Webinar Report

Community Engagement within Research Uptake: Maternal and Child Health

December 2021

Introduction

On 2nd December 2021, the Applying Research to Policy and Practice for Health (ARCH) programme and the Community Engagement hub, Mesh at The Global Health Network conducted the "**Maternal and Child Health**" virtual webinar, which was the first for the "**Community Engagement within Research Uptake**" webinar series.

Currently, there is a wide separation between teams that undertake health research, those making decisions on health priorities and policies, and those who are delivering healthcare and pushing social change, particularly in resource-limited settings. Nevertheless, if research is to deliver its maximum impact and positively change health outcomes, findings from health research should be translated into recommendations that are relevant to communities and can be implemented within policy and practice.

The session brought together experts in the field: **Dr Sabrina Rasheed** (Maternal and Child Nutrition, and Health Systems Specialist and Researcher) and **Dr Elizabeth Kimani-Murage** (Public Health Nutrition Specialist and Researcher) from Kenya from Bangladesh shared their experiences and gave their perspectives on the role of community engagement within the process of applying research to changehealth policy and practice.

Content Summary

Engagement with the community for Health in Bangladesh

Dr Sabrina Rasheed *works within Universal Health Coverage, Health System and Population Studies Division of icddr,b in Bangladesh*

Introduction

Bangladesh's health system suffers from shortage of medical products, human resources, and health inequities. The health systems has challenges in placing and retaining doctors, especially, females in remote rural areas.

Importance of community engagement

- Establishing networks, relationships, and processes in the local community
- Community contributions mobilised
- Increasing credibility and accountability for primary health
- Improving democratic outcomes including equity or fairness of a policy/project
- Gives an in-depth understanding around issues through public information sharing, discussion, and deliberation
- Provides the ability to make better decisions that incorporate communities' aspirations, have less duplication, and are sustainable

Community engagement in health: Lessons from a long-term project in rural Bangladesh (Chakaria Community Health Project, CCHP)

The CCHP project commenced in 1994 and was initially funded by the Swiss Red Cross. The project was implemented in a remote rural area (southeast Bangladesh) which was prone to natural disasters and manifested with poor health indicators. Residents were further suspicious of authorities and worried about being evicted in the land they settled. CCHP had had self-help in its core and started with teaching communities about preventive activities that could help them to stay healthy.

In the beginning project personnel were trained in participatory action research and sent to the area to create relationships with the communities and talk about the communities' priorities in order to create activities in line with their agenda. Existing Self-help organisations such as religious groups, and sports clubs were identified and engaged to conduct preventive activities and awareness raising activities on handwashing, WASH, nutrition, etc. Community members were referred to public facilities for care seeking. Activities involved building a relationship with the community, identifying self-help organisations, and bringing health in their agenda and creating volunteers. However, people complained that hospitals were understaffed, with poor quality of care and did not have female doctors which meant the women from the community were not comfortable using the hospitals for maternal health issues. Consequently, CCHP decided to training paremedics and midwives who would serve the community. The self-help organisations identified women from their community who were trained as midwives and paramedics by the project. Creating trained workforce was helpful but did not make adequate impact. So CCHP worked on desiging a community-based model of healthcare provision where the community would be actively involved and community resources will be engaged for health. The model developed "village health posts or VHP"which were funded and managed by the community. Community members provided land and managed the facility while the project provided a physician and medicine. Overtime, about 8% of the poorest families attended the VHPs) and from 1998-2000 the number of patients attending VHPs steadily increased, and antenatal care, postnatal care, and safe delivery services utilisation increased.

The experience from VHP was subsequently scaled up at national level by the governmentand now form the community based forst tier of health service provision in the country.

<u>Lessons learnt</u>

- It is important to invest inengaging with the community to obring health in their agenda
- One must be flexible to address the needs of the community
- Engagement must be respectful and designed with ability in mind
- One must understand the embeddedness of inequity in the fabric of the community as sometimes they may not even realise that they are leaving some people behind
- It is important to think through financial sustainability
- Need is not enough, there must be an environment for action e.g., a willing government

In their voices: Lived Experiences with Food Insecurity for the Urban Poor

Dr Elizabeth Kimani-Murage *is a Public Health Nutrition Specialist and a Research Scientist is the head of the Maternal and Child Wellbeing Unit at African Population and health Research Center (APHRC) in Kenya.*

Introduction

Sustainable Development Goal (SDG) 2 focuses on ending all forms of hunger and malnutrition by 2030. The right to adequate food is recognised globally and is key to attaining the SDG 2. As such, the constitution of Kenya in article 43. (1)c states that "every person has the right to be free from hunger, and to have adequate food of acceptable quality". Nevertheless, the goal is not actualised. In Kenyan urban slums, there is approximately 80% of household food insecurity, whilst approximately 50% under-fives are stunted.

Right to Food Public Engagement Project: Community engagement to bridge the gap

Using innovative participatory methods to stimulate dialogue on the right to food for the urban poor in Nairobi Kenya, the project aims to bridge the gap between the right to food and the lived experiences. The project used the public engagement approach in the urban-poor context through an international engagement fellowship from the Wellcome, whose funding ended but the work has continued and been expanded in Nairobi and other cities in Kenya. The project adopted a model of working with grassroot organisations i.e., community groups, which are youth groups that are trained in community engagement and nutrition, so that they can ultimately train their communities.

Methodology: Participatory methods

Each community group chooses the methodology they would like to use and engage with their communities in line with that chosen methodology. These methods include digital stories, Photovoice, dialogues, radio shows, Magnet Theatre, graffiti murals, human library, soup kitchens (dialogue), participatory mapping, and film screening.

Lived experiences of the Urban poor: Challenges reported by community members

- Economic access - Food is available in markets but not in their homes due to financial constraints
- Physical access - The nature of work for instance where one finishes late may compromise safety and as such people may be unable to access food
- Food safety - There is concern in how food is prepared, handled, and sold due to the nature of sanitation challenges in the area
- Food stability - People do not have ways of preserving food, when in abundance

Coping strategies

- Scavenging food from dumpsites to feed themselves and their children
- Stealing
- Child labour
- Sex work
- Begging in streets

Recommendations

- Training in urban farming through innovation to supplement food
- Other public engagement activities conducted by the speaker
- Public Engagement on the baby friendly community initiative (BFCI) - 2014
- Engagement among the Maasai Community - 2017
- Extension of the right to food project to Kisumu

Broader impact of these projects:

- Developing evidence informed policies
- Developing evidence informed actions/programming
- Public participation
- Global recognition of the work

Summary of Q&A

To Sabrina: What does the success to this approach looks like and how sustainable has it been?

"To avoid training midwives that would eventually leave public facilities and go to cities, the project asked community members to select individuals that they believed would stay, and these were trained and started to verve under the supervision of the project's physician. Nevertheless, community members had difficulties accepting these individuals because they were perceived as their peers. Consequently, the project had to send a physician to be with the workforce as a form of assurance. Nevertheless, women who were more educated and came from more improved livelihoods were not serving women that came from poor background. As such, the project switched from salary payments based on number of individuals served, to performance-based payment, i.e., serving the bottom 20%. After a year, the payment system stopped with the assumption that the workforce had been trained enough to do the work and serve the poor. Although this happened 10 years ago and the project ended, the women are still in these communities and serving their people to-date. They have created a healthcare facility where normal deliveries take place, and they have referral linkages with higher-level hospitals."

To Elizabeth: all the factors hindering food security are available in literature. What do your findings add regarding food-related factors?

"The engagement focused on the right to food and worked to get people to understand this and empowering them to have capabilities to impact change in their communities. The focus was for people to understand not only the evidence but breaking down concepts of food security for people to understand, and empowering people to participate in communicating through their voice. When the voice of people is used in communicating to policy makers, there is more impact than just presenting statistical facts. Through engagement people are also able to identify potential solutions and state what support they would need to actualize food availability."

To Sabrina: what are the specific barriers you faced in scaling this programme?

"The power of the models designed was to identify gaps and designing solutions to the system already in place and that the system can take and not and not additional healthcare workforce or designing something that an illiterate person cannot operate. The basis was to design and test the model to show that it works and look at the intended and unintended consequences of the model. Once the model was designed and tested and found to be useful for other existing programmes, policy opportunities came, and it was presented, and it was taken up and scaled up."

Call to action and next steps

We look forward to seeing you in the next event in the "Community Engagement within research Uptake" Webinar Series in 2022. You are encouraged to register for the free for the ARCH and Mesh knowledge hubs and at arch.tghn.org and mesh.tghn.org respectively. The webinar recordings and speakers' slides are shared here: Maternal and Child Health Webinar.

Demographics

A total of **370** people registered for this event, from **68 countries**, and **222 participants** attended the webinar which corresponds to an **attendance rate of 60%.**

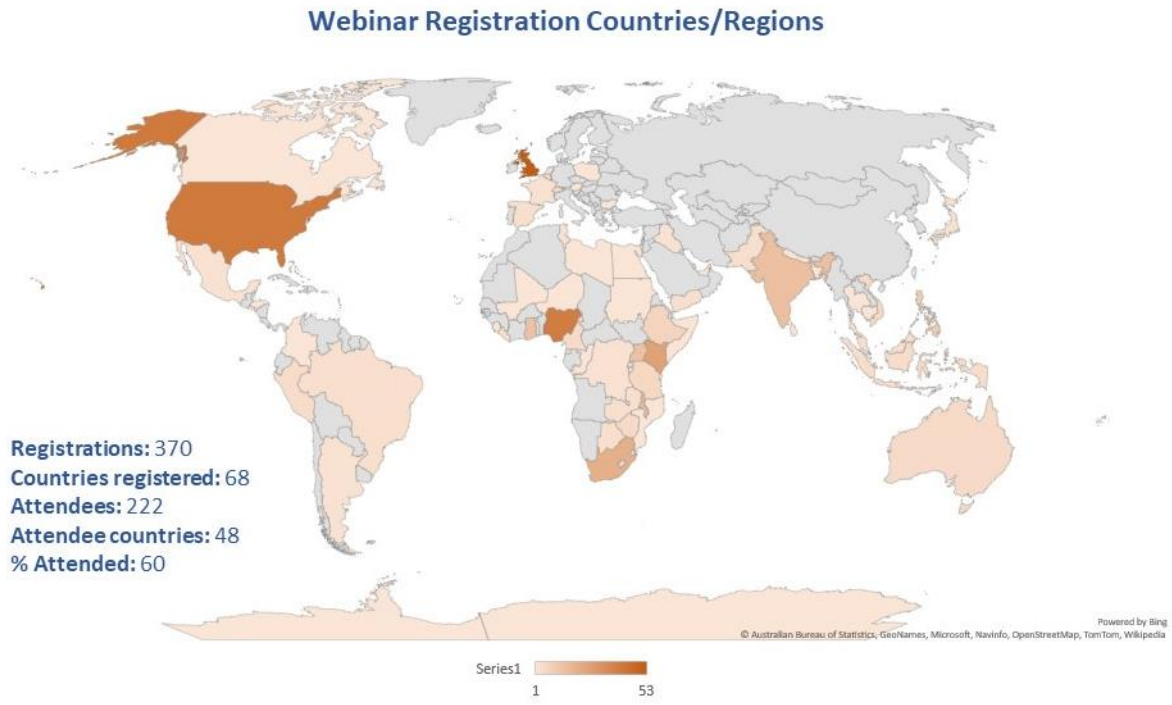

Figure 1. Heat map showing geographical distribution of webinar registrants. The scale bar shows how the colour corresponds to the number of registrants from each country.

Participants' work

In the registry, participants were asked to fill in their occupation. Most of the participants were health researchers, physicians, nurses, and other specialties within the health field.