Moving Toward **Viable, Integrated Community Health Platforms** to Institutionalize Community Health in National Strategies to End Preventable Child and Maternal Deaths

Background

The Maternal and Child Survival Program (MCSP) introduces and supports high-impact health interventions in 24 U.S. Agency for International Development (USAID) priority countries with the ultimate goal of ending preventable child and maternal deaths within a generation.[1]

Scaling up community-based approaches has been characterized as one of the success factors for countries on track to achieve Millennium Development Goals (MDGs) 4 and 5a, which call for a reduction in child and maternal mortality.[2] However, renewed interest in effective community health strategies, including the expanding role of community health workers (CHWs), comes with long-term concerns about how to achieve optimal effectiveness in context and maintain program integrity at scale.[3]

The multipartner Community Health and Civil Society Engagement Team in MCSP set a goal to accelerate the institutionalization of community health as a central component of country health strategies. MCSP will contribute to global learning on effective and sustainable practices in community health and give close attention to the fit between program strategies and country realities.

In seeking to achieve that goal, MCSP immediately faces two challenges:

1. **Inconsistent language**—Community health is defined differently by different people and organizations. What it encompasses can range from services delivered by diverse cadres of CHWs, from simply sharing knowledge and information on health promotion to delivering lifesaving drugs and organizing communities for targeted health and nutrition improvements or infrastructure work on health systems issues.
2. **Multiple contexts**—MCSP is already engaged in important community health work in response to requests from USAID Missions and countries; but all MCSP countries are at different stages of development and implementation in their own community health strategies.

How can MCSP Advance a Common Objective from the Diversity of Experiences, Projects, and Contexts?

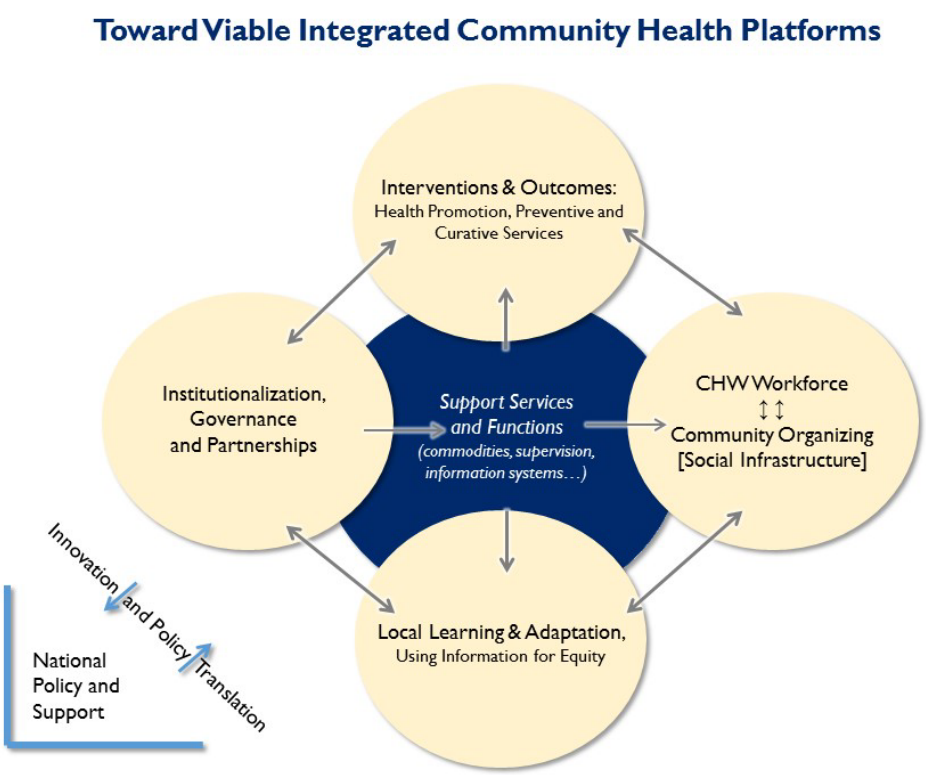
The Viable, Integrated Community Health Platform (CHP) is a central MCSP approach to institutionalize community health, seeking to provide a common direction that also respects program differences. The intention of the MCSP approach is to offer all programs a progressive process built on what has already been achieved in each country. Its language can help us contrast experiences and learn from different strategies toward a common purpose and vision.

MCSP: 1776 Massachusetts Avenue NW, Suite 300, Washington DC, 20036 tel: 202.835.3100 email: info@mcsprogram.org
Koki Agarwal, Director, Koki.Agarwal@mcsprogram.org; Anita Gibson, Deputy Director, Anita.Gibson@mcsprogram.org

USAID: 1300 Pennsylvania Avenue NW, Washington DC, 20523 tel: 202.712.4564
Nahed Matta, AOTR, nmatt@usaid.gov; Malia Boggs, Alternate AOR, mboggs@usaid.gov; Megan Rhodes, Alternate AOR, mrhodes@usaid.gov

What is a Viable, Integrated Community Health Platform?

Not every community health intervention fits the CHP model. To help define the approach, MCSP uses a simple visual model, the Looking Glass (right), to describe essential elements that community health strategies need to address systematically to advance comprehensiveness of services, sustainability, and scale. At its most basic level, building a CHP (different types are possible and expected) requires a coherent alignment of functions, structures, and resources, which can be organized as *lenses* in five focal areas.



***First Lens*—Interventions and Outcomes**

In a post-MDG world, to build on existing successes and experiences from countries, community health strategies need to progressively include a more complete package of reproductive, maternal, newborn, and child health interventions to improve health outcomes for mothers, newborns, and children.[4] This requires advancing a comprehensive set of *outcomes* at the community level.

The term *integrated platform* entails a community health system capable of adapting and progressively providing services in the full continuum of care, from households to community, and bridging the gap to health facilities. CHPs must ultimately integrate health promotion, disease prevention, nutrition behaviors and counseling, health care seeking and treatment, and the social processes required to continuously address the principal causes of morbidity and mortality of newborns, children, and mothers. In contrast, the high energy and resources, the narrow focus, and the on-and-off pattern of "campaigns," as useful as they may be, contrast to the development of CHPs.

***Second Lens*—Community Health Workforce and Community Organizing Structures**

The CHP approach considers both the community health workforce and the community support structures needed to maximize CHW program investments.

CHW programs have reemerged as a central and effective strategy for improving community health. In line with the *CHW Reference Guide*,[5] strategies need to clarify and define CHWs' roles, identity, and functions and address the fit between the tasks they are assigned, their profile, their capacity, and their coverage. Numerous models and strategies with potential and demonstrated value exist, and a platform needs to link CHWs with effective community organizing strategies. A central focus of the CHP is the strategic consideration of CHWs and community groups (formal or informal) as a subsystem with purpose, evolving roles, and responsibilities clearly related to the outcomes and interventions defined in the first lens. Examples can be found in the Care Group model,[6] the World Health Organization's recommendations on women's groups for maternal and newborn health,[7] CHW peer support groups,[8] groups of grandmothers, and others. The CHP approach focuses on the fit between dedicated human resources—the CHWs—and social infrastructure resources to advance the defined outcomes. The context of community health continues to evolve, and the CHP will need to regularly address which services are best provided by caretakers, social groups, volunteers, trained CHWs, and primary or secondary health care facilities as recommended in the World Health Organization's Packages of Interventions.[9]

Third Lens—Institutionalization, Governance, and Partnerships

Effective community health requires sound governance and support from Ministries of Health at the subnational (i.e., district) and national levels. It also requires effective partnerships with civil society, community groups, nongovernmental organizations (health sector and non-health sector), and CHW professional associations, where they exist.[10] Better functioning societal frameworks that promote an effective use of public and civil expertise and resources are likely to see with more sustainable outcomes.

A CHP approach will take explicit steps to support those partnerships, facilitate government to non-government (including private sector) partnerships for health, and build capacity and shared ownership. This approach brings together MCSP's Community Health and Civil Society Engagement Team with the Health Systems Strengthening and Equity Team, notably through the complementary concept of the Whole Market District Approach. Building CHPs that are soundly governed is an integral part of health systems strengthening.

Fourth Lens—Local Learning, Adaptation, and Information Use for Equity

A viable CHP requires the capacity to learn and adapt close to implementation. Neither communities, health systems, nor health threats are static, as the West African Ebola outbreak demonstrated. A viable platform requires local learning, informed decision-making, and the ability to take adaptive steps, notably through appropriate use of information where it is collected.

These concepts are not new. Different approaches already incorporate principles for local learning and adaptation to varying degrees, from Partnership Defined Quality,[11] to Social Accountability Strategies,[12] the Sustainability Framework,[13] or the use of the My Village Is My Home tool for immunization programs.[14] To sustain community health at scale, a CHP must focus on how information is used horizontally, close to communities and beneficiaries, and vertically, to and from facilities and further up the health system hierarchy, to foster cycles of local learning and program adaptation. Community health is part and parcel of building viable local systems.[15]

What information is produced and how it is processed and used are critical components for improving the quality, accountability, and equity of community services. For example, do the health district, facility, and/or community groups that support CHW work have appropriate population health indicators, as defined in the disaggregated Demographic and Health Surveys or right-sized Knowledge Practices and Coverage (KPC) surveys[16] for community members who do not reach facilities? The CHP gives some substance to the concept of empowerment, which encompasses beneficiary groups, communities, and health administration cadres that help make sense of the CHP strategy in context and give it value.

The use of information locally, close to implementation for learning and adaptation, is central to MCSP's Community Health and Civil Society Engagement Team's interests, and it is shared with the program's Measurement, Monitoring, Evaluation, and Learning Team, which works to improve collection and presentation of community health information to facilitate local understanding, dialog, ownership, and action.

Fifth Lens—Support Services and Functions

The fifth and final lens in the Looking Glass Model addresses the health systems' supportive functions to community health, from supervision to procurement and training to information systems. Programs cannot build community health systems without paying attention to the quality and details of these systems, which are largely reflective of WHO's building blocks model. The premise of the CHP concept is the need to address lenses one through four together to build these support functions in a viable manner.[17] This echoes the recent publication proposing a logic model for enhancing the performance of CHWs.[18]

Conclusions

- Viable CHPs are about sustaining effectiveness at scale, which demands acceptability, a strong fit to local and national contexts, potential for dissemination, and resilience to shocks, including the shock of multiple projects beginning and ending. Viable CHPs require that four major lenses of program design be kept in focus over time.
- The concept of the CHP approach is a work in progress, which will be tested and improved through MCSP country teams, who are leading MCSP's work in community health.
- The broad description of the CHP approach must be followed by defining principles and questions that assess how country programs are advancing toward institutionalized, comprehensive community health services in settings facing different opportunities and challenges.

[1] Acting on the Call: Ending Preventable Child and Maternal Deaths. USAID. 2014. http://www.usaid.gov/sites/default/files/documents/1864/USAID_ActingOnTheCall_2014.pdf

[2] Kuruvilla S et al. 2014. Success factors for reducing maternal and child mortality. *Bull World Health Organ* 92: 533–544.

[3] Hodgins S, Crigler L and Perry H. 2014. *Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policy Makers.* Chapter 1: Introduction. MCHIP. Washington, D.C. http://www.mchip.net/node/2140.

[4] *Placing Healthy Women and Children at the Heart of the Post 2015 Sustainable Development Framework.* The Partnership for Maternal, Newborn, and Child Health. 2015. http://www.who.int/pmnch/post2015_flyer.pdf?ua=1

[5] Hodgins S. Ibid.

[6] Perry H, Morrow M, Davis T, Borger S, Weiss J, DeCoster M and Ernst P. 2014. *Care Groups – An Effective Community-based Delivery Strategy for Improving Reproductive, Maternal, Neonatal and Child Health in High-Mortality, Resource-Constrained Settings: A Guide for Policy Makers and Donors.* CORE Group: Washington, D.C. http://www.coregroup.org/storage/documents/meeting_reports/Care_Group_Policy_Guide_Final_8_2014.pdf.

[7] World Health Organization (WHO) recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. WHO, 2014. http://apps.who.int/iris/bitstream/10665/127939/1/9789241507271_eng.pdf?ua=1.

[8] Langston A, Weiss J, Landegger J, Pullum T, Morrow M, Kabadege M, et al. Plausible role for CHW peer support groups in increasing care-seeking in an integrated community case management project in Rwanda: a mixed methods evaluation. Glob Health Sci Pract. 2014;2(3):342-354. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4168637/

[9] The interventions in the core package are based on the WHO Packages of Interventions for Family Planning, Safe Abortion Care, and Maternal, Newborn, and Child Health. 2010.

[10] Presidential Memorandum for the Heads of Executive Departments and Agencies: Deepening U.S. Government Efforts to Collaborate with and Strengthen Civil Society. 2014.

[11] Save the Children. 2003. *Partnership Defined Quality: a tool book for community and health provider collaboration for quality improvement.* http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/PDQ-Manual-Updated-Nigeria.pdf.

[12] Hoffmann, K. 2014. *The Role of Social Accountability in Improving Health Outcomes: Overview and Analysis of Selected International NGO Experiences to Advance the Field.* Washington, D.C.: CORE Group. http://www.coregroup.org/storage/documents/Resources/Tools/Social_Accountability_Final_online.pdf.

[13] Eric G Sarriot, Michelle Kouletio, et al. Advancing the application of systems thinking in health: sustainability evaluation as learning and sense-making in a complex urban health system in Northern Bangladesh. 2014, 12:45. http://www.health-policy-systems.com/content/12/1/45.

[14] Jain M, Taneja G, Amin R, Steinglass R, Favin M. Engaging Communities with a Simple Tool to Help Increase Immunization Coverage. Glob Health Sci PractMarch 1, 2015 vol. 3 no. 1p. 117-125. http://www.ghspjournal.org/content/3/1/117

[15] USAID. Local Systems: A Framework for Supporting sustained Development. April 2014. http://www.usaid.gov/policy/local-systems-framework

[16] Davis, R., Luna, J., et al. (2009). The rapid household survey: How to obtain reliable data on health at the local level. Macro International Inc: Calverton, MD; and Public Health Institute: Oakland, CA. http://www.mchipngo.net/lib/components/documents/MandE/PHI_RapidHealth.pdf. See also: http://mchipngo.net/controllers/link.cfc?method=tools_mande.
See also: Langston, AC, Prosnitz DM, Sarriot, EG. Neglected Value of Small Population-based Surveys: A Comparison with Demographic and Health Survey Data. J Health Popul Nutr. 2015 Mar; 33(1): 123-136. ISSN 1606-0997

[17] Taking the Long View: A Practical Guide for Sustainability Planning and Measurement in Community-Oriented Health Programming. 2008. http://www.cedarscenter.com/sfoverview.cfm

[18] Naimoli JF, Frymus DE, Wuliji T, et al. A Community Health Worker « logic model »: towards a theory of enhanced performance in low- and middle-income countries. *Human Resources for Health* 2 Oct, 2014, **12**:56 doi:10.1186/1478-4491-12-56 http://www.human-resources-health.com/content/12/1/56