How can we strengthen the relationships between communities and facilities?

A learning brief on Community–Provider Dialogues from Breakthrough ACTION-Nigeria

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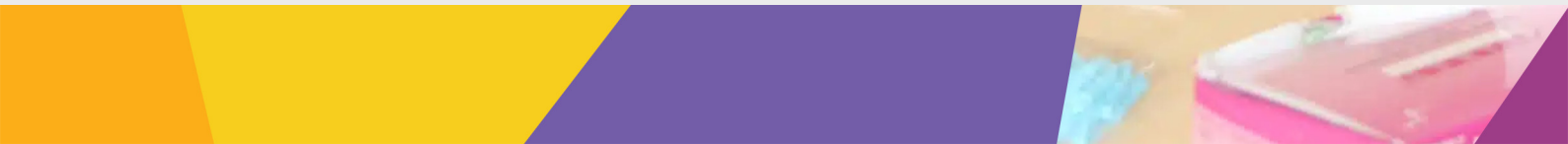

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Photo Credit: Breakthrough ACTION-Nigeria

Acronyms

ANC	Antenatal care
CHARP	Community Health Action Resource Plan
CPD	Community–provider dialogues
FCT	Federal Capital Territory
HCD	Human-centered design
LGA	Local Government Area
RMNCH	Reproductive, maternal, newborn, and child health

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Background

According to the 2018 Nigeria Demographic and Health Survey, service utilization rates are low across the country. Only 67% of pregnant women sought antenatal care (ANC), 58% of caregivers sought advice or treatment from a health facility or community health worker if they had a child under five with fever within the last two weeks, and only 39% of live births in the five years preceding the survey took place in a health facility.

Common reasons for low service utilization include dissatisfaction or distrust of health services, and a belief that patent medicine vendors, traditional healers, and traditional birth attendants provide better care. While public facility-based providers are often well-meaning and care deeply about serving clients, gaps in knowledge, misconceptions, poor communication skills, inattention to the rights of clients, and challenging work environments all limit their capacity to provide quality health services.

Solution: Through formative assessments, which included a literature review, human-centered design (HCD) approaches, and implementation learnings, Breakthrough ACTION-Nigeria identified a set of insights around provider attitudes and the community-provider relationship:

People are deterred from using health facilities because of poor health care experiences, their perceptions of quality, and low confidence in providers and modern treatment effectiveness.

People believe the health care they can receive within their own community from traditional healers and proprietary and patent medicine vendors is just as good as, if not better than, health facilities. They see facilities as only necessary in case of emergency.

The community needs a forum for ongoing communication between people and facilities to align expectations, share feedback, and address psychosocial and structural factors undermining care-seeking, provider behavior, and client–provider trust.

These insights informed initial designs and adaptations of the project's provider behavior approaches for building trust and relationships between healthcare providers and the communities they serve. Over the life of its work in Nigeria, Breakthrough ACTION implemented two approaches to achieve this: (1) the fishbowl discussion and (2) the community–provider dialogue.

This learning brief describes these approaches and lessons learned for others interested in implementing approaches that strengthen the relationship between communities and facilities.

> We met unfavorable provider attitudes on the ground. They were always in conflict with the community. Their attitude was more clinical and not up to national standards. Today there is more empathy between community people and health providers.
>
> —
>
> **Bassy Nsa,** State Coordinator for Breakthrough ACTION in Akwa Ibom State

> We discovered that [regarding] prompt care-seeking behavior and even uptake of health care, a lot was as a result of providers' behavior.
>
> **Mary Bassey,** Akwa Ibom State Ministry of Health

The fishbowl discussion

Overview

Breakthrough ACTION-Nigeria adapted an approach initially designed and implemented by the Johns Hopkins Center for Communication Programs' Nigeria Urban Reproductive Health 2 Project, which sought to increase the uptake of family planning services in Nigeria.

The objectives of Breakthrough ACTION-Nigeria's fishbowl discussions were to:

- Improve client-provider interaction and interpersonal communication.
- Improve providers' understanding about clients' views and perceptions.
- Identify and address provider bias and other barriers that affect the quality of health care received by clients.

The fishbowl dialogue is a group discussion technique that involves arranging participants in two concentric circles, with one group of individuals sitting in the center (the "fishbowl") and engaging in dialogue while the outer group observes. Participants for the fishbowl discussions were divided into two groups: (1) healthcare providers and (2) clients who were either mothers who had given birth at the nearby health facility within the last two years or caregivers who sought care for a febrile child under five at a facility within the past month.

Each group received an opportunity to be in the inner circle and the outer circle. While in the inner circle, participants shared stories on their perspectives about malaria and maternity care to encourage mutual understanding and empathy about the challenges each faces. Those sitting in the outer circle listened to the conversation. The technique is blinded: providers' identities are anonymous; they came from an entirely different community, and they wore street clothes (not their uniforms). The community members, when sitting in the inner circle, did not know those listening are providers until they switched. To reduce travel time and cost, Breakthrough ACTION-Nigeria's

community volunteers only selected and invited clients who met the criteria and lived close to the activity venues. Trained external facilitators convened the sessions; they were usually Local Government Area (LGA) health focal persons. After each fishbowl discussion, the project held a separate meeting with providers only to address specific action points they could employ to improve their behavior and quality of service.

Results and Learnings

Breakthrough ACTION-Nigeria conducted 104 fishbowl discussion sessions reaching 2,391 persons (providers and community members) in Bauchi, Ebonyi, Kebbi, and Sokoto States and the Federal Capital Territory (FCT).

Community members cited concerns related to disrespect and abuse, lack of privacy for women during childbirth, poor communication and counseling skills, and providers' poor attitudes toward work, among other issues, as the barriers leading to low uptake of health facility services. Meanwhile, providers noted one problem was the community's expectation that all services and commodities in the facilities should be given free-of-charge was also identified as a problem. They also identified other concerns, such as lack of adequate human resources, poor work conditions, and insecurity. All of these hindered smooth operations of their facilities.

Fishbowl sessions improved interpersonal communication between providers and their clients while enabling community members and providers to collaboratively address issues such as lack of privacy during ANC and labor, inability to have a birth companion, and disrespect and abuse during childbirth, which hindered service provision and usage. For instance, in Sokoto State and FCT, fishbowl sessions galvanized stakeholders to procure screens to provide privacy during childbirth.

> I have demarcated my delivery room with curtains. This has been helpful when we have two women in labor, to provide them with privacy.
>
> **Victoria Sule,** Officer-In-Charge, Narrahati Primary Health Center

Introducing Community Provider Dialogues

Why Did the Project Adapt?

After 15 months of implementing the fishbowl approach, in 2021, Breakthrough ACTION-Nigeria conducted an HCD formative assessment to identify the drivers of uptake for reproductive, maternal, newborn, and child health services (RMNCH) services in Ebonyi State and FCT. A key insight that emerged from an assessment of the fishbowl and other project activities was that community members continue to distrust health facilities because of poor health care experiences, perceptions of quality, and low confidence in providers and the effectiveness of modern treatments.

As a result, the project realized the fishbowl process needed to evolve into a forum for ongoing communication between communities and facilities to align expectations, share feedback, and address the psychosocial and structural factors undermining care-seeking, provider behavior, and client–provider trust. Project staff also realized the fishbowl approach could not meet all these needs and the approach would need to evolve, for the following reasons:

- The fishbowl is conducted by an external facilitator, who asks each set of participants, one at a time, structured questions about their perception of services. While one group spoke, the other side listened. However, only providers discussed potential solutions. The approach needed to shift to create a space where participants spoke openly with each other to understand each other's experiences and build consensus around solutions. Having everyone speaking and developing solutions together produces a joint sense of openness, inclusion, ownership, and trust.
- While the blinded design reduced the possibility of intimidation, having internal facilitators also meant trusted and known facilitators could create a safe environment where conversations, even when hard, could be had without fear of intimidation.

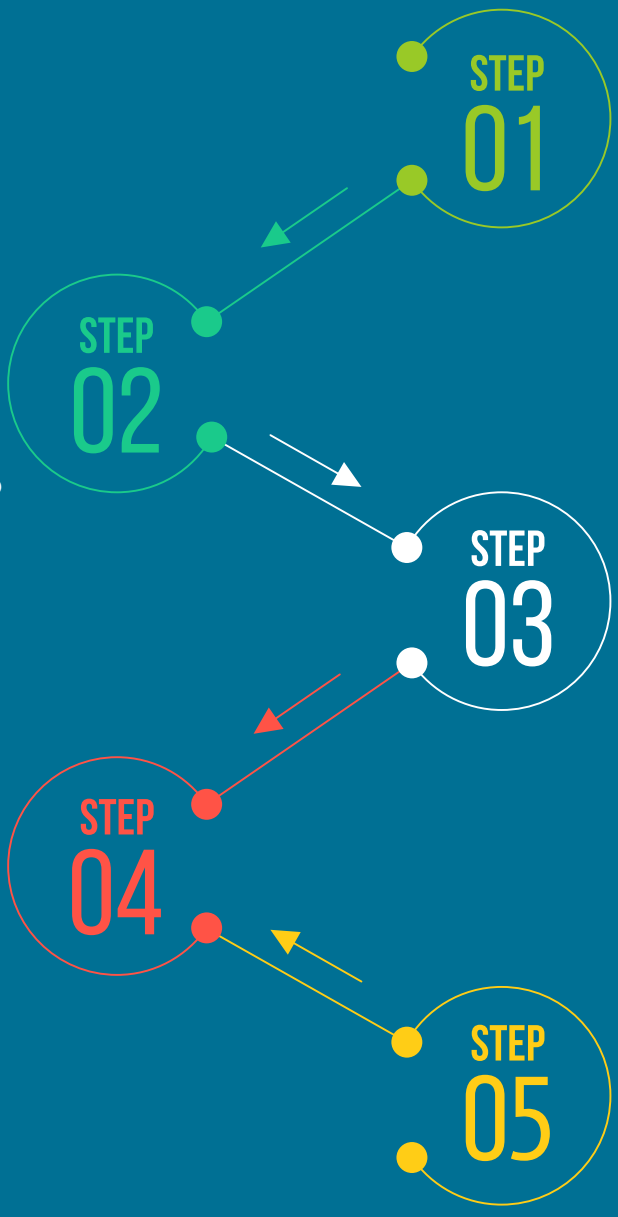
- During fishbowl discussions, the community member participants were only women. This sometimes created an uneven power dynamic when they realized that other participants were health care providers. Some women felt intimidated and concerned about potential repercussions when seeking health services in the future. Program staff were concerned this would limit the open discussions required to surface and resolve real challenges.
- While the project intended to use fishbowl discussions as a capacity building approach for LGA health focal persons, having facilitators external to the community to guide the dialogue did not guarantee effective follow-up. Additionally, external facilitation required resources to ensure local government staff were able to travel to facilitate and follow-up. This raised concerns about sustainability.

From Fishbowl Discussions to the Community–Provider Dialogue Approach

In response, Breakthrough ACTION-Nigeria developed an adapted approach called the Community–Provider Dialogue (CPD). Its goal is to connect facility-based providers with the communities they serve. Following the HCD approach, Breakthrough ACTION first rapidly tested this in a three-week pilot in Ebonyi State. It then conducted small-scale implementations in Sokoto, Ebonyi, and FCT. CPDs combined what worked about fishbowl and an existing Breakthrough ACTION-Nigeria intervention, the community capacity strengthening approach which works closely with Ward Development Committees (WDCs). WDCs are structures the government created to encourage community participation and increase access to primary health care services at the ward level. WDCs are established, nationally recognized, credible, trustworthy bodies representing communities' voices and interests. Communities accept, trust, and respect WDC members as community leaders.

A fishbowl session in Ebonyi state.

CPD sessions are a series of conversations that bring together 20 participants comprised of health providers and community members to do the following:



INCREASE understanding and empathy between both groups.

ENGAGE in constructive discussions around barriers and enhancers to service uptake.

AGREE on priority solutions.

DEVELOP a joint action plan with concrete actions and persons responsible.

MONITOR the implementation of the action plan using a community scorecard for accountability.

The community capacity strengthening approach, implemented by Breakthrough ACTION Nigeria in Bauchi, Kebbi, Sokoto, and Ebonyi States and FCT, seeks to expand community leaders and members' knowledge and skillset to engage more comprehensively in collective decision making around, participation in, and acting on health-related issues in their community. The project implements this approach through already-established and recognized community structures called WDCs. The Community Health Action Resource Plan (CHARP), which the community itself develops, outlines the various activities, roles, and responsibilities of both WDCs and more local Village Development Committees. The WDCs' core role is to implement the CHARP, while Breakthrough ACTION-Nigeria provides any necessary technical support. Breakthrough ACTION uses a performance-based, phased approach, starting with smaller, achievable community actions guided by the project, before moving to activities that require more active engagement and increased self-determination. For more information, see Breakthrough ACTION-Nigeria's Community Capacity Strengthening Resources and Tools.

CPDs are distinguishable from fishbowl discussions in the following ways:

1. **A community-led process:** Breakthrough ACTION leveraged its partnership with WDCs and trained them to lead the CPD process. Whereas the fishbowl discussions relied on external facilitators, CPDs place WDCs in the driver's seat. WDCs and community members facilitate every stage of the process, including organizing sessions, identifying issues and solutions, and monitoring their activities and impact. Sessions have co-facilitators, usually one being a trusted WDC member and the other a health facility officer-in-charge. Having facilitators from the community increases ownership, effectiveness, and sustainability. In fact, in several states, WDCs have fully planned, hosted, and conducted CPDs without Breakthrough ACTION-Nigeria support.

2. **Participatory conversations:** Rather than using two concentric circles, CPD sessions have community members and health facility staff sit together and have open interactions to draw out the issues faced by both sides. They then can collaboratively share the responsibility to develop solutions. Rather than blinding participants, everyone understands each other's roles in the community and facility ecosystems. Each

participant knows they have a responsibility to play in building trust and strengthening the relationships between clients and providers. While the conversations may be difficult, guidelines from Breakthrough ACTION support facilitators in ensuring the discourse remains constructive and builds mutual understanding.

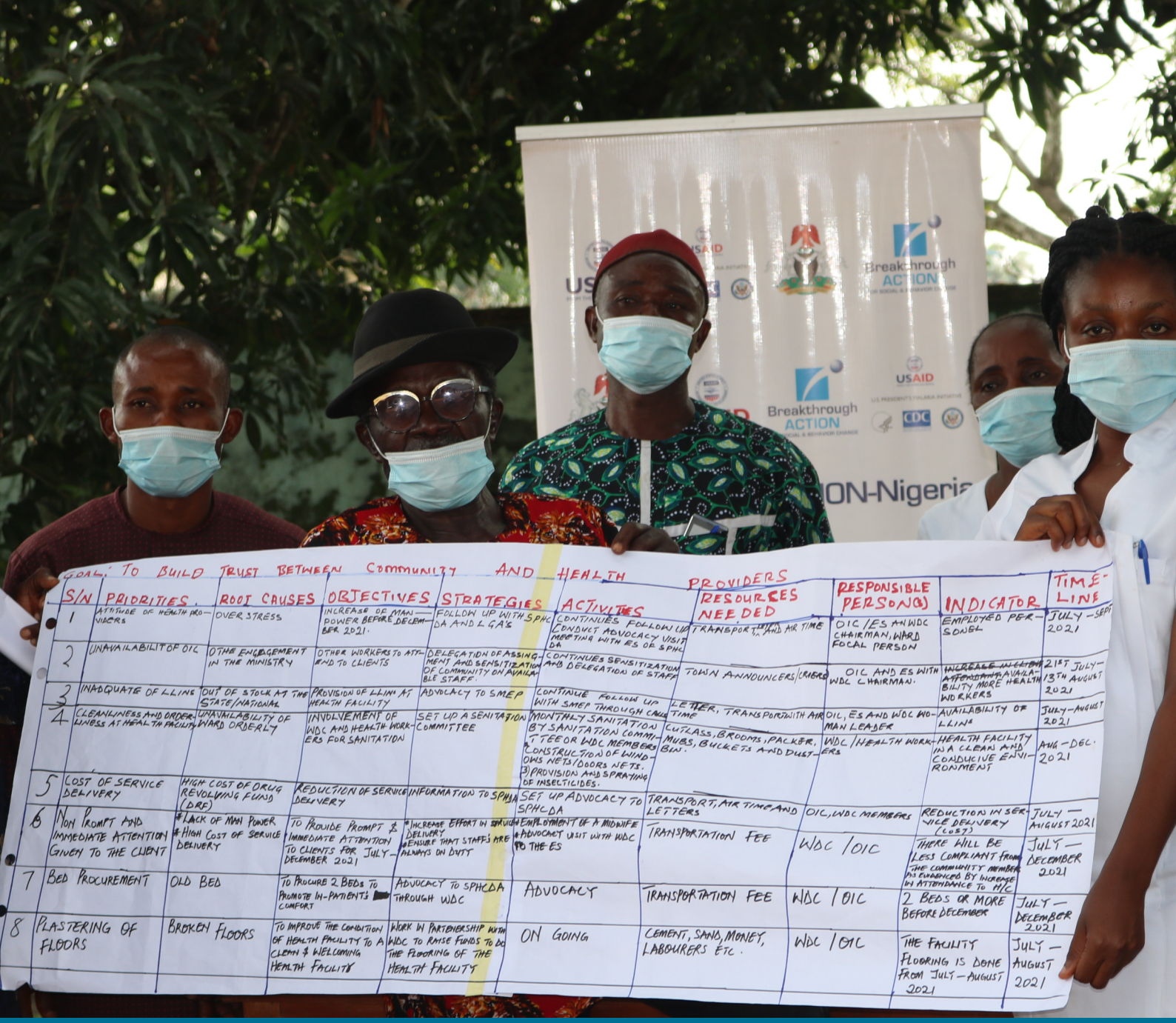
3. **Integration with CHARPs:** The WDCs host and lead the CPD sessions. They integrate action plans that emerged from CPD activities into their existing CHARPs. Updates and actions from the CPDs also become part of the WDC monthly review meetings, where members share updates, challenges, and lessons learned, and they seek a way forward on their activities with other WDCs.

4. **Wider representation of community voices:** CPD sessions went beyond women clients as participants and expanded to a variety of voices from the community. This included, but was not limited to, youth groups, women groups, motorbike riders, and associations of farmers. In this way, CPDs shifted the onus of participation from only women—who may face fears of repercussions (and who may have limited power and ability to effect changes)—to a broad base of community members. This approach also creates a more level playing field, where providers and community members view each other as peers.

5. **Elevating the role of the Health Facility Officer-In-Charge:** Breakthrough ACTION-Nigeria redesigned the CPD approach so that, in addition to bringing additional voices to the dialogue, health facility officers-in-charge could play a key role in community interactions. This enabled the community and facility to deepen their relationship. Officers-In-Charge organize and co-facilitate the CPD alongside WDCs.

6. **Re-positioning the health facility as a safe space:** Most CPDs are held at health facilities. Not only can this increase clients' familiarity and comfort with health facilities, but the location also allows providers to participate without having to shorten service hours. Hosting CPDs at facilities can also help providers feel safer during sessions, since having the sessions in the community may make providers feel summoned and interrogated about poor service delivery. Moreover, CPDs work deliberately to ensure participants do not see it as a fault-finding mission but, rather, as an avenue to discuss and find solutions to identified barriers to facility service uptake.

7. **Includes an accountability system:** Once a set of issues are identified, WDCs develop simple indicators to track solution implementation. They list the issues, solutions, and indicators on a community scorecard. The scorecard helps WDCs and CPD participants measure how they are progressing toward resolving the identified issues. Participants review scorecards, at a minimum, every quarter.



S/N	PRIORITIES	ROOT CAUSES	OBJECTIVES	STRATEGIES	ACTIVITIES	RESOURCES NEEDED	RESPONSIBLE PERSON(S)	INDICATOR	TIME-LINE
1	ATTITUDE OF HEALTH PROVIDERS	OVER STRESS	INCREASE OF MAN-POWER BEFORE DECEMBER 2021.	FOLLOW UP WITH SPHC DA AND LGA'S	CONTINUES FOLLOW UP CONDUCT ADVOCACY VISIT MEETING WITH ES OF SPHC	TRANSPORT, AND MR TIME	OIC/ES AND WDC CHAIRMAN, WARD FOCAL PERSON	EMPLOYED PERSONEL	JULY – SEPT 2021
2	UNAVAILABILITY OF OIC	OTHER ENGAGEMENT IN THE MINISTRY	OTHER WORKERS TO ATTEND TO CLIENTS	DELEGATION OF ASSIGNMENT AND SENSITIZATION OF COMMUNITY ON AVAILABLE STAFF.	CONTINUES SENSITIZATION AND DELEGATION OF STAFF	TOWN ANNOUNCERS/CRIERS	OIC AND ES WITH WDC CHAIRMAN.	~~INCREASE IN~~ AFFORDABILITY MORE HEALTH WORKERS	21ST JULY – 13TH AUGUST 2021
3	INADQUATE OF LLINS	OUT OF STOCK AT THE STATE/NATIONAL	PROVISION OF LLINS AT HEALTH FACILITY	ADVOCACY TO SMEP	CONTINUE FOLLOW UP WITH SMEP THROUGH CALL	LETTER, TRANSPORT WITH AIR TIME	OIC, ES AND WDC WOMAN LEADER	AVAILABILITY OF LLINS	JULY – AUGUST 2021
4	CLEANLINESS AND ORDERLINESS AT HEALTH FACILITY	UNAVAILABILITY OF WARD ORDERLY	INVOLVEMENT OF WDC AND HEALTH WORKERS FOR SANITATION	SET UP A SENITATION COMMITTEE	MONTHLY SANITATION BY SANITATION COMMITTEE OR WDC MEMBERS CONSTRUCTION OF WINDOWS NETS/DOORS NETS. 3) PROVISION AND SPRAYING OF INSECTICIDES.	CUTLASS, BROOMS, PACKER, MUBS, BUCKETS AND DUSTBIN.	WDC/HEALTH WORKERS	HEALTH FACILITY IN A CLEAN AND CONDUCIVE ENVIRONMENT	AUG – DEC. 2021
5	COST OF SERVICE DELIVERY	HIGH COST OF DRUG REVOLVING FUND (DRF)	REDUCTION OF SERVICE DELIVERY	INFORMATION TO SPHDA	SET UP ADVOCACY TO SPHCDA	TRANSPORT, AIR TIME AND LETTERS	OIC, WDC MEMBERS	REDUCTION IN SERVICE DELIVERY (COST)	JULY – AUGUST 2021
6	NON PROMPT AND IMMEDIATE ATTENTION GIVEN TO THE CLIENT	#LACK OF MAN POWER #HIGH COST OF SERVICE DELIVERY	TO PROVIDE PROMPT & IMMEDIATE ATTENTION TO CLIENTS FOR JULY – DECEMBER 2021	#INCREASE EFFORT IN SERVICE DELIVERY #ENSURE THAT STAFFS ARE ALWAYS ON DUTY	EMPLOYMENT OF A MIDWIFE #ADVOCACY VISIT WITH WDC TO THE ES	TRANSPORTATION FEE	WDC/OIC	THERE WILL BE LESS COMPLIANT FROM THE COMMUNITY MEMBERS AS EVIDENCED BY INCREASE IN ATTENDANCE TO H/C	JULY – DECEMBER 2021
7	BED PROCUREMENT	OLD BED	TO PROCURE 2 BEDS TO PROMOTE IN-PATIENTS COMFORT	ADVOCACY TO SPHCDA THROUGH WDC	ADVOCACY	TRANSPORTATION FEE	WDC/OIC	2 BEDS OR MORE BEFORE DECEMBER	JULY – DECEMBER 2021
8	PLASTERING OF FLOORS	BROKEN FLOORS	TO IMPROVE THE CONDITION OF HEALTH FACILITY TO A CLEAN & WELCOMING HEALTH FACILITY	WORK IN PARTNERSHIP WITH WDC TO RAISE FUNDS TO DO THE FLOORING OF THE HEALTH FACILITY	ON GOING	CEMENT, SAND, MONEY, LABOURERS ETC.	WDC/OIC	THE FACILITY FLOORING IS DONE FROM JULY – AUGUST 2021	JULY – AUGUST 2021

Results from the action planning session in the 3-week HCD pilot in Ebonyi.

Small-scale implementation results:

In total, nine CPD sessions were conducted. Through its implementation, the CPD approach:

Brought out structural and social barriers (e.g., ANC patients' examination room, inadequate human resources and insecurity) to the access and uptake of RMNCH services. Participants addressed some of these and stakeholders will address the issues remaining.

Proved to be an effective bottom-to-top approach style of implementation as discussion questions the project co-developed with the community, since they prioritized which issues they wanted to discuss.

Allowed for effective action planning, since it enabled the explicit identification of real people accountable to the community who would be responsible for the execution of specific tasks.

Brought about the active participation of WDCs, the community, and providers in joint planning and implementation of CPDs and their resulting action plans.

Across three states, WDCs have mobilized resources to increase the number of female staff at facilities, obtain water and needed supplies, and build a facility closer to their communities. WDCs have also been able to work with other local opinion leaders to promote health services among various populations within their communities.

> I have watched health facility problems I thought were insurmountable being handled in just a few weeks. Community-provider dialogues demonstrate the fact that a healthcare provider must have to work with their community structures to achieve person-centered care.
>
> **Felicia,** Officer-in-Charge, Onyirigbo Health Center, Ebonyi State

Participants have received the CPD approach well; with minimal guidance and supervision from Breakthrough ACTION-Nigeria, WDCs have demonstrated a willingness and ability to independently organize, implement, and monitor CPDs with the effective participation of providers, communities, and other key stakeholders.

Lessons Learned from Implementing Approaches to Strengthen Relationships Between Communities and Providers

1. **Integrate community–provider trust interventions into existing community structures,** like the WDCs. This integration promotes interventions being led by community members who understand the context, fosters sustainability, collective community problem-solving, and local solutions that are affordable and sustainable. It ensures interventions remain relevant and are rooted in community needs.

2. **Have inclusive representation of stakeholders in the dialogue process.** This helps identify root causes, fosters open and honest communication, and builds trust across the community stakeholders. It also increases resources available for co-created solutions.

3. **Ensure health facility leadership has an active role,** so community members perceive providers as equal partners in solution development, not as an object for blame.

4. **Use insider *community* facilitators where possible,** as they are likely to understand the community's nuances and can better facilitate discussions. Insiders also contribute to a greater sense of trust and continuity in the process.

5. **Encourage local governments to include these types of interventions in their regular operational plans and budgets.** This approach secures ongoing funding, helping to maintain momentum and support for community-driven activities over the long-term.

6. **Learn and adapt throughout implementation:** Behavioral insights can be gleaned from day-to-day programmatic activities not just when undertaking new research. As implementers learn from the approach in action, they should continue to refine SBC activities.

7. **Leverage the unique strengths of different approaches:** Breakthrough ACTION-Nigeria's experience demonstrated that fishbowl discussions are best suited for deep dives into pre-identified issues from the perspectives of a couple of key groups. They may be helpful in particular for sensitive issues such as respectful maternity care and can inform program design and build empathy. However, CPDs are more appropriate for situations when topics, issues, and actions are complex and need addressing with flexible approaches and solutions.

Resources

Adedokun, S.T., & Uthman, O.A. (2019). Women who have not utilized health service for delivery in Nigeria: who are they and where do they live? *BMC Pregnancy Childbirth,* 19, 93. https://doi.org/10.1186/s12884-019-2242-6

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