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## Achieving Health for All

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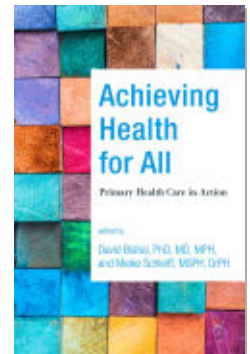
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## Four Principles of Community-Based Primary Health Care

*Support, Appreciate, Learn/Listen, Transfer (SALT)*

MARLOU DE ROUW, ALICE KUAN, PHILIP FORTH, RITUU B. NANDA,  
AND LUC BARRIÈRE CONSTANTIN

Is it possible to imagine a world where individuals and communities recognize and respect their common humanity and live out their full potential to contribute to society as a whole?

—*The Constellation* (2016)

When communities take ownership of their health challenges, they take action to overcome them. Ownership drives action that will not be dependent on external stimulus; it is the foundation of sustainability.

In various priority issues, such as maternal and child health or the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), the global health agenda emphasizes the importance of communicating and building partnerships with the communities affected by these issues. This community-based focus could generate solutions where community members participate in a health intervention, and this is often exemplified by the recruiting and training of community health workers to perform safe practices and promote health within their social circles. The term *community*, therefore, is used generously in delineating its significance to health program interventions. However, while global health stakeholders have used the term to a seemingly infinite extent, truly comprehending its meaning is a major challenge. Understanding who is considered part of a community and how they are bound together is a complex task due to the layers of nuanced history and evolution that shape how community members thrive as a group.

There are aspects of communities that can be clearly observed and delineated. On the most basic level, communities are made up of people who are geographically close to one another. They live in the same location and are

thus affected by the same issues impacting a certain area. Through daily proximity and interaction, community members build relationships with one another, naturally amplifying their mutual trust, recognition of shared concerns, and ability to work together to solve shared problems. Community members can build on each other's ability to create effective, realistic solutions that are aligned with the structures of their governance, culture, and values.

Stories of communities in this chapter exhibit a fluid definition of the term. Community boundaries vary depending on countless contextual factors regarding the identity of peoples who share common values, trust, and concerns in their daily lives. However, all the communities we discuss have undergone a learning process that enabled them to be more effective in using their own assets to create solutions. They illustrate community engagement as a participatory process in a cycle of problem-solving. These stories demonstrate how empowerment means community members realizing and acting on their potential to take ownership of challenges that they face collectively. Owning challenges brings responsibility to articulate their root causes and then to work toward solving the challenges with collective strengths to meet collective needs.

The approach we describe and illustrate here has been shown to be helpful across a wide spectrum of issues including child health, maternal health, nutrition, cholera, diabetes, Ebola, AIDS, malaria, poliomyelitis, water, sanitation and hygiene, palliative care, sexual and reproductive health, drugs, suicide prevention, and aging with dignity. Combined, these reflect a continuum of comprehensive, community-engaged, primary health care (PHC), as fully articulated in both the Alma-Ata and Astana Declarations. It is precisely in PHC where communities have an inevitable role to play—a role that is often forgotten but must now resurface as a recognized driving force in defining priorities, co-managing health facilities, creating demand, and engaging people to uptake needed health services to achieve PHC.

Truly successful PHC requires internal and central trust-building that begins with the people themselves, giving them the ability, the voice, and the equal playing field to become a part of the solution. The issues communities face every day are direct reflections of what needs to be improved in health systems. Their struggles are direct demonstrations that they should be included in designing the solutions to their problems, because they have lived with them and therefore have personal knowledge of what should be done about the problem. As a result, an inevitable link forms between PHC and communities that benefit from it.

We present three case studies in which communities have taken ownership of their health challenges. These case studies stress two principles that underpin the development of the community as it takes ownership of its challenge. The first principle asserts that *we appreciate strengths rather than analyze weaknesses*. When a community comes to appreciate its strengths, it can act based on those strengths to improve its situation. That improvement can become the basis for systematic action that moves the community toward its shared objective. The second principle asserts that *a community can take sustainable action only when its members recognize that they have a shared interest in a better future*. This recognition *comes through dialogue*. Dialogue requires that the many voices of the community are heard and listened to. The dialogue can produce coherent community action when all members of the community feel that their concerns have been recognized in the plans that the community makes.

### Ownership, Appreciation, and Coherence

Ownership means that the community decides on the action it wishes to take and that it takes this action. Ownership does not mean the rejection of resources that outside organizations can bring to support the individual and the community. However, there is a world of difference between outside experts telling people what they need to do and people asking for the resources and expertise they need to execute their own plans.

Ownership is not the definition of *empowerment*, though it is certainly an aspect of empowerment. Ownership implies more than consultation and engagement. Figure 6.1 develops the path to ownership in the context of Arnstein's (1969) ladder of participation: The ladder makes the point that there are gradations in participation in the depth and range of redistribution of power. Ownership goes beyond consultation, engagement, and empowerment. This understanding dates back to Article VII of the Alma-Ata Declaration, which states: "Primary health care . . . requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of PHC, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate."

The communities take ownership using a learning cycle. In this cycle, groups think about the actions that they intend to take, take those actions, and then reflect on the outcome of those actions with a view to improvement.



Figure 6.1. Arnstein’s model of community participation. Source: Arnstein 1969

One early implementation of the learning cycle was through the Deming Cycle (plan, do, study, act), which is now widely used in industry after its introduction in Japan after the World War II (Deming 1967). Applications of the learning cycle have spread beyond industry in a variety of forms (see, e.g., Kolb and Fry 1975).

Collison and Parcell (2004) recognized that an essential aspect of any form of learning cycle was the conversation that supported each stage in the cycle. If the learning cycle is no more than a mechanical process or executed by a narrow subgroup on behalf of the community, it will fail. At each step in the learning cycle, one objective is to bring together the different perspectives that are found in all communities. The dialogue that is part of each step in the cycle seeks to establish a coherent view within the community that is an essential element of sustained progress. Broadening the participation in the learning cycle expands the portfolio of community assets to confront the challenges.

When a community appreciates the strengths that it already has, these strengths can be the basis of further actions. The advantages of the strengths-based approach in comparison with a more traditional, deficit-based approach has been called appreciative inquiry (Cooperrider and Srivastva 1987). Appreciating one’s strength is a better spur to action than seeing only deficit.

When a community begins to use this form of a learning cycle, it needs the support of a facilitator who is experienced with the approach. In addition to helping the community apply the steps of the learning cycle, the facilitator supports the dialogue that develops a coherent view within the community and encourages the community to appreciate its own strengths. As time goes by, these skills develop within the community, and the need for an external facilitator fades away.

## The Community Life Competence Process and SALT

In this chapter, we present three examples in which communities have used a learning cycle approach to improve their health situation in Botswana (HIV control), India (increase in the uptake of immunization), and Guinea/Liberia (restoring trust between communities and health care workers after Ebola).

Figure 6.2 shows the steps of the learning cycle that have been used in the examples. A precondition is becoming motivated by knowing that action can result in a healthier and more prosperous place to live. Many people live lives of resignation. They do not know or do not believe that anything can improve their community. Ownership of the knowledge and belief in possibility precedes moving into action. The purpose of the first steps is to stimulate that ownership and the ensuing actions. The steps in the learning cycle are preceded by a Step 0, in which the community must come together to establish a common identity grounded in mutual humanity. This augmented learning cycle is referred to in this chapter as the Community Life Competence Process (CLCP). Augmenting the learning cycle with an initial step of unification of shared identity is critical to achieve coherence in the formation and execution of the action plan.

In Step 1 of the CLCP, the community defines a “shared dream”: the common objective for which the community will work.

In Step 2, the community defines its current position through a self-assessment. This is effective in stimulating productive dialogue within the community as members discuss their current position (Parcell and Collison 2009).

In Step 3, the community creates an action plan to move from its current situation to its desired situation.

In Step 4, the community carries out its action plan.

In Step 5, the community reflects on the progress that it has made to prepare for the next cycle. The community explores the lessons it has learned and the material that it can share with its peers to help them to progress.

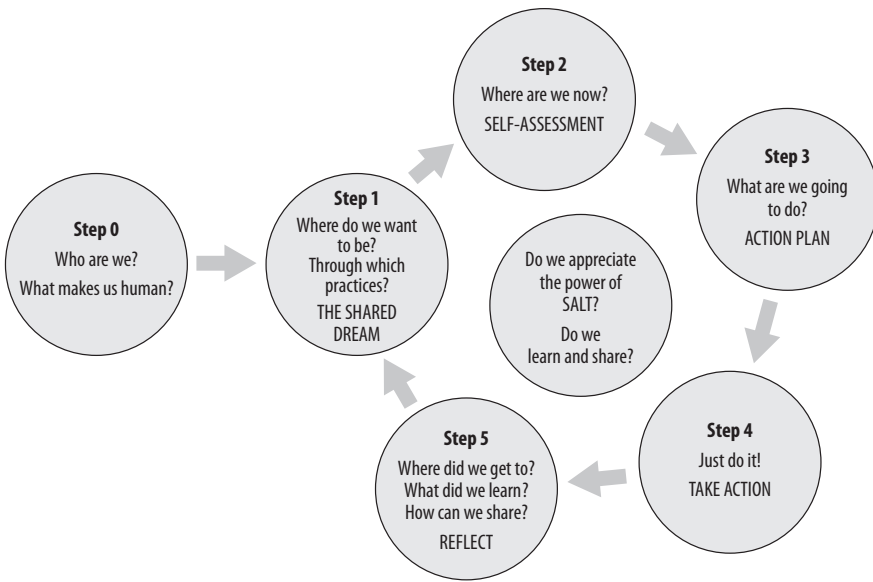


Figure 6.2. The community life competence process. SALT = support, appreciate, learn/listen, and transfer.

The style of facilitation reinforces the possibility that the community will take action. A challenge for the facilitator is to bring together a broad cross section of voices from within the community, many of which are rarely heard and even more rarely listened to. The discussion that arises within the structure of CLCP offers new perspectives. When these diverse perspectives are listened to with respect, this dialogue produces a broader view of the community challenge. We do not pretend that the community becomes united and takes action. Rather there is a coherence to the community perspective that opens the door to an agreed-upon set of actions, and the coherence can develop with those actions.

### Botswana: Communities Acting Together to Control HIV

ALICE KUAN (JOHNS HOPKINS), MARLOU DE ROUW AND  
RITUU B. NANDA (THE CONSTELLATION), WITH INPUT FROM  
NAHPA BOTSWANA AND UNAIDS BOTSWANA

Communities Acting Together to Control HIV (CATCH) encourages citizens of Botswana to put their own strengths and resources toward the health and social issues they are facing.

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## *Four Principles for Greater Community Ownership*

Here we describe how facilitators support the community as it applies the Community Life Competency Process (CLCP) to face its challenges. The approach is based on four main principles: it *supports* the community, *appreciates* its strengths, *learns* from the community, and *transfers* what it learns to its peers.

### The SALT Approach

SALT is an acronym that describes the mental model that facilitators use when they accompany communities through the CLCP, and it stands for support, appreciate, learn, and transfer. Traditional modes of education emphasize a passive receptive learner receiving knowledge from a teacher. Collaborative learning stresses discovery of a latent human ability to analyze problems and to find solutions to those problems. The SALT approach challenges everyone to leave the mind-set of teachers versus learners behind and to appreciate and develop strengths.

A central role of the facilitator in the CLCP is to ask questions that allow community members to recognize their strengths and achievements and to use them to take further action. Communities are usually only too well aware of their weaknesses; however, they are frequently unaware of their strengths.

The facilitator in the CLCP makes the community aware that it is not alone in working in this way on similar challenges and

can make the links between communities so that they can share their experiences, their hopes, and their concerns with each other and learn from one another. Those links may be between neighboring villages, but with technology the links can be half a world away.

There are several contrasts between facilitation that is expert-led and facilitation that is based on the SALT acronym:

- Experts rely on their own expertise, while the SALT approach to facilitation focuses on the strengths of people and communities to respond.
- Experts rely on specialists to define the problem and offer the solution to the problem, while SALT facilitation reveals strengths so a community can come together to find solutions.
- Experts instruct and advise, while SALT facilitation emphasizes learning and sharing.

SALT facilitation supports the community as it moves toward ownership of its challenge.

Lamboray (2016) provides more details on the development of the SALT approach in his book *What Makes Us Human*. The Constellation website provides further discussion of the approach (<https://www.communitylifecompetence.org/our-approach.html>).

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Although CATCH emerged from a concern for HIV, the community saw HIV in a broader light, helping them implement actions reaching far beyond the disease itself. Two success factors contributed to the enthusiasm of participants and the growth of the communities: (1) the involvement of traditional leaders and (2) a common tracking system.





Figure 6.3. A CATCH dashboard in the Sefhoke Ward in Tlokwen, a village in the South-East District of Botswana. Source: National AIDS and Health Promotion Agency

At the start of CATCH, communities shared concerns over the proliferation of HIV/AIDS; they had not yet organized ownership of their behaviors and potential to tackle relevant problems. Throughout the process of CATCH, not only were they able to take ownership of the problem, but they also became active learning communities that defined their actions based on lessons received from one another. In CATCH, communities capture their own progress on so-called dashboards—painted billboards that are set up strategically within the locality. The boards are their way of expressing ownership of the actions toward their vision, showing the communities’ dreams, action plans, progress, and achievements.

Participating communities revealed untapped ability to spread trust of the medical system through peer communication, and this had spillover effects beyond merely promoting HIV testing—defeating one obstacle often leads to overcoming other issues it has caused, as well as other related obstacles. Buy-in from the traditional leaders was crucial in forming strategic alliances to improve HIV screening and referral, and these alliances can evolve to serve other purposes. Some of the villages responded to CATCH in unexpected

ways. Their stories illustrate the fruits of the communities' intrinsic strengths, their unified spirit, and what happens when they take control of their own health as a contribution to successful PHC.

### *Background: HIV/AIDS in Botswana*

Botswana's people continue to confront a severe HIV epidemic, with 20.3% of adults aged 15–49 years old living with HIV (UNAIDS 2018). According to the National AIDS and Health Promotion Agency (NAHPA), many factors contribute to the epidemic, including multiple and concurrent sexual partnerships, intergenerational sex, alcohol and high-risk sex, stigma and discrimination, and gender-based violence (US President's Emergency Plan for AIDS Relief 2016).

### *Community-Based Strategy*

CATCH was designed to expand grassroots HIV responses under traditional leadership and community-engaged planning and action. It exemplifies the CLCP approach of figure 6.2 to convene community members to identify local challenges and solutions. CATCH facilitators started with inclusion of community leaders, followed by introducing CATCH to communities. Facilitators undertook a series of home visits to appreciate individual hopes and concerns, and they scheduled community-wide conversations where villagers developed a common vision, identified collective issues and strengths, and planned and implemented activities toward the vision.

During every step in this process, CATCH opened the space for community members to trust one another and share information, creating a vital, community-specific dialogue—a core aspect of progressing toward effective PHC. In the Tlokweg and Ba-Ga-Malete communities, the top three strengths that communities discovered in themselves through active listening and conversation were knowledge about HIV, openness to discussion, and shared desire to see a positive change in behavior (The Constellation 2016). When they put those strengths to work, common actions implemented by the villagers themselves included community member promotion of HIV testing, the organization of health and wellness days, condom distribution, and the building of a youth center. As better systems of youth engagement and materials distribution arose out of local leadership in CATCH, communities also contributed an insistence to sustain the gains they made. During the process, the *kgosis*, the traditional village leaders, took on a leading role. Facilitators

asked the simple but deep question “What are you proud of?”—and to respond, the kgosis rediscovered their assets as leaders and applied them to build enduring solutions.

Pogiso Botlhole, a traditional leader of Khudiring Ward in the Southeast District, was trained with seventy-four other chiefs in 2017. He recalled that at the outset not everyone in the community supported the CATCH project. Sometimes, villagers had questions about whether there were any personal benefits rather than shared benefits from participating in CATCH. To solve this, the Southeast District community and NAHPA hosted a knowledge share fair, in which villagers explored many initiatives regarding HIV and general health that had been started, led, and sustained by communities. Through this learning exchange, they came to appreciate and experience the SALT and CLCP methods by themselves, acknowledging the value of collective spirit and dialogue. After some time, Botlhole and other traditional leaders gained the support and trust of families for implementing this bottom-up approach. “SALT forms a bond with the people we visit; they may not change overnight but over time they will change,” Botlhole remarked. “As per an old saying . . . it takes the whole village to raise a child” (Botlhole 2017).

When CATCH first started, Botlhole realized that the problem at hand was not merely the HIV epidemic. “When a person is diagnosed with HIV,” Botlhole explains, “he or she often instantly defaults on expensive treatment because underlying problems may remain untouched! Many abuse drugs and alcohol.” Along with this, each community faced issues rooted in gender-based violence, teen pregnancy, and lack of prenatal care. Botlhole describes how they made SALT visits to the homes of people, particularly those who had ailments or difficulties such as drug abuse and HIV:

We did not visit once, we came back several times. These people now felt that they were not alone, they were supported. Through appreciation they realised that though they had major medical issues, their life had not come to an end. This increased their self-confidence. They started appreciating their own selves. We invited these people to dream together about the future of their village. Their dreams were like “Our children will not get infected by HIV” or “Our children will not use drugs.” “There will be a school in the village” was another one. Through this dream building the issues became a community thing and was no longer an individual issue. This, I think, encouraged them to take action. (Botlhole 2017)

The community conversations, during the self-assessment phase of the learning cycle, in which members reflect on their current position, helped bring

those issues forward. Botlhole now counts the results: some people stopped brewing alcohol illegally, and some admitted that they were defaulting on treatment.

### *Monitoring Progress*

Communities promoted monitoring and accountability on a “CATCH dashboard,” which was a painted billboard set up by the communities with the support of local artists (see fig. 6.3 on page 134). The board informed villagers on unfolding progress while also communicating events to “outsiders.” Dashboards mirrored community challenges and achievements by detailing three sections, each illustrating different information gathered by community members to monitor community-level issues, prioritize goals, envision solutions, and implement activities. The content of these sections was elaborated by the community through joined envisioning, self-assessment, and action.

The first section shows various illustrations detailing the community members’ common vision and main goals. The second section reviews challenges that the community believes should be prioritized for immediate action, by themselves. The final section highlights accomplishments of the community in light of the most urgent issues described in section 2. As a result, the billboard has the ability to mobilize community members for action.

The effects of the dashboard continue to be transformative. Communities use it to positively change each other’s attitudes toward health problems. Community members who see the dashboard become interested in the displayed issues, often inspiring their devotion to address them; they soon recognize, as a result, that they own not only these problems but also the solutions. This helps inform more villagers about the issues, mobilize neighboring communities to connect and coordinate with one another, and encourage agreement on their innate abilities to innovate. The process of taking ownership incites the transformation of communities from identifying a problem to working together to generate shared solutions, aligning with the goals of PHC and helping them become active learning communities. Botlhole (2017) describes the experiences they have had with the dashboard:

We have been fairly successful in reducing consumption of alcohol through [the] SALT process in Botswana. Our villages have dashboards where they share their dreams, hopes and concerns, self-assessment and action points. Where alcohol was an issue, villagers made action plans like bars would close between 12 pm [and] 8 am. The community members took their

dreams and action points to the authorities like police or people who issue bar license[s]. Community members were able to convince the authorities. We see that funding for churches and schools in the villages has increased and for bars has reduced in the areas where we are working.

## Assam, India: Improving Immunization Coverage through Villages Taking Ownership of the Challenge

PHILIP FORTH AND RITUU B. NANDA (THE CONSTELLATION)

There is a growing body of literature showing that demand-side interventions lead to significant improvement in childhood vaccination coverage in low- and middle-income countries (Oyo-Ita et al. 2012). With this growing realization that community-level factors influence vaccination uptake, more recent strategies to increase vaccination coverage have attempted to focus on community-based interventions. Existing community engagement programs, however, mostly focus on communication activities that do not actively involve communities in planning, monitoring, and surveillance activities (Sabarwal et al. 2015).

Despite a long-standing national program for immunization in India since 1985, only 65.2% of 12- to 23-month-old children are fully immunized (UNICEF India 2015). In 2015, the organization awarded a grant to the Constellation and the Public Health Foundation of India to implement and evaluate the SALT approach, which seeks to go beyond information and engagement to encourage communities to take ownership of the challenge of immunization. A study protocol for evaluation is described in Pramanik and colleagues' 2018 article "Impact evaluation of a community engagement intervention in improving childhood immunization coverage: A cluster randomized controlled trial in Assam, India."

The communities were supported by facilitators from the Centre for North East Studies in Bongaigaon and the Voluntary Health Association of Assam in Udalguri and Kamrup as they worked through the CLCP. The communities at stake here are defined as groups of people from the same location, sharing relationships or trust or interest: they live in the same village and neighborhood and are facing the same challenges. A team of three facilitators and a supervisor worked with the thirty communities in each of the three districts. During the year, the Constellation worked with the facilitators to develop their skills in the execution of the steps of the CLCP with the SALT approach.

As with CATCH in Botswana, facilitators identified and supported local champions in the communities to maintain the continuity of the process within the communities and to provide links between the facilitators and the community. The local champions were able to advise, for example, when flooding made access to a particular village difficult or when busy times in the fields made a visit inappropriate.

During the early stages of the intervention (Step 0 of the CLCP in figure 6.2), each facilitator visited individuals and small groups to discuss their hopes and concerns for the health of their children. As interest increased, the facilitators found that it was more effective to work as a team of three to lead the community through steps of the cycle. As the experience and confidence of the facilitators grew, they became skilled at documenting each step of the process for the community and then using that documentation in the succeeding steps.

In every village, there is an accredited social health activist (ASHA) who has the responsibility to create awareness of health, to mobilize the community, and to increase the use of existing health services. In doing so, ASHAs ensure greater access and participation of the communities' members in the delivery of these basic essential health care services. In Assam, the burden placed on the shoulders of ASHAs is large. ASHAs have remarked that more people are coming to them to find out the immunization schedule. In Kadamguri, Udalguri District, mothers now meet regularly, and their action plan has motivated some women to take on the responsibility of informing others about the immunization schedule. Nikunja Damaria, ASHA for Kadamguri, remarked: "The village is very large and I am not able to cover all houses and inform the mothers of the vaccination. I don't have time to go to each and everyone [*sic*]. My workload has been reduced because communication about immunization has been taken up by women from the community." In a similar vein, Alpana Chakravarty, ASHA of Gaurajhar village, said: "The SALT process has made our job easy. Earlier we had to give constant reminders to the community on the immunization schedule, but now the community . . . itself is keeping contact . . . with us to know the immunization schedule."

Amrit Rabha, a facilitator in Udalguri, has noticed some deeper changes. The women have come to realize that they have some common concerns. This has brought them together, and a network is developing. The ASHA tells two or three women about the immunization schedule, and the network shares the information. Such empowerment brings the community to another level, whereby people are taking action together, solving their problems, and

learning from what they are doing. Sonashi Mishra, a young mother, follows up with those who miss the vaccination. Anita Dumari, another mother, noted: “I should let other mothers know about immunization. Every child in my village should be healthy; it is my moral responsibility to help others.” “These meetings are a learning opportunity,” says a young mother. “I [have] never missed a schedule of vaccination but never bothered to ask why it was given. If everyone learns about this, no one will miss an immunization schedule of their babies.”

A second indicator of change is that as the community begins on the second cycle of the CLCP, the challenges that the community wishes to deal with often widen. The concern of the village broadens beyond the health of children to include the cleanliness of the village and the quality of the water supply to induce community ownership of other elements of PHC. People begin to ask, “If we can do something about immunization, why can’t we do something about the cleanliness of our village or the quality of our water supply?” Those issues strongly relate with the health and well-being of the population; these are elements of disease prevention that have direct impact on access and service delivery by reducing utilization of facilities. It also increases the social acceptance of proven methods and technologies for the improvement of health and well-being of the communities. A young woman in Jonkholi Village in Kamrup said: “We realized through collective discussion that the water supply problem could only be solved if we c[a]me together. So far, we have been working in twos and threes.” Communities have also started to take action around the Anganwadi centers: These are rural child care centers that were set up by the Government of India in 1985. In Batabari Village, their center had been washed away by floods, and through dialogue the community recognized that they did not have to wait for the government to rebuild the center. In another village, the center had not provided any food for the children for a year, so one lady began to cook in her home and bring it to the center in order to provide the children with a hot meal.

When a community begins to take ownership of their challenges, there is the potential for tension between those who seek to take ownership and those who feel that they currently have ownership. The tension can be an indicator that change is taking place. An important role of the facilitator is to support and to encourage the dialogue within the community so that these tensions are resolved and the community can move forward together in a coherent way. While these tensions have not been severe in Assam, they have been present. In Assam, the challenge for the facilitator is to work with the ASHA so that she does not see the SALT approach as a threat or an implicit

criticism of her work but rather as an approach that supports her and makes her job easier. Over time, the ASHA and the auxiliary nurse midwife in Udalguri began to understand that this approach does not threaten their position or status and that it can ease their workload. The ASHA of a village of Udalguri affirms that it is important that this kind of community conversation and action is replicated in other villages. She affirmed, “My work burden has been shared by the community; the vaccination rate is going up. I want other villages to also adopt this approach of coming together, talking to each other. Therefore, today I have invited the ASHA of village Batabari Number 2 to come here so that she can learn what we are doing so that this can be done in her village.”

Toward the end of the year of implementation of the SALT/CLCP approach, the communities came together to share what they had learned with one another and with representatives of the broader community in Assam. There was a daylong event in each of the three districts: the events were attended by forty-one, sixty-four, and forty-five community members in Udalguri, Bongaigaon, and Kamrup, respectively. A state-level event was held in Guwahati on the fourth day, at which the communities were represented by fifteen communities from the three districts. At each of these events, communities shared their experiences with their peers, and officials listened to the achievements of the communities. At one level, this was an opportunity for groups to learn from one another and to understand that others were facing and finding answers to the same challenges that they were facing. At another level, community members were stimulated to further action by the recognition that what they had done and what they had learned was of interest and importance to others. These events play a vital role in sustaining communities as they work to improve their situation.

The facilitators of the process needed to change the way they approached communities. Many facilitators have become comfortable with an approach where they offer something to the community, perhaps a commodity or money. With the SALT approach, they have nothing to offer, and it takes courage to approach the community empty-handed. One facilitator in Kamrup was particularly doubtful about this approach, but he came to recognize the power of appreciation and is now an enthusiastic supporter of the approach. “Every letter in SALT is powerful. Appreciation and learning are important for me. Appreciation has the power to create a comfortable environment. When we start to appreciate, it opens up doors for communication, and we become more approachable. In other projects I have worked on, we didn’t listen to people.” Now he receives invitations to work with



other villages in Kamrup. Similar changes in the behavior of facilitators who use the SALT approach have been documented by Zachariah and colleagues (2018).

Community and individual ownership of health concerns is not a challenge to existing systems. Rather, community ownership can be the basis for a partnership that opens the possibility of leveraging existing resources to deliver better results for essential health care delivery and other related areas in PHC at lower costs.

## Guinea/Liberia: Restoring Trust between Community Health Care Workers and Health Care Post-Ebola

LUC BARRIÈRE CONSTANTIN (THE CONSTELLATION)

AND ALICE KUAN (JOHNS HOPKINS)

### *Short Summary*

In early 2016, three Ebola-affected countries—Guinea, Liberia, and Sierra Leone—held open space conferences organized with the support of the German Institute for Medical Mission (and the Deutsche Gesellschaft für Internationale Zusammenarbeit). The goal was to hear communities and various actors of that region address the question of how the respective national health systems could be improved and what contributions communities could make to support government efforts. A serious loss of confidence of the population vis-à-vis health care providers was pointed out as a major detrimental effect of the outbreak of Ebola. The Regional Confidence Project (RCP) aimed at restoring relationships and trust between communities and health facilities on both sides of the border between Liberia and Guinea. Between September 1, 2016, and August 31, 2017, the project cooperated with seven health facilities and sixteen villages or communities. The RCP, as a whole, had three arms for action. The community mobilization arm aimed to empower communities to find solutions to health challenges with their own strength using the SALT/CLCP approach (Papkalla et al. 2017).

The purpose was to restore a constructive dialogue between communities and the health staff in a way that allows for greater participation and support of the community members to the health infrastructures. Such participation aimed at increasing access and utilization through demand creation for sound and socially acceptable health care. The facilitators were able to organize and execute community discussions with all actors, including health

staff and health authorities. These meetings were designed to reveal and rely on the strengths of each member, and to rebuild confidence between the various actors. Through the various steps of the CLCP cycle, communities managed to identify where they wanted to be in the near future and to mobilize local actors and energy for simple but effective actions. Practical collaboration such as maintenance and cleaning of health facilities and comanagement of the health system helped to reduce tensions, discomfort, and mistrust that were the source of reduced use of the health system. Communities decided to collaborate in a more practical way with health staff and also started to develop and implement their own activities in their context.

Between June 2016 and June 2017, there were very positive changes in both countries in the use of health services. Utilization has increased dramatically, especially in smaller health facilities at outpatient departments as well as in antenatal clinics (Papkalla et al. 2017). However, even though the confidence of the communities was restored through open and frank dialogue with health staff and health authorities, there is a need to point out that such renewed attendance could not have happened without improvements in the health services themselves. The complementarity of the community dialogue with the health system, on the one hand, and the improvements in health infrastructure, on the other, produced positive results. Improvements also came from the other arms of the same project. The combination of renewed and facilitated dialogue and the strengthening of the health infrastructures was critical to rebuilding confidence among communities.

Communities developed simple action plans that were doable with local resources. For example, after being guided by the community facilitator during discussions related to health issues, communities realized the potential of such practice to tackle other burning issues related to the life of their villages. Therefore, in addition to the results the project had envisaged, almost all villages made plans for the regular cleaning of public places and for increasing the number of public latrines. Some villages decided to create dumping sites, while others built cemeteries outside the village. They were able to manage access to clean water and more effective use of mosquito nets (Papkalla et al. 2017). As we consider a broader definition of health, the issues tackled by communities (those defined here as well as groups of people living in the same village and neighborhood and facing the same challenge) are strongly related to PHC. They became practical and socially acceptable when they were discussed and accepted, and owned by community members. The most important result of the project, however, was that it allowed people to

have goal-oriented conversations and made communication between communities and health facilities constructive. It is important to remember that these results were obtained after only ten months of intervention.

### *Purpose of the Interventions following the Ebola Virus Epidemic*

At the end of the open space conferences held from February to March 2016, one of the recommendations made by the representatives from the three countries (Sierra Leone, Liberia, and Guinea) was to restore the population's confidence in health workers and overall health services. Emphasis was put on comanagement of health infrastructures as well as the inclusion of Ebola survivors in management and increase of preparedness of communities toward epidemic outbreaks. The participation of community members in the management of health facilities is a powerful way to ensure people's acceptance, uptake, and accessibility to essential health care.

In that regard, partners of the project proposed the SALT/CLCP approach to be applied in a systematic and large-scale manner to further open communities' discussions on a lengthier time frame. This strength-based approach allowed community members to define the relevant actors; their vision of effective, acceptable, and accessible health services delivery; and how they would be able to contribute to that vision. Community facilitators who were trained to reveal and nurture people's strengths accompanied the various discussions and interactions within communities and with the actors to ensure practical implementation of the decisions made during these discussions.

### *Population-Level Responses*

Dialogue included community members as well as health staff and health authorities. District and prefecture authorities were also involved in order to institutionalize the dialogue. Two facilitators per community were identified among community members according to simple criteria, the most important being the need for the facilitator to be from the community and to be accepted as a facilitator by the community members themselves. They started to stimulate conversations with the support of community chiefs. Although there were some significant differences between communities, the facilitators organized at least one meeting every two weeks, and they also arranged to meet with specific groups in between. Facilitators initiated a mapping of the villages' public health assets so they could be seen at a glance. With additional

social mapping, community members analyzed how specific community members were affected by ill health, which risks exist, and which social groups are important for strengthening healthy behavior and practices. Together, they discussed and prioritized factors promoting and endangering health such as behavior, cultural rites, or social rules. There was broad attendance, including the chiefs, women, youth, and other specific groups during these community conversations. It is an important element of the SALT/CLCP approach to ensure proper and holistic representation of the community members so that everyone feels part of the proposed solutions.

With all this information, the community was able to shape its vision of what kind of community it wants to be, and where it finds itself on the path toward its vision. This paved the way to plan community actions that were needed to improve cleanliness and ensure regular meetings between health facilities and community members. During the SALT visits in which health staff usually participated, conflicts between health facilities and villagers were addressed and solved. In both countries, the health authorities of the counties or prefectures were part of the team and were involved in the emerging new dialogue between health facilities and communities.

One example of SALT's impact is encompassed in developing support for the Agape Health Clinic in Liberia. The clinic imposed high fees for their health services, rising even higher than prices for the same services from public dispensaries. SALT generated the needed conversations where both the faith-based health care provider and the villagers could voice their concerns and needs. The result was an agreement on the new fee for services and the building of a new consultation room at the clinic for antenatal care. The district authorities also agreed on the support of a part-time midwife (Papkalla et al. 2017). This not only benefited women who needed services but also encouraged villagers and district authorities to give their support to the clinic once again. The SALT/CLCP approach allowed for a frank discussion to occur between actors instead of unilateral decisions being made by the health staff and the faith-based personnel. It deliberately included women.

Rosaline Gamy, of Baala (Guinea), said: "Our village was very dirty because of the pigs. They dragged their defecations everywhere in the village. In addition, when you forget . . . food outside, they put their mouths [o]n it. After several meetings from September to November, it is at the beginning of December 2017 that all pig holders have agreed to put the pigs behind fences. Any pork found outside will be shot by young people chosen for the cause. So today, all pigs are [behind] fences. At least one step [has been] taken in the cleanliness of the village" (Papkalla et al. 2017).

Although the official project ended in August 2017, facilitators, communities, and health staff continued their dialogue for the improvement of various issues related to their action plans and the general life of the communities. Community members realized the opportunity to have a constructive dialogue, opening possibilities to take action using their local resources. That ownership of actions decided together during the process makes them sustainable. Nongovernmental organization facilitators (the trainers) have continued to ensure the support of community facilitators, months after the closure of the project. Local authorities have also requested expansion to other communities.

## Conclusion

The foundation of a sustainable response to health challenges can occur through ownership of those challenges at an individual and a community level. Ownership means that the community decides on the action that it wishes to take, and that it takes that action. Ownership means that the community asks for support that it knows it needs rather than relying on outsiders to give them what they think they need. It means that the community uses its own people's innovation, communicate what they want, and great change ensues. Ownership means increasing the demand on health services through increased participation of beneficiaries in the management of the health system. Finally, ownership means adapting the services to the needs of nearby communities—in particular, for essential care.

We presented three examples where communities have applied a modified learning cycle called the CLCP to allow them to take ownership of their particular challenges. The learning cycle alone will rarely lead to the sense of ownership and responsibility necessary for a sustainable response. Four factors under the acronym SALT (support, appreciate, learn/listen, and transfer) were a critical part of the facilitation that governed the learning cycle.

One factor critical for sustainable community action is that a wide cross section of a community's members recognize that they have a shared interest in a better future. This critical element of the community concept is reinforced along with the implementation of the SALT/CLCP approach as people are taking action together—solving problems—and are learning from their actions. At each step in the learning cycle, facilitators bring together the different voices that are found in the community and support a dialogue that seeks to establish a coherent view within the community. A second critical

factor to sustain action is that the community appreciates the strengths that it already has so that these can be the foundation of further action. The facilitator works so that communities recognize their current strengths and can begin to take action based on those strengths.

The communities in Botswana, Assam, and Liberia/Guinea described in this chapter illustrate that when communities have recognized that they have shared interests and appreciate their strengths, they will take action on a broad front.

### *Community Responses Extend beyond the Specific Challenge to the Root of Health Problems*

When the community dialogue in Botswana was opened, people discussed their dream for their village and the obstacles that stood in the way of that dream. Because trust was built during home visits, many villages felt confident to voice their hopes and concerns during community gatherings, and because the approach puts appreciation consciously at the center, these voices were now also being heard. From the open exchange between community members, it became clear that underlying causes of HIV, such as drug and alcohol abuse, needed to be addressed if the response was to be effective. In contrast with traditional disease-siloed programs that are often less flexible and only leave room for antiretroviral interventions, this time HIV was addressed in a holistic way, with communities themselves working on the roots of their problems. Community funds go to schools rather than bars. Communities' ownership is beautifully expressed in the centrally placed billboards where progress is measured and celebrated.

### *The Community Response Has Spread to Cover a Range of Issues beyond the Initial Concern*

The Liberia-Guinea example illustrates how communities develop ownership of the approach itself. With good facilitation, community members take an appreciation mode of interaction that carries them on to tackle other issues. The spillover effect of SALT/CLCP goes far beyond the entry point (in this case, the issue with the health system) but reinforces the participation aspect of the PHC through related scientifically sound and socially acceptable methods and actions for improving the health and well-being of the population. It is also a way toward sustainability of the activities.

## *The Community Response Has Supported and Strengthened the Formal System Rather Than Challenged It*

Assam showed a collaboration between ASHAs (the representatives of the formal state system of care) and the community. In Assam, ASHAs invited their peers from nearby communities to see what was going on in their community in hopes of spreading this idea of ownership. The crucial insight that this approach reduces the burden on the traditional system is beginning to spread without any formal intervention on the part of the facilitators. It would be shortsighted to see the SALT/CLCP approach as antithetical to the narrow system of health care service provision. These cases show an approach that supports the formal system and reduces the burden on that system.

The Alma-Ata Declaration of 1978 and the Astana Declaration of 2018 have placed the community, as the owners of their health, at the heart of PHC. The capacity of individuals and communities to organize themselves and to take effective action in service of their health is as critical to public health practice as epidemiology, policy-making, hygiene, and sanitation; indeed, an engaged community is essential to a sustained response. However, neither the Alma-Ata Declaration nor the Astana Declaration provide a blueprint to create, to support, and to sustain an engaged community. This chapter, using on-the-ground examples from three different countries, has provided and demonstrated the successful use of a methodology to carry out these important tasks that are at the core of PHC.

### REFERENCES

- Arnstein, Sherry R. 1969. "A ladder of citizen participation." *J Am Plan Assoc* 35 (4): 216–224.
- Bothhole, Pogiso. 2017. "Traditional leaders and bottoms up approach for effective HIV response." *Community Life Competence* (blog), November 2, 2017. <https://aidscompetence.ning.com/profiles/blogs/involve-traditional-leaders>.
- Collison, Chris, and Geoff Parcell. 2004. *Learning to fly*. Chichester: Wiley.
- . 2016. "CATCH Dashboard Sefhoke Launch News Article." *CATCH SE News*. <https://aidscompetence.ning.com/profiles/blogs/sefhoke-on-the-move>.
- Cooperrider, D. L., and S. Srivastva. 1987. "Appreciative inquiry in organizational life". In *Research in Organizational Change and Development*, vol. 1, edited by R. W. Woodman and W. A. Passmore, 129–169. Stamford, CT: JAI Press.
- Deming, W. Edwards. 1967. "What happened in Japan?" *Industrial Quality Control* 24 (2): 89–93.
- Kolb, David A., and Ronald E. Fry. 1975. "Towards an applied theory of experiential learning." In *Theories of group processes*, edited by Gary L. Cooper, 33–58. New York: Wiley.

- Lamboray, Jean-Louis. 2016. *What makes us human?* Balboa Press.
- Oyo-Ita, M., C. E. Nwachukwu, C. Oringanje, and M. M. Meremikwu. 2012. "Cochrane Review: Interventions for improving coverage of child immunization in low- and middle-income countries." *Evidence-Based Child Health* 7 (3): 959–1012.
- Papkalla, Ute, George Maxwell, Sanoh Yomba, and Luc Barrière Constantin. 2017. *With new confidence into a healthy future*. [https://www.communitylifecompetence.org/uploads/6/3/7/1/63712543/en\\_difaem\\_results\\_rcp\\_liberia.pdf](https://www.communitylifecompetence.org/uploads/6/3/7/1/63712543/en_difaem_results_rcp_liberia.pdf).
- Parcell, Geoff, and Chris Collison. 2009. *No more consultants*. Chichester: Wiley.
- Pramanik, S., A. Ghosh, R. B. Nanda, M. de Rouw, P. Forth, and S. Albert. 2018. "Impact evaluation of a community engagement intervention in improving childhood immunization coverage: A cluster randomized controlled trial in Assam, India." *BMC Public Health* 18 (534): <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5458-x>.
- Sabarwal, S., R. Bhatia, B. Dhody, S. Perumal, H. White, and P. Jyotsna. 2015. *Engaging communities for increasing immunization coverage: What do we know?* Scoping Paper 3. New Delhi: 3ie.
- UNAIDS. 2018. "Botswana 2018." <http://www.unaids.org/en/regionscountries/countries/botswana>.
- UNICEF India. 2015. *Rapid Survey on Children (2013–2014)*. <https://wcd.nic.in/sites/default/files/RSOC%20National%20Report%202013-14%20Final.pdf>.
- US President's Emergency Plan for AIDS Relief. 2016. "Botswana: Country Operational Plan (2016) Strategic Direction Summary." <https://www.pepfar.gov/documents/organization/257359.pdf>.
- Zachariah, B., E. E. de Wit, J. D. Bahirat, and J. F. G. Bunders-Aelen. 2018. "What is in it for them? Understanding the impact of a 'support, appreciate, listen team' (SALT) based suicide prevention peer education program on peer educators." *School of Mental Health*. <https://doi.org/10.1007/s12310-018-9264-5>.



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