

STRENGTHENING COMMUNITY ENGAGEMENT FOR IMPROVED HEALTH OUTCOMES

Lessons Learned from the Primary Health Care Performance Management Activity

Community Engagement: At a Glance

Effective engagement with communities and diverse stakeholders is a critical, yet often under-leveraged, driver of primary health care (PHC) performance, shaping how services are accessed, delivered, and sustained at the local level. The PHC Performance Management (PHC-PM) Activity, strengthened district leadership, management and governance practices to address PHC challenges as part of a tailored PHC Leadership Development Program (PHC-LDP). Through this approach, select District Health Management Teams (DHMTs) in Ghana and Rwanda facilitated more meaningful engagement with health centers, and communities, contributing to improvements across multiple PHC indicators. In all four districts, health outcomes improved and a midpoint outcome harvesting assessment confirmed that those gains were accompanied by strengthened community engagement linked to project activities. Key informant interviews (KIIs) at endpoint explored stakeholder experiences with the PHC-PM Activity, focusing on the nature, effectiveness, challenges, and sustainability of DHMTs' community and multisectoral engagement.



Data sources: KIIs and focus group discussions (FGDs) were conducted with DHMTs, facility leads, health workers and community leaders.

Key Questions	Key Lessons	Recommendations
Did the PHC-PM Activity improve the interaction between DHMTs and community members?	<ul style="list-style-type: none"> Across districts, community engagement mainly took the form of bringing health services closer to where people live. Challenges differed by context: Ghana faced resource dependence and national health insurance misconceptions. In Rwanda, demand outpaced availability of staff and equipment. 	<ul style="list-style-type: none"> Prioritize continuous training, supervision, and minimal reliable financing for community health workers (CHWs), DHMTs, and frontline staff, even amid high staff turnover rates.
Were there opportunities to collaborate across sectors that were missed or underutilized?	<ul style="list-style-type: none"> Engagement with new actors improved in all districts, but cross-sector collaboration — particularly with agriculture, faith-based, and social welfare actors — remained underutilized. 	<ul style="list-style-type: none"> Involve local leaders and influential community figures (e.g., traditional, faith, and women leaders) early in mobilization efforts to strengthen community engagement and expand reach beyond CHWs alone.
What do districts suggest for future improvements within community engagement?	<ul style="list-style-type: none"> Sustained improvements depend on embedding community engagement into routine governance, planning, and budgets. 	<ul style="list-style-type: none"> Improve equipment, medicine supply, digital tools, and multisectoral collaboration to sustain service quality and trust. Embed regular community–DHMT engagement, roles, and indicators into routine governance, planning, and budgets.
What areas exist for further learning?	<ul style="list-style-type: none"> Further need to explore resources, governance structures, and collaboration required to sustain gains made in community engagement. 	<ul style="list-style-type: none"> Identify potential private-sector partners and intentionally link other government initiatives to PHC priorities.

INTRODUCTION

PHC is the foundation of resilient and equitable health systems. Realizing this vision depends on strong local leadership, which is essential to ensuring accessible, high-quality care that responds to community needs.

In Ghana and Rwanda, district governments face constraints in resources, equipment, and workforce competencies to deliver adequate primary care services.

To address these challenges, DHMTs must not only strengthen internal planning and management but also engage communities as active partners. Community feedback and collaboration are critical to identifying bottlenecks, advancing health outcomes, and accelerating progress on district priorities. While community engagement was not a mandate of the PHC-LDP, DHMTs recognized community engagement as a key enabler of performance improvement, supporting their efforts to translate data and priorities into actions that are responsive to local needs.

Although resource allocation decisions are made at higher levels, their effects reach communities, shaping resource availability and access to essential health services. Through the PHC-PM Activity, Akwapim South and North Tongu districts in Ghana and Bugesera and Gicumbi districts in Rwanda each implemented four iterative performance improvement cycles identifying root causes of longstanding PHC challenges and creating action plans to enhance PHC service delivery and address community needs.

In Ghana, community engagement is the operational backbone of the Community-based Health Planning and Services (CHPS) policy, designed to bring health services closer to the community and promote shared responsibility for health outcomes. The CHPS system relies on Community Health

Management Committees (CHMCs) and other local leadership structures to mobilize resources, support service delivery, and strengthen accountability. However, before the implementation of the PHC-PM Activity, community engagement in PHC in Akwapim South and North Tongu districts largely fell short of this policy ideal, with varying degrees of success between the two districts. Existing structures such as traditional leaders, assembly members, and CHMCs were either inactive or inconsistently engaged by health providers in planning and oversight, particularly in Akwapim South. Engagement was often limited to short-term mobilization for outreach services, rather than sustained dialogue on performance, service gaps, and improvement priorities. Although DHMTs acknowledged the importance of these community structures, collaboration was unstructured due to inconsistent top-down monitoring and supervision, weak feedback mechanisms, and resource constraints. As a result, community participation in reviewing performance data, discussing challenges, and participating in joint problem-solving were overall infrequent, leaving community members unaware of health facility-level challenges and fostering misconceptions that undermined collective responsibility for improving health outcomes.

Similarly, in Rwanda, community engagement within the health sector involves multiple actors but remains uneven in practice. Key stakeholders include community members, CHWs, health centers, hospitals, local leaders, and DHMTs, operating under the stewardship of the Ministry of Health. At the district level, initiating engagement and soliciting feedback from communities are the responsibility of several departments, including the Department of Good Governance—which is mandated to link community feedback to decision-making—as well as the District Planning, Monitoring and Evaluation Committee and the District Health Unit. Through these platforms, districts are

expected to convene community members and involve them in planning and decision-making forums. In practice, however, CHWs are often not as active as expected and are insufficiently trained on the underlying causes of service delivery challenges. As such, they are unable to effectively engage the community on preventative behaviors and instead focus on general advice rather than targeted support. In both countries, engagement from health centers is limited, district supervision

and staff visits to communities are infrequent, and many health centers and community members are unaware of the DHMT’s role. Collaboration between hospitals and health centers is also fractured, as hospital-based doctors generally do not travel to health centers and communities.¹ These gaps point to the need for stronger coordination, clearer roles, and more effective use of existing district platforms to translate community input into meaningful PHC action.

What is the significance of community engagement and which stakeholders were involved?

The PHC-PM Activity engaged a broad range of community and multisectoral stakeholders, many of whom are critical for PHC because they influence community norms and health-seeking behavior, mobilize local financial and social resources, strengthen the legitimacy and accountability of health interventions, and serve as key channels for feedback between communities and the health system.

Table 1. Community stakeholders engaged in PHC in Ghana

Stakeholders	Importance
Assembly members and unit committee members	Formal administrative link between community and government. Support identified community plans and ensure they are captured in district plans. <i>Very important</i>
Community health committee members and community volunteers	The are operational anchor of the community. Influence service utilization and enhance facility-community trust. <i>Very important</i>
Traditional leaders and queen mothers (Ghana)	Traditional authority. Resolve conflicts and accelerate trust. <i>Very Important</i>
Clergy and faith-based organizations	Influence the shaping of values and norms in community health activities. <i>Important</i>
Schools and youth groups	Platform for health promotion activity. Youth groups for promoting adolescent health activities. <i>Important</i>
Development associations	Mobilization of financial and technical resources. <i>Important</i>
Private sector actors (to a limited extent)	Can provide some resources, innovations etc. <i>Important</i>

ASSESSMENT OVERVIEW

Data collection and analysis were led by Three Stones International in Rwanda and the Uboru Quality Institute in Ghana with support from Management Sciences for Health (MSH). In Rwanda,

qualitative data were collected through KIIs with district- and facility-level stakeholders in Bugesera and Gicumbi who were selected based on their direct involvement in implementing the PHC-PM Activity. Respondents included DHMT members, health center staff, and community-level actors such

¹ Source: Scoping KIIs conducted in June 2023

as village leaders and CHWs who participated in community mobilization and maternal and child health outreach activities.

In Ghana, qualitative data were collected through FGDs conducted during structured workshop sessions in Akwapim South and North Tongu districts in November and December 2025. Participants included DHMT members, sub-district health leads, community opinion leaders (such as chiefs, queen mothers, volunteers, and assembly members), and participants, including caregivers and

pregnant women who had participated in PHC-PM community engagement activities.

Across both countries, data were analyzed thematically to identify key lessons on community engagement approaches, stakeholder participation, and factors influencing sustained community involvement in PHC performance management. Emerging findings were validated with participants at the end of discussions to strengthen accuracy and credibility.

Table 2. Qualitative data collection by country, district, and stakeholder level

Stakeholder Level	Data Collection Method and Participants	Selection Procedures
Rwanda²		
DHMT Members	Bugesera (KIIs, N=7): Director of finance, Director of health, DHMT focal person, Director of nursing, CHW supervisor, CHW representative Gicumbi (KIIs, N=4): DAF, health center representative, DHMT focal person, CHW representative	Selection focused on formal DHMT members actively involved in PHC-PM activities including workshops, meetings, trainings, and implementation. In Gicumbi, some respondents could not be reached due to limited availability.
Health Center Staff	Bugesera (KIIs; N=6): 3 Heads of Health Center and 3 nurses at 3 health centers Gicumbi (KIIs; N=8): 2 Heads of Health Center, 1 nurse, 1 logistics officer, 2 accountants, 2 nutritionists, 2 CEHOs at 2 health centers	Health centers were selected in collaboration with the district focal person, prioritizing facilities with staff who worked closely with the DHMT, participated in project implementation activities, and had received training. Purposive sampling was used to select participants directly involved in PHC-PM implementation with sufficient experience.
Community Members	Bugesera (KIIs; N=4): 2 village leaders, 2 CHWs Gicumbi (KIIs; N=4): 2 village leaders, 2 CHWs	Village leaders and CHWs were selected with health center heads, prioritizing those trained through the Activity and active in community-level implementation activities, including mobilization, sensitization, and follow-up of maternal and child health services.
Ghana³		
DHMTs / Facility leads	North Tongu (FGDs; N=8), Akwapim South (FGDs; N=9): Participants included district director, accountant, health information officers, disease control officers, public health nurse	Facility leads or representatives and DHMT members who actively participated in the PHC-PM Activity.
Community / Opinion Leaders	North Tongu (FGDs; N=5), Akwapim South (FGDs; N=5): 2 CHMC members, 1 chief, 1 assemblyman, 1 volunteer per district	Opinion leaders were selected based on their participation in community-level project activities, such as community mobilization, durbars (traditional assemblies), outreach sessions, and other activities or received services through the Activity.

² Three Stones International undertook an internal validation process: two coders undertook the coding process, meeting on several occasions to discuss and agree on key themes and sub-themes. High-level findings were validated internally by Activity team members and were shared with MSH and Uboru for feedback.

³ Prior to the FGD, the DHMT and partners facilitated an interpreter for the opinion leaders' group since most could not express themselves clearly in English. A note taker was selected for both FGDs. A plenary involving all four stakeholders (DHMT, facility leads, opinion leaders, and participants) validated the results to complete the session.

Did the PHC-PM ACTIVITY improve the interaction between DHMT and community members?

Across districts, community engagement was most strongly enhanced through bringing services closer to households.

In Ghana, DHMTs described several important channels for engagement, including community clinics, new outreach points, weekend and evening child welfare clinics, radio education, community information centers, durbars, school-based activities, and targeted discussions with teachers, faith leaders, market queens, and opinion leaders. These approaches focused on improving desired measurable results through community engagement and reducing delays in care-seeking, particularly for elderly persons, persons with disabilities, and women with heavy domestic workloads. In several cases, engagement shifted from limited interaction to more structured, frequent, and sometimes data-driven processes, with communities involved in understanding trends such as teenage pregnancy and antenatal care (ANC) attendance. Although engagement intensity varied depending on resources and leadership buy-in, overall experiences were largely positive and reflected stronger collaboration between facilities and communities.

Home visits emerged as one of the most transformative engagement strategies.

Through financial support from catalytic grants, district teams trained and mobilized CHWs to provide more tailored support to families, particularly around nutrition and ANC attendance. These visits helped engage harder-to-reach groups who were often missed by broader sensitization efforts. They also helped shift the focus from general messaging to addressing specific underlying problems.

⁴ Umugunda is the mandatory national community service day in Rwanda.

As one respondent explained:

“Previously, we provided interventions such as milk, animals, and kitchen gardens, but stunting still persisted. This time, our focus has been on finding the root causes so that interventions can directly address them.... Additionally, CHWs were asked to share their findings with parents during home visits, explaining the causes of malnutrition and helping families create a plan to support the child. Through these home visits and community engagement, many parents became aware of the causes of malnutrition.”

More systematic home visits by health center and community-level staff to promote ANC attendance were viewed as a significant behavioral shift:

“Now, every woman who is pregnant or planning to become pregnant is tested and encouraged to complete all ANC visits. Thanks to community mobilization during Umugunda⁴, home visits, and community meetings, the community’s behavior has changed compared to before. Women now attend ANC, and almost all give birth at the health center.”

Outreach services in Rwanda were described as eye-opening experiences for both communities and providers.

This was especially true for dental and eye care and in settings where specialist shortages had previously limited access. One health center coordinator noted:

“We organized community outreaches, and these activities were highly appreciated by community members. During the outreaches, doctors from the district hospital were invited to support service delivery. Community members participated in large numbers, to the extent that the health services provided were sometimes overloaded because of the high demand. Many community members even expressed their wish for us to come back again, which showed how much the services were.”

The involvement of local leaders in community mobilization was another frequently cited positive shift. Training village leaders expanded responsibility beyond CHWs alone and improved ANC coverage in particular. Improved coordination among district teams, health centers, and communities further strengthened engagement. DHMT members increasingly accompanied CHWs during home visits and participated in community activities, enhancing service provider credibility, attendance at mobilization events, and—through supportive supervision—service delivery quality. As one nurse reflected:

“Before this project, I did not have much interaction with the DHMT and was not very familiar with their role. Through the PHC project, I came to understand who they are and what they do. They now visit us more frequently, not only for supervision but also to understand the challenges we face at the community level.”

Despite important gains in community engagement, the nature of implementation challenges differed across Ghana and Rwanda.

In Ghana, particularly in Akwapim South and North Tongu, some engagement commitments—such as quarterly church support—remained aspirational rather than fully operational. Persistent misconceptions about NHIS coverage reduced communities’ willingness to contribute resources, while inconsistent availability of medicines during community clinics undermined confidence in outreach services and diminished the perceived completeness of care. Transport constraints in

hard-to-reach areas further limited the reach and regularity of community-based services. In Akwapim South, limited community involvement in decisions around equipment selection contributed to perceptions of politicization when donated equipment was introduced without adequate consultation or information-sharing. In North Tongu, although engagement became more structured and data-driven, activities were highly resource-dependent and vulnerable in the absence of dedicated funding. Some influential groups—such as traditional leaders, faith leaders, and women leaders—were initially underutilized, and time and logistical constraints restricted the frequency of review meetings and follow-up engagements.

In Rwanda, challenges were less centered on misconceptions or politicization and more on system capacity constraints. Across both Gicumbi and Bugesera, increased community mobilization—particularly around ANC and outreach services (e.g., dental and eye care)—generated demand that often outpaced available staff and equipment. Facilities struggled to meet heightened expectations created by successful engagement efforts. Districts adopted adaptive strategies to mitigate these pressures: Gicumbi organized dental and eye care outreach services with support from district hospital specialists and reorganized patient flow by establishing dedicated ANCI consultation rooms in health centers. Bugesera purchased new equipment to improve efficiency and enable existing staff to cope with increased service utilization. Nevertheless, in both districts, the tension between strengthened community engagement and limited human and material resources remained a persistent constraint to sustaining impact.

Evolution of Community Engagement Under PHC-PM in Ghana

Through the PHC-LDP, the PHC-PM Activity introduced a deliberate focus on structured, inclusive, and data-informed community engagement, positioning communities not only as service users but as co-producers of health outcomes. This new focus emphasized regular dialogue in understanding trends such as anemia in pregnancy and ANC attendance, joint problem-solving, and shared review of performance data. Facility leads reported a marked shift from limited community interaction to more structured and frequent engagement. Demand for accountability improved as DHMTs demanded results from action plans. Monitoring and supervision became more frequent. DHMTs also engaged more often with more diverse stakeholders, such as religious leaders, queen mothers, District Assembly, CHMC members, some of whom had been engaged less frequently or not at all. Across both districts, the Activity reactivated dormant community structures and created new platforms for engagement, including:

- Regular LDP+ performance review meetings involving community leaders
- Use of community information centers and digital platforms (e.g., WhatsApp) for communication
- Joint planning and micro-planning meetings among DHMTs, providers, and community representatives
- School-based activities and targeted discussions with teachers, faith leaders, market queens, and opinion leaders

“Before, we didn’t know what was happening in the facilities. But now the nurse can call on us for review, and we also call on her whenever we see a problem.” (KII, PHC-LDP participant)

Were there opportunities to collaborate across sectors that were missed or underutilized?

Both countries reported tangible improvement in engaging with new actors; however, respondents felt that opportunities for broader cross-sector collaboration could have been further expanded.

In both districts in Rwanda, stakeholders noted that the PHC-PM Activity created space for DHMTs to engage more openly with new actors. Frequently cited areas included collaboration with the agriculture sector, particularly linking malnutrition efforts with initiatives such as Gira Inka⁵ and kitchen gardens to reinforce CHW messaging during home visits, as well as stronger partnerships with faith leaders. Working with pastors and churches was seen as an opportunity to identify newly wedded couples for targeted ANC messaging and to amplify health center messages, while helping to prevent contradictions around sensitive topics such as family

planning. Respondents also highlighted the value of both more systematic engagement with national and district-level leaders, who know their communities well and could strengthen mobilization efforts and greater collaboration with the education sector to amplify health messaging in schools. Less frequently mentioned but still important were partnerships with the private sector to address gaps in equipment and essential medicines. Ultimately, the use of new actors within the sector strengthened ties with existing health care workers, including health center representatives, nurses, and midwives.

District-specific reflections further illustrated these missed opportunities (see Figure 1). In Bugesera, respondents highlighted potential collaboration with the National Women’s Council (CNF) and village-level women leaders to strengthen ANC messaging as well as opportunities for deeper engagement with the Ministry of Health, particularly around social protection themes.

⁵ The “One Cow per Poor Family” program founded in 2006: <https://magazine.mkur.ac.rw/gira-inka-the-cows-that-heal-a-nation/>.

Figure 1. Engagement with external sectors in Rwanda. Findings highlighted agricultural sector partnership as a strong shared opportunity for strengthening PHC performance.

Descriptor Matrix	Codes								
	Collaboration with church/religious leaders	Collaboration with agriculture sector	Involving sector leaders	Private sector	WASH	Collaboration with Ministry of Health	Collaboration with CNF(Head of Women in the village)	Local government structures (e.g. social protection)	Collaboration with education sector
Bugesera	5	4	3	1		1	2		2
Gicumbi	3	5	3	2	2			1	2

In Gicumbi, respondents emphasized the potential benefits of collaborating more closely with the WASH sector and local government structures, particularly where root causes of district health priorities related to sanitation, hygiene, water access, and poverty. One DHMT member explained:

“I think we should have involved the people in charge of water and Gira Inka, because during home visits we observed communities that lack access to clean water or are very poor. If these officials had been involved, we could have identified households that most need a cow or addressed water issues directly. This would also contribute to reducing malnutrition, as lack of water affects hygiene, and poverty limits access to animal-source foods.”

Despite the positive changes reported, participants felt that collaboration with certain ministries – such as Women and Children’s Affairs and Social

Welfare in Ghana – was underutilized, and engagement with private businesses and philanthropists remained minimal (Figure 2). Many believed that more structured and proactive outreach could have attracted additional financial and in-kind support. As one participant from North Tongu reflected, *“If we had done a homecoming or a community event, our people abroad could have contributed more.”* Across both Akwapim South and North Tongu, several missed opportunities were identified. In Akwapim South, there was limited early engagement of community leaders in identifying priority equipment needs, as well as underuse of local government and non-health actors in sustaining outreach services. In North Tongu, traditional and opinion leaders were not consistently involved in data interpretation and planning processes, and there was untapped potential for more systematic collaboration with education, agriculture, and faith actors beyond ad hoc engagements.

Figure 2. Missed opportunities for community engagement in Ghana. Stakeholders in Ghana engaged several sectors to differing levels; While diaspora engagement shows moderate potential in both districts, all other collaboration domains remain emerging opportunities. Formalizing these partnerships within governance structures and district planning cycles will be critical to sustaining PHC gains. These findings are specific to Ghana and not generalizable across countries.

Descriptor Matrix — Missed Opportunities for Future Improvement (Ghana)							
<i>Context: Sustained PHC gains depend on institutionalising community engagement through strong partnerships with local leaders and CHWs, supported by ongoing training, reliable financing, and adequate systems rather than project-based efforts. Recommendations call for embedding engagement within formal governance structures, strengthening multi-sectoral committees, and integrating community engagement indicators into routine DHMT performance monitoring.</i>							
Descriptor Matrix	Codes						
	Collaboration with the diaspora	Collaboration with the private sector & civil society	Collaboration with agriculture sector	Collaboration with Ministry of Women & Gender	Collaboration with Assembly Member / Member of Parliament	Collaboration with Ghana Education Service	Collaboration with youth groups
Akwapim South	2	1	1	1	1	1	1
North Tongu	2	1	0	1	—	1	1
Recommendation note	Diaspora engagement not yet institutionalised	Civil society integration recommended for sustained PHC gains	Multi-sectoral committees recommended at district & sub-district level	Ministry of Women & Gender, formalise multi-sectoral health committees	Assembly Members & MPs; embed in formal governance & budgets	Ghana Education Service; align with district planning cycles	Youth groups; expand through community durbars & WhatsApp platforms

- 2 — Moderate opportunity identified
- 1 — Minor / emerging opportunity identified
- 0 — Not identified
- — — Data not available / not recorded

RECOMMENDATIONS

What do districts suggest for future improvements within community engagement?

Across both countries, sustained PHC gains depended on institutionalizing community engagement through strong partnerships with local leaders and CHWs, supported by ongoing training, reliable financing, and adequate systems rather than short-term initiatives.

In Rwanda, both districts emphasized the importance of sustaining and expanding collaboration with local leaders, particularly given its contribution to improvements in ANC coverage. Respondents stressed that this partnership should not be treated as a one-off strategy to boost

specific indicators, but rather institutionalized as a core component of primary health care delivery. They recommended extending engagement beyond village leaders to include other influential actors such as church leaders, sector secretaries, the National Women’s Council, and school leaders.

Continued training was also highlighted as a priority, especially in light of evolving PHC guidelines and high staff turnover. Training should target a broad group of health professionals, including CHWs, who were widely recognized as central to many of the program’s achievements. In addition, respondents called for sustained advocacy to secure more equipment at health center level, noting that adequate equipment improves efficiency, service quality, and staff motivation. Technological innovation was another forward-looking recommendation, including equipping CHWs with tablets for digital monitoring, providing SMS-based health messaging for pregnant women, and

improving the visualization of echography images to support better clinical decision-making by nurses and midwives.

Collaboration with local leaders and community health workers proved especially critical in driving improvements in ANC attendance and other priority indicators, while outreach and home visits helped address root causes and reach underserved groups.

In Ghana, recommendations focused strongly on institutionalizing and sustaining gains in community engagement. Districts proposed embedding regular community–DHMT review meetings within formal governance structures and budgets, strengthening CHMCs through continuous mentorship and clearer role definitions, and expanding the use of low-cost communication platforms—such as WhatsApp, community information centers, and community durbars—to enhance feedback and accountability. Integrating community engagement indicators into routine DHMT performance monitoring was also seen as critical to maintaining momentum. At the policy and system level, it was recommended that the Ministry of Health and Ghana Health Service provide clearer guidance on sustaining LDP+ practices, including allocating minimal but reliable financing for mobility and supervision. Strengthening and formalizing multi-sectoral health committees at district and sub-district levels, improving community education on NHIS coverage to manage expectations, and aligning engagement processes with district planning and budgeting cycles were also prioritized. Resource mobilization emerged as another key area for action, including developing structured strategies to engage the diaspora, private sector, and civil society—such as through homecoming events and digital platforms—and integrating resource tracking and maintenance into community scorecards to promote transparency. Districts further emphasized

the need to formalize community engagement as a routine component of district and facility planning rather than a project-based activity, involve community leaders upfront in identifying equipment and outreach needs, and strengthen medicine supply planning for community clinics to maintain trust. Key questions will be frequency of these activities due to fuel availability for movement/mobilizations. DHMTs are hoping to see some improvement in revenues with improve internal processes.

AREAS FOR FURTHER LEARNING

Overall, key takeaways across Rwanda and Ghana highlight that structured, consistent community engagement can significantly improve service uptake, trust, and accountability when it is embedded within routine health system functions rather than implemented as a time-bound project. A clear theme across the discussion in both districts was the transformation in the relationship between communities and health teams. The PHC-PM Activity made DHMTs more accessible and responsive. By intentionally engaging community-level stakeholders, PHC-PM ensured that lessons learned reflected lived experiences, local power dynamics, and contextual realities that are often invisible in routine health system reporting. Community leaders are uniquely positioned to observe changes in behavior, trust, and service utilization, making their perspectives essential for understanding both the depth and sustainability of PHC reforms. Assembly members advocated for PHC needs at the district level, ensuring that issues identified through the LDP+ process were reflected in district budgets.

At the same time, several unanswered research questions remain, such as:

- Which private sector actors are best positioned to serve as strategic PHC partners, and how can existing DHMT networks be better leveraged?
- How can government initiatives in WASH, agriculture, and education be more intentionally linked to PHC priorities?
- How does the depth of community involvement influence service uptake and sustainability?
- What is the minimum resource package required to sustain community engagement at scale?
- What are the long-term effects of structured community engagement on PHC service delivery?

Sustaining these gains requires institutionalization within governance structures, reliable minimal financing, strengthened supervision and training amid high staff turnover, and better alignment with district planning and budgeting cycles.

CONCLUSION

Community engagement is most effective when complemented by multi-sectoral collaboration, adequate equipment and medicine supply, and transparent resource mobilization strategies. However, cross-sector collaboration — particularly with agriculture, faith-based, and social welfare sectors — remained underutilized, and context-specific challenges such as resource dependence and NHIS misconceptions in Ghana, and demand outpacing capacity in Rwanda, continued to constrain progress. Sustaining and deepening these gains will require embedding community engagement into routine governance, planning, and budget processes, while ensuring continuous training, supervision, and reliable financing for CHWs, DHMTs, and frontline staff.

Finally, there is a clear need for further research to define the minimum resource package for sustained engagement at scale and to better understand how varying depths of community participation influence long-term maternal and neonatal outcomes.



ABOUT THE ACTIVITY

PHC is the foundation of resilient and equitable health systems. Strong local leadership is essential to ensuring accessible, high-quality care that responds to community needs. In Ghana and Rwanda, national and district health authorities are strengthening health system performance through the PHC-PM Activity, an initiative led by government partners and implemented with local institutions, with support from Gates Foundation and technical partners including MSH. At the heart of the model are four interlinked components, each designed to reinforce district leadership, evidence-based decision-making, and sustained PHC system improvement:

1. Leadership development
2. Operational data & integrated dashboards
3. Ongoing monitoring, evaluation, and learning
4. Catalytic grant funding

Through adaptive performance management cycles, district health authorities continuously analyze, monitor, learn, and adapt—maturing over time into effective stewards of district health systems. The PHC-PM Activity is a collaboration between MSH, Ubor Institute (Ghana), Building Systems for Health (Rwanda), Three Stones International (Rwanda), HISP Ghana, Zenysis, and district and national health authorities.

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