workers to empower community implementers for short-course directly observed treatments.

Broader systems effects have also been reported from using CDIs including: communities became increasingly aware of public health issues, health commodities and their rights to access health care; women became more outspoken, participated more actively and demanded that responsibilities be assigned to them; community-based organisations (CBOs) including women's groups became more involved. Interest in community development was observed to expand to other development issues.

2 Village Health Committees (VHCs)

Evidence suggests [16, 19] that providing support and stimulus for the formation and strengthening VHCs, communities have been empowered to mobilize for collective action in the interests of community health. This involves capacity building and small grant funding, which enable VHCs to work effectively with the local primary health care system to implement national priorities and to initiate the community's own initiatives. Examples include VHCs raising their own funds and resources to respond to local

health-related initiatives (e.g. establishing vegetable gardens for poor families and renovating community facilities); organizing community events to cascade information (e.g., vaccination campaigns); developing appropriate health promotion information and initiating peer to peer education in schools (e.g., HIV prevention). The process of empowering communities to act on their own to improve health taps into grass-roots level human resources, and is particularly effective at involving women.

Although VHC members enjoy an elevated status and respect from their communities, there is no evidence to suggest that this was associated with volunteers acting beyond their mandate and qualifications, such as treating illnesses.

3 Health facility committees (HFCs)

HFCs have been shown to be effective in influencing health systems and making services more responsive to local needs and interests [9]. The reviewers caution that this should not be implemented as a formulaic approach. It needs to be interpreted to fit in with the local context of the health system.

Seven roles for HFCs have been identified: (1) governance – to strengthen accountability of the health facility to the community; (2) co-management – of health facility resources and services; (3) resource generator – material resources,

labour and funds for the health facility; (4) community outreach – to help the health facility reach into the community and influence health-seeking behaviours; (5) advocacy – to act as a community voice to advocate to local politicians and managers higher up the health system on behalf of the facility; (6) intelligence – to provide a means of transmitting information about the views and needs of the community; (7) social leveler – to help mitigate social stratification by empowering marginalised sections of the community/public. Members are nominated and chosen democratically at community meetings (health personnel, officials, traditional leaders and other community representatives).

HFCs have been found to exert little or no direct influence over health care budgets, although they can galvanise bottom-up support for increased resources. Improved effectiveness is seen if there is external facilitation by a non-political civil society organisation that builds in inclusion of women, youth and marginalised groups to prevent domination and control by local elites. This can be improved by community mobilisation and generation of interest in the process prior to the selection of representatives. Factors that influence effectiveness are clarity and consensus on their mandate and authority to monitor accountability and performance of the health facilities (including discretionary power to reward well-performing health workers and to discipline poor performers); effective leadership; quotas to ensure adequate representation of different segments of the community.

4 Community-based monitoring of health services

Primary health care is often ineffective in developing countries because of ineffective systems of monitoring and weak accountability relationships to hold providers accountable to communities. Evidence shows [22] that when communities are empowered to monitor their local primary health care providers, this leads to improved accountability, with improved performance of the services (both quality and quantity), leading to better treatment and prevention outcomes.

Typically, local non-governmental organisations (NGOs) facilitate village and staff meetings in which community members discuss baseline information on the status of local health service delivery relative to other providers and the government standard. Community members are encouraged to identify key problems and the steps that providers should take to improve health service provision. A process of community-monitoring is then embedded which is up to the community to sustain and lead.

5 Community health nurses/officers (CHOs)

Re-assigning nurses from sub-district clinics to village residences (sometimes built by the community) has been shown to be effective [17] in reducing childhood mortality as they improve vaccination coverage, enable rapid diagnosis and treatment of illnesses, and provide health education. Re-designating the nurses as CHOs can help to emphasise their role as village-based providers of door-to-door primary health providers distinguishing them as different from their traditional clinic-based responsibilities. CHOs provide ambulatory care at their residence and visit all compounds in the community in regular cycles for health education, follow-up and diagnosis. Effectiveness and acceptability are increased with involvement of the community and village leaders in the planning stages.

CHOs have been found to be effective [7] in improving the health of communities by making regular visits to households (approximately 500) to promote improved hygiene and environmental sanitation. These mechanisms included construction and use of latrines, hand washing and safe water storage in the home. The effectiveness of the intervention decreased when the number of households increased, reducing the time spent with each household and therefore the quality of the intervention. Visits were supplemented with monthly visits from community health promoters, which increased intervention effectiveness. Engagement with women was essential to the effectiveness.

6 Community health volunteers (CHVs)

CHVs have not been shown to be effective [17] in reducing childhood mortality when working alone, although they have been found to be effective when working in conjunction with community health nurses. Appointed by village health committees, health volunteers (often male) are trained to visit households to talk about hygiene, child immunization, and other health issues, and to make it known that they are available for basic treatments and referrals to the clinics and hospitals. They can be supplied with basic medicines (such as paracetamol, chloroquine, and multivitamins) but not with antibiotics or vaccines.

Evidence suggests [17] that CHVs may even contribute to poorer health outcomes because they may divert health-seeking behaviour away from more skilled care available in sub-district clinics as mothers may seek advice and basic treatment from the CHVs where they would have otherwise have taken their children to the clinic, delaying or preventing the delivery of more effective health-care and treatment.

CHVs have been shown to be effective [7] in improving hygiene and environmental sanitation when working in conjunction with CHOs. Monthly visits to households proved to be the most effective approach to help change and embed health promoting practices, behaviours and environmental adaptations.

Community-based volunteers (CBVs) have been shown to have a significant impact [8] particularly with adherence to drug treatment. CBVs work in the community they live in. They need training and ongoing support and supervision. Evidence suggests that if CBVs do not have their own transport, they should only be expected to work within a radius of 2 km. CBVs should have clear job descriptions; their good will should not be abused by overloading them with responsibilities. Service providers also reported that through CBVs they have a much stronger connection and relationship with the communities that they serve. They see the work of CBVs as complementing their services. Large-scale adoption of CBV systems requires substantial support from both the central and local governments.

7 Community-promoters/agents

Hiring local community members at a low-wage to promote chlorine use among their neighbours is highly effective at increasing use [5]. Incentivising these promoters had only modest effects. Communities with point-of-collection chlorine dispensers in combination with promoters saw dramatic increases in the percentage of households chlorinating their water, suggesting that this is a highly cost-effective way to promote take up.

Publicly visible non-financial incentives (such as displaying a progress chart in the window of a business) have been shown to be more effective than simply low or high financial incentives [15]. Evidence shows that the non-financial incentives leveraged 'intrinsic' motivation for the cause, and social comparison (competition) among neighboring businesses increased motivation when the number of neighboring businesses involved in the non-financial incentives increased.

Financial approaches

8 Pricing health-promoting products

There is conflicting evidence [4, 5, 20] whether pricing policy of low-cost products (such as chlorine to sterilise water) influences whether people use the product. Some evidence suggests that when people buy very heavily subsidised products, they may have less investment in using them than when they have paid a slightly higher price. Higher prices may screen out those who would not use the products (even if heavily subsidised) because they do not sufficiently value them. This suggests that subsidies on low-cost health promoting products should not be too high as it does not increase their use, and may even reduce their use. Prices of low-cost health-promoting products need to be affordable to a critical number of people, but this challenges the assumption that simply reducing the price will result in increased uptake and use.

However, there is evidence [5] to show that free chlorination dispensed at water sources along with community promot-

ers provided the most effective strategy to improve water cleanliness, preventing diarrheal incidence in rural areas. Other evidence [20] from 10 randomised evaluations suggests that charging small fees in an attempt to balance access and sustainability may be the 'worst of both worlds' as small fees raise little revenue, but dramatically reduce access to important health promoting products for the poor (including de-worming medicine, insecticidal bed nets, water disinfectant, and hand washing soap).

9 Cash transfers

Cash transfers are direct, regular and predictable non-contributory cash payments that help poor and vulnerable households to raise and smooth incomes. The term encompasses a range of instruments such as social pensions, and child grants) and a spectrum of design, implementation and financing options.

While the primary purpose of cash transfers is to reduce poverty and vulnerability, the evidence shows [2] that they have proven potential to contribute directly or indirectly to a wider range of development outcomes. While poverty is multidimensional, low and variable income is central to the problem. Modest but regular income from cash transfers helps households to smooth consumption and sustain spending on food, schooling and healthcare in lean periods without the need to sell assets or take on debt.

Over time, transfer income can help households to build human capital (by investing in their children's nutrition, health and education), save up to buy productive assets, and obtain access to credit on better terms. Cash transfers can thus both protect living standards (alleviating destitution) and promote wealth creation (supporting transition to more sustainable livelihoods). Depending on context, they may also help prevent households from suffering shocks and transform relationships within society, and between citizens and the state.

Cash transfers can help the poor overcome demand-side (cost) barriers to schooling or healthcare, but they cannot resolve supply-side problems with service delivery (e.g. teacher performance or the training of public health profession-

als). Cash transfers therefore need to be complemented by strategies to improve service quality. Nutrition may be an exception: households receiving transfers spend more on food, resulting in significant gains in children's weight and height in several countries.

There is consistent evidence [2] that demonstrates using cash transfers in low-income countries can raise living standards of the poor, directly reduces poverty, hunger and inequality, and that it helps households sustain and improve livelihoods in the face of vulnerability and shocks.

Evidence from South Africa, Kenya and Liberia [2] has demonstrated that electronic payment systems involving smartcards or mobile phones can significantly reduce costs and leakage, while promoting financial inclusion of the poor. One review of programmes [6] concluded that for social protection cash transfers to work optimally requires sustained community participation in transparency and downward accountability: decisions on inclusion and outcomes for beneficiaries need to be non-political and fair, and targeting and monitoring needs to be accurate. Guidelines must be easily understood by communities and local implementing staff alike. Ineffective engagement with communities and potential beneficiaries is likely to reduce programme impact.

10 Conditional cash transfers (CCTs)

CCTs offer financial incentives to reward specific behaviours, in our case related to health. Their effectiveness is variable, and programmes are sensitive to the specific design. In the developing world, CCTs have involved incentives for households, parents or children to engage in healthy behavior or to increase schooling attainment and performance.

There is conflicting evidence of the effectiveness of CCTs for men and women to maintain their HIV negative status. One study [12] showed that CCTs were not effective in reducing reported risky male sexual behaviour although small positive effects were found using CCTs in reducing risky female sexual behaviour. Another study [13] found a significant reduction in STI infections using CCTs.

CCTs to improve school attendance and direct payment of secondary school fees for young women, have been shown to be very effective in reducing sexual activity, teen pregnancy, and early marriage in addition to improved education outcomes [23].

11 Finance for non-profit health care providers

There is evidence that providing financial aid to non-profit health care providers leads to more laboratory testing, lower user charges and increased service use which leads to improved health in the communities they serve [25].

Communication

12 Community-level mass media Exposure

People with greater HIV/AIDS knowledge, as instrumented by community-level mass media exposure, are significantly more likely to have behavioural attitudes conducive to preventing HIV/AIDS than people with lesser knowledge [14]. Both men and women with greater HIV/AIDS knowledge are significantly more likely to use condoms, agree that it is acceptable to talk about condoms on the radio, discuss HIV/AIDS with partners and agree about the importance of teaching children about condom use at school. Furthermore, men with greater HIV/AIDS knowledge have significantly more positive attitudes toward women, are less embarrassed when buying condoms and are more likely to know that condoms cannot be reused.

However, greater knowledge and behavioural attitudes conducive to preventing HIV/AIDS translates into a significant reduction in HIV/AIDS prevalence only amongst women who reached expected sexual maturity after the start of the information campaign.

13 Investment in communications

Communication including advocacy, social and community mobilisation, information and education can increase the efficacy of a number of health interventions [3, 20]. There are no formulaic communications strategies but a range of evidence suggests that tailored communication strategies that use appropriate channels can contribute to increasing the efficacy of a range of health activities. Communications strategies need to be tailored to reach different segments of the population.

Communications strategies have been effective [3] in increasing immunization rates because they can prevent negative publicity and resistance to immunization and build trust in vaccination programmes. Community participation is key to identifying gaps in knowledge and culturally acceptable messages when developing communication strategies. Positive attitudes and good interpersonal communications skills of frontline health workers are decisive in promoting long-term compliance. Grassroots communication strategies are more likely to succeed if they are integrated into the provision of other community health and social needs.

Elements that contributed to a tailored communication strategy to increase enrollment in community-wide tuberculosis preventative therapy in gold mines and hostels in South Africa [24] included extensive consultation with the key stakeholders; working with a communication company to develop a project 'brand'; developing a communications strategy tailored to each intervention site; involving actors from a popular television comedy series to help inform communities about the intervention. One-to-one communications used peer educators along with study staff, and participant advisory groups facilitated two-way communication between study staff and participants. Treatment 'buddies' and text messaging to promote adherence proved less successful.

14 Peer approaches

Peer-led programmes have been delivered in many formal and informal settings [10]. They build on the exchange of information between people of similar age or status acting as agents of change. One systematic review [10] articulated six factors that contribute to likely programme success. These include:

- (1) community needs assessment – prior to designing the programme it is necessary to find out what the target group already knows, how they talk about the topic, and the cultural norms and practices to ensure the cultural appropriateness of the language and the messages to be given out; the needs assessment may be the first step of community engagement;
- (2) community involvement – active input from the target community and community stakeholders is necessary to ensure the message and methods are effective, while acceptance and support from those in power paves the way for a successful and sustainable programme; it also helps to facilitate recruitment of most appropriate peer educators (PEs);
- (3) training – required for both adults and youths, but the training needs of young people are greater and different from adults. Training needs to include community-specific issues related to the moral belief systems and cultural practices, message delivery and communication skills, literacy and self-care. Programmes are more successful when staff train PEs directly rather than cascade models where local leaders are trained to train PEs. Refresher trainings are useful for programmes with an extended timeframe;
- (4) supervision – a structured method for regular contact between supervisory staff and PEs helps to ensure that the intervention is implemented and delivered with integrity; provide opportunities to problem-solve, gain confidence and enhance social investment in the programme, aiding retention;
- (5) retention – strategies for PE retention that have been shown to be successful are reimbursement for expenses, financial incentives (such as microcredit, bicycles, ability to sell con-

doms for a small profit), development of professional and work-related skills, acknowledgement, participation in project development and decision-making, and support/supervision;

- (6) sustainability – local ownership of the programme by an established organization (either NGO, health or education system) increases sustainability and provides a mechanism to find replacement PEs and to train them.

The same review [10] also found four factors that contribute to the limitations of peer-led approaches. These include: (1) the programme has to be implemented well in order to work; (2) adults and older adolescents with more schooling may be better at communicating complicated medical information than young people; (3) close peers may be 'too close for comfort' or have an on-going relationship with members of the target group to ensure confidentiality – but the risk of this will be mitigated if the community needs assessment establishes what will be most effective and acceptable with the target community; (4) without monitoring and evaluation funds may be misdirected, opportunities lost and weak or ineffective programmes perpetuated.

Evidence from 24 synthesised evaluations [10] showed that youth leaders were effective in reducing risks of HIV infection in young people's knowledge and awareness of risk, and increased condom use; were somewhat successful in changing community attitudes and norms; but were less successful in reducing the onset of sexual activity and reducing sexually transmitted infections. Another long-term randomised controlled evaluation [16] of a large-scale carefully implemented school-teacher led education complemented by youth peer education found similar results. Positive changes in knowledge, attitudes and reported behaviours do not always lead to a positive impact on HIV, STDs and unwanted pregnancies. The authors concluded that there is a need to address structural (societal) issues, such as gender inequality, that are drivers of the HIV epidemic.

Male peer discussion leaders to deliver educational sessions to other men about the importance of men's support and engagement with programmes to prevent mother to child transmission of HIV (pMTCT) was found to be effective in increasing men's knowledge and acceptability of efforts to reduce pMTCT [11].

Breastfeeding counsellors – exclusive breast feeding for the first 6 months of life has been estimated as one of the most effective preventative strategies to reduce child mortality. It needs to be undertaken within the framework of prevention of mother to child transmission of HIV, such as one antenatal visit and four post-delivery visits [1]. Although this approach increased exclusive breast feeding it had no effect on diarrhoea.

EFFECTIVE ENGAGEMENT OF CITIZENS AND CIVIL SOCIETY

So what are the conditions necessary to maximise citizen engagement in health promotion activities? Two extensive reviews [26, 27] shed some light on these issues. One review [26] articulated six important findings for those seeking to foster positive developmental and democratic outcomes through citizen engagement:

- (1) Citizen engagement can be linked positively in a number of instances to the achievement of both development outcomes – such as those linked to health, water, sanitation and education – and democratic outcomes linked to building accountable institutions and making real national and international human rights frameworks.
- (2) Active and effective citizens who can help deliver these development and democratic gains do not emerge automatically. As with the process of building states and institutions, other intermediary measures of change are also very important.
- (3) While 'good change' can happen through citizen engagement, there are also risks. Careful attention must be paid to the quality and direction of change, as well as to its incidence. Positive outcomes of citizen engagement can be mirrored by their opposite.

- (4) Change happens through multiple types of citizen engagement: not only through formal governance processes, but also through associations and social movements that are not created by the state. Strengthening these broader social change processes, and their interactions, can create opportunities for state reformers to respond to demands, build external alliances and contribute to state responsiveness.

- (5) Citizen engagement – especially when citizens are challenging powerful interests in the status quo – gives rise to the risk of reprisals, which can range from state and political violence, to economic and social forms of recrimination against those who speak out. Donors and policy-makers alike can play an important role in protecting and strengthening spaces for citizens to exercise their voice, and can support the enabling conditions for citizen engagement to occur. In particular, they can promote the value of broad social movements for both democracy and development, support champions of engagement within the state, and monitor state reprisals against increased citizen voice.

- (6) For donors and development actors working in fragile and weak settings, the research points to the need to recognise early the role which local associations and other citizen activities can play in the strengthening of cultures of citizenship, which can contribute to building responsive states.

Another review [27] reported that 'when it works, engagement strengthens people's sense of citizenship and contributes to more effective citizen practices, which in turn help to create more responsive and accountable states and more inclusive and cohesive societies. When it fails, however, engagement can lead to disempowerment, more clientelistic practices, a less responsive state and an increasingly divided society'. It offered the following recommendations:

For NGOs and civil society actors

Assess the benefits and risks of various strategies of engagement – actors seeking change through citizen engagement need to carefully assess which spaces of change to enter, which strategies to employ, and how to minimise the risks of negative outcomes.

Develop clearer strategies and policies for mediating and linking across actors – using multiple strategies across levels of power and spaces of change means building alliances and linking them with others. These relationships often require effective mediators – individuals, organisations, or networks that link various actors in an accountable and collaborative way. Mediation done well allows for stakeholders at different levels to shape the framing of the issues and contribute to a strategy for action.

For sustainable results, develop approaches that build the constituencies for change – there are pressures on civil society organisations to deliver quick results that can be easily counted and measured. But sustainable change means strengthening and empowering citizens affected by those policies and services, so that they can maintain the gains through their own voice and action. The style of intervention can make a big difference to whether it just delivers quick results, or whether it builds constituencies for change that can address the underlying causes of the problem in the long term.

For donors

Think 'vertically' as well as 'horizontally' – many international donor agencies are often divided between departments which work with governments and those which work with civil society, and may be layered into separate global, national and local offices or programmes. This structure does little to encourage the intersections of change between states and societies, and across the levels of political authority. Donors can do more to encourage building both horizontal and vertical alliances for change.

Help to protect the space for citizen engagement, including for social movements – citizen engagement requires security – the freedom to participate without fear of violence and reprisal, whether in the household or from the state. Donors can do more to link their concerns with violence and security to the concern to protect the spaces for participation. Though some donors may find it difficult to fund social movements, they can play a role by supporting the enabling conditions in which they occur, and urge against reprisal.

Give citizen engagement more time – the pressure for rapid results in the name of more effective aid can encourage shortcuts to the sometimes slow process of building citizen engagement. But the longterm process of citizen engagement does not fit within the two- or three-year project cycle. Donors would do well to recognise – and measure – the development of citizen awareness, efficacy and engagement as building blocks of aid effectiveness.

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