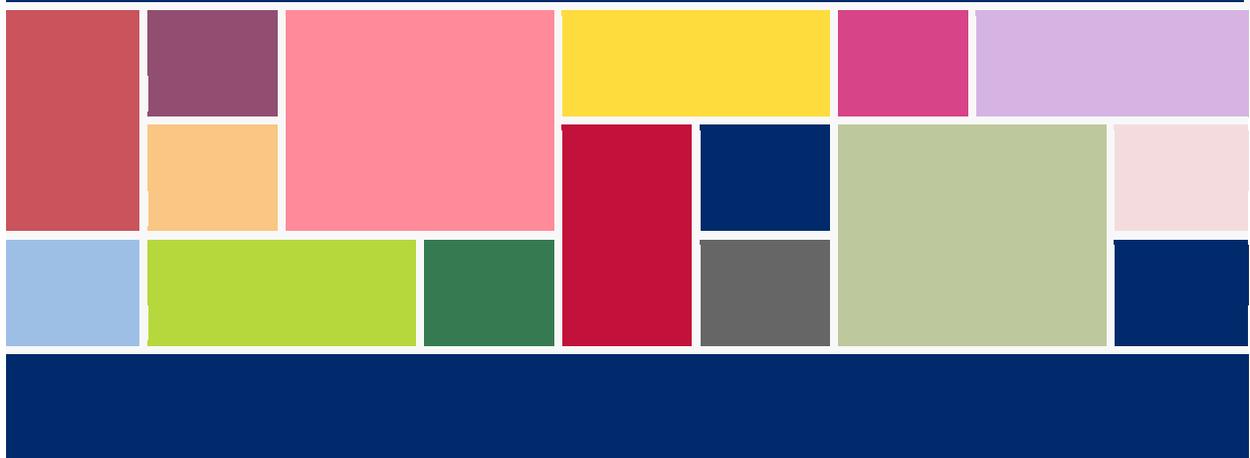




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Strategies to Strengthen Community Maternal, Newborn and Child Health: Findings from a Cohort of Child Survival and Health Grants Ending in 2014



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Introduction

“Leveraging USAID’s expertise, the United States Government (USG) has invested over \$15 billion since 2009 in a series of innovative measures designed to accelerate reductions in mortality rates, working closely with countries and partners. To date, the commitment has helped spare the lives of 2.4 million children and 200,000 mothers in two dozen countries with high mortality rates.”¹

This statement from the recently released *Acting on the Call: Report to End Maternal and Child Health (2015)* serves as a progress report on commitments made in 2012 at the Child Survival Call to Action. At that time, a new global goal was crafted to end preventable child deaths within a generation and then expanded to include maternal mortality. A Promise Renewed is a movement based on a shared responsibility and has mobilized and brought together more than 178 governments and hundreds of civil society and faith-based organizations who have signed a pledge vowing to do everything possible to end preventable child and maternal deaths.

USAID is focused on 24 priority countries for maternal and child health that together account for 70 percent of all the child and maternal deaths. As the Millennium Development Goals give way to the Sustainable Development Goals, USAID has released the 2015 *Acting on the Call Report* to demonstrate progress, contribute to accountability, and make a recommitment to investing in what is needed to meet the ambitious targets. Investing in partnerships between governments, civil society, and the private sector to strengthen community health is a priority, as underscored by a growing evidence base and country success stories².

This strategic focus builds on decades of remarkable progress. Through USAID’s Child Survival and Health Grants Program (CSHGP, 1985 to present), USAID’s investment has helped accelerate reductions in maternal, newborn, and child mortality in the countries with the greatest need. For more than two decades, this partnership has evolved to address shifting global and national policies and strategies and has strengthened the capacity of U.S. private voluntary organizations, governments, and civil society in 65 countries to deliver results and save the lives of millions of children, newborns, and women in the most marginalized and underserved communities. From 2008 to 2012, USAID invested in 30 partnerships with 19 international nongovernmental organizations (INGOs) in 23 countries to build evidence for innovative community-oriented approaches to strengthen health policies and programs for women and children.³ Community-oriented approaches developed and tested by INGOs through the CSHGP have been shown to accelerate reductions in child mortality by improving behaviors in households and communities.⁴

A set of reforms, called USAID Forward, was developed in 2010 to strengthen the work of USAID and its partners. Innovation and research are among the principles of USAID Forward, and building on a strong implementation science platform USAID formally introduced Operations Research (OR) within the CSHGP

¹ *Acting on the Call: Ending Preventable Child and Maternal Deaths*. USAID Global Health Bureau, Washington, DC, June 2015, page 6.

² *Acting on the Call: Ending Preventable Child and Maternal Deaths*. USAID Global Health Bureau, Washington, DC, June 2015, pages 60-61.

³ *Operations Research for Accelerating Results toward Ending Preventable Child and Maternal Deaths: Testing 30 Innovative Community and Health System Solutions in Underserved, Vulnerable Populations across 23 Countries*. Maternal and Child Health Integrated Program. See http://pdf.usaid.gov/pdf_docs/pa00js5s.pdf.

⁴ Ricca, Jim, et al., “Community-based intervention packages facilitated by NGOs demonstrate plausible evidence for child mortality impact,” *Health Policy and Planning* 2013; 1–13. See <http://heapol.oxfordjournals.org/content/early/2013/02/22/heapol.czt005.full>.

projects. CSHGP's strategic direction, which integrated research in local capacity building and implementation platforms, reinforced the roles of INGOs as influencers and collaborators with local actors, capable of bridging the persisting gap between implementation and policy in local and national systems—particularly for testing and scaling up community health approaches.

The CSHGP has provided flexibility to enable INGOs to collaborate with local and national ministry of health counterparts and a range of civil society actors to define priorities and develop solutions that address in-country needs. This paper is among the different knowledge products such as evaluation briefs, OR, and learning briefs generated for the portfolio (2008 to 2012) and is an effort to examine common learning themes focusing on community health across projects with final evaluations in 2014.

Crosscutting Learning Themes

The cohort of 10 grants ending in 2014⁵ provided an opportunity to evaluate individual and collective experiences in creating strategies, partners, and structures to promote maternal and child survival and health. In mid-2014, consultations with USAID, the grantees, and their evaluators identified crosscutting learning themes around which collective experiences could be organized from the final evaluations. The figure on the next page illustrates the conceptual framework for the evaluations, with crosscutting themes reflecting CSHGP priorities as the foundation. Each theme encompasses different strategies the grantees applied in their CSHGP grants. Grantees received support to strengthen their theories of change in light of the crosscutting themes, and the evaluators received guidance on incorporating specific themes into data collection and analysis.⁶

The final evaluations were designed not to test specific strategies, but to assess the overall outcomes and learning from the grants. Despite the geographic and thematic variety, a number of promising approaches emerge in a review of these projects, particularly around the following two crosscutting themes:

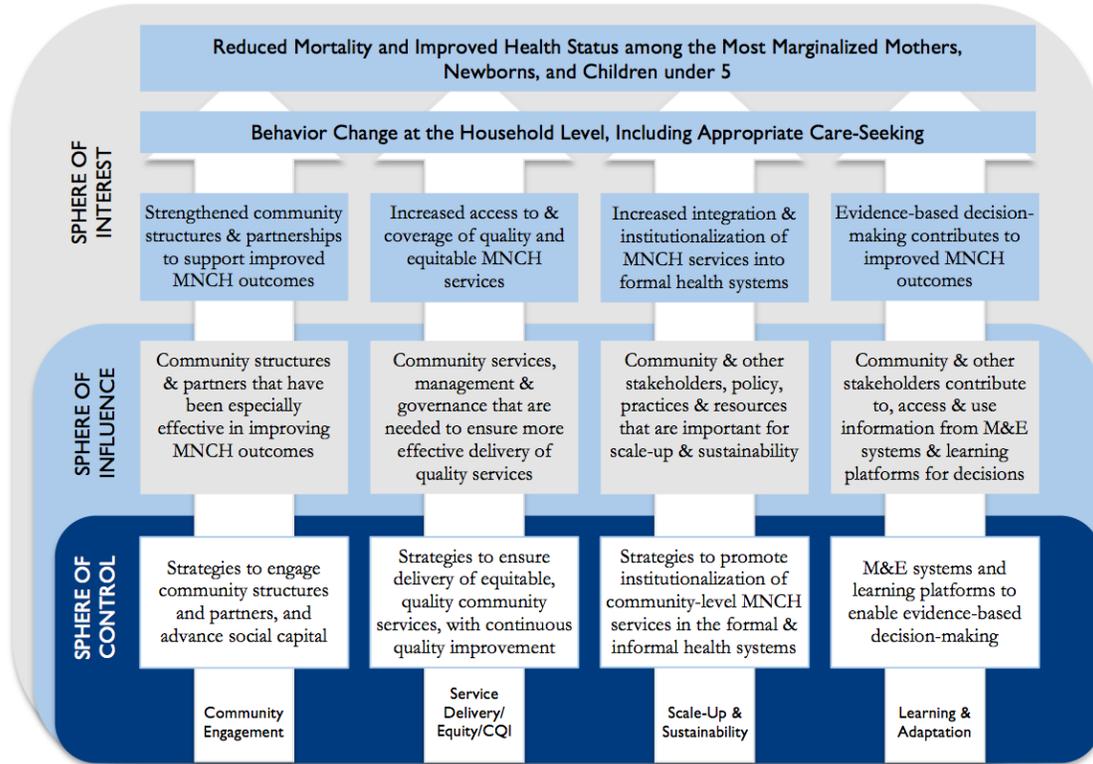
- **Community engagement:** Strategies to engage community structures and partners that have been especially effective in improving MNCH outcomes
- **Community-based service delivery, equity, and continuous quality improvement (CQI):** Services, management, and governance that help increase access to and coverage of high-quality, equitable maternal, newborn, and child health (MNCH) services

⁵ Due to changes in grant length, 2014 marked the end date for four Child Survival XXV and seven Child Survival XXVI grants. Grants in Bangladesh, Benin, Cambodia, Indonesia, Niger, Peru, Rwanda, South Sudan, and Zambia sought to improve coverage, quality of care, and demand for community-based MNCH services. The grant in Mozambique addressed tuberculosis. The eleventh grant in Liberia is not included, as its final evaluation did not take place due to Ebola.

⁶ Despite efforts to incorporate the four crosscutting themes into evaluations for this cohort, evaluation preparation was already well underway for some grants, and USAID did not require grantees to participate in this process.

Conceptual Framework for Crosscutting Learning Themes

What strategies have been most effective in achieving community-level impact?



Methods and Limitations

Information in this paper is derived from the final evaluation reports from 10 grants, which include findings from baseline and endline knowledge, practice, and coverage surveys; OR reports; qualitative data collected by the evaluation team; and other relevant information. The final reports were coded around the crosscutting themes in Dedoose (an online tool for qualitative data analysis), and each theme was examined to determine whether there was adequate information on strategies and results.

The extent to which evaluators specifically focused on the crosscutting themes in data collection and reporting varied considerably, as did the quality of the final reports. Final evaluation documents generally contained some information on the grantees' strategies or approaches, and all evaluations included findings from the endline knowledge, practice, and coverage surveys. However, information was not always available on the intermediate results that explain the pathway between the grantee's strategy and any changes in caretaker behavior or coverage. Few final evaluations highlighted specific strategies toward the crosscutting themes of **scale-up and sustainability** and **learning and adaptation**.⁷ Projects may have addressed some of these aspects, but there was not sufficient information in the reports. Therefore, learning gleaned for this paper, limited to the actual content of the project evaluations, focuses on community engagement and community-based service delivery.

It should be noted that the seven strategies highlighted in this paper are probably not the only strategies of interest in these crosscutting themes, but they are the strategies for which sufficient information could be pulled from the final evaluation reports.

⁷ The theme of "scale-up and sustainability" reflects strategies, policies, partnerships, practices, and resources that promote institutionalization, scale-up, and sustainability of community-level MNCH services in the formal health system; "learning and adaptation" reflects monitoring and evaluation systems and learning platforms that enable evidence-based decision-making by community groups and other stakeholders.

Crosscutting Theme I: Community Engagement

Four strategies from the CSHGP projects' final evaluations stand out as promising approaches for empowering communities in managing health care. Although the contexts varied widely—spanning not only the globe, but also a range of methods and challenges—each case provides insight for strengthening the community's role, particularly in how to organize and how to increase accountability for care provided at the community level. Strategies range from building permanent community structures to strengthening links with the wider health system to creating modalities for engaging community-based workers and those they serve for improved quality of care.

Promising Community Engagement Models

- Bangladesh: People's Institutions
- Benin: Quality Improvement Collaboratives
- Peru: "Sectorization" Strategy
- Zambia: Community Action Cycle

The following sections offer examples of grantee strategies in Bangladesh, Benin, Peru, and Zambia.

Building Independent, Self-Sustaining Health Care Organizations in Bangladesh

When World Renew began the Healthy Child and Mother (SUSOMA) project in 2009, it brought substantial experience in using the "People's Institution" model for community engagement. This model helps poor communities form community-based organizations that collaborate with the informal health care system (village doctors and community volunteers) and the public health sector (clinics) to provide a package of evidence-based interventions. The model, which World Renew developed to reflect to governance structures in Bangladesh, represents a promising public-private partnerships approach for improved health service delivery at the community level.

The People's Institution is a community-based organization composed of smaller committees and village-level groups that work to improve MNCH at the community level. The aims are to: help empower the poorest and most marginalized community members; mobilize local financial and human resources for health; motivate communities to advocate for policy change; and strengthen community-facility links to improve quality, availability, and access to services. The model has a three-tiered structure aligned with administrative structures in Bangladesh: village-level women's and men's "primary groups," central cooperative committees that support groups of villages, and the People's Institutions at the sub-district (*upazila*) level. People's Institutions are also encouraged to establish emergency health funds (described under the findings for Theme 2) through savings and income-generating projects to further support community members in accessing MNCH services.

Promising Results for Scale-Up and Sustainability

All four People's Institutions established with SUSOMA project support are now registered as independent NGOs with the Social Welfare Department of Bangladesh. This makes them eligible for government loans for social welfare programs; it also means that poor pregnant women and widows can receive government allowances through the People's Institutions.

World Renew is continuing its partnership with SUSOMA's two main local partners, the NGOs SATHI and PARI, to build on the People's Institution structures. Applying the strengthened capacity they gained as SUSOMA partners, SATHI and PARI are continuing to advocate independently with the government for ongoing support of the People's Institutions.

SUSOMA used the People’s Institution model to improve MNCH outcomes in Netrokona District in central Bangladesh, a rural area with a population of about 530,000 and high levels of poverty and maternal and neonatal mortality. In the first two years, community health trainers employed by the project worked to build the capacity of the primary groups, cooperative committees, and People’s Institutions. Initially, trainers went from household to household to build awareness and engage women in forming primary groups to address maternal and newborn health concerns. They trained and supported primary group members to work together to solve problems, claim their rights, and track improvements. In turn, the primary groups selected community health volunteers and trained traditional birth attendants to promote maternal and newborn health in their villages. Training topics included leadership and management, recordkeeping, gender considerations, local resource mobilization, audit preparation and response, advocacy, monitoring and evaluation, and capacity measurement. Through a training-of-trainers strategy, more than 40,000 community members received People’s Institution-related training.

Once established, each primary group selected two representatives for the cooperative committee, which in turn provided six representatives for the People’s Institution. Under each People’s Institution, one sub-team was responsible for overseeing local MNCH services. In the two *upazilas* covered by the project, 22 cooperative committees and four People’s Institutions were established with support from SUSOMA and the community trainers. The addition of male primary groups in 2012 further enhanced MNCH promotion by encouraging mixed-gender leadership. By the end of the project, there were 541 primary groups—at least one in each of the project’s 494 villages. Of these, 42 percent were functioning at a high level (independently), 38 percent at an intermediate level of development, and the remainder (20 percent) were emerging. Project staff developed criteria to assess functionality. To be rated as independent, a primary group had to (among other criteria) hold regular meetings and keep up-to-date records without SUSOMA’s help, have a significant amount in a health savings fund, and have trained traditional birth attendants and community health volunteers active in the community.

“In *upazila* and district level we are respected ... our information helps government ... in [a] district level meeting the community health trainer represented us. She told us that our information influence government decision.”

— *Primary group member, Kendua*

Operations research in the project area indicated that the People’s Institution model was crucial for increasing the social capital of marginalized people, including poor women of reproductive age (15 to 49 years). The project areas saw significant increases in key MNCH behaviors, as documented by the knowledge, practice, and coverage surveys. Through the People’s Institutions, the project created a new cadre of grassroots leaders, increased communication and networking between and among government and People’s Institution leaders, and increased understanding of and access to government and private sector health and social services. People’s Institution members had higher levels of solidarity, trust, and cooperation than non-members, and stated that they were more confident in conflict resolution.

Forging Community-Level Partnerships for Child Survival in Benin

In Benin, community health workers are seen as an essential part of the health system, and provide access to essential services at the community level. Yet, enabling and motivating them to perform at a high level and stay in their positions are long-standing challenges. In 2010, the Benin Ministry of Health had initiated an incentives policy that provides the equivalent of \$20 per quarter to each community health worker, with up to \$10 more for performance on specific indicators.

To help address the challenges of retention and motivation, the Center for Health Services (CHS) adapted a proven model for improving quality of care to the community setting through the Partnership for Community Child Survival (PRISE-C). The project's central strategy was the creation of community-level quality improvement (QI) collaboratives across targeted communities. This approach, which CHS adapted from a model it has implemented mainly in health care facility settings in Benin and elsewhere, is designed to foster testing of solutions and learning from others for more rapid improvements and scale-up of high-quality health services.

Each PRISE-C-supported collaborative focused its activities around prioritized community-based preventive services (including hygiene), neonatal health, infant and young child nutrition, and community case management of illness. The collaboratives worked on improving community health worker performance related to these interventions, while furthering retention. PRISE-C staff conducted formative research to identify appropriate QI team members and then helped communities form QI teams, composed of community health workers and village stakeholders. Each village had an 8- to 10-member team that received five days of training on QI methodology from PRISE-C staff. The QI teams were then tasked with improving performance on specific child health indicators for their target areas.

The QI collaboratives approach provided a structure for community members and community health workers to meet monthly to chart their performance on key indicators based on community health worker registers and identify strategies to improve areas of low performance. The QI teams then implemented the strategies in their communities, sending representatives to share data and strategies at quarterly learning sessions with the larger collaborative (four were created across the project area). Sharing included both strategies with demonstrated impact and those showing less impact. Graphs of each team's performance were posted at the health center to encourage transparency and accountability with the community. To build capacity, supervisors and community health workers, selected for their ability to achieve results and mentor others, conducted quarterly coaching visits with community health workers and the QI teams.

The quarterly learning sessions accelerated uptake of effective improvements and, according to interview data, the QI teams fostered a new kind of engagement for the community. As opposed to simply discussing community health activities once a year as a part of

Adapting a Facility-Based Model to Improve Community-Based Quality of Care

Since 1998, URC-CHS has implemented more than 100 improvement collaboratives, with USAID support, to solve a wide variety of health care challenges. At the facility level, the model involves forming QI teams from different clinics, hospitals, and levels of the health system and supporting them to work together to improve specific aspects of the system. The teams share experiences as they test improvements. Higher-level health authorities can then spread successful changes on a wider scale.

PRISE-C took this facility-based model into the community setting in Benin. QI teams, comprising community health workers and a broad spectrum of village stakeholders, identified improvement strategies and tracked performance on specific child health indicators, and QI teams came together periodically to share learning. The community-level collaboratives generated significant improvements on some key indicators, including breastfeeding and antenatal care. Community health workers in the project areas performed better than their counterparts in other areas.

“These group meetings...help me perfect my work, since others show what they did in the other villages and I can take what worked well, and correct what didn't work well and use it in my village. This is what contributes to change and improvement.”

— *Community health worker participating in the QI collaborative*

annual work planning—as is generally the case with the village health committees—the team’s monthly meetings enabled community health workers and village leaders to decide how to improve based on analysis of specific indicators. QI team members expressed feelings of responsibility for their communities’ health status and provided instrumental support to the community health workers. This support was guided by discussions during supervisors’ coaching visits, which allowed for facilitated identification of problems and improvements that the QI teams and community health workers could undertake.

The project evaluation looked at the QI collaboratives zone and a comparison zone without collaboratives. Operations research findings showed a significant difference in mean community health worker performance (measured by knowledge, practice, coverage, and community health worker referrals) between the intervention group and the comparison group for 10 of the 12 performance outcomes. Community health workers whose communities participated in the QI collaborative were more than 11 times more likely to achieve a performance score higher than 50 percent, compared to those who received only financial incentives.⁸

Results included increased coverage for treatment of fever and diarrhea, breastfeeding, and antenatal care. The project evaluation noted the need for consistent supervision of collaborative activities to maintain this level of performance. Overall, findings indicate that the QI collaborative is a promising strategy to improve community health worker performance, when combined with Benin’s current financial incentive scheme. Benin’s National Department of Public Health is examining how to scale up the community engagement aspects of the community QI collaborative.

Extending the Reach of Health Services for Mothers, Infants, and Children in Rural Peru

When Future Generations launched the Health in Hands of Women project in 2010 in four remote and rural Andean districts in Peru, people in the target area had poor access to safe water, sanitation, and electricity, and poor MNCH outcomes. The area saw high turnover among health workers, low involvement of health facilities with communities due to lack of incentives, time, and distance, and therefore little health promotion among the population.

Communities in the region had little experience in managing health service delivery or health promotion.

Peru’s Ministry of Health has promoted a policy of “sectorization”—which organizes primary health facilities to carry out community outreach targeting the poorest and most-at-risk community members—but it had not yet defined operational mechanisms to implement the policy.

Adapting a Government-Championed Policy for Scalable MNCH Gains

Sectorization makes individual health workers responsible for meeting the health needs of one or more specific communities, while strengthening community health planning and health promotion. By the end of the Health in the Hands of Women project, community management of health facilities had increased from 41 percent to 70 percent. Although the region still faces important challenges, such as staff turnover at health facilities, sectorization has strengthened links between communities and municipalities, demonstrated in part through increased municipal funding for community facilitators. Another promising development is a permanent regional capacity-building center focused on scaling up health promotion across the region.

⁸ The final evaluation report does not compare per diem/travel with the routine financial incentives, so it is not possible to state whether this would have been an additional financial motivator. However, per diem/travel amounts were small compared with the financial incentives.

Building on the sectorization policy—and successful components of pilot projects in primary health care from the last decade in Peru—Future Generations worked with local partners to draft a strategy to strengthen links between communities, health facilities, and municipalities to improve maternal and newborn care, infant and young child feeding, and control of diarrheal disease. The strategy incorporated community priorities through a local planning process and coordination with municipal institutions to fund community facilitators to supervise the work of “women leaders” (female community health workers). This strategy thus created links between the “sectorists” (facility-based health workers) and the communities. The strategy also expanded the sectorists’ role, making them responsible for providing community facilitators and women leaders with training in primary health promotion.

The project trained and supported 42 community facilitators, 779 women leaders, and 96 “tutors” (drawn from health personnel) to test an empowerment-based participatory teaching methodology called “Sharing Histories.”⁹ Women leaders were responsible for doing monthly home visits to pregnant women and mothers of children under 2 years in their neighborhood. The threefold purpose of these home visits was to educate mothers on key practices, monitor them and their children for key behaviors and use of preventive health services, and observe them for danger signs for referral to a health facility. Each women leader was responsible for a group of about 30 households, responsible for about five pregnant women and children under age 2. The project provided tools to help the women leaders teach mothers (a set of seven flipcharts) and a set of forms to monitor and refer her target groups and report to health facilities and municipalities.

Community facilitators, selected in a local competition, were typically older community health workers with five or more years of experience. Each community facilitator was responsible for 20 women leaders. Their roles included: ensuring that women leaders attended monthly training sessions at the health center; reinforcing the monthly training topic with smaller groups of women leaders in decentralized community meetings, based on the Care Group approach; and jointly conducting home visits until each woman leader gained confidence to visit on her own. Community facilitators also attended the monthly training in the health facility. For this work, they received a half-time stipend from the municipality. By the end of the project, there were 129 active Care Groups of women leaders led by community facilitators, surpassing the target of 93 groups.

These community-based partners helped pregnant women and mothers of children under 2 years (considered “at-risk community members”) to improve their health knowledge and practices and ensure they were fully connected to the services of the project area’s 26 primary health care centers, which served 180 communities and 93,000 inhabitants in four districts. By the end of the project, the facility-based tutors and sectorists, community authorities, and municipalities articulated the critical role of community facilitators (all 42 are now contracted directly by the municipalities) and women leaders in improving community health. Municipalities have increased support in a number of ways: funding stipends for community facilitators, financing training, and contracting health personnel; constructing and renovating infrastructure and providing equipment; and helping fund transportation for health personnel supervision in the communities. The strategy may expand nationwide if the Ministry of Economics and Finance decides to promote community facilitator financing through a Municipal Incentive Program.

In a move toward sustainability, the Huánuco Regional Ministry of Health established a permanent Center for Development of Competencies in Health Promotion in the Acomayo Health Center. The goal of the

⁹An embedded OR project testing the innovative “Sharing Histories” using a cluster-randomized control trial to compare results on maternal knowledge and practice and child growth in project areas. In the intervention group, the women leaders and community facilitators were trained using the Sharing Histories approach. In the control group, the standard training method had been used. Results showed a significant reduction in chronic child malnutrition in children 0 to 23 months living in intervention jurisdictions as compared to those living in control areas.

center is to sustain the new approach to community health promotion by guaranteeing the ongoing training of trainers (the tutors) for continuous support of community facilitators and women leaders on a wider scale. In addition, the Regional Government of Huánuco established Regional Ordinance No. 903-2014-CR-GRH, declaring the sectorization strategy as an official policy for Huánuco, to be scaled up to every primary health facility in the region (about 400 facilities). The Sectorization Guide developed by the project and validated by the regional Ministry of Health is cited as the primary document for implementation, and is being promoted as a national guide for sectorization.

Peru's sectorization policy still faces implementation challenges, including high turnover among health personnel and rural primary health care facilities and sustaining funding for community facilitators' contracts. Regular lobbying of local governments during the annual budgeting process will need to continue to sustain funding for the community facilitators' stipends, unless the Ministry of Economy and Finance makes it an obligation to fund the stipends through a Municipal Incentive Program. It will also help increase women's influence and membership in the community management associations, which tend to be dominated by men, to increase their focus on MNCH.

“The communities accept us better. They [community facilitators and women leaders] speak their language.”

— A “sectorist” reflects on the value of collaboration with community facilitators and women leaders

Overall evaluation findings offer strong evidence that providing health education to mothers through home visits and through innovative community health worker methodologies significantly improves mothers' health-related knowledge and behaviors. The results indicate that behavioral changes in mothers can be gained through a well-organized educational program in the home.

Fostering Collective Action to Achieve Health Outcomes in Zambia

When Save the Children began the Lufwanyama Integrated Neonatal and Child Health (LINCHPIN) project in 2009, access to services in the project area was limited by a lack of trained staff, poor communication infrastructure, limited roads with seasonal impassability, and lack of transportation in general. Most peripheral health facilities were extremely understaffed, and retention of trained health workers was a reported problem at many facilities. In this context, a high proportion of basic health services were provided by minimally trained community-based health workers, traditional birth attendants, and family planning distributors.

To address these issues, LINCHPIN worked to build the capacity of the Neighborhood Health Committee, a structure that existed before the project began and is found throughout Zambia, whose role is to support community-based agents, promote behavior change, and link the community to its health facility.¹⁰ Each committee serves up to 1,000 people, and 118 of these committees are active in LINCHPIN's target district. Each health facility links with 8 to 11 Neighborhood Health Committees. The LINCHPIN team knew that involving this existing and respected structure would be central to improving any community demand needed to drive improvements in health service quality, access, and availability. Consequently, the project aimed to further empower the committees and the communities they served to make informed decisions about MNCH, develop and implement local improvement plans, and strengthen or develop community-based

¹⁰ Kalesha P., “Overview of Community IMCI in Zambia,” Sub-regional Conference on Community-Based Child Health Interventions, Lusaka, Zambia, May 3, 2007.

referral systems to enable better responses to obstetric, newborn, and child health emergencies. This laid the groundwork for one of the project’s primary strategies (discussed in detail under Theme 2): teaming community health workers and traditional birth attendants to bridge gaps in infant and child health care.

To encourage collaborative, community-level action planning and mobilize communities to take a stronger role in MNCH, the project trained Neighborhood Health Committee members to use the Community Action Cycle. The approach uses participatory methods to build capacity for informed decision-making about MNCH and action planning to address gaps, improve referral practices, and support community health workers and trained traditional birth attendants. By the end of LINCHPIN, all 118 Neighborhood Health Committees had action plans in place, and 73 percent had raised funds to implement their plans. Nearly one-quarter of the committees had a female chairperson.

The Community Action Cycle

The Community Action Cycle has seven phases:

- Preparing to mobilize
- Getting organized
- Exploring the MNHC issue and setting priorities
- Planning together
- Acting together
- Evaluating together
- Preparing to scale up

The project used a “cascade” training methodology to train the environmental health officer at the health facilities, who then trained members of the 8 to 11 Neighborhood Health Committees in the health facility catchment areas. LINCHPIN also employed community mobilizers to work with the District Health Management Team (another part of Zambia’s formal health system) to train and mentor Neighborhood Health Committee members. Mobilizers received salaries, motorbikes, and fuel for site visits, and were responsible for ongoing oversight and support during the mobilization and action planning process. The committees received training, regular supervisory visits, and links with partners that could support local projects. To promote sustainability, the project formed partnerships with Save the Children Korea (for infrastructure development), the Swedish International Development Agency (for capacity building in financial management and governance), and Rotary International (for bed net procurement and distribution).

Overall evaluation findings indicate that community action planning and the resulting links with partners for funding have resulted in improved community-level structures for MNCH. With LINCHPIN support, Lufwanyama was among the first 11 districts to roll out Integrated Community Case Management under the national strategy. Neighborhood Health Committees have improved the availability of transportation for referrals (for example, through the provision of a district ambulance and bicycles for community health workers). Availability of referral services also improved following the rehabilitation of 14 primary health care units. These changes represent examples of successful leveraging for improvements in the availability of health services as a result of Community Action Planning. To sustain their success, Neighborhood Health Committees need continued attention and support. Therefore, a strong commitment to community capacity building is needed from the Ministry of Community Development, Mother and Child Health and other partners. Local staff will need skills to continue mentoring and support, and ongoing financial and human resources will be required from the ministry in the long term.

Crosscutting Theme 2: Community-Based Service Delivery

As with Theme 1, several strategies from the project evaluations stand out as promising models for organizing, delivering, and sustaining MNCH services that emphasize equity and quality of care. This section takes another look at the People’s Institution project in Bangladesh and LINCHPIN in Zambia through the lens of service delivery, and explores two service delivery interventions in Cambodia. Each case offers insight for programs that are seeking to foster community-run health service delivery and health promotion or organize and incentivize community health workers to deliver critical health interventions.

Promising Service Delivery Strategies

- **Bangladesh:** Community-Run Referral Systems and Emergency Health Funds
- **Cambodia:** Hearth Approach and Fathers’ Groups
- **Zambia:** Teaming Community-Based Health

Enabling Access with Community-Run Referrals and Emergency Funds in Bangladesh

The People’s Institution model described in detail under Theme 1 was instrumental in engaging and strengthening communities to organize around improving health outcomes for the poorest people. Two specific approaches related to improving access to and use of health services were a referral system and an emergency health services fund.

Community-Managed Funding and Referrals

SUSOMA successfully encouraged communities to establish no-interest financing schemes that give poor women the ability to pay for emergency health services when they need them. This approach, coupled with the project’s work to strengthen collaboration on referrals to health facilities, has helped expand access to MNCH services in one vulnerable district.

The People’s Institution established a referral system, run collaboratively with health facilities and government officials, in which poor mothers with referral slips were prioritized at health facilities. Community- and facility-based providers trained in the referral system met monthly at family welfare centers (union level) and community clinics (ward level) to synchronize referral follow-up and plan care, and the People’s Institutions ensured coordination and follow-up.

Stakeholders across the spectrum perceived the referral system as well-established and respected, and reported that patients with referral slips were prioritized. Community health volunteers, trained traditional birth attendants, and People’s Institution leaders made 5,156 referrals for antenatal care, delivery, postnatal care, and illness/emergency care through this system, consulting by cellphone with health providers and often accompanying pregnant women and mothers of newborns for emergency care. Eighty percent of sampled facilities reported receiving referrals by the endline, compared with 37 percent at baseline—a 116 percent increase.

“Isn’t it good if we spend for our mothers and children when they will need emergency health care! Suppose the mother needs to deliver in the hospital, then we should take her immediately. This is our main [responsibility].”

— *Primary group member, Kendua*

Another strategy to enhance access and use was the establishment of emergency health funds through community savings and income-generating projects, under the auspices of the People’s Institutions.

Community members could draw on the emergency fund or interest-free loans to finance treatment for mothers and children. Open to the entire community, the emergency fund was managed by a health fund management committee with five members: three from People’s Institution health sub-team, the People’s Institution chairperson, and one community health volunteer. At the time of the project evaluation, 2,400 women had used this fund to access financing for health services, about 4.7 percent of the pregnant women and newborns identified in project-served *upazilas*.

Over the course of the SUSOMA project, the availability of weekly antenatal care services at health facilities, which had not been consistently available on a weekly basis, increased from 60 percent to 90 percent. In addition, 24/7 delivery services increased from 3 percent to 17 percent, and significant improvements in coverage for some interventions have been seen since the baseline.

Engaging the Whole Family to Improve Nutrition in Cambodia

From 2010 to 2014, International Relief and Development (IRD) worked through the Evidence-based Interventions for Evidence-based Interventions for Improved Nutrition to Reinforce Infant, Child and Maternal Health (ENRICH) project to reduce infant, child, and maternal mortality in Boribo Operational District in central Cambodia, a region with high rates of infant and under-5 mortality, and acute malnutrition. The project implemented a multi-behavior change communication strategy focusing on improving infant and young child nutrition, using communal events and group and individual counseling to engage the whole family and the wider community in positive behaviors for improved MNCH and nutrition.

A Family-Centered Approach to Child Nutrition

ENRICH approached infant and child nutrition as a family- and community-centered issue, engaging fathers and other caretakers as well as mothers, with results that surpassed expected targets for several indicators. As a result of project-supported fathers’ groups, nearly all of the targeted families reported increased engagement by fathers in child care practices. With the “hearth” approach to nutrition rehabilitation, which brought mothers together to share their techniques for nutrition, nearly 200 malnourished children achieved healthy weight. The hearth approach is now a standard, community-led practice for all children, not just those who are malnourished.

As part of its family-focused behavior change communication strategy, the ENRICH team mobilized and educated fathers to increase their involvement in child care and feeding. Beginning with formative research with fathers to understand their needs and motivations, the project structured health-related messages for fathers that were congruent with those motivations and needs. The men formed 323 “fathers’ groups” throughout the target area, with more than 2,400 fathers participating and more than 2,700 attending in the events, surpassing project targets by 139 percent and 200 percent, respectively. At the project baseline, for 51 percent of children under 3 (0 to 35 months), male relatives participated in feeding, bathing, and “watching over”; by project end, 94 percent of women surveyed reported that their male relatives did these activities. Beyond the numbers, women and men reported in focus group discussions that fathers had given up smoking around children and spouses and reduced their alcohol consumption. In addition, there was a notable decrease in domestic violence reported in the last two years of the project.

To rehabilitate malnourished children, ENRICH used the “Positive Deviance” Hearth Approach, which involves identifying positive deviants—those providing uncommon, but beneficial practices—among mothers or caretakers of well-nourished children from impoverished families, and shared these practices and behaviors with community members who had malnourished children. The “hearth” is a community space where nutrition education and rehabilitation took place. Caretakers and volunteers learned to prepare “positive deviant” foods based on those made by the mothers of well-nourished children. Children in the 40 target villages were weighed and monitored frequently to assess their growth, and were given extra care if needed.

The project focused on food diversity—ensuring the child was fed the minimum number of food groups (three for breastfed children 6 to 23 months and four for non-breastfed children). Widely available local porridge was used and enriched by foods from all food groups. The project also promoted active feeding by a mother or caregiver and feeding solid/semi-solid food a minimum number of times each day (twice for children 6 to 8 months and three times for those 9 to 23 months).

Seven rounds of hearth feeding occurred with project supervision, with rounds occurring every two months. ENRICH supplied food and support for only the first two rounds, with participants providing all major foods for the subsequent rounds (locally available porridge, vegetables, oil, fruits, fish, eggs, etc.). Participants also provided firewood for cooking. For all seven rounds, the project supervised growth monitoring, and provided a per-child stipend to cover vegetable oil, peanuts, some basic cooking ingredients, and micronutrient

supplementation and health promotion. The project team also promoted the use of local porridge enriched regularly by foods from all food groups, and promoted the incorporation of the “positive deviant” behaviors.

“Maybe we should have a positive deviant inquiry process to identify good fathers for us to follow.”

— *A father reflects on the value of the Positive Deviance approach in encouraging nutrition among mothers*

Of the 372 children enrolled in hearth in the first round, 310 had moderate malnutrition and 62 had severe malnutrition. By the seventh round, 72.5 percent of those with moderate malnutrition had improved their nutrition status, and 85.5 percent of those with severe malnutrition had improved their nutritional state. Children “graduated” from the feeding rounds when their weight increased by at least 20 percent and passed from severe to moderate or moderate to mild malnutrition (or better). Because some children still had poor nutrition status after round 7, the project added an eighth feeding round, bringing the total number of graduates to 199. The few children who did not increase their weight over any two rounds were referred to local health centers for follow-up. The eighth round was also possible because community members provided most of the inputs for the hearth, generating sufficient savings in the program to cover the cost of the additional round.

In a step toward scale-up and sustainability, mothers in the project-supported villages decided that hearth feeding should not be limited to malnourished children, but should include all children. In 2013 and 2014, the hearth sessions were being led entirely by village health volunteers or other members of the community. At this point, community participants were providing all of the inputs/ingredients without project support. Importantly, after the eight project-supported hearth rounds, mothers continued to meet in small groups to undertake group feeding. In focus group discussions, mothers in hearth villages said the group feedings would continue after the project ended, because they now held them as a regular practice.

Findings from the project evaluation indicate that ENRICH contributed to significant change in some nutritional status measures of children under 5 at the household level, and that community-level changes in health-related behavior have been established for the medium to longer term.

However, outside encouragement and facilitation, most likely from local Ministry of Health partners, will be needed to maintain systems for supervision and education. In particular, the evaluation noted a need to disseminate the evidence on specific behavior change communication and mobilization approaches.

Teaming for Better Neonatal and Child Health in Rural Zambia

Complementing the Community Action Planning approach described under Theme 1, Save the Children developed and evaluated a “teaming” intervention to provide continuity of selected services for pregnant women and children under 5 (0 to 59 months) under the LINCHPIN project. In rural areas like Lufwanyama, where access to any health facility is often limited, traditional birth attendants typically provide care in the early newborn period (0 to 2 months), and community health workers typically provide care in infancy and childhood beginning when the infant reaches 2 months of age. These community workers—all volunteers—often work in proximity, but rarely coordinate their activities. This has repercussions in the form of poor continuity of care and lack of follow-up in rural Zambia, where many people rely on the volunteers for basic health services. The teaming approach sought to bridge this gap, with support from the Neighborhood Health Committees, whose members were trained in community mobilization for MNCH to support the teams.

The Teaming Approach

By encouraging volunteer health providers to work together in a rural area where residents have limited access to health facilities, the LINCHPIN project supported a collaborative approach to MNCH. This pilot project teamed community health workers and traditional birth attendants, showing measurable improvements in malaria treatment and care-seeking behavior related to other important MNCH issues.

To implement the approach, LINCHPIN conducted formative research to identify characteristics of effective community teams, and then trained community health worker/traditional birth attendant teams to collaborate in the following ways:

- Joint two-week, six-week, and eight-week postnatal home visits to familiarize community health workers with new mothers and their children and establish the community health worker as a community-based provider
- Joint health education and promotion during home visits and outreach/community events
- Mutual support and problem-solving
- Promoting and facilitating referrals for sick mothers, newborns, and children

The teams worked together for two years. With training from LINCHPIN, Neighborhood Health Committee members bolstered the teaming approach by: promoting key health practices and recognition of danger signs; providing emergency support and referral for newborns, young children, and pregnant women; promoting community case management; and monitoring the effectiveness of the teams. Community members and health managers reported that teaming community health workers and traditional birth attendants helped create well-informed and educated communities, increase referral support, and improve rates of facility-based delivery and postnatal care.

“The fact is, we didn’t know much about childbirth, birth spacing, danger signs during pregnancy, and child growth. The [teams] have been doing a very good job educating and counseling us ...”

— *Neighborhood Health Committee member*

Operations research showed that the teams were associated with increased coverage with key newborn and child health interventions, including an increase in antenatal care visits, clinic-based deliveries, and postnatal care visits. Measures of team performance were associated with improvements in 12 out of 14 MNCH indicators, with significant improvement in early and complete treatment of malaria with artemisinin-based

combination therapy, pneumonia care-seeking and treatment with amoxicillin, and care-seeking for other severe illness.

Several challenges to the approach were also reported, including monthly supervision and coaching required for success, and team attrition (30 percent of the teams became inactive over two years), most commonly because the community health worker obtained a paying job. Despite these factors, community support for the teaming approach was unreserved, with recommendations to introduce the approach in other rural areas.

Emerging Lessons for Maternal and Child Survival Programming

The projects presented here demonstrate that there are many pathways to community-level impact. In each example, the CSHGP grantee adapted approaches and strategies, often based on models they had implemented elsewhere and in different contexts, to the local context in which they were implementing their grant. Each project demonstrates inspiring approaches with potential to be replicated or scaled elsewhere. Several common lessons emerge from these experiences, which have application both for these specific approaches and, more broadly, for community-level health programming.

There is immense benefit in building on strategies that have been applied elsewhere, and/or were championed by the government. Innovation was often incremental as many projects refined existing models to make them even better. Given decades of progress in ending preventable maternal and child deaths, an effective adaptation of a model that can be replicated or has reliable outcomes may be more important than a wholly new “innovation.” In Bangladesh, for example, the approach was in leveraging World Renew’s 18 years of success with the People’s Institution model to improve maternal and newborn health outcomes. In Benin, CHS built on successful applications of the QI collaborative for facility-based improvement and applied lessons to improvement efforts at community level for MNCH. In Peru, the Health in Hands of Women project refined a Ministry of Health strategy that had been mostly on paper, making “sectorization” operational in ways that benefited and linked communities, health providers, and municipalities with a new focus on community health promotion and behavior change. In collaborating at all levels of the Peruvian health sector, and with regional and local government, to adapt an existing policy for improved MNCH at the community level, Future Generations earned ready-made government and health-sector champions who could begin collaboratively planning to scale up project successes.

Effective community engagement requires finding meaningful, contextually sensitive ways to do so. Given the multiple models of generating local commitment to MNCH that have been explored in the past 30 years, selecting a contextually sensitive approach is essential. In Bangladesh, Benin, Cambodia, and Zambia, the CSHGP grantees introduced systems and strategies that gave community members locally relevant mechanisms to get things done and see concrete results, with evidence of increasing social capital, equity, and improvement of service delivery at the community level. World Renew’s People’s Institution model was designed to fit into familiar governance structures in Bangladesh. CHS’s QI collaboratives in Benin brought together a broad spectrum of community representatives, including religious leaders and health volunteers themselves, to contribute to decision-making for improved quality of care. In Cambodia, IRD conducted formative research with men to craft behavior change communications that would resonate with them and encourage them to engage more fully in the health of their children. At the same time, the project’s use of the Positive Deviance approach helped communities combat malnutrition by encouraging families with well-nourished children to guide their peers in adopting new feeding practices. In Zambia, Save the Children worked with and through a respected community structure already present throughout the country, the Neighborhood Health Committee, to bolster community engagement in MNCH, while testing a promising model to fill gaps in community-based care for women, newborns, and children under 5 years.

Bolstering collective accountability for community health worker performance yields results. The strategies presented here addressed community health worker performance as a collective responsibility: as a community issue, through coordinated efforts around performance monitoring, as in the QI collaboratives in Benin; as a collaborative teaming effort between community health workers and traditional birth attendants in new roles, as in Zambia; or through links between the formal health system, local government, and

community activities, as in Peru and Bangladesh. In Bangladesh, the People’s Institution groups oversaw the community health workers, who linked directly with the local health facility and government officials to coordinate care, share data, and address gaps—a powerful strategy. Each program saw some important gains in performance and coverage for MNCH, indicating that these are promising mechanisms for improving community health worker performance from different angles, depending on the country context. Each program also saw challenges in health worker retention.

Empowering and mobilizing women and engaging men sustain gains and improve performance. These grants demonstrate the power of connecting with the whole community to overcome resistance to women’s participation and leadership, increase men’s involvement, and build community leaders’ support for MNCH. The experiences of World Renew in Bangladesh and IRD in Cambodia are notable examples. The People’s Institution model started with marginalized women, mobilizing them to become leaders, and then moved into the wider community, creating men’s primary groups in response to a need for more gender equity and encouraging commitment and participation from community elites, political leaders, and government. In Cambodia, the ENRICH project had an explicit and successful focus on engaging men in child care. In Peru, Future Generations introduced and tested a participatory methodology for training female community health workers, “Sharing Histories,” that empowers them to be effective change agents and, in turn, empower mothers in their communities to significantly reduce chronic malnutrition in their children.

Community health workers need continuous supervision and support. Motivating volunteer health workers to high performance and retaining them in their positions was challenging for all 10 projects. Financial incentives for community health worker supervisors (community facilitators) were linked with high rates of retention in Peru; there was sustained municipal funding after the project ended. Scale-up of municipal financing for community facilitators will be the primary challenge for this model. Nonfinancial incentives, such as the intensive supervision used in Benin, enhanced health workers’ performance, but questions remain as to whether the health system can sustain this approach without outside support. The evaluation of the QI collaborative showed that offering financial incentives along with intensive supervision yielded better outcomes, compared with financial incentives alone. This suggests that multiple financial and nonfinancial approaches would be required to maximize community health worker motivation—with important implications for all health projects that rely on similar cadres.

The projects described here offer a vision of what can be accomplished in increasing community engagement and equitable, high-quality service delivery at the community level. Although the final evaluations are not impact evaluations, they offer plausible results that demonstrate the ways in which communities can be engaged and link with strengthened health systems and local government, and the kinds of results that can be expected under programs such as these. They show the possible.

Five Lessons

- Build on proven strategies.
- Engage communities in contextually sensitive ways.
- Bolster collective accountability for community health worker performance.
- Empower and mobilize women, and engage men, to sustain gains.
- Recognize the need for continuous supervision and support for community health workers.

Conclusions

The cohort of CSHGP grantees with final evaluation reports reviewed for this analysis implemented a range of interventions focused on community health platforms and, to varying degrees, health facilities. In most cases, grantees interacted with district-level and national health program managers. All programs included community engagement and support to community-based health workers to increase use of high-impact interventions, and all sought to implement scalable, sustainable approaches that built on data for learning and adapting.

Seven strategies and five lessons learned emerged from a review of the project evaluations. These strategies and lessons, which were all described above, are applicable to future community-level MNCH programming under the Call to Action. Five of the project evaluations furnished enough information to illustrate these lessons and potential learning for others: Bangladesh, Benin, Cambodia, Peru, and Zambia.

Based on real grantee experiences, as documented in their final evaluation reports, these strategies and lessons learned reflect what can be accomplished in community engagement and equitable, high-quality, community-based service delivery for MNCH. For further information on illustrative results and links to numerous other knowledge products from this grantee cohort, please see [Annex A](#).

Annex A. Illustrative Results from the CSHGP Grantees

The charts below offer a glimpse of some of the results from the cohort of CSHGP grants that ended in 2014. Project evaluation briefs and a host of other materials are available at <http://www.mcsprogram.org/CSHGPproducts>.

Note: Asterisks (*) reflect statistically significant results at $p < 0.05$.

People's Institutions in Bangladesh (World Renew)

Figure A-1. Maternal and Newborn Health Services and Practices

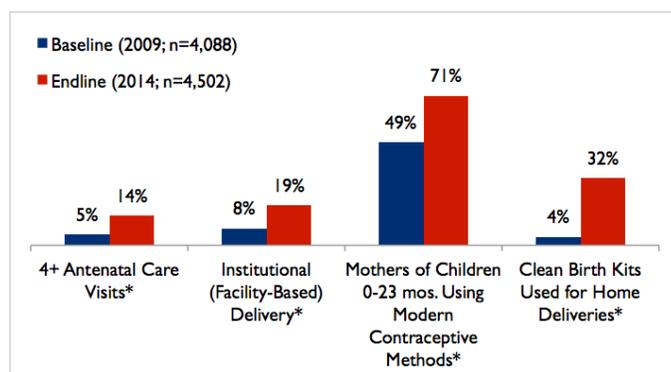
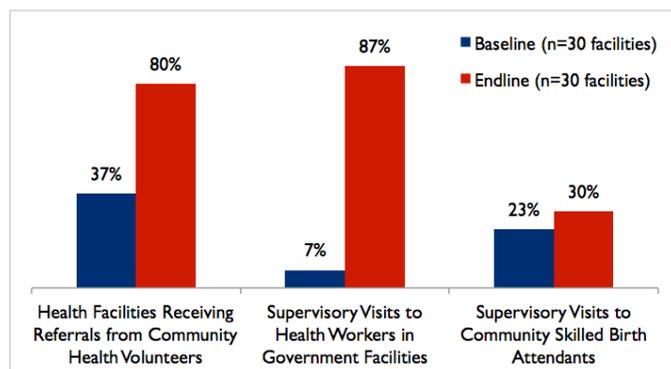


Figure A-2. Referrals and Supervision at Facilities



Note: Data in this chart are from a rapid health facility assessment, which did not test for significance.

Quality Improvement Collaboratives in Benin (CHS)

Figure A-3. Maternal Engagement in Community Health Services

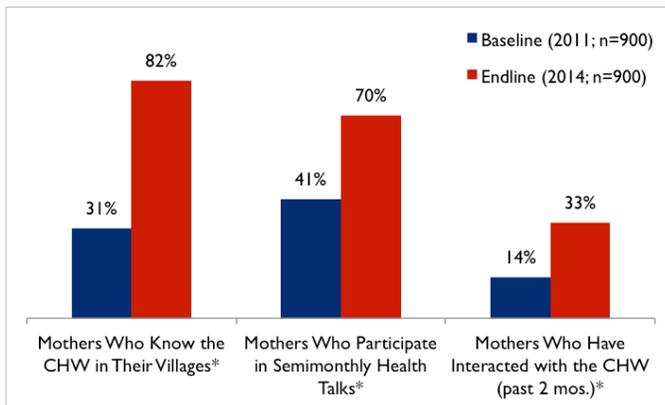
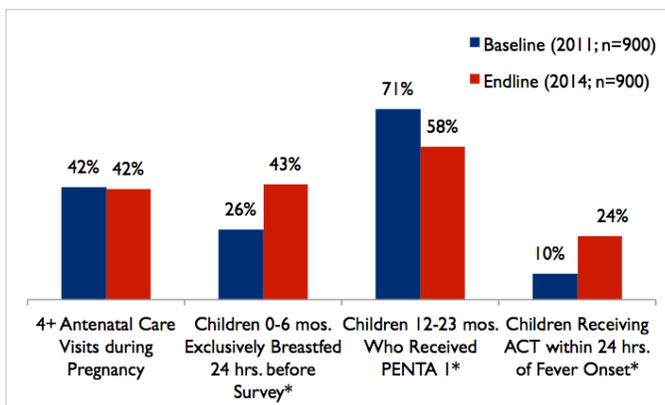


Figure A-4. Maternal and Child Health Practices



Positive Deviance/Hearths in Cambodia (IRD)

Figure A-5. Child Nutrition

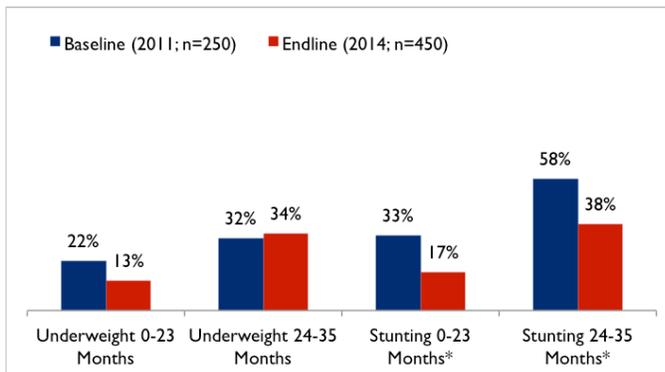
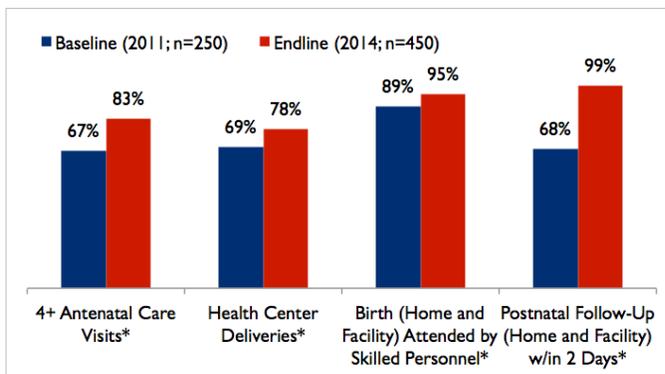


Figure A-6. Maternal and Newborn Care



Sectorization and “Sharing Histories” in Peru (Future Generations)

Figure A-7. Maternal and Child Nutrition Practices

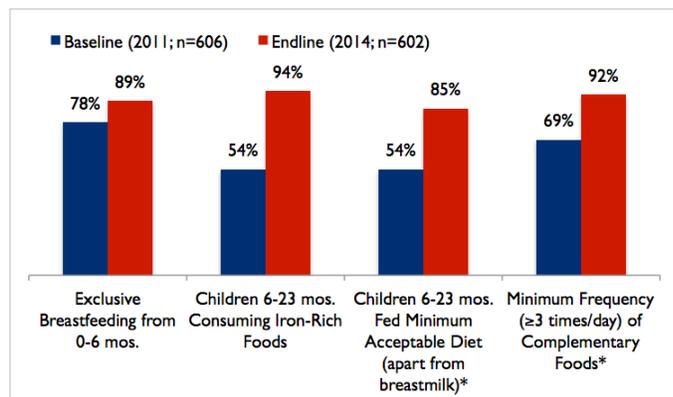
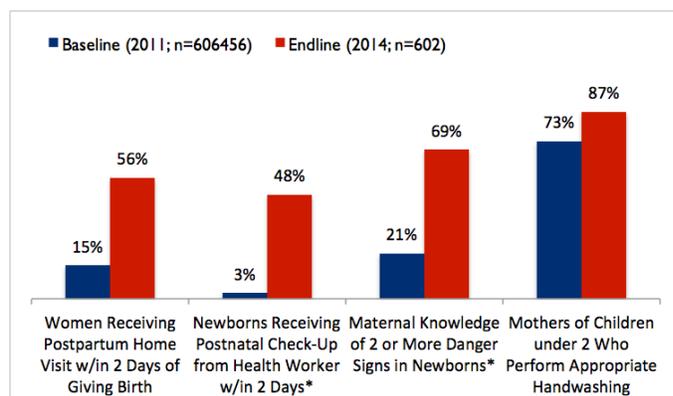


Figure A-8. MNCH Knowledge and Practices



Community Action Cycle and Traditional Birth Attendant/Community Health Worker Teaming in Zambia (Save the Children)

Figure A-9. Integrated Community Case Management for Children in Lufwanyama

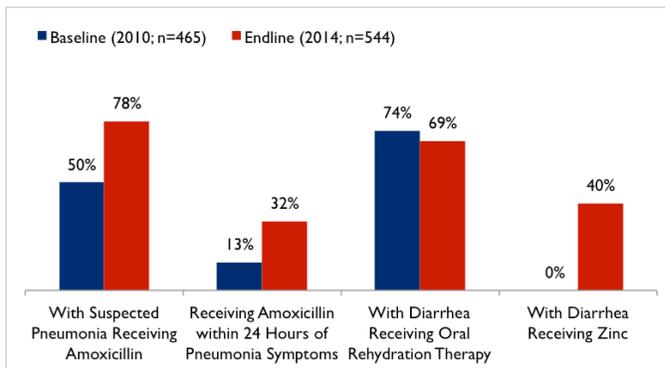


Figure A-10. Key Maternal and Infant Services

