

TECHNICAL BRIEF



Can Communities Manage and Finance Basic Health Facility Maintenance?

INTRODUCTION

When the Ebola outbreak in West Africa was finally contained in 2015, USAID's Bureau for Global Health began investing in the health systems of Guinea, Liberia, and Sierra Leone to help them recover from the outbreak's devastating effects. Between 2015 and 2019, JSI Research & Training Institute, Inc. (JSI) managed seven post-Ebola recovery programs in these three countries.

Following the Post-Ebola Recovery of Health Services (PERHS)¹ program that improved 305 health facilities in five districts of Sierra Leone, USAID asked JSI to develop a pilot program for community-led health facility maintenance and preventive maintenance (M/PM). The resulting Sustaining Health Facility Improvements (SHFI) program was active in 70 communities in three rural districts (Bombali, Port Loko, and Tonkolili).² The program's community-focused interventions ran for approximately four months in early 2019.

OBJECTIVES

SHFI aimed to: 1) develop community "ownership" of local health facility M/PM needs; and 2) determine whether facility management committees (FMCs),³ using locally developed facility improvement action plans (FIAPs) and other tools, could lead and manage resource mobilization and basic repairs for M/PM.

SHFI's goal: Test community and local support for health facility and equipment maintenance and preventive maintenance by way of in-kind and financial contributions guided by local facility management committees.



FMC and VSLA members in Mawoma repair the PHU's water tap.

- 1 The components of a "full package" site in the 2015-2017 PERHS program included access to water (drilled and hand-dug wells, storage tanks, solar-powered submersible pumps, and handwashing sinks); improved sanitation (waste pits and incinerators); physical facility repairs; solar-powered lighting; basic medical equipment and furniture; enhanced reproductive, maternal, newborn, and child health skills for health workers; invigoration of FMCs; and support for development and roll-out of a new national policy for the community health worker program.
- 2 There were 110 "full package" sites (five districts) under PERHS.
- 3 According to the Ministry of Health and Sanitation, FMCs "give ownership to the people to ensure that health workers are accountable to the communities they serve and act as a liaison between the community and the health facility."



Members of the Mafoimara Community Health Post in Port Loko receive training on masonry and carpentry.

APPROACH

All 70 of the health posts that received “full package” support under PERHS in these three districts were included in the SHFI program. Each facility had formed an FMC during PERHS, although their operational state at the start of the SHFI program varied widely.

Working with CARE Sierra Leone and local partners RODA and MADAM, early interventions included revitalizing and expanding the FMCs to include representatives from other villages within the facility’s Ministry of Health and Sanitation-defined coverage area. Roles, responsibilities, and leadership were discussed in early meetings with the 70 FMCs. After joint assessments to identify, discuss, and document facility maintenance problems, each FMC developed a FIAP that indicated whether maintenance needs, including technical skills and replacement parts, could be supported locally or would require outside resources.

Each FMC monitored progress on its FIAP using the Community Scorecard (CS)⁴ process to ensure openness and transparency. They disseminated their FIAPs widely and posted them at their health facility for all staff and visitors to see and read. To support local involvement, the SHFI program gave each facility/FMC a set of simple tools for minor repairs and trained 408 staff and community members on accountability and cash management; advocacy; basic carpentry, plumbing, and masonry skills; and maintenance of solar-powered systems.

⁴ The CS is a two-way and ongoing tool for assessment, planning, monitoring, and evaluation of health services. The CS joins the demand (“service user”) and the supply (“service provider”) sides of a particular service to analyze and overcome underlying service delivery problems. The CS increases participation, accountability, and transparency between service users, providers, and decision-makers.

SHFI engaged 40 existing and helped create 30 new village savings and loan associations (VSLAs) to contribute to facility maintenance needs. Various FMCs sought financial support from their district councils, other government entities, and private organizations, while others gained support from the local village development committee (VDC).

At the national level, important interventions included the development of a budgeting tool for district health facility M/PM, and national M/PM standards and guidelines. Radio broadcasts and WhatsApp groups were used to highlight community engagement, emphasize the value of regular M/PM, and answer questions and exchange ideas related to health facility M/PM.

KEY RESULTS

- In the three rural districts, 100% of the 70 FMCs/communities mobilized resources to support basic repairs at their local health facility. In-kind contributions, such as labor and building materials, were provided at all sites, while 60 (86%) collected cash. While cash amounts were small by US standards, with an average of \$300 over the four-month intervention period, at least three FMCs raised more than \$800. These were significant amounts of money for these communities, which, along with in-kind labor, allowed them to make basic repairs at the facility. (See illustration on page 3.)
- During the four-month intervention period, 64 of the FMCs met monthly to revise their FIAPs and conduct related business, especially fundraising.
- Some FMCs went beyond their immediate communities by engaging VDCs, next-level community leaders, and local businesses. This resulted in small household taxes, direct contributions from the private sector, and improved coordination of in-kind contributions.
- VSLAs and social fund M/PM contribution goals attracted additional community members and mobilized cash for facility maintenance.

ADDITIONAL FINDINGS AND INSIGHTS

- FMCs communicated M/PM needs and tasks to the greater community through the FIAPs and related advocacy efforts, and used the CS process to facilitate good governance and promote participation, transparency, accountability, and informed decision-making. The FIAP and CS processes also improved the community's ability to identify and solve problems.
- The SHFI program enhanced relations between communities and health facility staff by clarifying roles, responsibilities, and expectations. As one FMC member commented during an early meeting with program facilitators, "(previously) we thought the facility belonged to the nurses."
- Encouraging FMC members to lead decision-making related to their FIAPs and M/PM interventions was critical to their success, as were open communication and strong leadership.
- In-kind contributions, such as labor and building materials, were harder to mobilize from communities that were more distant; similarly, it was harder to engage distant communities in regular FMC meetings. Transport costs were a common barrier.⁵
- Between the end of PERHS and the assessment phase of SHFI, physical facilities, especially wells, roofs and ceilings, doors and windows, plumbing fixtures, and electronics broke down rapidly. This was generally due to the lack of M/PM, occasional operator error, and Sierra Leone's harsh climate. To ensure that the facilities were fully functional at program's end, SHFI hired local contractors to complete a range of physical facility, plumbing, pump, solar, and electrical repairs at 48 sites.⁶

RECOMMENDATIONS

Water, sanitation, hygiene, and infrastructure

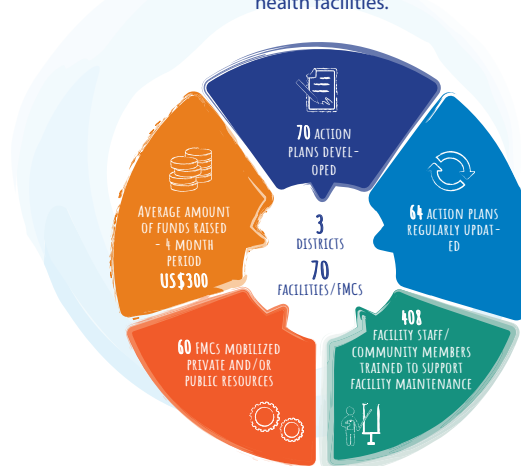
- When community access to water is limited and the health facility has a water source, members of surrounding communities will push to use water from the facility. Various potential challenges arise, including overuse of the well and non-job related managerial burdens on health facility staff. Local groups, such as Village Development Committees, need to define procedures for facility and community use of the water source and ensure its security. The facility should install an outside tap to avoid disruption of health services.

⁵ SHFI did not pay transport or other costs for FMC meetings.

⁶ This was a USAID requirement at the start of the program.

COMMUNITY SUPPORT FOR HEALTH FACILITY MAINTENANCE

APC built the capacity of Facility Management Committees (FMCs) and communities to support basic maintenance of health facilities.



Involving communities to maintain their own health facilities created ownership, enhanced community cohesion, improved relationships between communities and health care workers, and led to self-reliance.

- Health facilities need at least one indoor sturdy "slop sink" for laundry, foot washing, etc. The sink should have legs on the floor (rather than being wall-mounted).
- In many rural communities, health facility staff quarters, when they exist, do not have running water. Either the health facility or its staff quarters should have (at least) one shower.
- Health facility latrines, toilets, and handwashing sinks need to be kept in good working order to support the quality of care and to support good hygiene and infection prevention practices.

Community engagement, ownership, and facility maintenance

- During this program, FMCs and communities led FIAP development and management and met many of their facilities' basic repair needs. USAID should strongly consider similar community-led maintenance-focused programs in other settings and countries.
- Some facility repair needs are beyond the financial and skill capabilities of local committees and volunteers. Programs seeking to strengthen health facility maintenance must develop district-level technical and managerial capacity and find sources of financial support for "big ticket" maintenance needs within public-sector health facilities.



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