

Health Campaign Effectiveness Coalition Test & Learn

Community Factors Shaping Campaign Effectiveness: Q&A

Panelists: Taylor Cook, Gwen Gage, Arotin Hartounian, and Caroline Kusi

1. Have virtual platforms been used effectively in helping engage the community level in campaign design? Connectivity is always an issue, but access to mobile phones down to the community level continues to expand. Has including community-level thought leaders virtually in district and national-level discussions on campaigns been considered or documented as being effective?
 - a. Answer: I can say that I haven't heard of much, but this is definitely not our area of expertise in terms of the virtual platforms being used. I know that we read several pieces on them being used by the campaign workers to streamline that process, in particular looking at the campaign worker burden. But one thing I would say is I think this gets at an interesting question, which is that one issue that we saw is that there's really a difference between having that content and incorporating that content in a very real way and letting it direct how things are going to work. A lot of the time, people will say "Oh yes, we heard from the community, it's very important that they trust their community healthcare worker and that it's someone from their community." But then we would talk to people who had worked as community healthcare workers, and they're not necessarily working in a community that they're familiar with, or there were other barriers. So it still seems like there's a disconnect between actually hearing that information and truly saying, "okay, we're going to change the way we've run things for, say, 25 years and actually do it a little bit differently." (GG)

2. Have you found any examples of where these "power imbalances" have been evened out to allow for community level innovation? What factors allowed that to happen? How was that recorded?
 - a. Answer: I will say that we heard of examples--it may have been Tanzania--in which a pilot program that had run around polio campaigns had specifically built in this structure to have greater engagement with local leaders. This is something I feel like everybody references as something that would be great to have, but with this one, they had really gone out of their way and built these strong relationships, had those community leaders really involved in the process so that, once the campaign was going, they were a voice and an advocate for that campaign to their community. They saw quite a good result from that and people were really engaged in the campaign, but then I believe the funding was cut, and they were unable to do that program anymore. It was very disappointing, because it had been so successful.

We also saw civil society and local grassroots organizations who were able to address specific issues, like getting men and fathers more involved in health and immunizations. Bringing these smaller, local solutions into the campaign system requires the national and global systems to be able to use that feedback and the flexibility to innovate. (GG)

3. One of the primary goals of the HCE Coalition is to bolster opportunities for campaign integration and country ownership. I'm wondering if you can reflect on how a shift towards these integrated approaches can provide opportunities to improve on the "inadvertently exploitative working conditions" for community health workers.
 - a. Answer: The shift to an integrated delivery approach, I think, would certainly help, because you're not creating a competitive market. People are employed by a group rather than having to pick between campaigns. I think the biggest thing that would shift that exploitative working condition is a decision and a mental shift to really treat these workers as employees and to give them the support that they are asking for. Just because something is integrated doesn't necessarily mean that there will be an inherent change in the support for transportation, training, or the stipend that they're given. And those were really the things that we heard created the exploitative situation, rather than simply being between campaigns. (GG)
 - b. Community healthcare workers have been a good...we've seen it in Liberia and some in Ethiopia, great examples--where there is a really strong pulse with the community healthcare workers, they really know what's going on, and are better able to collect what's going on in their local context and bring it up, either to their national-level campaign program or to the global level. But those campaign workers, the longer they work in the job, the more they have that local context knowledge and know the patterns where an outside worker would not. And so when they leave, they take that local knowledge with them as well, and it further deteriorates the ability to stop the exploitative conditions. The cycle builds up without stranger advocacy for the workers and the communities they work for. (AH)
4. Having done some research talking to "decision makers" within campaign planning, there is often a lot of different types of data they have to process and synthesize to make a decision. Sometimes the decision is made through group consensus, other times a decision is advocated for with the final "decision" made by the decision maker. Your work mentioned multiple possible data streams and factors to consider especially at the community-level, but how should a decision maker prioritize the relative weight of different data? If you have competing data have you found any good tools or frameworks to *prioritize* action or decision outcomes?
 - a. Answer: I don't know if we have found any specific frameworks of how to prioritize the data. I think that's actually one of the unsolved questions, which is, "which data is actually going to give you the right formula?" What's the secret sauce to get the response you want? Our perspective is that things have been

designed in the same way and function in the same way for several years, so we haven't had a lot of chances to see how prioritizing different data will get a different result. In this case, I think the ideal would be if there were smaller scenarios of pilot programs, perhaps in a very specific region, that could try running or designing a campaign by weighting the scales a little bit differently, by prioritizing something that you wouldn't normally, and just testing that hypothesis to see what type of outcome you get. That proof of concept is really needed by the people designing and running the campaigns in order to elevate this conversation. (GG)

- b. I think it would depend on more dynamic planning and having different solutions depending on what the community's needs are. Every community has different needs, so it's not going to be a one-size-fits-all answer. (TC)
5. How could working conditions be adequate for workers to complete their campaign work and be seen as sustainable from a country government perspective?
- a. Answer: There are a lot of factors that impact their mental health and the on-the-job experiences for the community health workers. When you talk to program managers on the ground at the district level and regional level, it always points to, in my opinion, money. It's tied to the implementing partner and the donor. You often hear program managers complain, "there's no money, so we can't..." For example, community health workers are given a certain number of households to reach within a certain number of days. So they might have 4 days to reach 500 households. Then you also have to think about 1) them retrieving the medicines, and 2) moving from household to household, which sometimes requires out of pocket expenses. All of these, at the core, really have to do with funding. There are different factors, but I think the way to tackle it is to really work with the implementing partner and the donor at the global level and saying, "you're giving the country this much and this is what they're able to do, but if they had this much, the campaigns would be more effective." The donor and the implementing partner have to be convinced that this is an issue and requires an investment, otherwise it's just business as usual. How do we incorporate mental health, coping mechanisms and training for these workers? So far I don't think a lot of countries have thought about incorporating that component into their training. (CK)
6. The challenges for different campaign may be perhaps unique based on the nature of campaign and also vary based the culture and structure of social network. Can we a little bit disaggregate the challenges accordingly. Is it actually the challenges from the community or effects of down-ladder political/government platform that allows community engagement?
- a. Certainly the organizations and political bodies closer to the community level are more likely to be engaging directly with communities. However, we found in our research that those bodies' ability to engage with communities hinged on decisions made higher up the ladder. Limitations on donor funding, for instance,

was often a barrier to lower-ladder actors creating better community engagement in the form of more robust social mobilization or improved training for campaign workers. While challenges likely vary from region to region, donor funding and policy at the top, set the table for what is even possible at the bottom. We would like to see the global level actors spend greater attention on the variability and importance of community level factors and design strategies and funding structures that enable actors closer to the community to engage with those community challenges more robustly.

One example that might relate is a story we heard from a program in Ghana. A local health organization designed a program to get fathers more involved in vaccination through soccer. This kind of bottom-up strategy would necessarily be designed by those organizations closest to the communities. But their ability to fund and create such programs relies on a level of flexibility from global partners.
(GG)