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HANDBOOK FOR COMMUNITY PARTNERSHIPS

FOR PRIMARY HEALTH CARE DEVELOPED IN IRAQ

DISCLAIMER

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TABLE OF CONTENTS

TABLE OF CONTENTS	I
PREFACE	II
ACRONYMS	III
1.	CONTEXT
.....	1
2. CURRENT STATUS OF COMMUNITY PARTNERSHIPS IN PHC.....	2
3.1 SUCCESSES AND CHALLENGES	2
3.2 OBJECTIVE OF THE HANDBOOK	3
3.	COMMUNITY HEALTH PARTNERSHIPS (CHP)
.....	5
3.1 COMMUNITY PARTICIPATION OR INVOLVEMENT IN HEALTH.....	5
3.2 DEFINITION AND TERMS	5
3.3 ROLE OF HEALTH CARE PROVIDERS.....	5
3.4 CHARACTERISTICS OF SUCCESSFUL CHPs	6
4.	COMMUNITY HEALTH PARTNERSHIPS: TOOLS AND TECHNIQUES
.....	8
4.1 BUILDING A COMMUNITY PROFILE	8
4.2 ENGAGING THE COMMUNITY	9
4.2 IDENTIFYING IMPEDIMENTS TO ENGAGING MARGINALIZED GROUPS	11
4.3 SOLICITING COMMUNITY FEEDBACK	12
4.4 ESTABLISHING LOCAL HEALTH COMMITTEES	13
4.5 MEASURING COMMUNITY PARTICIPATION	15
5. RESOURCES	17
<i>ANNEX A: Suggested Activities for Local Health Committees</i>	18
<i>ANNEX B: Group Work: Guidance for Facilitation</i>	19
<i>ANNEX C: Planning for Conducting Group Talks</i>	21
<i>ANNEX D: Checklist for Major Health Issues</i>	22
<i>ANNEX E: Interview Guidance (applies to semi-structured and open interviews)</i>	23
<i>ANNEX F: How to Use IEC Materials for CHP</i>	25
<i>ANNEX G: Description of Communication Channels for use in Action Planning</i>	27
6.	REFERENCES
.....	28

Preface

Community Health Partnerships (CHPs) are affiliations set up between health care service providers and their target communities to support a wide range of health services delivered in homes, health centers and clinics. CHP is also the provision of integrated health and social care, delivering local health improvement that helps to close the health inequality gap. CHP depends on community participation, which is an integral requirement of PHC services.

The purpose of CHPs is to build effective community feedback mechanisms. Increasing community engagement can measurably contribute to better services and increase community consumption of the health care system.

To respond to the need for increased community involvement in their own health care, as well as the implementation of health programs and delivery of essential services, the United States Agency for International Development (USAID), represented by the Primary Health Care Program in Iraq (PHCPI), has developed this Handbook for Community Partnerships. The handbook focuses on the best practices for building effective partnerships between health care service providers and the communities they intend to serve.

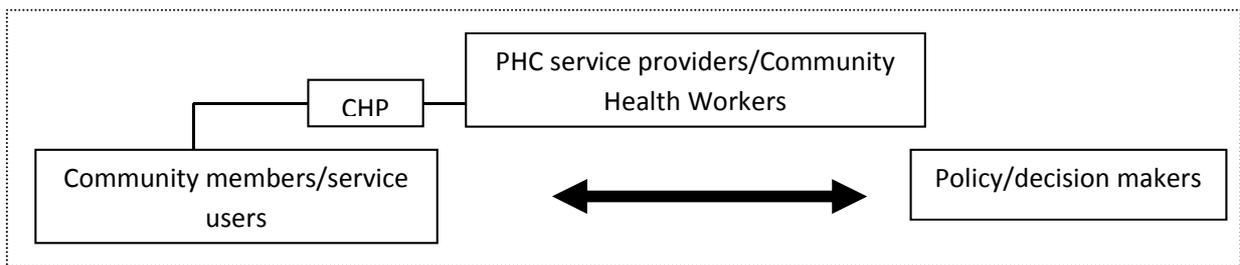
Acronyms

BCC	Behavior Change Communication
BHSP	Basic Health Services Package
EML	Essential Medicines List
EPI	Expanded Program on Immunization
EQA	External Quality Assurance
GoI	Government of Iraq
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSI	Management Systems International
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCPI	Primary Health Care Project Iraq
SCM	Supply Chain Management
SOP	Standard Operating Procedures
QI	Quality Improvement
URC	University Research Co., LLC
USAID	United States Agency for International Development

1. Context

Building linkages between primary health care service providers and the communities they intend to serve creates a space for dialogue that ultimately results in improved quality of health services. Primary health care (PHC) centers are uniquely situated to receive direct information about community health needs and to then communicate these needs to higher levels of the health system and to health policy makers. Through strong community partnerships, PHC centers can become strong advocates for their clients. Similarly, by communicating priorities and preferences, and by providing feedback on the quality of PHC services received, community members are empowered to take an active role in their own health care and to contribute to the improvement of the overall status of their community.

PHC service providers can play an important role in encouraging greater community participation by building community health partnerships (CHPs) in the communities they serve. Thus, service providers act as a two-way bridge for information flow from the communities to policy/decision makers.



A successful community health partnership results in the following:

- Improved health awareness of the local community through education and adoption of healthy practices.
- Improved health promotion and disease prevention through community participation.
- Improved utilization of primary health services by the target community.
- A safe and healthy environment for all involved.

2. *Current status of community partnerships in PHC*

As articulated in the MoH's National Health Policy and Basic Health Services Package, PHC services in Iraq are provided to clients at main PHC centres, PHC sub-centres, and community health houses (planned).

Main PHC centres are staffed by doctors, nurses, midwives, laboratory technicians, and pharmacy technicians. Most PHC centres serve a population size ranging from 10,000-30,000; however, large PHC centres that offer emergency and obstetric care services may serve a population of up to 45,000. PHC main centers provide a wide range of preventive and curative services, and are equipped to handle many difficult cases of childhood illness.

PHC sub-centres have no medical doctors. They are staffed by trained health workers (nurses or paramedics, and a vaccinator) and serve a population of 5,000 – 10,000. These sub-centres are equipped to offer preventive and basic curative services, including simple diagnostic procedures, normal deliveries, immunizations, and a few essential laboratory services. These centres also engage in Information, Education, and Communication (IEC) activities that are designed to encourage clients to adopt healthy behaviors.

Planned community health houses¹ are designed to be staffed by male and female community health workers (CHWs) who will have an advisory and supportive role in strengthening the link between the community and the PHC centres. Services provided will include IEC activities, distribution of condoms and oral contraceptives, support for vaccination campaigns, and growth monitoring and micronutrient supplementation for children under five. CHWs will provide limited curative care under the Integrated Management of Childhood Illnesses (IMCI) program, as well as act as DOTS providers to tuberculosis (TB) patients. Female CHWs will provide care for normal deliveries, identify danger signs, and refer patients to health centres. CHWs will serve a critical function in the building of CHPs.

3.1 *Successes and challenges*

Although the establishment of formal CHPs is a relatively new concept in Iraq, there is evidence of successful community partnerships for PHC already in place. Examples include:

- TB treatment with DOTS. Active community participation in this effort has led to an increased cure rate and a decrease in recurrence among treated TB patients. Early detection and treatments of malaria cases by community volunteers.

¹http://www.emro.who.int/iraq/pdf/basic_health_service_package_en.pdf

- Community mass health education campaigns implemented by community members have helped raise awareness on HIV/AIDS, anemia in pregnant women, oral rehydration therapy, and family planning.
- Parent-Teacher Associations (PTAs) have organized activities related to school health and building healthy environments.

However, challenges remain in scaling-up CHPs. Traditionally, development programs focusing on health in post-conflict societies seek to improve the quality of technical and clinical skills of health care providers. However, in Iraq, despite the ongoing political instability and security risks, there remains a significant contingent of providers who are highly competent clinicians. Despite this comparative advantage, in many communities within Iraq there is a strong sense that existing primary care systems do not adequately reflect and respond to the communities' needs.

In 2011, a rapid assessment in 75 PHC centres in 13 districts was conducted by PHCPI. The assessment revealed that almost all provincial stakeholders (90%) acknowledged the important role of the community in PHC. However, PHC and community linkages are not strong, as only 40% of PHC centres said they regularly meet with community groups. PHC Directors reported that there is no official mechanism to ensure the active engagement of civil society and the community in identifying health priorities, planning service delivery, improving quality, and reducing barriers to seeking care. Due to insecurity and resource-constraints, the Ministry and district-level units struggle to meet the needs of all community members, particularly internally displaced populations (IDPs), the disabled, and other vulnerable groups.

To ensure that in the future PHC centres are more responsive to the needs of the community, and that in turn the community is more engaged in taking ownership of its own health care, CHPs need to be introduced in an orderly and well coordinated manner. The first step is to sensitize and train PHC service providers on the concept of CHPs. It is important that they understand the need for CHPs in health planning and service delivery strategies to promote/enhance community participation, and the importance of monitoring and evaluating participation by communities in health.

3.2 Objective of the handbook

This Handbook for Community Partnerships in Primary Health Care is intended for use by health professionals in Iraq working at the PHC main centre, sub-centre and community levels. This handbook serves as a guide on how to develop partnerships with target communities and learn how to engage community members in a process of planning, implementing and evaluating services based on the needs, priorities, and demands of the community.

After reading this handbook and attending training sessions on CHPs, the user will be able to:

- Understand the ideas and concepts of CHPs;
- Apply techniques and tools of CHPs in local situation; and
- Transfer CHP knowledge and skills to the individuals from the community who are involved in building and sustaining partnership efforts.

3. Community Health Partnerships (CHP)

3.1 Community participation or involvement in health

Building CHPs is the process of involving communities in setting health priorities, developing and implementing quality improvement activities, and evaluating the success of these activities in improving the health status of the community. The process itself is empowering and builds skills and confidence in the people involved. It is also a mechanism of mobilizing human and material resources at the local level for health and development efforts. Community participation is neither sporadic, superficial consultation with community leaders, nor does it imply abdication by the health centre of its responsibilities in providing health services.

3.2 Definition and Terms

Community: a group of people living in close proximity to one another who have formed relationships through several overlapping and interacting social networks and through a shared sense of needs and local common good (adapted from Eng & Blanchard, 1991). The community is the core of PHC, as all health functions and tasks have a community component. Communities can be defined by different characteristics that members share. Every person is a member of many overlapping communities. Some examples of communities include all people living in village X, mothers of children under five, women of reproductive age, members of religious/traditional groups, IDPs, etc.

Civil society: an organized group of people in the community that is not a business and is not a part of the government. Civil society is the sphere of institutions and individuals in which people associate voluntarily to advance common interests. Anyone who has joined a group to advance or defend a cause is a member of civil society.

Community Health Partnerships (CHPs): partnerships that organize the community to provide a wide range of community based health services delivered in the community at households, health centres, or other community venues. CHP facilitates the provision of quality, integrated health and social care that helps to close the health inequality gap. Increasing community engagement and partnership begins with a better understanding of the community being served.

3.3 Role of health care providers

The World Health Organization (WHO) recommends that the focus in health service provision be shifted from “encouraging communities to participate in health” towards “preparing health services for community involvement in health”.

For many health workers, working together with a community is a new experience. This is true for communities as well. It is a process of mutual learning. Mutual recognition of capacities and worth is a key requirement for collaborative effort. There is evidence to suggest that health care service professionals significantly undervalue the expertise of communities (El Ansari et al, 2002) and are often not aware of the existence of community organizations.

The degree to which the community is involved will depend initially on the extent to which community organizations already exist, as well as their relationship with the health centre. Involvement will be built up from there, increasing as the community develops capacity to participate in health development.

The challenge to health workers is to change their way of working from one of expertise-based intervention to one of facilitation and community leadership. A shift in perspective by PHC staff enables the building of shared solutions, and utilizes collaborative language and thought processes. Examples of shifts in language to facilitate dialogue with the community are presented in the table below:

Shifts in Perspective for Health Service Providers	
From	To
We believe in our own expertise.	We believe in the peoples' strength to respond.
We control disease.	We encourage good health practices to prevent disease.
We define your problem.	We can work together to find solutions.
We provide services to you.	We can partner to determine best practices.
We instruct and advise.	We learn and share.

3.4 Characteristics of successful CHPs

Self-efficacy in CHPs is critical to their success. This self-efficacy can be achieved through:

- Involving the community in the planning and management of activities;
- Engaging and mobilizing community manpower;
- Encouraging community members to volunteer their time;
- Developing means for the community itself to finance the activities undertaken by CHPs.
- Sharing in identifying and prioritizing problems. Allowing the community itself to suggest changes in attitudes and behaviors that will result in better health outcomes.

The general idea is to ensure that the community plays the role of *active participant* and not *passive recipient*. When this occurs, the people feel more connected to the process and are more invested in the outcomes.

Some examples of community engagements in common health problems:

Health issue	Community Role	Family role	PHC center role
Nutrition	Plant nutritional crops.	Encourage breast feeding practices. Provision of good weaning food. Grow their own vegetables.	Identification of nutritional difficulties e.g. health surveys, clinic data.
Water	Protection and maintaining local water supplies.	Clean storage of water.	Send sample of water for checking.
Maternal care	Organize transport for mothers. Encourage TBA to have proper training.	Clean room for delivery. Encourage mothers to attend PHCC.	Regular antenatal care. Prophylactic medicine during pregnancy. Detecting and referring mothers at risk.

4. Community Health Partnerships: Tools and Techniques

Full partnership with the community can be achieved only when the community is well-informed, capable of assessing its own problems, and capable of developing solutions. Communities do have the requisite potential; they only need to be encouraged to use it. PHC service providers can facilitate this process using the tools and techniques described in this section. It is advisable to begin by:

- Identifying PHC staff who will be responsible for driving this process (the PHC main centre team should support CHPs in sub-centres and community health houses);
- Identifying existing community structures (e.g. women's and youth groups, NGOs, traditional and religious groups, political organizations, etc.);
- Identifying the additional structures which need to be formed, including local health committees or other representative community structures; and
- Identifying intersectoral linkages, both with other public departments (water, education, agriculture, etc.), and also with private sector health providers and local businesses.

4.1 Building a Community Profile

Methods: Community mapping, health surveys, focus group discussions, in-depth interviews

Communities are rarely, if ever, homogenous entities with the same levels of knowledge, access to services, and practices. Therefore, before engaging with the community, more specific information must be gathered to ensure more complete representation. This information can be grouped into the following categories:

Economic and Social Context

- How the community is naturally organized— social classes, ethnic groups, religious groups, age?
- Are there traditional groups or structures that play a role in decision-making? What are their functions?
- What is the economic status of most of the population? Is there a general trade or form of labor that is common to a large sector?
- What is the average family income? Family size?
- What is the current overall economic situation? Is the community largely self-sufficient, or does it rely a great deal on external assistance/trade?

Status of Different Genders and Gender Roles

- What are traditional roles?
- How do traditional roles determine access?
- What are the relationships between the sexes?

- Is there a difference in perception of gender roles among younger versus older generations?

Political Organization

- Who are the official community leaders?
- Are there other members or groups who participate in decision-making?
- How are decisions made for the larger community?
- What links does the community have to the greater political system?
- Is there a strong tie between the central government and the community? Is this region considered a “priority area” or a neglected area?
- Are any particular leaders stronger or have greater support compared with others?

Health Systems

- How is the PHC centre perceived by the community?
- What is the relationship between public, private, and traditional/alternative health services?
- How is health care financed in the community?

As one gets to know the communities in the catchment area served by the PHC centre, one will come to realize that the status of their health is intimately influenced by many social determinants. Important determinants include socio-economic status, life style choices, health seeking behaviour, cultural beliefs and practices, religious beliefs, education and general awareness. Health professionals have the technical knowledge and skills, but the communities have the knowledge about their culture and social organisation. That knowledge needs to be tapped into when designing and implementing health programmes to ensure that they will be accepted and utilized by the community. An important issue to note is that marginalized or minority groups are frequently overlooked or underrepresented during community profiling. In Iraq, some communities are comprised of large pockets of IDPs, who are often recent arrivals to an area and are not accounted for in existing surveys. Some may also suffer from diseases or other health issues that are not present in the larger community; they may not have access to the PHC centre or even be aware of the services they offer. The same is often true of orphans or war widows, especially in areas that are not deemed safe enough for free movement without a male escort for protection.

4.2 Engaging the Community

Methods: Formal community meetings, Group facilitation, Local Health Committees

Approaching community leaders

Engagement may begin by reaching out to the community leaders and representatives from community organizations—the official “decision makers” for the population. Community leaders

are the greatest resource and by working closely with them it can be ensured that the health care system is part of their responsibility.

In engaging community leaders, ensure that they will not feel marginalized or offended by not being given formal notice that might challenge their authority before reaching out to the community at large. A delicate balance must be struck here to ensure that the community does not perceive any new initiatives as “belonging” to one or other political or official group that might discourage participation or be perceived as having a specific agenda.

Facilitating community meetings

Once the community leaders are on board, PHC Center Outreach staff should engage the community at large by invitation to attend a meeting. This invitation can be extended through radio, flyers, newspaper, commercials, through schools, or as part of another community meeting or gathering. If the target community already has an existing meeting place or time, such as after Friday prayers, near traditional events, a community center, or around a sporting event, it may be useful to try to organize at least an initial meeting close to one of these existing central points: this helps prevent fatigue with new initiatives, which can often happen in areas that are the focus of many new interventions and development activities.

During the initial meeting, the overall concept and goals of community partnership with the PHC Centers could be presented to the attendees. This concept should be outlined to orient attendees, and referred to throughout the course of the meeting.

The orientation should include:

- Introduction of PHC Center staff and community member attendees
- Confirmation of community leaders’ support for engagement
- Presentation of the concept of “community partnership”
- Description of the process the PHC Center plans to implement to engage community more with health services
- Description of the PHC Center services available to the community
- Discussions of the health issues the PHC Center has identified as priority
- Invitation to participants to comment on the priority areas, offering their feedback
- Confirmation of follow-up meeting session time, date, and location

Participants should be invited to share their vision of quality health services; identify their perceived barriers to achieving those quality services; and try to outline strategies to mitigate those barriers. In brief, the community should be given a distinct and more important role in health matters and their management.

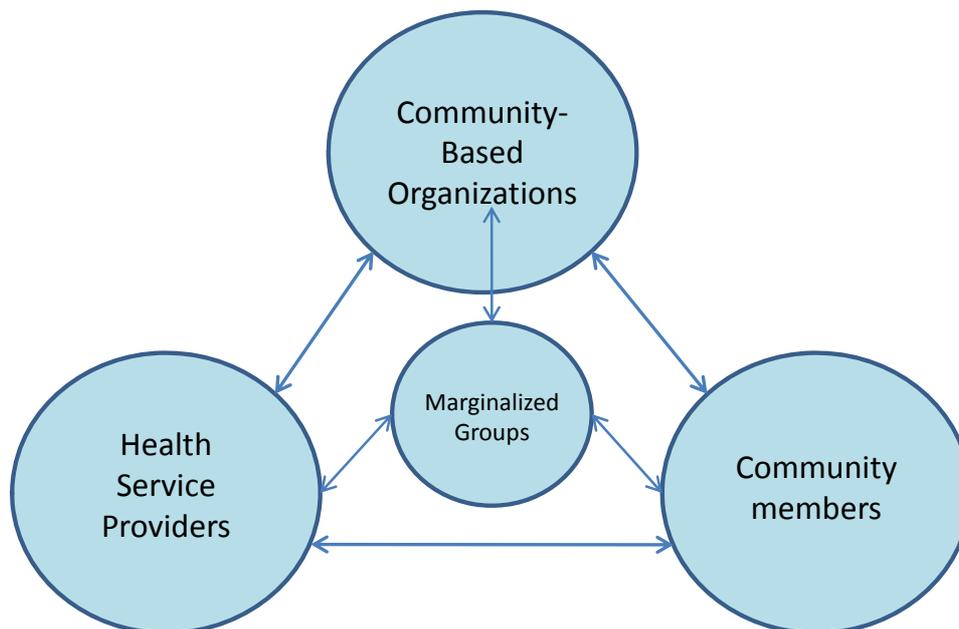
4.2 Identifying Impediments to Engaging Marginalized Groups

Despite the best efforts of PHC centre staff, there will be some community members who face barriers, real and perceived, to participation. These limitations may include time constraints; physical limitations related to access to community gathering places; cultural limitations that may prevent some members of the community from attending public gatherings; lack of identification with other participants; lack of knowledge about the meeting; or perception that certain groups and their input are not welcome.

Part of the PHC centre staff's responsibility is to encourage the voluntary attendees to help identify and engage those community members who may not otherwise contribute or participate. If the non-engaging community members are also not utilizing health services, it will be important for PHC centre staff to understand why not in order to address the issues that may be the cause. There may be perceptions that the quality of care is not acceptable; that people outside of certain economic, religious, or ethnic groups may face discrimination if they utilize the health services; or that the cost of care is too high to be accessible.

PHC centre staff focusing on outreach to the community may need to start with getting community leader buy-in to the need to incorporate these marginalized groups. In cases where there is no stigma attached to the participation of marginalized groups, this may come thru appeals to leaders' understanding of the inclusive nature of their leadership role and their duty to reach out to less-informed groups. Incorporation of stigmatized groups is far harder, but may be approached piecemeal by enlisting the most sympathetic leader figure first, and making it their task to diminish the stigma among other leaders.

Staff reaching out to the marginalized groups themselves will have to make concerted efforts to engage them. This includes IDPs, war widows, other single females living in the community, and orphans /vulnerable children. An entry point to these groups may be found with civil society or existing Community Based Organizations (CBOs) that have already initiated programming or activities. This engagement should be continuous and allow flow of information between major interested stakeholders, as pictured below:



The PHC centre staff may need to conduct in-depth interviews with identified key stakeholders to ask for more insight into the presence of marginalized groups; how to find access points to those groups; and what might the cultural barriers be to engaging those groups. Additionally, household surveys or home visits may be necessary at the initial stages in order to build direct ties between clients and providers.

4.3 Soliciting Community Feedback

Methods: Client exit interviews, Suggestion/Complaint box, Focus group discussion, in-depth interviews

Once the PHC centre staff and community have established partnerships, the next step is to focus on soliciting feedback from the community regarding health needs and health services. As the ultimate goal in establishing partnerships is to improve overall health services, it is critical to avoid having community engagement taper off without actually garnering any important feedback that can be translated into tangible action at the PHC centre level.

Some of the methods for soliciting community feedback include:

Focus Groups, which are carefully, planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (Krueger and Casey, 2000). Focus groups allow for a large volume of information to be gathered from a number of community members at the same time.

Interviews with community leaders and other key stakeholders, which can help to pinpoint which actions appear to have improved coordination and collaboration and which are not proving effective.

Patient exit interviews, where users or clients of the PHCC are interviewed as they leave the PHC centre and can offer fresh impressions about the care they received. These can be done in the form of short, anonymous patient satisfaction surveys or brief interviews by a PHC centre staff person as the client exits.

Suggestion or Complaint box, which may be placed at the PHC centre for community member to post their messages anonymously.

Follow up of non-users, which may help to gain information or feedback from non-users of the clinic's services. Similar to conducting household surveys or household visits, the PHC centre staff can utilize this opportunity to visit three distinct groups of community members: 1) those who do not use the services offered at the clinic; 2) those that have used them and stopped; and 3) those who continue to use them. Follow up questions will enable PHC centre staff to reevaluate program design and service delivery accordingly.

An important factor to note when attempting to gauge community satisfaction with results of the new partnership relationship is that realistic milestones must be established for changes and shared with the community. Frequently, communities lose faith in new interventions or processes because they expect results much more quickly than is actually feasible or practical. Therefore, PHC centre staff must underscore that, while all health issues raised by the community are important, the most urgent ones must be prioritized. Moreover, some may require months or even years before change can be affected, due to the need for MoH buy-in or approval at the policy level that might slow down the visible products of PHC centre engagement.

4.4 Establishing Local Health Committees

The WHO advocates the use of Local Health Committees (LHCs) to manage and convey health needs and priorities of the local population to health care service providers in their target communities. The MoH in Iraq has accepted the WHO-recommended model of LHCs as an effective means to understand local health needs and other issues considered priorities by the community. While the model of LHCs is familiar at the PHC centre level, the presence and practice of utilizing LHCs remains largely conceptual, rather than an active component of PHC. Building on this understanding, the MoH can activate a model of PHC Health councils, updated and implemented to meet current expectations and integrate into the modern PHC system in Iraq.

Structure and membership

Members of a PHC LHC may include medical staff, PHC service providers, social workers, and members of the community. Membership should include those persons who may be recognized as natural leaders in the community, with good interpersonal skills and dedication to the betterment of the community's overall health and well-being. LHC membership should not exceed more than 7 members, with no more than two from the PHC centre, ensuring that greater emphasis is placed on the community's involvement.

The committee should meet regularly (for example, on a monthly basis) to apply CHP activities in the area covered by the PHC centre and implement local activities that complement the work of the PHC centre.

Initially, during the beginning phase of the LHC, PHC staff should orient, advise, and brainstorm about:

- the local problems and how to prioritize them
- identifying the specific interventions needed
- identifying who should carry out the activities needed

Roles and responsibilities

- Performing community mapping including structure of the community, health risks, diseases, activities, socioeconomic factors, education, resources for financing and human resources; identify avenues for provision of certain services in the community.
- Establishing a focal point or first point of contact, to direct members of the community to needed services.
- Recognizing and prioritizing local community health problems.
- Identify assets/ resources: grants, volunteers, donations etc.
- Recognizing the type of services that could be provided to the beneficiaries.
- Providing supplies and means to provide services including recommendations for avenues and ways of recognizing, contacting and mobilizing the beneficiaries to receive service.
- Planning and organizing health promotion events.

Measuring the outcomes and achievements of LHC activities

LHCs should be able to prioritize and select certain problems to act on and then be able to measure the impact of their activities. The process of measuring the outcomes and achievements of LHC activities can be as follows:

1. Identifying and analyzing the problem
2. Finding suitable action to work on
3. Deciding on goals of community health partnership, for example:
 - Increasing patient satisfaction

- Increasing utilization of health services at the PHCC
 - Involvement of the community on decisions on health care
 - Number of community activities done
 - Working on life style factors and changing behavior
4. Drafting an action plan: The draft action plan should include a review of health threats, identification of at-risk groups and interventions (e.g. BCC) needed for said groups, and expected results.
 5. Follow-up of action plan: Follow-up of action plan should be done at subsequent meetings or at periodic intervals. This provides the opportunity to LHC and PHCC to assess whether the activities are ongoing as planned, any barriers or obstacles noted and what modifications are needed to overcome problems in achieving the results.

The draft action plan developed by the community groups is not necessarily a fixed document or plan for implementation at the clinics. Rather, it is a means by which to engage the community and begin the dialogue between the community members and PHC centre staff. As PHC centre staff facilitate the meetings, they will be able to collect valuable information on community dynamics, key stakeholders whom they might not have come across in their previous research, and some unofficial channels of communication or hierarchy that are part of the community.

4.5 Measuring Community Participation

Methods: Clinic uptake and coverage data analysis

Community participation in the partnership process is ultimately measured by the increase in uptake of PHC services. The degree to which targeted groups, especially those previously marginalized and “outside the system” are brought into the decision-making process and express a sense of belonging to and ownership of the system are also strong indicators. Increased awareness by the community of resources and opportunities available to them by the PHC centre are also good indicators. Moreover, when the community begins to truly value their health care system, there should be a measurable increase in incorporating the services available in the PHC centres in other community-based initiatives. Ultimately, however, the increase in community utilization of health services at the PHC level indicates a successful community partnership that leads to better overall health outcomes for the community as a whole. It is important to recognize however, that community engagement and awareness alone will not produce “demand” for services. Improvements system-wide in supply chain, adherence to universal precautions, improvements in human resource management and training, and services delivery are essential to realize gains in community linkages. Patients must receive timely and affordable care at each visit to the health center. In addition, challenges persist for vulnerable groups and those requiring a seamless continuum of care.

Some of the methods for measuring community participation include:

Client Service Records, which include medical records and clinic attendance sheets obtained at the PHC Centers. In general, the community's perception that services improved will result in an increase in the use of services. Comparisons to baseline use of services, such as immunizations, deliveries, routine checks, etc. should show an increase, or can indicate that the partnership methods currently in use are not fully effective and should be revisited.

Special studies, which measure the community participation, for example: pre and post evaluations of behavior change communication campaigns.

5. Resources

Annex A: Suggested Activities for Local Health Committees

Annex B: Group Work: Guidance for Facilitation

Annex C: Planning for Conducting Group Talks

Annex D: Checklists for Major Health Issues

Annex E: Interview Guidance (applies to semi-structured and open interviews)

Annex F: How to Use IEC Materials for CHP

Annex G: Description of Communication Channels for use in Action Planning

ANNEX A: Suggested Activities for Local Health Committees

- Refuse disposal
- Water chlorination and supply
- Environmental sanitation
- Family and personal hygiene
- Provision of WC at family level
- Food safety
- Presence of iodized salt
- Smoking
- Health promotion
- Reporting births and deaths
- Logistically providing transportation for referred persons
- Presence of vaccines in PHCC in immunization campaigns
- Ante and post natal care
- Child vaccinations
- Growth monitoring for the under fives
- Oral rehydration
- Vitamin A supplementation
- Iron deficiency anemia
- DOTS (Direct oral tuberculosis therapy)
- Malaria
- Detecting and follow up of diabetics, hypertensive and renal conditions
- Recognizing the physically disabled and supporting them by the community
- Mapping different risk areas in the area inhabited by the community and preventing deaths
- Recognizing groups and persons affected by chronic diseases and disorders , malnutrition and under nutrition, the aged , mentally ill
- Premature labor
- Occupational health
- Emergency conditions and preparedness to deal with it
- Village mapping
- First aid in the community
- School involvement
- Or any other relevant local health problem
- Social service for the displaced and the disabled
- Emergency health services: like community preparedness or first aid or ambulatory first aid services

ANNEX B: Group Work: Guidance for Facilitation

Knowledge of the Subject Matter:

- Introduces the topic of CHP and guides discussion.
- Answer questions as the situation demands.

Monitors Group Work:

- Starts group work by giving clearly defined group tasks and time allowed;
- Motivates, keeping attention and interest high;
- Keeps time and checks the progress of the groups, shortening or expanding time, if necessary;
- Introduces rules for group work, if necessary.

Monitors Group Dynamics:

- Encourages equal participation of group members;
- Handles opposition, protest and doubts regarding the subject matter;
- Handles conflicts between group members;
- Handles difficult group members.

In addition to the information garnered from group meetings, a number of direct interviews with key stakeholders will be necessary at the outset of the partnership process (i.e. to develop health issues checklist and other tools used). Interviews should be conducted with community leaders and other key informants who should be knowledgeable about the community's makeup and dynamics. It is important that open-ended questions be used during interviews so that new information or queries can be included in group work specific to that community.

Interview questions for key informants/community leaders should include:

- How is the community organized?
- What is your role in this community makeup?
- Are there informal/formal community leaders? How do they relate to each other/interact with each other?
- Has the community been able to incorporate new community members/groups? Have these new groups affected the daily dynamics of the community?
- What do you see as the most important priorities for the community?
- Has the community previously been involved in addressing health issues?
- Do you utilize the local PHC Center? Do you feel confident that the local PHC Center can address your health needs and those of your family?
- Do you rely more on secondary/tertiary care centers?
- What might prevent you from utilizing the PHC Center nearest to your community?

Effective qualities of CHP facilitation:

Efficient	<ul style="list-style-type: none"> organizes, conducts, directs health education activities according to the needs of the community he/she is knowledgeable about everything relevant to his/her practice; has the necessary skills expected of him/her
Good listener	<ul style="list-style-type: none"> facilitator hears what's being said and what's behind the words facilitator is always available for the participant to voice out their sentiments and needs
Keen observer	<ul style="list-style-type: none"> keep an eye on the process and participants' behavior
Systematic	<ul style="list-style-type: none"> knows how to put in sequence or logical order the parts of the session
Creative/Resourceful	<ul style="list-style-type: none"> uses available resources
Analytical/Critical thinker	<ul style="list-style-type: none"> decides on what has been analyzed
Tactful	<ul style="list-style-type: none"> brings about issues in smooth subtle manner does not embarrass but gives constructive criticisms
Knowledgeable	<ul style="list-style-type: none"> able to impart relevant, updated and sufficient input
Open	<ul style="list-style-type: none"> invites ideas, suggestions, criticisms involves people in decision making accepts need for joint planning and decision relative to CHP in a particular situation;
Sense of humor	<ul style="list-style-type: none"> knows how to place a touch of humor to keep audience alive
Change agent	<ul style="list-style-type: none"> involves participants actively in assuming the responsibility for his/her own learning
Coordinator	<ul style="list-style-type: none"> brings into consonance of harmony the needed community's health care activities
Objective	<ul style="list-style-type: none"> unbiased and fair in decision making
Flexible	<ul style="list-style-type: none"> able to cope with different situations

ANNEX C: Planning for Conducting Group Talks

Source: Interpersonal Communications & Counseling Skills for Reproductive Health

- Prepare notes for the presentation. Help the audience keep track of what you are saying by organizing the points clearly.
- Think about the words you will use. Use short sentences and words. Avoid long, drawn-out descriptions, jargon, family planning abbreviations, and technical language. Keep your illustrations brief and to the point.
- Time the talk so that it is not longer than 15 minutes.
- Write a list of questions to stimulate discussion and evaluate the talk. Possible questions might include:
 - What are your two biggest priorities for family care?
 - Does anything prevent you from using the Center more often?
- Prepare your flip charts in advance if possible. Don't use light-colored markers not visible from a distance. If you are presenting to a large group, use large print, and do not write on the bottom quarter of the page.
- Take markers and masking tape with you if you anticipate needing them. Take sufficient numbers of printed materials or handouts with you.
- If someone is introducing you, you may want to write out comments for him or her to use. Your suggestions can include rapport builders' with your audience, such as a common group membership, past contact with them, or your knowledge about the community.
- Check the room or place where the talk will be given. Choose a quiet place with enough space. Ideally, the arrangements of the room should be for the comfort of the participants. However, you may have no control over how the participants are arranged, although you can make changes in where you will stand. You do not want to be too distant from the nearest member of the audience.
- If you are using a microphone, make sure it is in good working order so that you do not have to tap it or make adjustments after you begin.
- Position visual aids where you want them. If you are showing a film, make sure the screen is in the proper position and that the projector is functioning properly.

ANNEX D: Checklist for Major Health Issues

Ask the health service provider to help the community prepare a checklist of major health issues for the group to respond to. When risks are identified, produce a list of needs and channels to address them in partnership.

<i>Risk identified</i>	<i>Target groups identified</i>	<i>Appropriate IEC material selected</i>	<i>Appropriate method selected for provision of type of services required</i>	<i>Appropriate channel selected and adopted</i>

ANNEX E: Interview Guidance (applies to semi-structured and open interviews)

Source: Interpersonal Communications & Counseling Skills for Reproductive Health

Reflecting: Provides a mirror to what a person is communicating. Accurate acknowledgment of client’s feelings is necessary and critical to the counseling process. Once client believes that the provider hears and understands her/his feelings and individual needs and concerns, then they are ready and willing to deal with a situation, listen to options, and make an informed and appropriate decision. Noting key feelings and helping the client clarify them can be one of the most powerful, helpful things a counselor can do.

Paraphrasing: Reflecting content back provides an opportunity to cross check what was said with what was heard. Feeds back to the person the essence of what has been said by shortening and clarifying client comments. Paraphrasing is not parroting; it is using the counselor’s own words plus the main words of the client to check accurate understanding of what the client has said.

Summarizing: Confirms mutual understanding and reinforces key points. Is similar to paraphrasing except that a longer time period and more information are involved. Used to begin or end an interview, start a new topic, or provide clarity in lengthy and complex client issues or statements. It recaps what has been said.

Types of Questions:

Close-Ended Questions	Open-Ended Questions	Probing Questions	Leading Questions
When to use: Begin with close-ended question (for example, a question used in taking a medical history)	Continue with an open-ended question.	Then use a probing question in response to a reply, as a request for further information. NOTE: Out of context, probing questions may sound leading. Explanation of an earlier statement.	Avoid using leading questions
Requires: Brief and exact reply; often elicits yes or no response.	Longer reply; demands thought, allows for explanation of feelings and concerns.	Why do you think that oral contraceptives are difficult to use?	Leads respondents to answer the question in a particular way or tells them about something that they might not otherwise have

			thought of.
Examples: How many children do you have? Are you married?	What have you heard about the oral contraceptive? What are the concerns of young people today?	What has made you believe your child is sexually active?	Have you heard that oral contraceptives are dangerous? Did you hear that the injectable stops the menses? Don't you prefer this method?

ANNEX F: How to Use IEC Materials for CHP

Source: Interpersonal Communications & Counseling Skills for Reproductive Health

HOW TO USE POSTERS

There are two kinds of posters, those used to **educate** and those used to **motivate** clients.

1. Display motivational posters in places of high visibility around the health center, such as waiting rooms, counseling and examination rooms. Think about what the poster is meant to do and who will see it. You also can use posters to stimulate discussion with your client.
2. Ask clients what they see and what it means to them. If correct, reinforce positively his/her understanding. If incorrect, correct the understanding in a polite and patient way.

HOW TO USE FLIP CHARTS

1. Position the flipchart so that everyone can see it.
2. Point to the pictures, not the text.
3. Face the client or audience (for group talks). Move around the room for groups with the flipchart if the whole group cannot see it at one time. Try to involve the group.
4. Ask the client(s) questions about the drawing to check for accurate understanding.
5. If the flipchart has text, use it as guide, but familiarize yourself with the content so that you are not dependent on the text.

HOW TO USE BOOKLETS

Booklets are designed to reinforce or support verbal messages of health workers. If used properly, they strengthen the messages given to clients. The following are suggestions on how to use the booklets:

1. Go through each page of the booklet with the client. This will give a chance to both show and tell about a health problem or practice and answer any questions the client has.
2. Point to the pictures, not to the text. This will help the client to remember what the illustrations represent.
3. Observe the clients reactions. If the client looks puzzled or worried, encourage him/her to ask questions or talk about any concerns. Discussion helps establish a good relationship and builds trust between you and the client. A person who has confidence in his or her health worker will often transfer that confidence to the method or health practice selected.

ADVANTAGES, LIMITATIONS AND USES OF IEC MATERIALS

TYPE OF MATERIAL	ADVANTAGES	LIMITATIONS	USES
Pamphlets Booklets Leaflets	<ul style="list-style-type: none"> ▪ Can be given out to large numbers of people. ▪ Clients can read at their own speed, as often as they want. ▪ Clients can share them with their family and friends. ▪ They are easily produced. 	<ul style="list-style-type: none"> ▪ No opportunity for discussion unless Clinic Provider reviews with clients. ▪ Less effective with people who don't read. ▪ Paper is not strong, they are easily lost and sometimes are thrown out without reading. ▪ Can be expensive. 	<ul style="list-style-type: none"> ▪ For people who can read ▪ To present words and pictures. ▪ For detailed information/instruction ▪ To get information to a lot of people ▪ To remind people what you have taught them.
Posters (usually have one message – a slogan and a picture) Charts (usually have a lot of information) Photographs	<ul style="list-style-type: none"> ▪ Can be made locally. ▪ Can be used repeatedly. Can carry easily. ▪ Can show things that cannot be easily demonstrated on real objects. (e.g sex organs) ▪ Good for many topics. 	<ul style="list-style-type: none"> ▪ The message may not be understood by audience; may need explanation. ▪ Can be expensive because they are easily destroyed. ▪ Making them requires time for pre-testing. ▪ Cannot communicate many written messages. 	<ul style="list-style-type: none"> ▪ To reinforce message. Small or large groups. ▪ To be put in places where seen easily. ▪ To promote and idea, event or service. ▪ Can be used in counseling.
Flipcharts Flipbooks (A collection of pictures arranged in order and fastened at top.)	<ul style="list-style-type: none"> ▪ Can be made locally ▪ Can be made to suit needs of individual groups ▪ Good for maintaining audience interest. ▪ Can be used repeatedly. 	<ul style="list-style-type: none"> ▪ Not good for large groups ▪ If not well made, charts may tear when flipping over. ▪ Audience may not remember everything if there are too many charts 	<ul style="list-style-type: none"> ▪ For step-by step presentation (e.g instructions, story) ▪ For small groups or individuals.
Models	<ul style="list-style-type: none"> ▪ Close to reality; will lead to better understanding ▪ Can be made in a larger form for clearer viewing. ▪ Allows persons to practice a task or skills ▪ Allows use of all senses 	<ul style="list-style-type: none"> ▪ May need skills and materials to make them. ▪ Can be expensive. ▪ Can't use with large groups. ▪ Easily damaged. ▪ Usually not as good for demonstration as real object or person. 	<ul style="list-style-type: none"> ▪ Giving instructions, demonstration (e.g. preparing oral rehydration solution, how to use pill packets). ▪ Good for one-to-one or small groups.

ANNEX G: Description of Communication Channels for use in Action Planning

Communication channels:

- Mass media, i.e., radio, television, print advertisement, billboards
- Print materials/audio-visual, i.e.,(brochures, posters, booklets, videos, flip charts
- Public Relations/Special Events, i.e., print and broadcast news, news conferences, site visits, one-on-one interviews
- Interpersonal communication, i.e., face-to-face counseling, hotlines, peer education, group discussions
- Community-based communication, i.e., drama, puppet shows, dance, village theatre, social mobilization

Type of channel	Advantages	Limitations
<i>Mass media</i>	<ul style="list-style-type: none"> • Reaches many people • Messages conveyed frequently • Creates awareness • Reinforces messages delivered through other channels 	<ul style="list-style-type: none"> • Reach and frequency • Cost • Does not necessarily create measurable behaviour change
<i>Interpersonal communication</i>	<ul style="list-style-type: none"> • Audience can ask questions and receive detailed information and counselling • Motivates individuals to change their behaviour • Privacy - Good for discussing sensitive or personal issues 	<ul style="list-style-type: none"> • Limited audiences reach • Requires training of counsellors • Very time-consuming • Need to be promoted through other channels to create demand • Stigma associated with the health issue may limit audience participation
<i>Public relations/special events</i>	<ul style="list-style-type: none"> • Centralized information and referral • Distribution, promotion or subsidizing of services • Ability to interface with large segments of community at one time 	<ul style="list-style-type: none"> • Not enough time to show effect • Audience may be apathetic, defensive • Response mechanism- no convenient, easy way to respond to message, take action • Not prepared to deal with controversy/Bad Timing
<i>Community-based communication</i>	<ul style="list-style-type: none"> • Creates enabling community environments; strengthen existing networks (e.g., form community health committees) • Improved links to community resources 	<ul style="list-style-type: none"> • May be perceived as ignoring local knowledge • Directing campaigns only towards individuals with community involvement

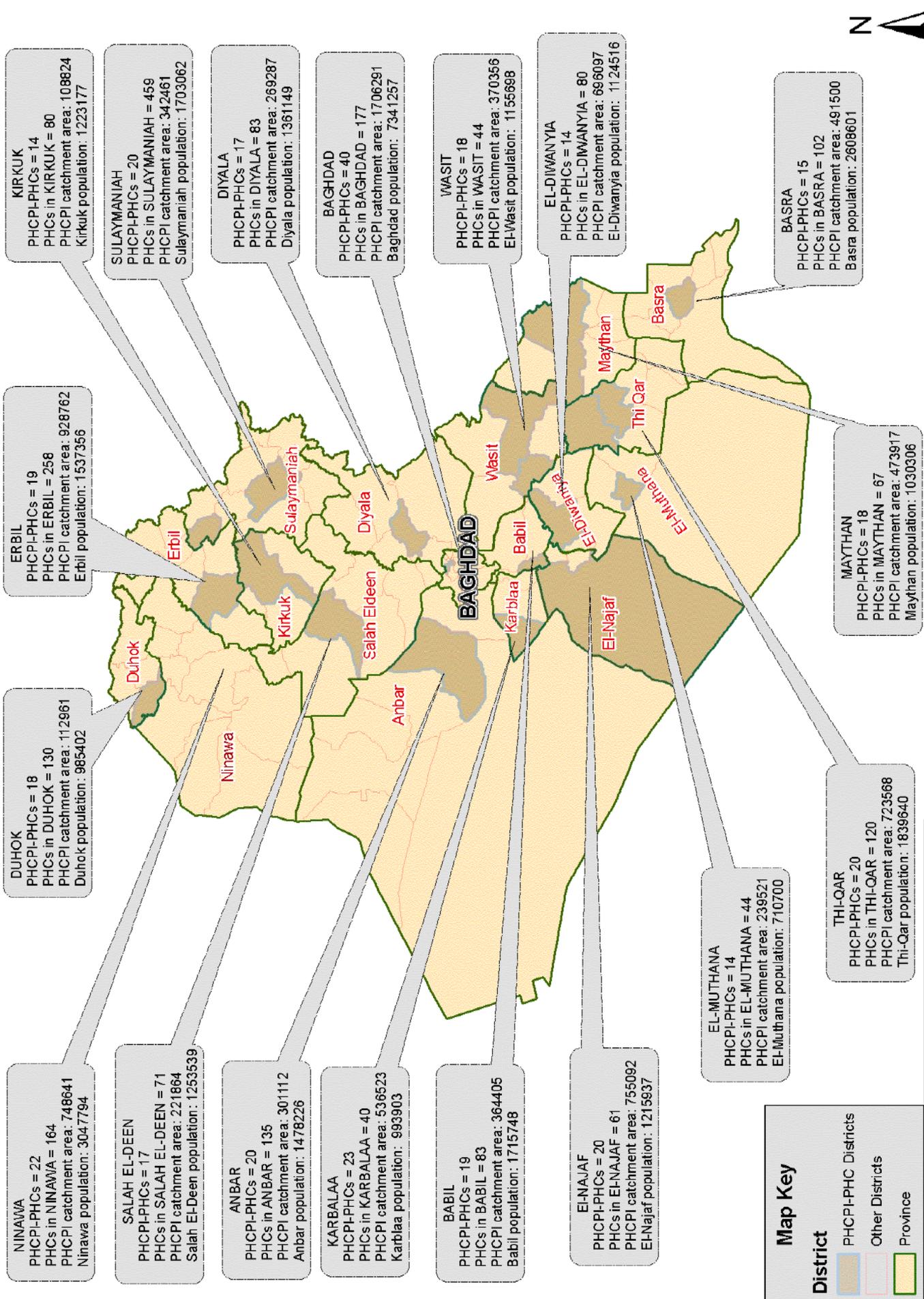
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PHCPI-PHCs population mapped to IRAQ population



Map Key

District

- PHCPI-PHC Districts
- Other Districts
- Province

U.S. Agency for International Development
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<http://phciraq.org/>
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