Global Health

Community Health Framework

Distilling decades of Agency experience to drive 2030 Global Goals

Version 1.0

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Dalberg

Built in collaboration with Dalberg Global Development Advisors

The Community Health Framework

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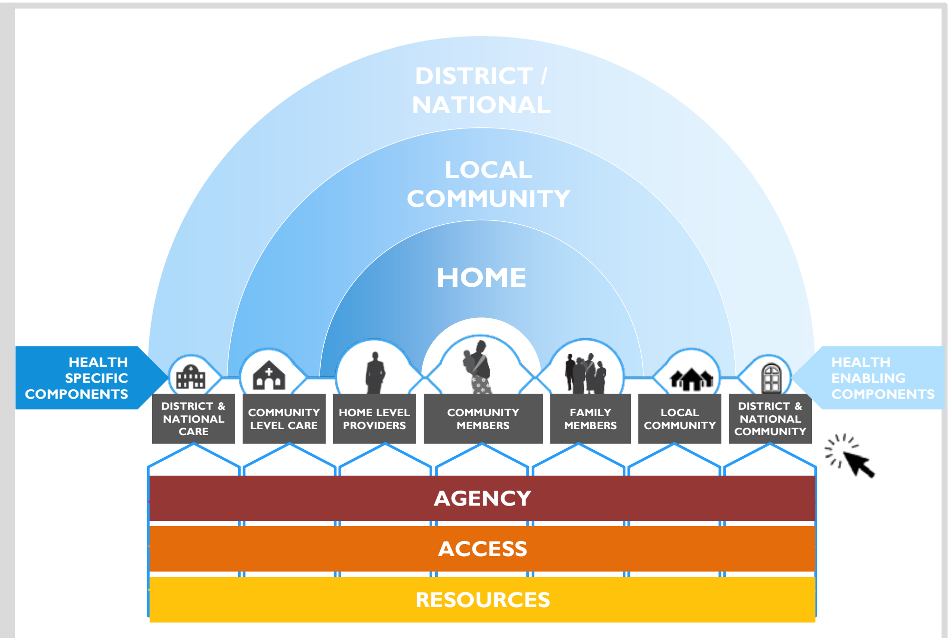
WHY should we care about community health?
Community health is foundational to attaining many of the SDGs.

WHAT is needed to create a strong community health ecosystem?
An ecosystem of heath specific and health enabling actors and structures, both formal and informal, working together and supported by the agency, access, and resources needed to ensure the health of community members:

- *Agency, e.g., awareness of needs, empowerment, and incentives to act;*
- *Access, e.g., access to care, access to referral systems; and,*
- *Resources, e.g., financial resources, medical suppliers.*



HOW can we take action to strengthen community health ecosystems?
A five step process can help leaders bring the right data to bear for decision making, and set up sustainable community health programs with clear accountability.

WHERE can we find examples of effective models and innovations for community health?
This framework includes a library of existing models across each component of community health as well as detailed case studies.

This framework has been developed to support decision makers in answering key questions about community health

The community health framework is intended to support Ministries of Health in developing and strengthening programs for improved community health outcomes. The intention is for USAID missions and other advisors to use the framework to structure a dialogue, develop recommendations, and foster continuous learning with Ministries of Health.

The community health framework does…

- Bring together a **wealth of existing knowledge and models** that articulate components of community health
- Provide a flexible framework for national level **diagnosis of needs and planning of actions**
- Enable a **long-term view** to planning and developing strong community health outcomes
- Allow for a "common language" with a **classification of interventions and tools** and the creation of a living and growing toolbox

The community health framework does not…

- Serve as a **strategy or action plan** with specific programs, targets, or budgets
- Seek to provide a **one size fits all view** on community health structures, programs, or interventions
- Represent **an exhaustive list** of actors, needs, or opportunities
- **Prescribe an impact measurement or continuous learning agenda** for countries and programs

In the process of developing this framework, **over 60 community health experts** were interviewed and **over 70 academic articles, reports, and evaluations** were reviewed. A full bibliography and list of individuals interviewed is available in the annex to this document.

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It is important to acknowledge that community health is not a new concept and that many programs have existed for decades

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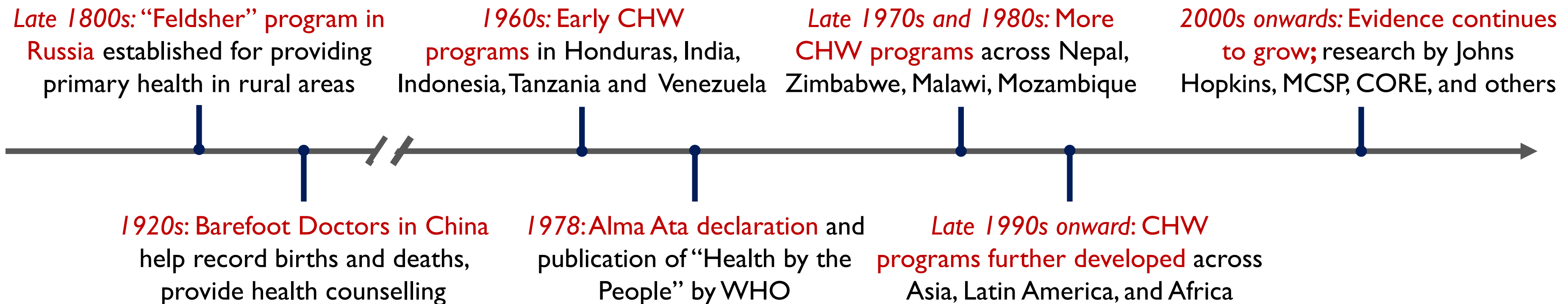
Community health programs have a long history



Today, different countries have very different approaches and are at different stages with community health

Wide variety of roles	Unpaid Village Health Workers in Nigeria **only do health promotion** work
	Health Extension Workers (HEWs) in Ethiopia **treat life threatening diseases**
Mix of public vs. private provision	Lady Health Workers in Pakistan are **paid government employees**
	Health Workers in Tanzania are **volunteers**
Varying integration with formal health system	Community Health Assistants in Brazil are **managed by local nurses**
	HEWs in Ethiopia are **part of the formal healthcare system**
Wide disparity in level of investment in health	Nigeria spends **4% of its national budget on health**
	Uganda spends **22% of its national budget on health**

Source: USAID MCHIP; World Bank; Dalberg analysis

Today the global health community has a long way to go to achieve the Sustainable Development Goals (SDGs)

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Health Issue	*Core Corresponding SDGs*	*Gap to Achieve SDG Targets*[1] (Not Comprehensive)	
		■ 2012/13	
Child health	2 Zero Hunger; 3 Good Health and Well-Being; 6 Clean Water and Sanitation; 10 Reduced Inequalities; 17 Partnerships for the Goals	**Under-5 mortality per 1000 live births** SSA: 98 Developing: 53	**SDG target = 25 (in every country)**
Maternal health	1 No Poverty; 3 Good Health and Well-Being; 5 Gender Equality; 10 Reduced Inequalities; 17 Partnerships for the Goals	**Maternal mortality per 100,000 live births** SSA: 510 Developing: 230	**SDG target = 70**
Infectious disease	3 Good Health and Well-Being; 6 Clean Water and Sanitation; 9 Industry, Innovation and Infrastructure; 10 Reduced Inequalities; 17 Partnerships for the Goals	**HIV Incidence rate**[2] SSA: 1.02 Developing: [VALUE]	**SDG target = 0**
Non-communicable diseases (NCDs)	3 Good Health and Well-Being; 9 Industry, Innovation and Infrastructure; 17 Partnerships for the Goals	**NCD related deaths per year** Global: 36M	**SDG target = Reduce by 1/3**
Water & sanitation	3 Good Health and Well-Being; 4 Quality Education; 6 Clean Water and Sanitation; 10 Reduced Inequalities; 17 Partnerships for the Goals	**People lacking access to clean drinking water** Global: 0.7B	**SDG target = 0**

[1] SSA refers to Sub-Saharan Africa; Developing refers to Developing Regions, all regions except all of Europe, Russia, US, Canada, Australia, New Zealand, and Japan. [2] New infections per year per 100 people age 15-49. Source: United Nations; WHO; Millennium Development Goals Report.

Community health is a very efficient means of driving certain health outcomes and has a critical role to play reaching SDGs

Health Issue	Community approaches are effective in delivering health outcomes…	.. and may even be able to do so in a cost-effective manner	Costs compared to WHO cost-effectiveness threshold (GDP per capita)
Child health	• **Up to a 33% reduction in under-5 mortality** after a year from a community monitoring RCT in Uganda • **Up to 24% reduction in risk of deaths** from child pneumonia across seven countries	• **$26 per disability-adjusted life year** [DALY] saved using community strategies for severe acute malnutrition in Bangladesh, compared to **$1,344** per DALY in facilities	Cost / DALY: 26; GDP Per Capita: 1,093
Maternal health	• **Up to 23% reduction in maternal mortality** shown by using participatory groups • **Effective administration of injectable contraception** by CHWs proven in at least nine countries	• **$6 per DALY** saved by using community-based strategies in India to treat post-partum hemorrhage with misoprostol	Cost / DALY: 6; GDP Per Capita: 1,596
Infectious disease	• **115 of the 313 tasks that are essential for HIV prevention and treatment** can be performed by CHWs, as per the WHO	• **Evidence is limited but early studies show $60.7 per patient** to treat tuberculosis in Ethiopia using Health Extension Workers (HEWs), compared to **$158.9** in facilities	Cost / DALY: 61; GDP Per Capita: 565
Non-communicable diseases (NCDs)	• **Potential to effectively monitor and diagnose NCDs** (e.g., conduct blood pressure tests and cardiovascular screenings)	• **Evidence is limited, but early studies show $370 per DALY for hypertension management** counseling by CHWs in South Africa	Cost / DALY: 370; GDP Per Capita: 6,478
Water & sanitation	• **53% reduction in child diarrhea** due to a promotion of handwashing behavior by CHWs, based on an RCT in Pakistan	• **$3.35 per DALY for hygiene promotion efforts in low and middle income countries** to reduce diarrhea related deaths	Cost / DALY: 3; GDP Per Capita: 4,264

Source: Bjorkman and Svennson, 2009; Datiko and Lintjorn, 2010; Gaziano et al, 2014; Neupane et al, 2014; Perry and Zulliger, 2012; Prost et al, 2013; Puett et al, 2013; Sutherland et al, 2010; World Bank; Dalberg analysis

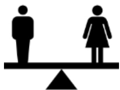
Community health also accelerates other community-based development objectives, magnifying its impact further

Improved education

Being **healthy is core to maximizing the benefits of education**. Under-nutrition and hunger are documented barriers to enrolling and paying attention in school; UNICEF estimates that a child's poorer school performance results in future income reductions of up to 22 per cent on average.

Increased employment

Better health outcomes facilitate better employment outcomes. Moreover, community health programs provide the opportunity for **formal employment of hundreds of thousands of people**, particularly women and youth. There are an estimated 450,000 CHWs across Africa currently.



Empowerment of women

Community-based approaches have been associated with **improved indicators of male support and improved gender equity**. CHW programs often exclusively employ women (e.g., India, Pakistan, Ethiopia). Employment is associated with a range of indicators of empowerment, such as **better health, higher levels of education, and a lower level of intimate partner violence**.

Reduced inequality

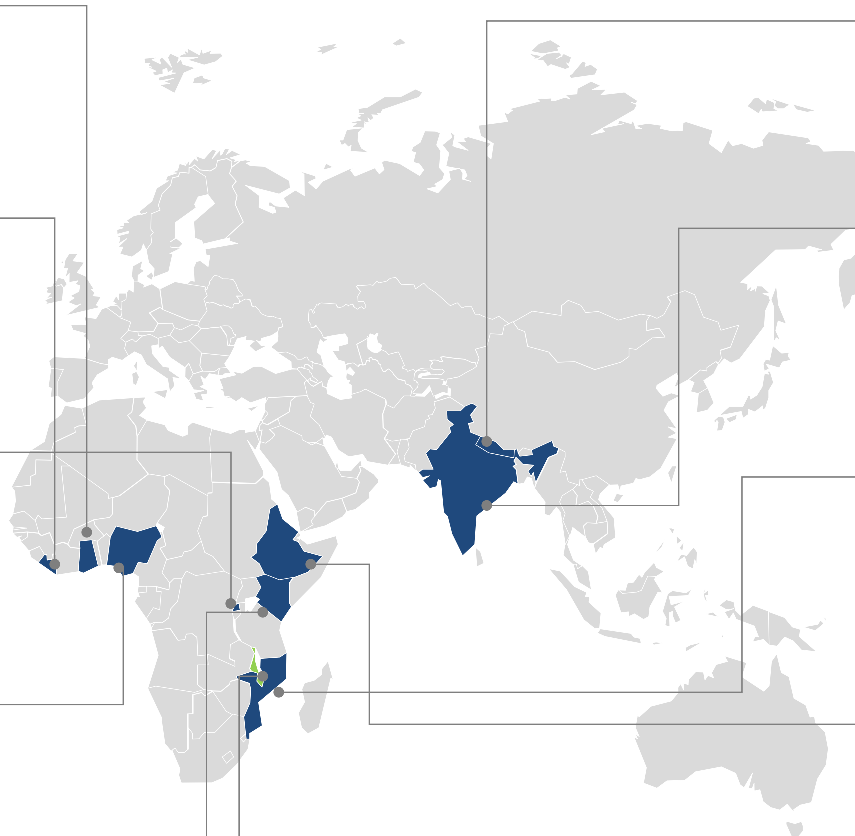
Socio-economically disadvantaged groups have a lower utilization of facility-based services. Community based health delivery increases **utilization, coverage, and equity** of curative and preventive services.

Increased capacity & trust

A literature review of 34 articles that used community-based approaches to improve child health, survival, and development showed that in nearly all cases, **these approaches improved community capacity, engagement, and trust**.

Source: Farnsworth et al, 2014; Perry and Zulliger, 2012; Perry, Zulliger, and Rogers, 2014; UNICEF; UN DESA; UN Special Envoy for Financing the Health Millennium Development Goals and for Malaria; USAID; Dalberg analysis

Recognizing the value of strong community health programs, many countries have increased investment in community health



GHANA:
Scaled up the existing community health program (Cell3) nationwide in 1999

LIBERIA:
Finalized a Community Health Roadmap in 2014 to create / expand CHW programs nationwide

RWANDA:
MOH worked with three international NGOs in 2006-2011 to integrate community support groups into government CHW programs

NIGERIA:
Launched the Village Health Workers program in 2014, planning the deployment and training of 10,000 VHWs

KENYA:
Defined National Standards for Community Health Workers in 2014 to coordinate among programs across the country

NEPAL:
CHW role expanded to include integrated community case management (iCCM), family planning, and newborn care

INDIA:
Over 900,000 ASHA workers in India in 2015 compared to 143,000 when the program was started in 2005

MOZAMBIQUE:
World Relief launched the Care Group model in two districts in 1999, it is now scaled to reach almost half of the population

ETHIOPIA:
Less than 5,000 Health Extension Workers (HEWs) when the program began in 2004, over 38,000 today

MALAWI:
Expanded role of health service assistants from disease control to include iCCM and family planning

Source: One Million Community Healthcare Workers; Perry, 2012; USAID; National Rural Health Ministry of India; World Relief International; Edwards, 2007

However, countries continue to face challenges related to building and strengthening their community health programs

A few examples of challenges countries are facing in delivering community health include:

Challenges related to the health workforce

- **Shortage of skilled health providers** who are willing to work in certain communities
- **Lack of adequate supervision, monitoring and training** for current health workers

Challenges related to health related infrastructure

- **Poor referral systems** from community based health care into formal health systems
- **Frequent stock outs** of essential supplies

Challenges related to health behaviors and healthcare utilization

- **Low education** and literacy levels of health workers and community members
- **Lack of women's empowerment** causes challenges in seeking care, leading to poor health outcomes
- **Friction between socio-cultural practices and good health practices** leading to opposition from cultural leaders or religious leaders
- **Lack of trust** between communities and healthcare providers

Access the community health framework and accompanying toolkit

Source: USAID; Expert interviews; Dalberg analysis

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Community health can be visualized as a series of components working together to serve community members (1/2)

COMMUNITY HEALTH

DISTRICT / NATIONAL

LOCAL COMMUNITY

HOME

HEALTH SPECIFIC COMPONENTS

Formal or informal actors and structures focusing exclusively on health

- DISTRICT & NATIONAL LEVEL CARE
- COMMUNITY LEVEL CARE
- HOME LEVEL PROVIDERS
- COMMUNITY MEMBERS
- FAMILY MEMBERS
- LOCAL COMMUNITY
- DISTRICT & NATIONAL COMMUNITY

HEALTH ENABLING COMPONENTS

Formal or informal actors and structures that play a supporting role in health

AGENCY, e.g., awareness of needs, empowerment and incentives to act

ACCESS, e.g. access to care, access to referral systems

RESOURCES, e.g. financial resources, medical supplies

Source: Dalberg analysis

Community health can be visualized as a series of components working together to serve community members (2/2)

COMMUNITY HEALTH

DISTRICT / NATIONAL

LOCAL COMMUNITY

HOME

1 **Community members are at the center** *of the community health ecosystem; all other components act in their service*

2 **Health specific and health enabling components, must work together** *to deliver health outcomes for community members*

3 *Components* **closer to the community members have more direct influence** *over community health outcomes*

4 *Components outside of the community provide* **needed support to components within the community**

HEALTH SPECIFIC COMPONENTS

Formal or informal actors and structures focusing exclusively on health

DISTRICT & NATIONAL LEVEL CARE

COMMUNITY LEVEL CARE

HOME LEVEL PROVIDERS

COMMUNITY MEMBERS

FAMILY MEMBERS

LOCAL COMMUNITY

DISTRICT & NATIONAL COMMUNITY

HEALTH ENABLING COMPONENTS

Formal or informal actors and structures that play a supporting role in health

5 *Each component needs three domains of action -* **agency, access, and resources** *- in order to function successfully and support other components*

Source: Dalberg analysis

Health specific components are necessary to build a vibrant community health ecosystem

HEALTH SPECIFIC COMPONENTS

HEALTH ENABLING COMPONENTS

	Definition of component	Examples of actors or structures	Role in community health
Home level providers	Health-related infrastructure and health care providers (preventive and curative) available to the community member within the home	• Health systems actors (e.g., CHW, CHEW, community health volunteers) • Traditional healers, midwives, etc. • Health-related home infrastructure (e.g., water filtration)	*Home level care can plays a role in* ***prevention; early diagnosis; referrals; and increased coverage of healthcare services****. Such care can also facilitate collection of previously unavailable data on health needs*
Community level care	Health-related infrastructure and health care providers (preventive and curative) available to the community member within the community	• Community groups (e.g., Participatory learning groups, care groups, CHW led sessions) • Local clinics or health outposts • Pharmacies • Community infrastructure (e.g., water treatment, sanitation)	*Community level care* ***can mobilize community resources to provide preventive or curative care at accessible locations****, as well as to monitor and collect data on community-level health risks*
District & national level care	Health-related infrastructure, health care providers (most commonly curative), and health-related **located outside the community**	• District or national hospitals • National treatment protocols • National drug approvals • Health supply chain management • MOH / district health officials • National health spending	*National and district hospitals* ***fill knowledge and resource gaps in community and home level care****; providing care for more serious conditions, providing access to new types of drugs, and building treatment/ supervision protocols for the rest of the health system*

Source: Expert interviews; Dalberg analysis

A range of **health enabling components** must also work together to ensure a vibrant community health ecosystem

HEALTH SPECIFIC COMPONENTS

HEALTH ENABLING COMPONENTS

	Definition of component	Examples of actors or structures	Role in community health
Home and family	Immediate living environment for each community member, including family members within the home, family-specific norms and environmental conditions within the home	• Family friends and family members • Location of home • Home structures (e.g., availability of running water) • Family-specific norms	*The home and family is a **primary influencer of any community member's actions and beliefs**, as well as a primary source of healthcare resources. Living conditions can also directly drive health outcomes*
Local community	Community level environment, including community level norms, groups, and infrastructure	• Community, cultural, religious leaders • Community-level gathering places (e.g., schools, community centers) • Other sector infrastructure (e.g., Microfinance / Agriculture ext. workers, retail stores) • Local transportation infrastructure	*The community level environment **determines community norms** (including health norms), provides a support network for community members, and contains other types of service providers who can potentially deliver health care*
District & national community	National or regional context in which the community member operates	• National socio-cultural norms (e.g., child marriage) • Policy on education, infrastructure, women's rights • National mass media • Celebrities	*The national context influences community norms, actions and beliefs and **determines the broader social and economic environment that the community operates in***

Source: Expert interviews; Dalberg analysis

There are three distinct and complementary **domains of action** needed by each component of the ecosystem

Needs listed under each type are not exhaustive

Domain of Action	Description
Agency	Each component needs to have the **agency, e.g., awareness of needs, empowerment, and incentives to act**. *Example: Health users need* • *Awareness that they need preventative or curative healthcare* • *The willingness to seek out that care* • *To be empowered to make their own decisions about whether to seek care*
Access	Each component needs to be able to have **access to the other parts of the community health ecosystem** that provide needed inputs for success (e.g., access to care, to referral systems) *Example: Community level health providers need* • *Access to their clients (list of clients to contact and means to reach them)* • *Access to a referral system, on-going supervision and training from district or national level healthcare providers*
Resources	Each component **needs resources (e.g., financial resources, medical supplies)** to ensure that they are able to perform their intended actions *Example: Local clinics need* • *Skilled staff* • *Sufficient supply of medical equipment and drugs* • *Funding to cover operating costs*

Source: Expert interviews; WHO Precede Proceed Model; Dalberg analysis

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There are five important steps that should be taken to identify and implement community health strategies and programs

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SET TARGET OUTCOMES	UNDERSTAND EXISTING COMPONENTS	ANALYZE BOTTLENECKS	DEVELOP OR STRENGTHEN PROGRAMS	IMPLEMENT, MONITOR, AND EVALUATE PROGRAMS
The first step is to set **target outcomes**, for example: increasing coverage of key lifesaving behaviors or services; reducing specific types of mortality or morbidity; or mitigating inequities	The next step is to ask a series **of key questions to understand the components** that currently deliver these outcomes	The third step involves asking **key questions to diagnose priorities** based on bottlenecks in the current ecosystem and the required domains of action	Program design can then be conducted using resources such as **best practices and models that have worked elsewhere**	Once programs are developed, it is important to **ensure accountability** through effective implementation, monitoring and evaluation
Example: *Maternal mortality in a community is highest on the day of birth and having a skilled attendant present at birth is a life saving intervention. Increasing incidence of skilled attendants at birth could be a target outcome*	***Example:*** *Understanding the status quo in maternal health could involve determining who seeks and delivers maternal care, where care currently occurs, and who influences decision to seek or provide care*	***Example:*** *If family members usually decide where births occur and who is present, lack of awareness could be a barrier to seeking care.*	***Example:*** *Attendance at birth could be integrated into existing community health worker roles*	***Example:*** *Effective implementation could include ensuring CHW awareness of expanded roles; regular monitoring and evaluation could help determine if the program is achieving target outcomes*

Components

All fives steps should consider the necessary <u>components</u> and understand how to address the <u>domains of action</u>

Domains of action

Source: Expert interviews; Dalberg analysis

Each of these steps involves asking a series of targeted questions seeking data in answer them

Key Questions

SET TARGET OUTCOMES	UNDERSTAND EXISTING COMPONENTS	ANALYZE BOTTLENECKS	DEVELOP OR STRENGTHEN PROGRAMS	IMPLEMENT, MONITOR, AND EVALUATE PROGRAMS
• Where are the **largest gaps in coverage of life saving behaviors or services**? • What are the **leading causes of morbidity and mortality** for the country / community? • Are there **inequities** in provision of coverage?	• Who are the community members most at risk for this issue? • Who are the health-specific **actors and influencers** that are currently involved in addressing this issue? • Who are the health-specific **actors and influencers** that are currently involved in addressing this issue? • What is the **policy / regulatory / financing environment** in place for this issue?	• What are the biggest underlying **barriers** that the existing components, actors and influencers face to achieving target outcomes? • Are there **other components, actors or influencers** that are better suited to achieve target outcomes? • What are the **domains of action** required to ensure those components function well?	• What will new or existing programs **do and how will they be financed**? • How can a program be **designed for sustainability** from the start? • What **models and innovations** have been used elsewhere to address these priority components and domains of action? Are these relevant in this specific **country context**? • Who are **potential partners**?	• Is there **administrative and policy capacity** to implement the program • Are monitoring processes in place to **ensure accountability** in program implementation • What types of **evaluation is necessary** to ensure that programs deliver on target outcomes

Click to access full step by step question guide available in the toolkit

Source: Dalberg analysis

When developing or strengthening programs six design principles should be kept in mind

Guiding Principle	Description
Engage communities	• Programs that do not involve communities in design, implementation, and monitoring are less likely to succeed; engaging with communities can accelerate success[1] and drive accountability.
Design for sustainability and country ownership	• Taking a long-term approach that has support from national and regional governments involved can prevent programs from being unsustainable when the first round of financing is depleted (especially if the program is donor-funded).
Leverage partnerships & constituencies	• There are several innovative models of partnerships to achieve community health outcomes, including across sectors and across types of actors (private-public partnerships, partnerships between community health workers and traditional healers, involvement of CSO and other constituencies, etc.)[2]
Focus on mitigating inequities	• Ensuring that program design is inclusive of and sensitive to the constraints of potentially marginalized groups promotes sustainability and supports broader benefits beyond health outcomes
Promote gender empowerment	• The health of women and girls, and subsequently, communities, is disproportionately affected by gender-related inequalities and disparities. Program design should reflect awareness of these issues, and promote gender inclusion and empowerment to alleviate them.
Leverage existing models and innovations	• There are several examples of models and innovations that tackle various aspects of community health; and a wealth of existing tools that document how to build strong community health programs. A few salient ones are highlighted in this framework but many more exist.

Source: [1] U.S. Government Evidence Summit, 2012; USAID Local Systems Framework [2] USAID Global Health Programs Principles; Expert interviews; Dalberg analysis

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Models and innovations in community health

- The models and innovations, case studies, and external tools included in this toolkit have been selected based on their **promise** for delivering community health outcomes in specific contexts
- Inclusion or exclusion in the toolkit is **not intended to reflect an endorsement or rejection** of any one tool, rather these models / innovation provide **a sampling of programs** across the community health ecosystem
- This toolkit is intended to be a **living resource** which will be updated frequently by the USAID team

Source: Dalberg analysis

The accompanying toolkit highlights promising innovations, tools, and case studies from global efforts in community health

	DISTRICT & NATIONAL LEVEL CARE	COMMUNITY LEVEL CARE	HOME LEVEL PROVIDERS	COMMUNITY MEMBER	FAMILY MEMBERS	LOCAL COMMUNITY	DISTRICT & NATIONAL COMMUNITY
Promising Models & Innovations	D-tree e-records in SA	Community Action Cycle in e.g. Kenya	BBC Media Action in India		Positive Deviant in e.g. Vietnam	Engaging communities Bangladesh	Safe Love Campaign in Zambia
	Maternal MAMA in e.g. Nigeria	VHTs in Uganda	D-Tree Deliveries in Tanzania		Open Days in Kenya	Integrated delivery in Nepal	
	GSK CHW Training e.g. Cambodia	Novartis AP in India				Community volunteers in Honduras	
	Secretariat Model e.g. Angola	Care Groups in e.g. Mexico					
External tools							

Cross-component case studies

LivingGoods | MEDIC MOBILE | muso | Ethiopia CHW | Rwanda CHW | Project DANFA

Source: Expert interviews; Dalberg analysis

The toolkit can also be searched geographically for models and innovations or case studies on community health by country

BBC Media Action in India

Integrated delivery in Nepal

Project DANFA in e.g. Ghana

Living Goods in Uganda

Novartis AP in India

Engaging communities Bangladesh

Positive Deviant in e.g. Vietnam

Project Muso in Mali

VHTs in Uganda

Community volunteers in Honduras

Care Groups in e.g. Mexico

Medic Mobile e.g. Guatemala

Maternal MAMA in e.g. Nigeria

Ethiopia CHW Program

GSK CHW Training e.g. Cambodia

Safe Love Campaign in Zambia

Open Days in Kenya

Community Action Cycle in e.g. Kenya

Rwanda CHW program

D-Tree Deliveries in Tanzania

Secretariat Model e.g. Angola

D-tree e-records in SA

Model / innovation

Full Case study

Source: Dalberg analysis

Click on a model to see details

Toolkits

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I. PROCESS FOR STRENGTHENING COMMUNITY HEALTH

II. LINKS TO EXTERNAL TOOLS

III. INNOVATIONS AND INTERVENTIONS

IV. CASE STUDIES

Toolkits

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I. PROCESS FOR STRENGTHENING COMMUNITY HEALTH

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III. INNOVATIONS AND INTERVENTIONS

IV. CASE STUDIES

The first stage is to define target community health outcomes, three key questions can help to quickly do so

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Key questions	Potential analyses to answer question	Illustrative outcomes
What is the coverage of known high impact technical interventions	• Analyze gaps in coverage of priority interventions in maternal and child health (Countdown Indicators) to identify specific interventions or populations where largest gaps lie	In two districts in the country, only 30% of mothers give birth with a skilled birth attendant present Target outcome: Increase assisted births in these districts to 45% through community based interventions
What are the leading causes of morbidity and mortality?	• Identify highest preventable mortality rates or leading causes of death either across the country or in certain geographies (DHS data) • Identify the sub-groups that are most at risk	Unplanned pregnancy rates may be highest for women of certain castes Target outcome: Provide family planning services to all women through community based interventions
Are there inequities in coverage of existing health across the population?	• Identify existing health sector priorities that are primarily dependent on community health or have high mortality and morbidity among harder to reach populations (Tracking UHC) • Identify sub-groups that may be at risk but are unable to currently access healthcare	There could be a lack of trained healthcare providers and healthcare clinics that provide basic maternal health services in certain regions of the country Target outcome: Provide essential maternal health services in low-coverage areas through community based interventions

Output: Target Outcome

Source: Dalberg analysis

Next, a series of key questions should be asked to understand components that currently relate to the target outcome

Goal	Key Questions	Illustrative Example
Identify community members at risk for this issue	• Who are the populations at risk for this issue? • Are there sub-groups that may be more at risk, or that are likely to be marginalized?	The population at risk for malaria is children under-5. Incidence is particularly high in poorer households and marginalized sub-communities Community members at risk: Homes with children under 5
Identify and understand health specific components	• Who currently provides health care for this issue? • If preventive care for this issue occurs, does it occur at the home or community level? • Does the majority of diagnosis & treatment for this issue occur at home, in the community, or at the national level?	Preventive care and diagnosis are provided by caregivers and CHWs at home, treatment is provided at local clinics Relevant actors/structures in health specific components: Homes with children under 5, CHWs, local clinics
Identify and understand health enabling components	• Who is informally stepping in to fill gaps in care? • Do care seekers consult others before seeking care? • Are there any social or cultural practices or beliefs, especially gender-related practices or beliefs, around how community members view this issue?	It is a community norm that families first consult traditional healers before seeking care Relevant actors/structures in health enabling components: Families, traditional healers, community leaders
Understand policy, regulatory, and financing environment	• What are the critical parts of the policy and regulatory environment that affect how this issue is prevented or treated? • How much funding is available for the issue?	Malaria is not part of the CHW portfolio; any care occurring is informal. There is no line item for CHWs in the district budget, the program in place is informal.

Output: List of components to analyze in further detail, understanding of the policy and funding environment

Source: USAID Local Systems Framework; Dalberg analysis

The third step is to analyze bottlenecks that existing actors are facing, it is important to identify underlying bottlenecks here

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- Within the identified components, there may be actors or structures that can **accelerate progress but do not currently play a role**
- The ecosystem is tightly interconnected, **bottlenecks seen in one part of the ecosystem can often originate in a different part** of the ecosystem
- **Asking the key questions should therefore be done iteratively**, if one component is facing a bottleneck, it may be because an underlying need (access, resources, or agency) for that component is not being met

The following process can help to identify bottlenecks across the complex ecosystem

Do the actors / structures in identified components have the agency, access, and resources they need?

No → What are the ***underlying bottlenecks*** to obtaining this agency, access, or resources needs? → Priorities lie in programs targeting the actor or structure that can influence the underlying bottleneck

Yes → Is there ***another actor or structure*** that is not currently involved who could accelerate progress? → Priorities lie in programs targeting a new actor or structure

Output: List of bottlenecks that programs should focus on

Source: Expert interviews; Dalberg analysis

Home level care: Key questions to analyze bottlenecks

Refers to the health-related infrastructure & health care providers (preventive and curative) available within the home

	Key questions to identify bottlenecks	Illustrative metrics
Questions related to agency	Are home level health providers **aware of their role**?	• Measures of household health behaviors such as handwashing[1] • Surveys of traditional healers[2]
	Are home level health providers **empowered to perform their role**?	• Percentage of CHWs from marginalized communities reporting difficulties in accessing clients[3]
Questions related to access	Do home level health providers have **access to their clients**? E.g., do they have the transportation to reach client homes?	• Percentage of children receiving a post-natal care visit at home[4] • Percentage of households reporting contact with a health educator in the last 3 months[4]
	Do home level health providers have **access to the support** they need from the rest of the health system? E.g.: do they have access to adequate training and supervision	• Number of CHWs passing iCCM (or other) knowledge test after 6 months in training[1] • Percent of community level health providers with a direct supervisor whom they interact with at least monthly[4]
Questions related to resources	**Are there enough** home level health providers to meet community needs?	• Number of health workers per capita[5]
	Do home level health providers have the **resources they need** to serve their clients? E.g., do they have medical supplies they need to conduct their work?	• Percentage of CHW drug kits with key drugs[3]

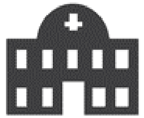
Source: [1] USAID; [2] UNAIDS [3] Evaluation of ASHA Program, 2010; [4]"Strengthening Primary Health Care through Community Health Workers: Investment case and financing recommendations," 2015; [5] WHO; Dalberg analysis

Community level care: Key questions to analyze bottlenecks

Refers to health-related infrastructure and health care providers available to the community member within the community

	Key questions to identify bottlenecks	Illustrative metrics
Questions related to agency	Are community level providers aware of their role?	• Number of CHWs passing iCCM (or other) knowledge test after 6 months in training[1]
	Do community level providers have **the support they need from the community**?	• Metrics that match CHW profiles with community needs[2]
	Do community level providers have **support from district or national level actors**? E.g. do district health offices consider them when designing programs?	• Do District Budgeted Plans include CHW program activities, aligning with budgeted plans that support other Cadres?[3]
Questions related to access	Do community level health providers have **access to support they need**? E.g. are there clear treatment protocols, adequate training, and supervision?	• Ratio of CHW supervisors to CHWs[4] • Existence of a national primary care training program with theoretical/practical component[5]
	Do community level health providers have **access to support their patients need**? E.g. are there strong referral systems to national/district hospitals?	• Percentage of children who arrived at the referral site with a referral slip[6] • No. of patients referred by CHWS[5]
	Do national /regional decision makers have **access to the data** they need to understand community health needs?	• Inclusion of community health workers in iHRIS or similar information systems[7]
Questions related to resources	**Are there enough** community level health providers? E.g. are there enough CHWs or local clinics?	• Health center and health post density (per 100,000 population)[8]
	Do community level providers have the **resources they need** to serve their clients? E.g., do local clinics have appropriate facilities and stock of medical supplies?	• Basic equipment availability[5] • The proportion of CHWs for whom stock card data was included on all resupply worksheets in the past quarter[6]

Source: [1] UN Special Envoy for Financing the Health MDGs and Malaria; [2] Ministry of Health, Rwanda; [3] WHO Monitoring and Accountability Initiative; [4] Ghana CHW Roadmap; [5] Primary Health Care Performance Initiative [6] WHO Rapid Assessment of Referral Systems; [7] USAID IHRIS [8] WHO; Dalberg analysis



District & national level care: Key questions to analyze bottlenecks

Refers to health-related infrastructure and health care providers (most commonly curative) located outside the community

	Key questions to identify bottlenecks	Illustrative metrics
Questions related to agency	Do national / district hospitals have **adequate support from health policy makers and regulators? E.g. are new and effective drugs expediently approved by regulators?**	• Availability of essential medicines and commodities[1] • Average drug application processing time[2]
	Are national and regional decision makers have **the required knowledge and capacity** to design programs?	• Existence of a CHW officer in the Ministry of Health[3]
	Do **national and regional decision makers have agency** to determine target outcomes and design programs?	• Percentage of health funding that is externally financed[4]
Questions related to access	Do national /regional decision makers have **access to the data** they need to understand community health needs?	• Usage of iHRIS or other health information management system[5]
Questions related to resources	**Are there enough** national / district hospitals?	• Hospital bed density and service utilization[6]
	Are there **sufficient skilled health care** providers?	• Health service access[6]
	Do hospitals have the **resources they need to provide care using current best practice**? E.g., do they have adequate funding for staff, facilities & stock of supplies?	• Availability of essential medicines and commodities[6] • Basic equipment availability[7] • Proportion of GDP spent on healthcare[4]
	Do national / district hospitals have **the resources they need to invest in advancing options for care**? E.g. is there adequate funding devoted to health-related R&D?	• Proportion of GDP spent on health related R&D

Source: [1] WHO 100 Core Health Indicators; [2] U.S. Food and Drug Administration; Initiative [3] WHO Monitoring and Accountability Initiative; [4] WHO; [5] USAID; [6] WHO 100 Core Health Indicators [7] Primary Health Care Performance; Dalberg analysis

Families: Key questions to analyze bottlenecks

Refers to the immediate living environment for each community member, including family members, family norms & living conditions

	Key questions to identify bottlenecks	Illustrative metrics
Questions related to agency	Do families have the **knowledge to provide preventive care or early diagnosis** for the target outcome? E.g. are families aware of their health needs for the target outcome?	• Surveys of household awareness of specific health needs[1]
	Are **there family-specific norms that work to the detriment** of achieving the target outcome? E.g. are there family-specific gender biases?	• Gender-specific mortality and morbidity rates[2]
	Are there **community or national level norms that influence families (or specific types of families)** to the detriment of achieving the target outcome? E.g. are certain families marginalized within the community?	• Health outcome measures by community
Questions related to access	**Are there existing providers of preventive or curative care** that families can avail of? E.g., are local clinics within reasonable distance of families?	• Distance to nearest facility[1] • Health center and health post density (per 100,000 population)[3]
	If yes, **do families have infrastructure support from** their community to reach these providers? E.g., are there adequate roads and public transportation options?	• Time to nearest facility[4]
Questions related to resources	Do families have the **resources they need to invest in their living environment for preventive care**? E.g. can they afford access to clean water and sanitation?	• Percentage of households with access to improved water and/or sanitation facilities[5]
	Do families have the **resources they need to seek curative care?** E.g. do they have the financial resources and the time to seek care?	• Access barriers due to treatment cost[3]

Source: [1] WHO [2] UNICEF; [3] Primary Health Care Performance Initiative; [4] MEASURE; [5] World Bank; Dalberg analysis

Local communities: Key questions to analyze bottlenecks

Refers to the community level environment, including community level norms, groups, and infrastructure

	Key questions to identify bottlenecks	Illustrative metrics
Questions related to agency	Are community members **influenced by broader norms** that affect their actions and beliefs relating to the target outcome? E.g. are there religious beliefs around the health issue relating to the target outcome?	• Health outcomes by religious groups • Employers not discriminating against those with HIV[1]
	Are **community members aware of their role** in supporting the target outcome? E.g. are there community support groups or other types of networks available to community members?	• Existence of community support groups
	Are **community members engaged in their role** in supporting the target outcome? E.g. are community leaders or community groups actively engaged with healthcare providers?	• Measures of legitimacy/credibility (the degree which community members consider CHWs to be making a valued contribution)[2] • Measures of prestige (the value and/or status that community members accord to CHWs)[2]
Questions related to access	**Are there existing providers of preventive or curative care** that communities can avail of? E.g., are local clinics within reasonable distance of the community?	• Distance to nearest facility[3] • Health center and health post density (per 100,000 population)[4]
	If yes, **do communities have infrastructure support from** their community to reach these providers? E.g., are there adequate roads and public transportation options?	• Time to nearest facility[5]
Questions related to resources	Do communities have adequate **infrastructure to support health needs** of community members? E.g. is there funding for building roads, providing electricity to local clinics, and gathering places for community groups?	• Percent of rural populations with access to improved water[6] • Percent of paved roads[6] • Vehicles per km of road[6]

Source: [1] USAID [2] U.S. Government Evidence Summit, 2012; [3] WHO [4] Primary Health Care Performance Initiative; [5] MEASURE; [6] World Bank; Dalberg analysis

National / global community: Key questions to analyze bottlenecks

Refers to the national or regional context in which the community member operates

	Key questions to identify bottlenecks	Illustrative metrics
Questions related to agency	Is the **national context conducive to building awareness and support** for healthcare? E.g. are there influential national or regional level actors that support the target outcome?	• Civil society strength indices[1]
Questions related to access	Are there national awareness campaigns related to the importance of health? Are these accessible to people from all regions and socio-economic classes within the country?	• Literacy level and school completion rates by age, geography, gender[2] • No. of national awareness campaigns on health (e.g. Handwashing Day)
	Are there **well-functioning supply chains** to transport drugs and equipment across districts and to communities?	• Logistic performance indices[2]
Questions related to resources	Are there **adequate resources available to support the availability of skilled healthcare professionals**? E.g. are there enough universities and vocational training centres?	• Number of graduates from health workforce educational institutions (including schools of dentistry, medicine, midwifery, nursing, pharmacy) during the last academic year per 1000 population[3]
	Are there **adequate resources to support infrastructure related to health care**? E.g. is there adequate funding for roads and electricity?	• Percent of roads that are paved[2] • Infrastructure spending, % of GDP • Measures of quality of public infrastructure

Source: [1] Overseas Development Institute; [2] World Bank; [3] WHO 100 Core Health Indicators; Dalberg analysis

Once underlying bottlenecks are identified, lifting them may involve strengthening existing programs or developing new ones

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Key Questions	Description	External Resources
How will program development / strengthening **be financed?**	• Are there clear cost estimates that include initial costs and on-going costs such as training, supervision, and maintenance? • Will funding be sourced domestically or from external donors? • Are there innovative funding sources that can be used?	USAID Financing Framework for EPCMD USAID iCCM Costing and Financing Tool UN Special Envoy Financing Recommendations
How will we ensure that program development / strengthening is **sustainable?**	• If this program is not self-funded, what will happen when the first round of financing ends? • Is there demonstrable demand and ownership for this program from both communities and from national / district governments? • Is the program reflected in the local, district, or national strategy / budget for community or public health?	USAID, From IDEA to IMPACT USAID Project Design Sustainability Analysis Tool
What **models and innovations** have been used elsewhere to address these priority areas for focus?	**TOOLKIT: Models & Innovations**	

Source: Dalberg analysis

Finally, oversight, monitoring, and evaluation process are need to ensure accountability and effective program implementation

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Goal	Key Questions	Key external Resources
Ensure there is administrative and policy capacity to implement the program	• Do all the entities involved in the program (health components, community components or other entities) have the **skills, knowledge, and training** needed to make the program work? • Are the various entities involved in the program able to **communicate** with one another effectively? • Is this program **adequately funded**?	Lives Saved Tool MEASURE tools UNDP M&E USAID M&E USAID Global Health Principles M&E Guide WHO M&E World Bank M&E

Ensure accountability in program implementation through monitoring	• Is the program being **implemented as intended**? E.g.:
	  • Do community support groups that are intended to include marginalized members actually include such members?
	  • Are participatory learning action groups meeting as frequently as the program intended?
	  • Are clinics disbursing supplies to all community health workers it is intended to support?	

Ensure programs deliver target outcomes through evaluation	• Is there an evaluation plan in place that monitor or measures whether the program is **meeting intermediary outcomes**, e.g., whether it is meeting the agency/access/resource needs it was intended to meet? • Is there an evaluation plan in place that monitors or measures whether the program is **ultimately meeting target outcomes such as coverage of high impact interventions or reducing mortality/morbidity/inequity**?	

Source: WHO Precede-Proceed Model

Toolkits

I. PROCESS FOR STRENGTHENING COMMUNITY HEALTH

II. LINKS TO EXTERNAL TOOLS

III. INNOVATIONS AND INTERVENTIONS

IV. CASE STUDIES

Home level care: External tools

Reports

- Report: UN Special Envoy, Strengthening Primary Care through Community Health Workers: Investment case and financing recommendations

Resource Collections

- Resource Collection: CHW Central
- Resource Collection: mPowering Frontline Health Workers, ORB Platform for Community Health

Measurement

- Measurement: Primary Health Care Performance Initiative (PHCPI), Vital Indicators

Toolkits

- Toolkit: USAID BASICS, A guide to helping CHWs provide health messages
- Toolkit: USAID / CORE Group, Designing for behavioral change
- Toolkit: USAID, CHW Program Functionality Assessment Tool
- Toolkit: USAID, CHW-AIM Matrix
- Toolkit: WHO, Guidelines for Training Traditional Healthcare Practitioners

Source: Dalberg analysis

Community level care: External tools

Reports

- Report: USAID, Enhancing Community Health Worker Performance through Combining Community Health and Formal Health Approaches

Resource Collections

- Resource Collection: CORE Group, Diffusion of Innovations for Community Level Care
- Resource Collection: mPowering Frontline Health Workers, ORB Platform for Community Health
- Resource Collection: USAID, Advancing Partners and Communities

Toolkits

- Toolkit: K4 Health, Community Health
- Toolkit: Primary Health Care Performance Initiative, Vital Indicators
- Toolkit: PATCH Model for Community Health
- Toolkit: UNICEF and Frog Design, Backpack Plus
- Toolkit: UNICEF, Newborn Bottleneck Analysis Tool
- Toolkit: UNICEF, WASH Bottleneck Analysis Tool
- Toolkit: WHO, Community health mobilization toolkit for HIV
- Toolkit: WHO, Healthy Villages Guide

Source: Dalberg analysis; Images from ASHA and Pathfinder

District & national level care: External tools

USAID
FROM THE AMERICAN PEOPLE

Reports

- Report: UN Special Envoy, Strengthening Primary Care through Community Health Workers: Investment case and financing recommendations
- Report: USAID Summit, Support that the formal healthcare system can provide community health

Resource Collections

- Resource Collection: John Snow International, Strengthening supply chains for public health

Toolkits

- Toolkit: Capacity Plus, Strengthening the health system through gender responsive strategies
- Toolkit: USAID, From IDEAS to IMPACT: Guide to Introduction and Scale of Global Health Innovations
- Toolkit: USAID, iCCM Costing and Financing Tool
- Toolkit: IntraHealth, Health Workforce Productivity Analysis and Improvement Toolkit
- Toolkit: USAID, Financing Framework to End Preventable Child and Maternal Deaths
- Toolkit: WHO, Assessing the National Health Information System

Source: Dalberg analysis; Images from GSK; Karagwe.com

Families: External tools

Reports

- Report: WHO, Demand side financing in health for developing countries
- Report: WHO, Engaging men and boys in reproductive, maternal and child health
- Report: WHO, Psychosocial support for HIV

Toolkits

- Toolkit: CHANGE Project, Behavior change toolkit for maternal survival
- Toolkit: CORE Group, Social and behavioral change for family planning
- Toolkit: FHI 360, Communicating for Change: Social and behavioral change
- Toolkit: MEASURE, Engaging men and boys in family planning
- Toolkit: Population Council, Respectful maternity care resources
- Toolkit: USAID / CORE Group, Barrier analysis for behavioral change

Source: Dalberg analysis; Images from K4Health and ICRW

Local communities: External tools

Reports

- Report: UNFPA, Integrated approaches to service delivery for community health
- Report: WHO, World Conference on Social Determinants of Health

Resource Collections

- Resource Collection: mPowering Frontline Health Workers, ORB Platform for Community Health
- Resource Collection: PATH, Community mobilization resources
- Resource Collection: PSI and USAID, Ebola Community Action Platform

Toolkits

- Toolkit: CARE, Community ScoreCard
- Toolkit: K4Health, Engaging traditional leaders for HIV
- Toolkit: Peace Corps, Social and Behavioral Change Toolkit
- Toolkit: PHI, Resources for Community Mobilization
- Toolkit: USAID, Agricultural and Nutritional Context

Source: Dalberg analysis; Images from The Hindu and Pathfinder

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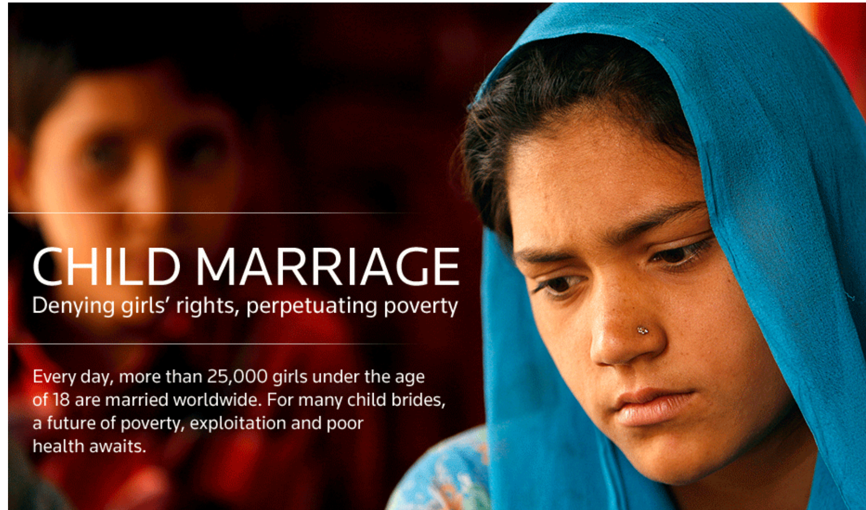
District & national community: External tools



Resource Collections

- Resource Collection: mPowering Frontline Health Workers, ORB Platform for Community Health
- Resource Collection: The Global Public Private Partnership for Handwashing Campaigns

Toolkits

- Toolkit: Health Workforce Advocacy Initiative, Human Resources for Health Advocacy
- Toolkit: MAMA, mHealth Mobile Messaging
- Toolkit: UNDP, Strengthening Civil Society Partnerships
- Toolkit: USAID and FHI360, Interactive Radio for Agricultural Programming
- Toolkit: WHO, Advocacy for Chronic Diseases

Source: Dalberg analysis; Images from Pathfinder and GirlsNotBrides

Toolkits

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Home level care: Models and innovations

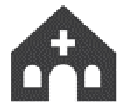
1: BBC Media Action: Mobile Kunji ("MK") Community Health Cards in India

Overview	MK is a pack of 40 cards illustrated with health messages. Each card has a unique toll-free code that when dialed by the health worker, takes the listener to audio with further elaboration.				
Key successes	▪ Mothers exposed to MK are more likely to prepare for birth (28% increase) and to engage in complementary feeding practices (13.5% increase)	**Criteria for success**	▪ Enable accessibility from any mobile phone handset (no special software required) ▪ Provide free messages	**Cost**	< US$ 2 M[1] for 5 years (2010-2015)
Additional Information	MIT Press Journal; MSBC India Story; Rethink1000Days Website				

2: D-Tree Safer Deliveries Project in Zanzibar

Overview	D-Tree (a technology company) collaborated with Tanzania's MoH, Jhpiego and Gates Foundation to equip traditional birth attendants and CHWs with tools to register and screen pregnant/postpartum women and newborns				
Key successes	▪ Reaches > 50% of rural population ▪ 3,690 pregnant women registered ▪ Facility delivery rate increased from average of 35% to 75%	**Criteria for success**	▪ Work with trusted care providers ▪ Link with local transport providers for referrals ▪ Use mobile money payments	**Cost**	Not available
Additional Information	D-Tree Website; USAID – mHealth Compendium Volume 5				

[1] Estimated by BBC Media Action. Source: Dalberg analysis



Community level care: Models and innovations

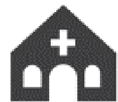
1: Community Action Cycle Approach

Overview	The community action cycle is a 5-step participatory problem-solving and community engagement approach used in multiple countries.				
Key successes	▪ Successfully applied to address different health disparities (e.g., tobacco use in the U.S., post-abortion care in Kenya)	**Criteria for success**	▪ Facilitate group discussions ▪ Provide feedback and ensure accountability to community	**Cost**	Not available
Additional Information	Guide to Action for Community Mobilization and Empowerment Focused on Post-abortion Complications in Kenya; PMC journal article; USAID – Community Action Cycle Implementation Guide				

2: Village Health Team (VHT) program in Uganda

Overview	Uganda's MoH started the VHT program in 2001 to improve maternal / child health. VHT members are community elected volunteers who work together to promote healthy practices in immunization, sanitation and nutrition				
Key successes	▪ Reduction in neonatal mortality	**Criteria for success**	▪ Standardize training ▪ Enable supportive supervision ▪ Offer incentives (financial and nonfinancial)	**Cost**	Not available
Additional Information	National Village Health Teams (VHT) Assessment In Uganda; Article; – The Experience of a Village Volunteer Programme In Yumbe District; Article – Healthy Child Uganda Survey; Article – Newborn Survival in Uganda				

Source: Dalberg analysis



Community level care: Models and innovations

3: Novartis Arogya Parivar Model in India

Overview	Novartis recruits and trains community members as "health educators," who do health prevention and counselling. Local teams work with doctors to organize health camps and mobile clinics. This model is also being tested in Kenya.				
Key successes	▪ Treatment/diagnosis to 760,000 people and education to10 million across 10 states between (2010-2013)	**Criteria for success**	▪ Focus on most prevalent diseases ▪ Target under-served populations	**Cost**	Not available
Additional Information	Novartis Website; Novartis Arogya Parivar Fact sheet; GBC Health Award to Novartis; INSEAD Case for Novartis' BOP Strategy for Healthcare in Rural India				

4: Care Groups: Using Community Volunteers to Rapidly Expand Coverage

Overview	A Care Group is a group of 10-15 volunteer community based health educators who regularly meet with a facilitator. They then visit their neighbors to share what they learn. Care Groups have been used in over 29 countries				
Key successes	▪ Increased coverage of child survival interventions ▪ Better nutrition/lower diarrhea	**Criteria for success**	▪ Define scope of group clearly ▪ Conduct regular "small dose" training ▪ Do not require significant travel	**Cost**	US$ 3/yr/person[1]
Additional Information	▪ "Care Groups: An Innovative Community-Based Strategy," Part I and Part II; CORE Group Resource Guide				

[1] Perry et al, 2015; Source: Dalberg analysis

District & national level care: Models and innovations

1: D-Tree Electronic Protocol Support

Overview	D-Tree is a technology company that equips health workers with an electronic patient assessment tool for PDAs/cellphones. The tool incorporates electronic clinical protocols for a variety of conditions, for e.g. HIV / iCCM				
Key successes	▪ More accurate diagnoses ▪ Easier updates to changes in treatment protocols ▪ Reduced burden on clinicians	**Criteria for success**	▪ Provide easy to access and use interface on mobile devices ▪ Design to be usable by rural health workers or CHWs	**Cost**	Not available
Additional Information	D-Tree Website; Journal article for iCCM; HIV-AIDS				

2: Mobile Alliance for Maternal Action: Text Messages Directly to New & Expecting Mothers

Overview	Mobile Alliance for Maternal Action (MAMA) works to improve maternal and newborn health by delivering text messages with localized information that corresponds to the woman's pregnancy or child's development stage				
Key successes	▪ Higher health knowledge & preparedness ▪ Higher clinic attendance and more interaction with care providers	**Criteria for success**	▪ Provide free messages ▪ Craft messages in close collaboration with global experts ▪ Adapt messages to context based on WHO and UNICEF guidelines	**Cost**	US$10 M investment in 3 countries
Additional Information	MAMA Website; MAMA's 2012 Global Monitoring and Evaluation Framework document; Evidence Hierarchy of Mobile Messaging for Improved MNCH document				

Source: Dalberg analysis

District & national level care: Models and innovations

3: CORE Group Secretariat Model: Coordinating across civil society actors

Overview	The Secretariat Model is an independent coordinating secretariat across various government and non-profit health actors in a country. The secretariat identifies gaps in capacity, helps with planning, M&E, and facilitates partnerships				
Key successes	▪ Applied successfully to address polio, child health, malaria and flu pandemics across 15 countries ▪ Instrumental in WHOs declaration of India as "polio-free" in 2014	**Criteria for success**	▪ Leverage partnerships, providing a neutral space for collaboration ▪ Share best practices ▪ Support M&E	**Cost**	Not available
Additional Information	Core Group Secretariat Model				

4: GSK-CARE CHW Training in Afghanistan, Bangladesh, Cambodia, Laos, Myanmar, and Nepal

Overview	Program to support the training of frontline health workers (e.g., midwives, nurses, health extension workers, CHWs, volunteers), in collaboration with local governments.				
Key successes	▪ 16,500 health workers trained ▪ Nearly 4 million people reached ▪ Positive improvements in morbidity and mortality in the project area	**Criteria for success**	▪ Promote prevention and early referral ▪ Build capacity ▪ Leverage partnerships	**Cost**	£10 million reinvested to date
Additional Information	Care International Website – Project Description; ODI and Care Report - Improving Maternal and Child Health in Asia through Innovative Partnerships and Approaches: The case of Nepal				

Source: Dalberg analysis

Families: Models and innovations

1: Maternity Open Days in Kenya: Engaging families in maternal care

Overview	Maternity Open Days (MODs) provide an opportunity for pregnant women and their families to interact with health care providers and visit the maternity unit to demystify birthing practices and mitigate any fears regarding childbirth				
Key successes	▪ Over 3,000 women and their families reached in 13 sites in Kenya ▪ Attendance by men increased over time; better engagement with families seen over time	**Criteria for success**	▪ Ensure privacy and confidentiality ▪ Invite community leaders and health providers to speak about care and treatment	**Cost**	Not available
Additional Information	"Open Maternity Days: Respectful Maternal Care," Population Council and USAID; "Training Guide"; Study Design				

2: The Positive Deviant/HEARTH model: Helping families reduce malnutrition

Overview	PD/Hearth is a behavior change intervention for families with underweight preschool children. Behaviors practiced by caretakers of well-nourished children are identified and transferred to others in their home or "hearth."				
Key successes	▪ Implemented in 40 countries by World Vision ▪ Reduced under-5 malnutrition in five countries by 22% in 2 months	**Criteria for success**	▪ Utilize community volunteers ▪ Use PD to complement more clinical approaches ▪ Design localized menus / foods	**Cost**	Range from US$0.73 to US$9 / person[1]
Additional Information	CORE Group essential elements of a successful PD Model; World Vision Overview; Impact Report; Toolkit				

[1] Estimates from World Vision. Source: Dalberg analysis

Local communities: Models and innovations

1: BRAC Manoshi – Building Community Engagement in Urban Slums in Bangladesh

Overview	BRAC Manoshi is a highly successful MNCH program in urban slums in Bangladesh. The model used several community mobilization strategies include social mapping, census taking, and community based governance				
Key successes	▪ Home births fell from 84% in 2010 to 13% in 2013 ▪ Maternal mortality fell by 56%, neonatal mortality fell by 60%	**Criteria for success**	▪ Involve communities in program design, governance, and accountability ▪ Encourage communities to seek care from CHWs and / or facilities	**Cost**	US$ 25 million over 5 years
Additional Information	BRAC Website – Manoshi Profile; BRAC Report – The BRAC Manoshi Approach; CCIH Presentation; WHO - A Brief Note on the Manoshi-Urban MNCH Project; Center for Health Market Innovations Website – BRAC Manoshi Profile;				

2: Feed the Future - Knowledge-based Integrated Sustainable Agriculture & Nutrition (KISAN)

Overview	KISAN aims to reduce poverty and hunger in Nepal through an integrated approach of agricultural and nutritional interventions for farm families and families with expecting/new mothers and children under 5				
Key successes (planned)	▪ Train 60,000 households ▪ Improve access to water & sanitation, health & nutrition behaviors among mothers and children	**Criteria for success**	▪ Use private sector input suppliers & service providers ▪ Disseminate sustainable and market-based technologies	**Cost**	US$ 20.4 million over 5 years
Additional Information	USAID – KISAN Project Overview; USAID and Winrock International – Quarterly Report July-Sep 2013; USAID Press Release – Two New Agriculture Initiatives to Reduce Poverty and Hunger Across Western Nepal				

Source: Dalberg analysis

Local communities: Models and innovations

3: Reducing under-nutrition using *Atencion Integral a la Ninez en la Comunidad* (AIN-C) in Honduras

Overview	AIN-C is a community based growth monitoring approach that uses community volunteers to weigh children, detect potential issues, counsel mothers, conduct home visits, treat simple cases, and refer as needed to facilities				
Key successes	▪ Increased incidence of exclusive breastfeeding, appropriate feeding, immunization, and vitamin supplementation. Impact 2-3 times greater for poorer households	**Criteria for success**	▪ Regular communications delivered by trusted community members ▪ Support from local governments and local clinics	**Cost**	US$2.73 per child per year[1]
Additional Information	World Bank: AIN-C approach; BASICS: AIN-C Evaluation				

Source: Dalberg analysis

District & national community: Models and innovations

1: USAID – Safe Love Campaign in Zambia

Overview	The Safe Love campaign aimed to tackle HIV in Zambia by addressing low and inconsistent condom use, multiple concurrent partnerships, and low uptake of HIV treatment and testing services				
Key successes	▪ 6-14% increase in condom acquisition and condom use at last sexual encounter ▪ 22.5% increase in partners getting tested for HIV in the past 6 months	**Criteria for success**	▪ Conduct focus groups to understand cultural dynamics at play risky sex behaviors ▪ Create targeted messaging ▪ Quality customized mass media	**Cost**	US$ 9 million over 3-4 years
Additional Information	USAID Website – Safe Love Campaign Outcome Evaluation; IBTCI Mid-Term Evaluation of Safe Love; Chemonics Project Description; USAID Zambia – Safe Love Cost-Effectiveness Report				

Source: Dalberg analysis

Toolkits

I. PROCESS FOR STRENGTHENING COMMUNITY HEALTH

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IV. CASE STUDIES

Case Study – Living Goods

LivingGoods

A Best-Practice Community Health System Linked to Low-Cost Business Model

Living Goods supports networks of community health promoters who go door-to-door teaching families how to improve their health and distributing life-changing products and services including diagnosis and treatment of malaria, diarrhea, and pneumonia; safe delivery kits, fortified foods, clean stoves, water filters, and solar lights.

Mobile Powered Performance Tools

- Every CHW uses a smartphone with best-in-class health apps
- Automates iCCM diagnosis for childhood diseases
- Registers pregnant women and sends timed SMS health messages
- Managers see real time performance data on every CHW on any device

Integrated Health Delivery

Healthy Pregnancy and Family Planning

Newborn Survival

Nutrition

Childhood Diseases

Sales Pay for CHW Compensation and Product Costs

- CHWs are neither volunteers nor salaried workers--they are paid for results
- CHWs earn a margin on products they sell
- Recovers 100% of product costs
- Covers some operating costs making net cost to funders under $2 per capita annually
- Key health commodities always in stock

WHAT IS THE MODEL?

- **Living Goods empowers** Community Health Promoters (CHPs) to deliver products and services to homes
- CHPs **sell specific preventive or curative products and** also **provide basic health services** such as screening and referral and family planning counselling
- An RCT showed a **25% reduction in under-5 mortality** using the Living Goods approach

WHAT COMPONENTS ARE USED?

- **Health specific components**
  - **Home level care**
  - **District & national level care** through private supply chain logistics
- **Health enabling components**
  - Involvement of **local community** leaders in CHP ceremonies

KEY SUCCESS FACTORS

- **Use of an integrated platform** to deliver care across four areas – pregnancies, nutrition, newborn survival, and childhood diseases
- **Use of mobile technology in partnership with Medic Mobile** to record performance, help CHPs register and track pregnancies, and provide mothers with reminders for key health needs
- **Use of private sector expertise** in supply chain management and performance management for CHPs

Additional information: Living Goods Website, Video, Randomized Controlled Trial

Source: Dalberg analysis; Images from Living Goods

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Case Study – Medic Mobile

WHAT IS THE MODEL?

- Medic Mobile is a nonprofit technology company that has a **suite of mHealth products to improve quality and access** of healthcare delivery
- Health workers can use Medic Mobile to **support antenatal care, childhood immunization, disease surveillance & stock monitoring**
- Products range from **SMS to more complex web and mobile based applications**

WHAT COMPONENTS ARE USED?

- **Health specific components**
  - **Home & community level care** by CHWs, nurses and community members
  - **National/district level care and oversight** – Working with local partners to replicate programs in new districts
- **Health enabling components**
  - **Local community support** to share knowledge and best practices

KEY SUCCESS FACTORS

- Medic Mobile **partners with a range of implementing organizations**
- The software toolkit is (i) **free and scalable**, (ii) **designed for health workers and health systems in remote areas**, (iii) supports **any language**, (iv) works **with or without internet**, and (v) **runs on basic phones**, smart phones, tablets, and computers

Additional information: Medic Mobile Website; Skoll Foundation Award to Medic Mobile

Source: Medic Mobile; Skoll Foundation; Dalberg Analysis; Image from Medic Mobile

Case Study – Project Muso

WHAT IS THE MODEL?

Muso seeks to remove barriers and bring care to patients proactively through a **4-step model**:

1. **Proactive search:** CHWs search for patients through door-to-door home visits
2. **Doorstep care:** CHWs provide a package of life-saving health care services at home
3. **Rapid access clinics:** Patients are brought to rapid access clinics
4. **Care without fees:** Patients access care from CHWs and in clinics with no point-of-care fees

WHAT COMPONENTS ARE USED?

- **Health specific components**
  - **Home level care** by CHWs
  - **Community level care** by rapid access clinics
- **Health enabling components**
  - **Local community** members help search for patients

KEY SUCCESS FACTORS

- **Proactive model:** Health care providers go door-to-door to proactively search for patients
- **Integrated approach to removing barrier:** Muso conducted ethnographic research to identify key barriers faced by patients and designed an intervention that simultaneously removes all of these barriers
- **Community-led:** Muso taps the power of social networks, community leaders, and local women

Additional information: Project Muso; Journal article by PLOS ONE

Source: Project Muso; PLOS ONE; Dalberg analysis; Image from Project Muso

Case Study – Ethiopia's Community Health Model

WHAT IS THE MODEL?

- Ethiopia has two cadres of community workers.
- **Health Extension Workers (**HEWs) are paid, full time employees in the health sector and engage in health promotion, disease prevention and treatment of uncomplicated illnesses
- **Health Development Army (HDA) are** volunteers who increase utilization of health services through education.
- Ethiopia has made **significant progress towards lowering maternal and child mortality**. This progress is largely credited to community health programs

WHAT COMPONENTS ARE USED?

- **Health specific components**
  - **Home / community level care** by HEWs and HDA volunteers;Village Health Committees to select and oversee HEWs
  - Supervision of HEWs by **district health systems**
- **Health enabling components**
  - **Local community:** Involvement of the *kebele* (ward) council in program planning, implementation, and evaluation

KEY SUCCESS FACTORS

- **Focus on preventive care** across a range of disease areas
- **Integration of community health efforts with the formal healthcare system** including supervision and oversight
- **Multiple cadres of CHWs** to address varying needs

Additional information: Ethiopian Ministry of Health; Case Studies of Ethiopia by WHO, MCHIP

Source: USAID MCHIP; Dalberg analysis; Images from UNICEF and IntraHealth

Case Study – Rwanda's Community Health Model

WHAT IS THE MODEL?

- There are **three CHWs in each village**: a male-female pair (*binomes)* that provide basic care and integrated community case management (iCCM) for children; and a CHW in charge of maternal health called an *Agent de Sante Maternelle* (ASM)
- All CHWs are **volunteers**, with MOH-funded **performance based incentives**
- The CHW program is a primary reason why Rwanda is very close to **achieving its maternal and child health-related MDGs** by 2015.

WHAT COMPONENTS ARE USED?

- **Health specific components**
  - *Binomes* and ASMs operate at the **home and community level**
  - **National & district level care:** Staff at local health centers supervise CHWs; the Ministry of Health provides incentive-based financing to CHWs
- **Health enabling components**
  - **Local community:** CHWs are elected by village members

KEY SUCCESS FACTORS

- **Multiple cadres of CHWs** with clear role definition for varying needs
- **Integrated approach** towards child health
- **Integration of community health efforts with the formal healthcare system** including supervision and oversight

Additional information: Rwandan Ministry of Health; Case Study of Rwanda by MCHIP

Source: USAID MCHIP; Dalberg analysis; Images from USAID and JSI

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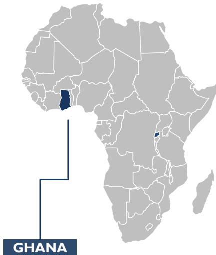
Case Study – Project DANFA in Ghana



DANFA COMPREHENSIVE RURAL HEALTH & FAMILY PLANNING PROJECT: GHANA

UCLA

ANNUAL PROGRESS REPORT

January-December 1974

WHAT IS THE MODEL?

- DANFA was an **integrated family planning, maternal and child health program** implemented by Ghana Medical School, MoH, UCLA, and USAID in the 1970s.
- The project used **community based volunteers** for health education and supplies disbursement
- **Facility and health post staff and local universities / hospitals** were also involved in delivering care and strengthening

WHAT COMPONENTS ARE USED?

- **Health specific components:**
  - **Home level care** by volunteers and health professionals
  - **National & district level care** by MoH and Ghana Med School
- **Health enabling components**
  - **Family members and local community**
  - **National & district community –** Involvement of hospitals and universities

KEY SUCCESS FACTORS

- **Involvement of the local community** including schools, families, village leaders, etc. from the planning stages
- Development and leveraging of several existing **community based groups**
- **Knowledge sharing** and development of treatment protocols with local universities and hospitals

Additional information: PubMed article; POLINE by K4Health article I and II; UCLA Annual Progress Report;

Source: Dalberg Analysis; Images from UCLA and TripMondo

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II. BIBLIOGRAPHY

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2. Akua Kwateng-Addo	2. Alyssa Sharkey, UNICEF
3. Allisyn Moran	3. Anthony Gitau, Novartis
4. Anne Peniston,	4. Ari Johnson, Project Muso
5. Ariel Pablos-Mendez	5. Carolyn Moore, mPowering Frontline Health Workers
6. Claudia Conlon	6. Daniel Kress and Katie Porter, Bill & Melinda Gates Foundation
7. T. Dan Baker	7. Daryl Burnaby, GlaxoSmithKline
8. David Jacobstein	8. David Shanklin, CORE Group
9. David Milestone	9. Emma Sacks, Johns Hopkins
10. Diana Frymus	10. Eric Sarriot, MCSP
11. Elizabeth Fox	11. Henry Perry, Johns Hopkins
12. John Borrazzo	12. Jacqueline Edwards, Medic Mobile
13. Joseph Naimoli	13. Janine Schooley, Project Concern International
14. Joseph Wilson	14. Jennifer Snell, HealthRight
15. Kama Garrison	15. Jerome Pfaffmann, UNICEF
16. Katherine Taylor	16. Joseph Petraglia, Pathfinder International
17. Kenneth Sklaw	17. Karen LeBan, CORE Group
18. Kerry Ross	18. Kate Tulenko, Intrahealth International
19. Kim Connolly	19. Laura Altobelli, Future Generations
20. Lawrence Barat	20. Lesley-Anne Long, mPowering Frontline Health Workers
21. Lisa Baldwin	21. Mohini Bhavsar, Dimagi
22. Michael Manske	22. Molly Christiansen and Chuck Slaughter, Living Goods
23. Nahed Matta	23. Na'im Merchant and Katy Voburg, Last Mile Health
24. Nazo Kureshy	24. Nathan Miller, UNICEF
25. Nikki Tyler	25. Phyllis Heydt, MDG Health Alliance
26. Niyati Shah	26. Serufusa Sekidde, Aspen Management Partnership
27. Rochelle Rainey	27. Sharon Kim, One Million CHW
28. Sara Zizzo	28. Tom Davis, Feed the Children
29. Shawn Malarcher	
30. Stephanie Levy	
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