Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

How do COMMs build community capacity for maternal and child health?: A realist evaluation in Uganda and Tanzania

August 22, 2017

Brynne Gilmore
gilmorb@tcd.ie
Centre for Global Health, Trinity College Dublin

centre for global health

The Team

Investigators

Ms. Brynne Gilmore, *Centre for Global Health, Trinity College Dublin, Ireland*

Prof. Nazarius Tumwesiyge, *Makerere University Institute of Public Health, Makerere University, Kampala, Uganda*

Dr. Henry Mollel, Ifakara Health Institute & Mzumbe University, Tanzania

Dr. Fiona Larkan, *Centre for Global Health, Trinity College Dublin, Ireland*

Dr. Frederique Vallieres, *Centre for Global Health, Trinity College Dublin, Ireland*

Prof. Eilish McAuliffe, *School of Nursing, Midwifery and Health Systems, University College Dublin, Ireland*

Advisors

Ms. Jane Mushaija, *AIM Health Programme Manager, Tanzania*

Mr. James Muhumuza, *AIM-Health Project Manager, World Vision Uganda, Kampala Uganda*

Ms. Jacquie Muyama, *AIM-Health Programme Manager, World Vision Uganda, Kabale Uganda*

Ms. Nicola Dunne, *AIM Health Programme Assistant, World Vision Ireland*

Mr. Magnus Conteh, *Global Health Programmes, World Vision Ireland*

Dr. Michele Gaudrault, *World Vision International Health Team Capacity Building Coordinator*

Presentation Overview

- Research Question and Objectives
- Methodology
- Study Phases
- Initial Programme Theories
- Methods and Tools
- Findings: Presentation of Refined Theories
- Findings: Country and case specifics
- Implications and Recommendations

Research Objectives

Research Question:

How does (if it does) community capacity building for community systems strengthening by Community Committees work?

Research Objectives:

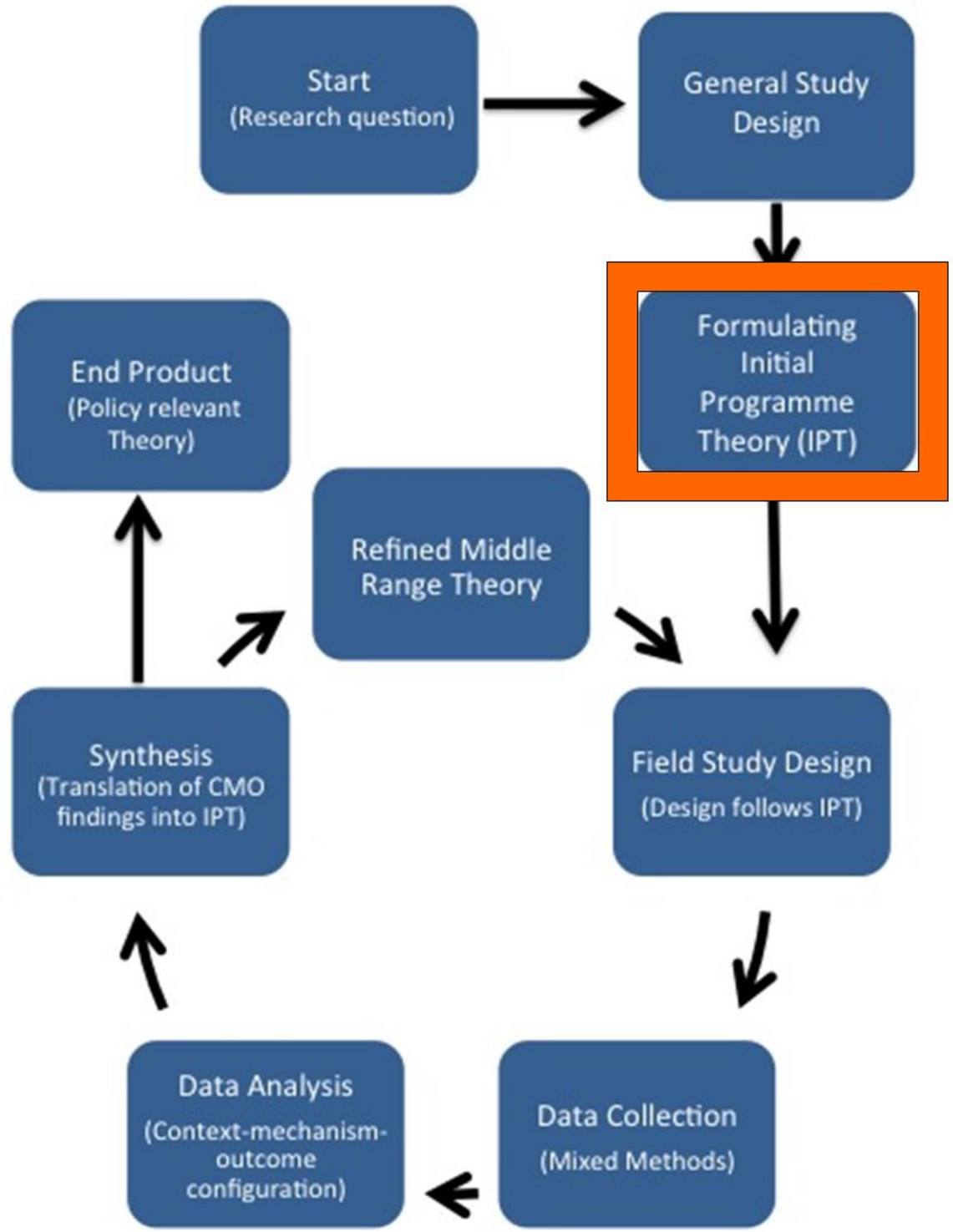
1. Elicit an Initial Programme Theory for 'how, why and for whom' COMMs build community capacity
2. Refine programme theories using contextually relevant case studies: Uganda and Tanzania
3. Develop middle-range theory for how COMMs work to build community capacity for maternal and child health

Research Methodology:

To best answer this question, the methodology of a realist evaluation was chosen as it works to explain "how, why and form whom" complex health interventions work (or don't). Six intra-programme case studies of COMMss from NGO (World Vision) MCH programme were conducted: 3 in North Rukiga, Uganda, and 3 Mundemu, Tanzania.

Methodology: Realist Evaluation

- Form of theory based evaluation (TBE), which seeks to understand and explain how programmes work, why they work, and for whom they work best
- Used for complex health interventions, understanding that CONTEXT is an important influencer or programmes
- Work by eliciting initial theories on how programme works, and subsequently refining by investigating Context (C), Mechanisms (M) and Outcomes (O) Configurations of programmes (generative causation)



Eliciting the Initial Programme Theories

- Literature and Document Review
- Key Informant Interviews with 4 COMM programme implementers / architect
- Findings work to develop Phase 2: the Field Study Design as methods are chosen to best refine the IPT

Open Access Protocol

BMJ Open

How do community health committees contribute to capacity building for maternal and child health? A realist evaluation protocol

Brynne Gilmore,[1] Eilish McAuliffe,[2] Fiona Larkan,[1] Magnus Conteh,[3] Nicola Dunne,[3] Michele Gaudrault,[4] Henry Mollel,[5] Nazarius Mbona Tumwesigye,[6] Frédérique Vallières[1,7]

To cite: Gilmore B, McAuliffe E, Larkan F, *et al*. How do community health committees contribute to capacity building for maternal and child health? A realist evaluation protocol. *BMJ Open* 2016;**6**:e011885. doi:10.1136/bmjopen-2016-011885

► Prepublication history and additional material is available. To view please visit the journal (http://dx.doi.org/10.1136/bmjopen-2016-011885).

Received 11 March 2016
Revised 29 July 2016
Accepted 29 July 2016

ABSTRACT

Introduction: The proposed research is part of ongoing operations research within World Vision's Access: Infant and Maternal Health Programme. This study aims to identify key context features and underlying mechanisms through which community health committees build community capacity within the field of maternal and child health. This may help to improve programme implementation by providing contextually informed and explanatory findings for *how* community health committees work, *what* works best and for *whom* do they work for best for. Though frequently used within health programmes, little research is carried out on such committees' contribution to capacity building—a frequent goal or proposed outcome of these groups.

Methods and analysis: The scarce information that does exist often fails to explain 'how, why, and for whom' these committees work best. Since such groups typically operate within or as components of complex health interventions, they require a systems thinking approach and design, and thus so too does their evaluation. Using a mixed methods realist evaluation with intraprogramme case studies, this protocol details a proposed study on community health committees in rural Tanzania and Uganda to better understand underlying mechanisms through which these groups work (or do not) to build community capacity for maternal and child health. This research

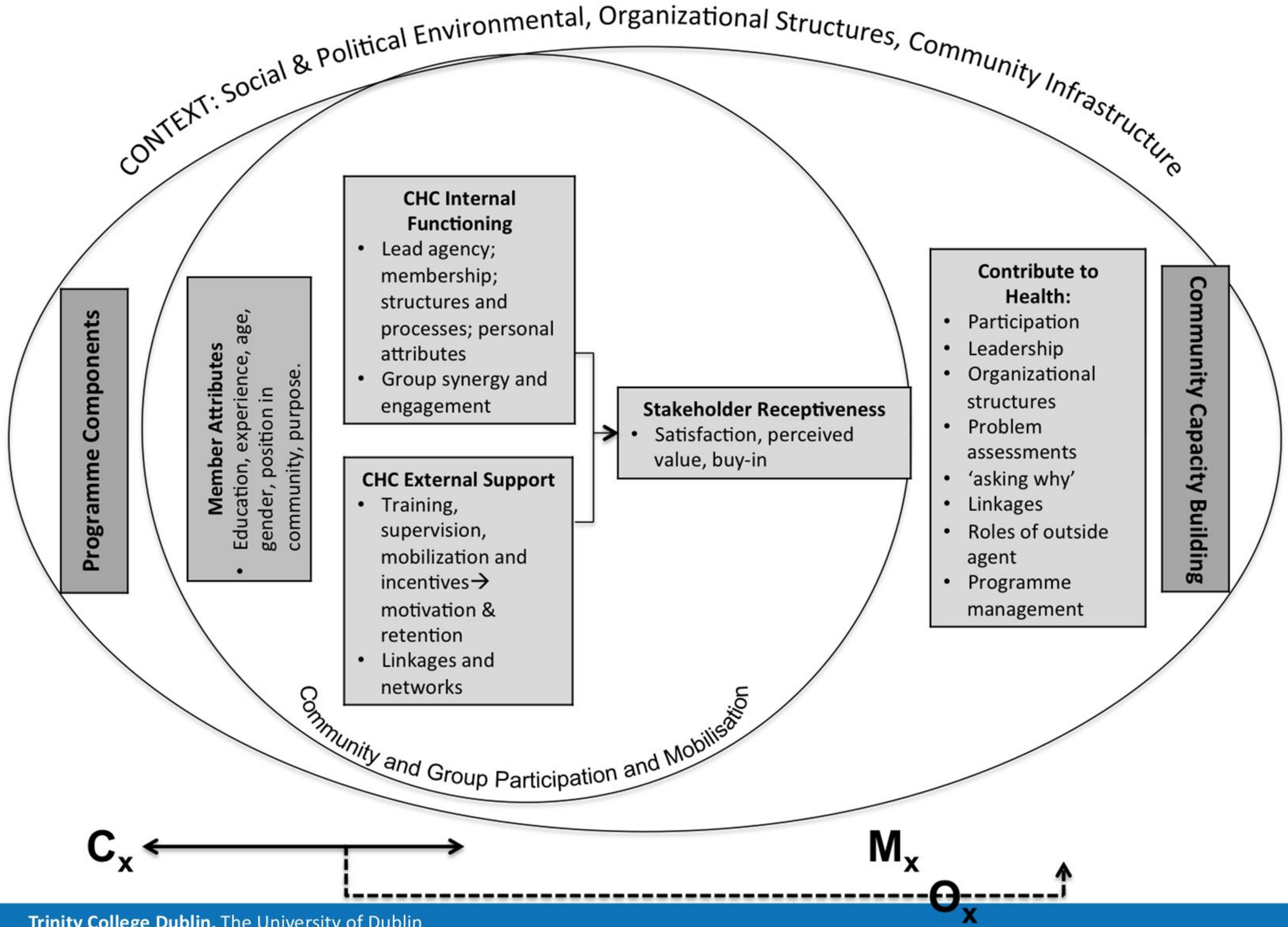
Strengths and limitations of this study

- Though frequently used within health promotion activities in low-income settings, there is a dearth of evidence on community health committees and how they work to build capacity for health.
- Evidence that does exist on community health committees often fails to take a systems-thinking approach to the evaluation of such committees and neglects the contextual factors and human conditions that influence programme functioning.
- As realist evaluations work to explain *what works best, for whom and why*, this research has the potential to provide more contextually relevant and person-centred recommendations for increasing efficiency and effectiveness of community health committees for maternal and child health.
- Difficulties and limitations with this chosen methodology may arise, however, as there has been little research using realist evaluations in low-income countries and therefore limited precedent to follow.

INTRODUCTION

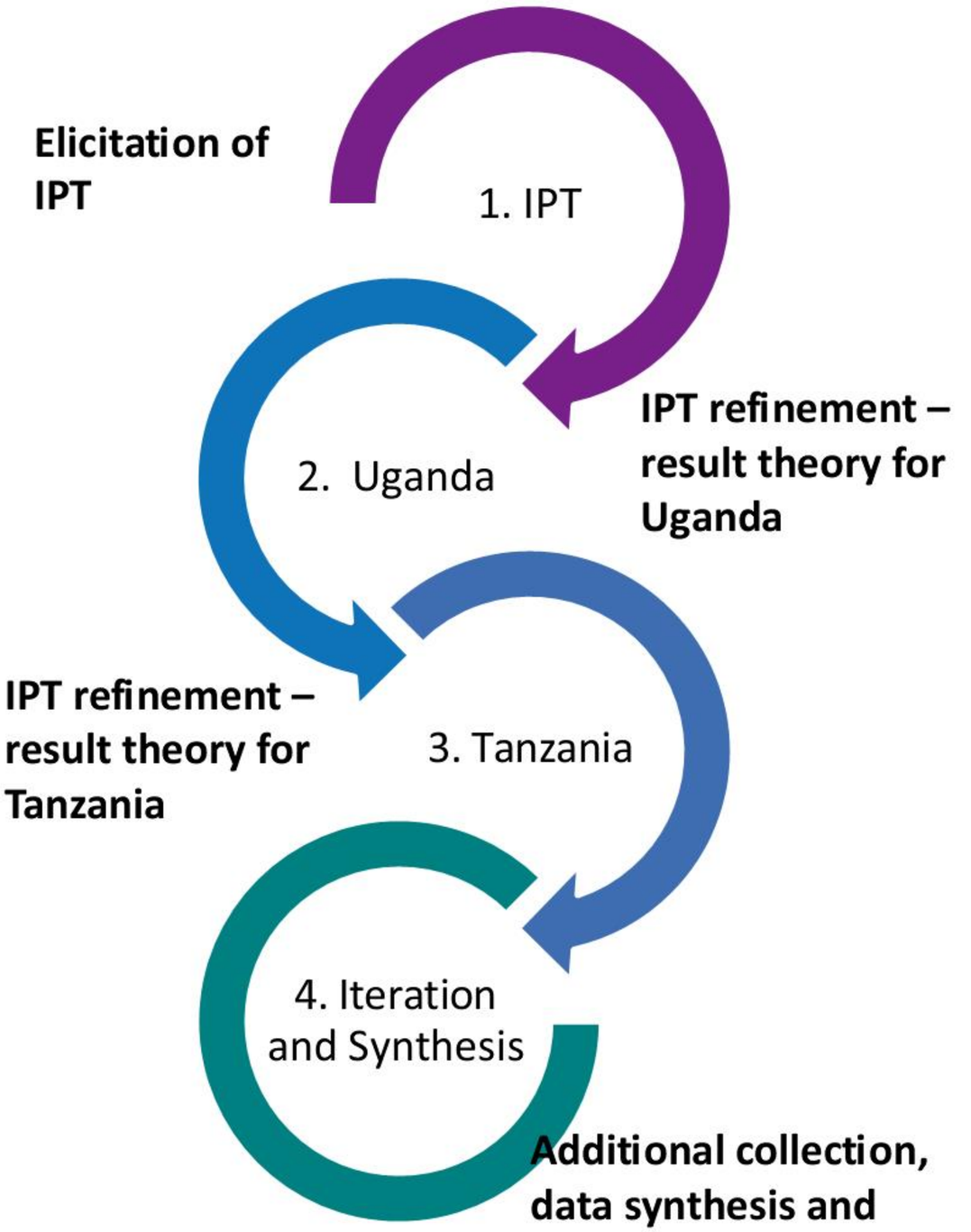
As set out in The Ottawa Charter for Health

Theory Visualization



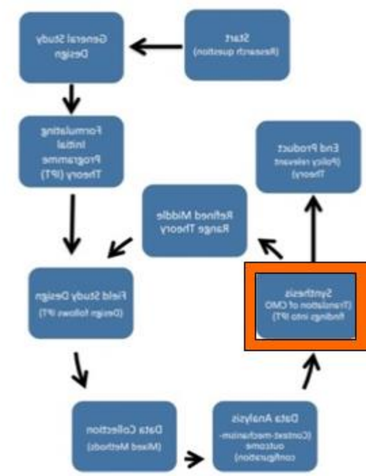
Methodology: Phases and Data Collection

1. Document and literature review. Key Informant Interviews with programme architect and implementers (n=5). Consultations with with team.
2. 3 CHCs: 9 FGDs (n=88); 16 IDIs; 5 KIIs; surveys for all. Total 116
3. 3 CHCs: 8 FGDs (n=63); 12 IDI; 5 KIIs; surveys for all. Total 97
4. Refined theory feedback to interested previous participants, additional refinement. Synthesis of Tz and Ug theories into Middle Range Theory.



Elicit Initial Programme Theories

Methods: Field Study Design



Uganda Case Study 1

Uganda Case Study 2

Uganda Case Study 3

Tanzania Case Study 1

Tanzania Case Study 2

Tanzania Case Study 3

PTs for Case 1

PTs for Case 2

PTs for Case 3

PTs for Case 1

PTs for Case 2

PTs for Case 3

Synthesis of Case Studies

Synthesis of Case Studies

Middle Range Theory for "How, why and from whom COMMs work for capacity building for community systems strengthening for Maternal and Child Health"

*PTs = Programme Theories

Case Study 1

KII, FGDs, SSIs, CCAT and Capacity Assessment
Minute meetings, document reviews
observations

Data review and preliminary analysis

Iteration

Data check & clarification
Preliminary finding feedback and refinement

PTs for Case 1

Case Study 2

KII, FGDs, SSIs, CCAT and Capacity Assessment
Minute meetings, document reviews
observations

Data review and preliminary analysis

Iteration

Data check & clarification
Preliminary finding feedback and refinement

PTs for Case 2

Case Study 3

KII, FGDs, SSIs, CCAT and Capacity Assessment
Minute meetings, document reviews
observations

Data review and preliminary analysis

Iteration

Data check & clarification
Preliminary finding feedback and refinement

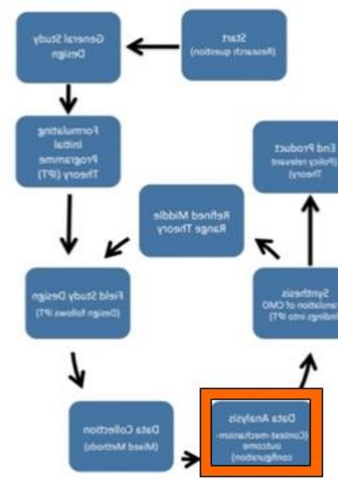
PTs for Case 3

Wider Contextual Observations: Political, social, orgnaisational

Synthesis of Case Studies

*PTs = Programme Theories

Results: Participants and Data Types



	Source of Data	Quantity of Data
1	Observation and Field Notes	Notes from primary researcher and two research assistants over 14 weeks
2	COMM Monitoring Documents	• 13 COMM Meeting Minutes • 3 Meeting minutes with COMMs and other groups • 3 Reports by COMMs to MoH and World Vision • 6 Reports prepared by MoH • 4 WV and MoH quarterly reports
3	In-depth Interviews	• 14 IDI with COMM members
4	Key Informant Interviews	• 3 KII with Local Chairperson • 2 KII with Health Worker • 2 KII with District Health Officers • 5 KII with World Vision Mangers
5	Focus Group Discussions	• 6 FGDs with women community members • 6 FGDs with men community members • 6 FGDs with village health team members
6	Community Capacity Assessment	• 213 (116 Uganda, 97 Tanzania)
7	Coalition Self Assessment Survey	• 50 (21 Uganda, 29 Tanzania)

Method	Participants	Total Number
Focus Group Discussions	Uganda	(9 groups) 88
	Tanzania	(9 groups) 63
Total		**151**
COMMs Interviews	Uganda	14
	Tanzania	12
Total		**26**
Key Informant	Uganda	7
	Tanzania	5
Total		**12**
COMM survey	Uganda	21
	Tanzania	29
Total		**50**
Capacity Survey	Ugnada	116
	Tanzania	97
Study Total		**213**

Analysis and Case Specific Study Findings

***Please email for more information on data analysis process and findings specific to each case study

World Vision

Research Report:

How Community Committees Contribute to Capacity Building for Maternal and Child Health

North Rukiga, Uganda
March 2016

World Vision

Research Report:

How Community Committees Contribute to Capacity Building for Maternal and Child Health

Mundemu, Tanzania
July 2016

Refined programme theories

13 refined theories across 4 socio-ecological levels: individual, organisational/committee, community and society

Refined Theories for Community Committees contribution to community capacity building for community systems strengthening	
Individual	Individuals within COMMs are likely to have continued and active engagement with responsibilities if there are intrinsic and extrinsic **motivational factors**, such as financial compensation and/or reimbursement, positive reinforcement cues resulting from their work, and community recognition of their services.
	In contexts where there COMMs are closely connected to the community (community-centered) a strong sense of community is able to develop and relationships can form, which can lead COMMs to be more **committed for volunteering (altruism)** to ensuring the health of their peers, especially in contexts with precarious health systems.
	Individual attributes of COMM members, such as their level of education, political affiliations, previous experience with community activities, their stability and leadership and decision-making skills, influence their social capital and positionality within communities, ultimately influencing the level of **trust and respect** given to them by others.
Committee	In contexts with limited health system capacity and strong social hierarchies, COMMs who are respected attain **positions of power**, which enables them to have influence within the community, the health facility and other stakeholders.
	COMM member sustainability and engagement is influenced by members' perceptions of their **cost-benefit of being involved**. This cost-benefit relationship can be influenced by individual benefits members receive, such as expanding knowledge, encouragement and satisfaction, and also through more tangible benefits such as reimbursements.
	To work towards sustainability and active engagement of COMMs members, the committees require clear **management** processes and procedures for their operationalization and functioning, which work to make commitments clear and allow members to have a frame of reference for inactivity and reprimand. Pre-defined rules and regulations should include aspects of: selection and membership regulations (i.e. relating to length of service, location of members) regularly planned meeting schedules, training on COMM roles and responsibilities and committee management (i.e. note taking and conflict resolution). COMMs require support to assist in ensuring such procedures are followed.

Refined programme theories

Community	When COMMs have, and follow, clear processes of transparency, feedback and inclusion of community members and other stakeholders, communities can become more **invested and engaged** into their own health actions and recognise COMM activity. This can lead to increased community knowledge of health activities, increased understanding of the role of the COMM and increased trust of COMMs by communities.
	In contexts where the roles, process, actions and outcomes of the COMMs are transparent and visible to community members and partners, communities trust in the COMMs, and empowerment of stakeholders is facilitated, which can increase perceived effectiveness, value, **buy-in and support** for COMMs and their activities.
	Frequent engagement with COMMs, communities and community services, can lead to mutual respect, recognition of each other's contributions and value for their work. These can impact on the **relationships** between these groups leading to trust, intervention responsiveness and support for COMM implementation from other networks. This can also assist in having a strong community voice and feedback mechanisms, as individuals feel more comfortable to participate in health within their community.
	In contexts with strong community support services, such as community groups, COMM groups that are given space and support are able to create and/or utilise existing **networks and linkages** with other actors to increase outreach and sustainability. These connections are more easily made when COMM groups focus their activities at the community level as opposed to solely at the health centre.
Social/Political	In contexts where there are **strong implementing partner relations** (MoH and World Vision) and COMM stakeholders, forged by open communication, pre-existing positive relationships, commitment of partners to shared goals, equal sharing of responsibilities, clear roles and responsibilities, and respect for each other's work**,** harmonization of COMM activities can lead to more cohesive and strong programme implementation.
	COMM implementation that occurs in contexts with **supportive policies and infrastructure** will have more impactful and sustainable efforts. This requires that COMM implementation is harmonized to these policies, and that there is a minimum level of health infrastructure which allows for COMMs to properly work within the health system.
	Across all levels (Individuals in COMMs, MoH, World Vision) **COMM champions** are required to ensure proper implementation and keep COMM objectives focused and of priority. Champions arise from individual leaders who are motivated to serve the goals set out before them, believe in the purpose of the COMMs, have strong knowledge on COMMs, are respected and/or in positions of power, and are supported and encouraged by other stakeholders.

Exist Within:

Level of Health infrastructure

Harmonization with MoH activities

Supportive Policies

Leadership

Open Communication

Strong Partnerships

Respect

Shared goals

Champions

Communities need:

Networks and Links

Visibility of Value

Buy-In

Visibility of Value

Engagement

Knowledge

Relationships

Trust

Committees have:

Procedures and Policies

Power

Social Hierarchies

Strong Management

Offsetting benefits

Cost-benefit relationship

Members Are:

Respected

Social Capital

Motivated

Extrinsic

Intrinsic

Altruistic

Community Centered

Country Specific Findings

Uganda

- All aligned to HCs; operate as MoH HUMCs with harmonisation of activities and support
- 6-8 members – potential underrepresentation of groups (Men >60 years)
- MCH focus diluted – overall health
- Proximity to community – changing group mandate and 'community' focus
- Partnerships (horizontal and vertical) essential

Tanzania:

- Some aligned with HCs; newly initiated groups, little MoH/government involvement
- 12-14 members – diffusion of responsibility, lack of focus, power influence within groups
- Lack of ' health base' – inactivity and direction
- Far proximity to implementing organisation, less supervision and support (MoH)

- "One apple spoils the bunch" (or improves it!)
- Group make-up: Political influence; selection; length of service;
- Training, supervision and motivation factors consistent with CHW literature

Implications and Recommendations:

“MCH- focused”

- ‘Community Systems Strengthening’ approach might not allow for a MCH focus, though it will inevitably be influenced by stronger systems

Location (and History) is Key

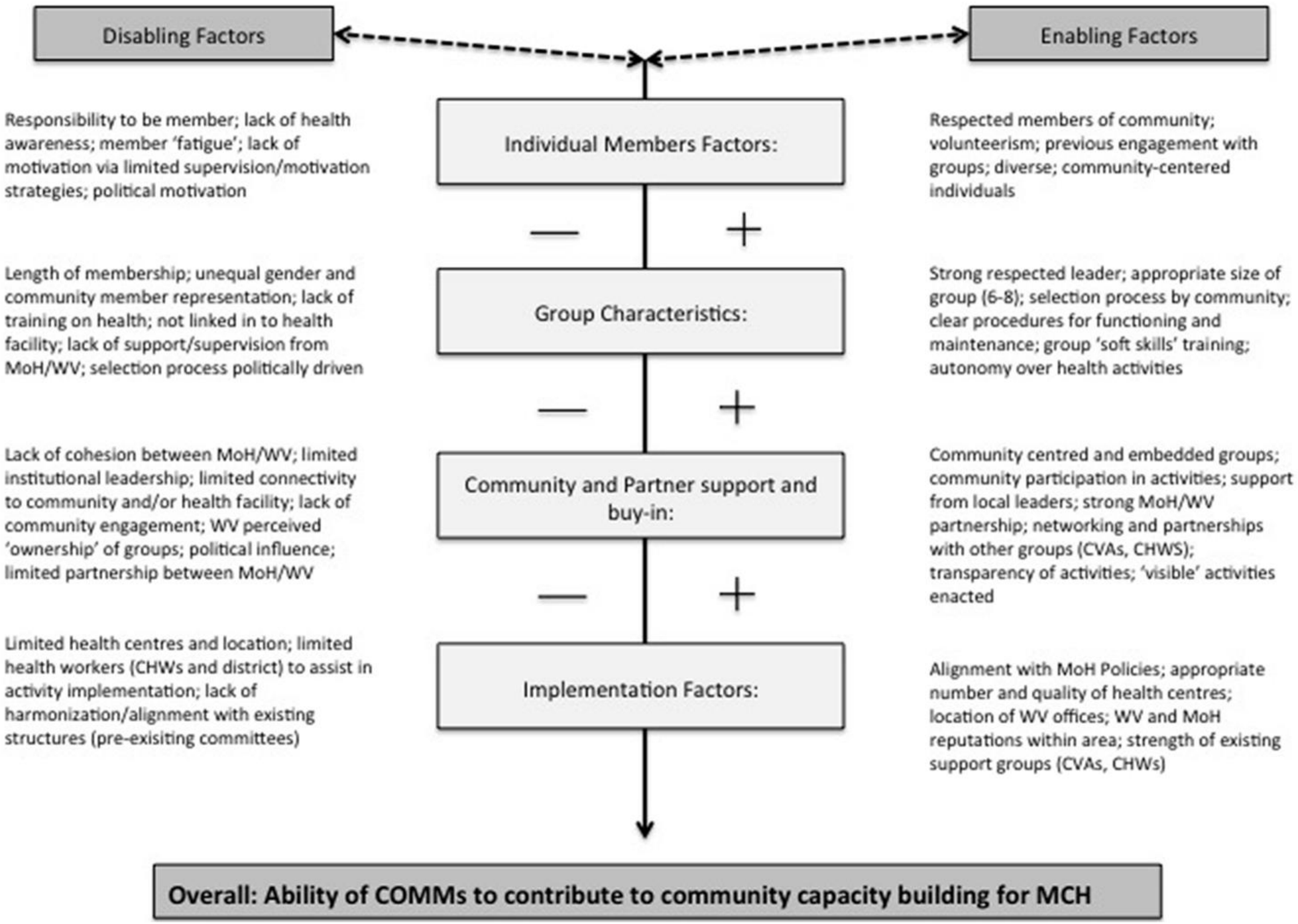
- Influences the operation of COMMs; if closely connected to health facility (or in the case of Uganda HUMCs trained on COMMs), the ‘community’ aspect may be reduced
- Especially true the higher the health centre

Partnerships!!!

- Within communities, between community interventions, and between MoH and WV

Implications and Recommendations:

More details provided at end of presentation



Study Dissemination

- 2x policy briefs (country specific)
- 2x country reports
- 1x combined report
- 1x peer reviewed publication (BMJ Open)
  - 1-2 still to come
- 1x CHW Central Blog
- 1x oral presentation at Irish Forum for Global Health international conference
- 2x oral presentations at Health Systems Global, 2016 (Vancouver)
  - 1 led by Brynne
  - 1 led by James Muhumuza
- 1 PhD thesis (October)

Realist Evaluations for Operations Research in LMICs

Feedback

- Potential for power issues related to data collection technique – 'theory translation'
- Highly accepted from multiple stakeholders
- Iterative component very valuable
- Time commitment not to be underestimated
- Overall, strong potential to positively contribute to operations research and programme implementation

Recommendations

- Clear expectations and understanding of process, commitment and limitations from all parties
- Explore and understand M&E
- Additional time for ethics, unclear data collection process pre IPT elicitation
- Capacity building of in-country researchers

Acknowledgements

The people of Ireland and Irish Aid for their support of AIM-Health. Health Systems Global for showcasing our work. The countless staff members from World Vision Ireland, Tanzania and Uganda, the Ministries of Health within Tanzania and Uganda and the research assistants for whom without this work would not have been possible. Lastly, the numerous participants and communities who were involved in this work.

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Thank You!!!

centre for
global
health

Recommendations Cont…

Individuals within Committees

- Review member policies on activity level and time served, and ensure COMMs are enforcing guidelines
- Review member selection processes, to ensure that political motivation for selection is minimal, that community health objectives are at the forefront. Members should express an interest in serving their community, as opposed to being solely selected by local councils (as was the case in many COMM groups)
- More thought into balancing the COMM make-up: having 'respected' members (which is of vital importance) and those that are community-centered and focused on needs
- Increase and sustain motivational influencers of COMMs. COMMs, like other community voluntary groups require appropriate training, support (supervision), extrinsic factors (such as travel stipends, non-financial goods), and intrinsic factors (visibility of service, community recognition)

Recommendations Cont…

Committees as a Group

- Ensure committees are knowledgeable on, and follow, policies and procedures. This may involve additional training for members on this such as: minute taking, accounting, requisitions etc. It is also important that COMMs visibly show these to the communities, such as accounting for any donated finances and feedback on trainings
- Re-evaluate the desired number of COMM members. Within Uganda, 6-8 members worked well, especially those that were very community focused. However, 12 members appears to result in 'diffusion of responsibility' and difficulty in coordination
- Foster a leader within the COMM (likely the chairperson) to become a champion for COMMs and community health. This may involve additional training
- COMMs are the sum of their parts – as such, the membership make-up, leadership and priorities will influence the direction and activity level. Within Tanzania, re-evaluate the membership make-up to focus on those that have an interest in community health, and are best placed to work within it. Within Uganda, re-evaluate members and their political aspirations for membership.

Recommendations cont…

Committees within the Community

- Support and encourage COMMs to build relationships and networks, or capitalize on existing ones, with other community groups such as savings and loans, church groups, and especially Community Health Workers and local leaders
- Encourage COMMs to implement activities that show community members their worth, such as visible infrastructure projects, or community outreach activities. Also, work to ensure transparency in other activities, especially those involving any finance. Communities build buy-in and trust when they see visible changes and that COMMs are accountable
- Committees' connectivity to the community will influence their activities. For more community centric activities, implement COMMs at lower levels of health facilities or governance. More specifically, within Uganda consider having a COMM within each of the 13 parishes, and then additional ones at Health Facilities III and IV (total 16) as the latter operate more as facility governance structures.

Recommendations cont…

Committees within the Wider Context

- Ensuring the collaborative implementation of COMMs between World Vision and the Ministry of Health. This may involve realigning priorities, making clearer roles and responsibilities, implementing coordination and communication monitoring and working on partnership strengthening activities.
- Ensure COMM implementation aligns to existing policies, such as any pre-existing community health group or health facility committee. In cases where this was not previously done, re-evaluate the COMM implementation and revise if able to better fit within existing structures.
- In contexts with limited health capacity, such as staff members and/or health facilities, consider alternative sources to 'ground' the COMMs, such as working off other community, MoH or government initiatives. If there is a limited capacity within communities to support such a group, reconsider COMM initial objectives and mandates. It may be more beneficial for longer term community capacity building and community systems strengthening to limit the sites of COMM implementation or narrow the focus and/or membership of COMMs. For instance, within Mundemu the lack of support from health facilities, the MoH and other community outreach groups (such as CHWs) limits COMMs' ability to function for community health systems strengthening. Such groups may gain more success if they have a 'slow-start', working with existing community activities (if any) to build up the required support structures before working for other COMM activities.
- Foster MoH and/or WV champions for COMM implementation and supervision/support. Ensure regular communication between champions and COMMs