



30 Years of the Child Survival and Health Grants Program (CSHGP): Building Systems with Communities and Countries to Save Lives and Improve Equity



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Cover photo: (Left) Community Health Volunteer Mariam Diarra explains the importance of monitoring a child's rapid breathing to several mothers, including Bintou Souko (right), who is holding her sick eight-month-old baby, during an outreach visit in Kabe Village in the western Kayes Region.

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# Table of Contents

<b>Acknowledgments</b> .....	<b>iv</b>
<b>Abbreviations</b> .....	<b>vi</b>
<b>I. Introduction</b> .....	<b>vii</b>
A. Major Contributions of the CSHGP to Global Health.....	6
<b>II. Origins, Evolution, and Features of the CSHGP</b> .....	<b>10</b>
A. Origins and Evolution of the CSHGP .....	10
B. CSHGP Operational Features and Partnership Structure .....	11
<b>III. Improving Health and Saving Lives through Increased Coverage of Essential Health Services and Household Practices</b> .....	<b>145</b>
A. Increasing Coverage of Essential Health Services and Practices.....	15
B. Estimating Lives Saved .....	17
C. Reducing Inequities in Coverage.....	18
D. Achieving Sustained Health Outcomes.....	19
<b>IV. Strengthening Health and Community Systems to Respond to the Needs of the Most Vulnerable</b> .....	<b>223</b>
A. CHWs: Linking Communities with the Health System .....	24
B. Integrating Promotion of Key Family Practices Critical for Health and Nutrition .....	26
1. Empowering Communities to Improve Health Outcomes and Agency .....	28
C. Increasing Appropriate and Accessible Health Care and Information from Community-Based Providers .....	30
1. iCCM: An Equity-Focused Strategy for Children Brings Services and Information to Communities.....	31
D. Improving Partnerships between Health Facilities and the Communities They Serve.....	33
1. Increasing Skilled Birthing Care .....	33
2. Increasing Community-Friendly Outreach Services .....	34
3. Partnering with Community Health Committees .....	34
4. Working Together to Improve Quality of Care.....	35
5. Creating Feedback Mechanisms to Promote Citizen Participation, Build Accountability, and Improve Governance.....	36
E. Working along a Multi-Sector Platform.....	37
<b>V. Care Groups: An Illustration of the CSHGP Evidence, Learning, Innovation, and Diffusion</b> .....	<b>3940</b>
<b>VI. Conclusion</b> .....	<b>423</b>
<b>VII. References Cited</b> .....	<b>46</b>

# Acknowledgments

This document was developed in the spirit of the strategic partnership model of the Child Survival and Health Grants Program (CSHGP), in which USAID supported and managed: 1) a direct partnership with International Non-Governmental Organizations (INGOs), with required local partnerships, through grants/cooperative agreements; 2) a technical support mechanism to ensure overall quality and consistency with international best practices and standards; and 3) a networking function to facilitate sharing of evidence and lessons to advance community health across the INGO partners and the broader health and development community. Nazo Kureshy, U.S. Agency for International Development’s lead for the Child Survival and Health Grants Program (CSHGP) from 2006-2017, provided the overall leadership, direction, and vision for USAID’s legacy document in collaboration with Leo Ryan, ICF’s lead for technical assistance to the CSHGP (1998-2014) and Karen LeBan, CORE Group’s lead for strategic networking and collaboration (2002-2016).

This document reflects a small but important glimpse of the USAID-facilitated CSHGP partnership, spanning 30 years. It highlights the commitment, creativity, and perseverance of countless CSHGP pioneers at the frontlines of this program all over the world, including diverse institutions (INGOs, local NGOs, government staff) and communities (community health workers, community groups and structures, community leaders, other community members and community-based and civil society organizations). These trusting partnerships and networks on the frontlines prioritized the poorest communities all over the world to make ‘health for all’ a reality – since the Alma Ata Declaration in 1978 -- in the most vulnerable populations and contributed to developing national and local systems and a noteworthy global evidence base to support the centrality of communities in health and development. We hope that the numerous leaders, champions, supporters, and friends of the Child Survival and Health Grants Program – at the local, national and global levels -- will use and continue to build on the knowledge and evidence highlighted in this document to prioritize and debate the essential role of empowered communities as key allies and resources in the primary health care of the future.

We salute all the heroes of this program at all levels who continue to inspire us to make communities central in the movement for primary health care. We dedicate this legacy document to the values, principles and the spirit of hope that the giants of primary health care and community health instilled in countries, communities, and all of us associated with the Child Survival and Health Grants Program. They include: Warren and Gretchen Berggren (Harvard University, World Relief, Save the Children), Jim Grant (UNICEF), John Grant (USAID), Halfdan Mahler (WHO), and Carl Taylor (Future Generations, Johns Hopkins University). We also dedicate this document to the 2 million community members at the heart of this program -- primarily women – in 65 countries who have made the impossible possible, over and over again, and demonstrated the power that can be unleashed through partnerships with communities to deliver on and revitalize primary health care. They are testimony to Carl Taylor’s firm belief that *“Our greatest mistake has been to oversimplify the Alma-Ata vision of primary health care. Real social change occurs when officials and people with relevant knowledge and resources come together with communities in joint action around mutual priorities.”* It is fitting to celebrate the achievements and lessons of USAID’s Child Survival and Health Grants Program with the launch of this legacy document at the Global Conference on Primary Health Care in Astana in 2018, harnessing the force of our partners to define the way forward in revitalizing primary health care in the decades to come.

The CSHGP Legacy report was authored by Nazo Kureshy (USAID), Karen LeBan (independent consultant, previously CORE Group), Nancy Newton (independent consultant), and Leo Ryan (ICF). Many champions of community health contributed to the USAID CSHGP legacy document and made it better and include the following: Meredith Crews (USAID), Henry Perry (Johns Hopkins University), Tanvi Monga (MCSP), Melanie Morrow (MCSP), Michel Pacque (MCSP), Mary Beth Powers (Save the Children), Jim Ricca (MCSP), Eric Sarriot (Save the Children), David Shanklin (Core Group). We are grateful for the support of the USAID’s Maternal and Child Survival Program and USAID communications team members (Charlene Reynolds and Andrea Surette, MCSP; Jennifer Jackson and Chris Thomas, USAID) in preparing this legacy document for the Global Conference on Primary Health Care, and the current CORE Group leadership (Lisa Hilmi) for the production and dissemination of the CSHGP legacy document at the Global Conference on Primary Health Care in Astana and as a part of a primary health care social media campaign engaging the

CSHGP partners and the broader health and development community. We also thank Dalberg for developing the powerful CSHGP infographic included in this legacy document.

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A Call To Serve International	International Relief and Development Inc.
Adventist Development and Relief Agency	International Rescue Committee
Africare	Johns Hopkins Bloomberg School of Public Health
African Methodist Episcopal Church Service and Development Agency	La Leche League International
Aga Khan Foundation	Lutheran World Relief
American Red Cross	MAP International
Amref Health Africa	Medical Care Development International
CARE	Medical Teams International
Catholic Relief Services	Mercy Corps
Center for Human Services	PATH
ChildFund International	Partners for Development
Concern Worldwide	Partners In Health
CORE Group	Pearl S. Buck International
Counterpart International	Plan International
Curamericas Global (formerly Andean Rural Health Care)	Population Services International
Episcopal Relief & Development	Project Concern International
Esperança	Project HOPE
Eye Care International	Relief International
Food for the Hungry	Rotary International
Foundation of Compassionate American Samaritans	Salvation Army World Service Office
Freedom from Hunger	Save the Children
Future Generations	WellShare International (formerly Minnesota International Health Volunteers)
Global Health Action	World Relief
GOAL International	World Renew (formerly Christian Reformed World Relief Committee)
Haitian Health Foundation	World Vision
Health Alliance International	
HealthPartners	
HealthRight International	
Helen Keller International	
HOPE Worldwide	
International Aid	
International Child Care	
ICF	
International Eye Foundation	
Institute for International Medicine	

# Abbreviations

ADRA	Adventist Development and Relief Association
BASICS	Basic Support for Institutionalizing Child Survival
CBIO	census-based, impact-oriented
CBPHC	community-based primary health care
CHC	community health club
CHW	community health worker
CLAS	local health administration committee
CSHGP	Child Survival and Health Grants Program
DHIS	district health information system
EBF	exclusive breastfeeding
FP	family planning
HEW	health extension worker
HH/C-IMCI	household and community integrated management of childhood illness
HHP	Home Health Promoter
iCCM	integrated community case management
IMCI	integrated management of childhood illness
INGO	international nongovernmental organization
IRC	International Rescue Committee
JHU	Johns Hopkins University
KPC	knowledge, practice, and coverage
LiST	Lives Saved Tool
MCH	maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MNCH	maternal, newborn, and child health
MOH	ministry of health
ORT	oral rehydration therapy
PDQ	partnership-defined quality
PSSC	USAID/Senegal-funded Community Health Program (PSSC is its abbreviation in French)
PVO	private voluntary organization
QI	quality improvement
SBA	skilled birth attendant
SBC	social and behavior change
SC	Save the Children
SDG	Sustainable Development Goal
TA	technical assistance
TBA	traditional birth attendant
UCO	community health unit (abbreviation in Spanish)
UHC	universal health coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	US Government
WHO	World Health Organization





A Care Group in Nampula Province, Mozambique, facilitated by World Relief and its local partners. A Care Group is a group of 10-15 volunteer, community-based health educators who meet regularly with project staff or local MOH counterparts for training and supervision. They are different from typical mothers' groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned, and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. *Photo by Allison Flynn*





# I. Introduction

From the child survival revolution of the mid-1980s through the end of the Millennium Development Goals era in 2015, the Child Survival and Health Grants Program (CSHGP), funded by the United States Agency for International Development (USAID), has played a foundational role in global and national efforts to achieve a vision of “[health for all](#).”<sup>\*</sup> Focusing on primary health care is a means to reach goals in health—including reduced mortality and morbidity through improved health and nutrition status and equity—in resource-constrained settings.<sup>†</sup> Established in 1985 as part of USAID’s investment in the Child Survival Initiative with a congressional earmark, the CSHGP’s multifaceted partnership leveraged and strengthened the work of international nongovernmental organizations (INGOs)<sup>‡</sup> and their local and national partners to improve the health and well-being of vulnerable populations in developing countries. CSHGP-supported INGOs improved coverage of evidence-based interventions, broadening these over time to include maternal, newborn, and child health (MNCH) and infectious diseases in response to epidemiological and demographic shifts.

The CSHGP was the largest USAID-NGO partnership for health and the second largest such partnership in the USAID portfolio (see list of all NGO partners in acknowledgements). The CSHGP mobilized US citizens, national and local governments, civil society organizations, and communities in 65 countries. Participation of communities as valued partners of governments and health systems actors—in a global and national investment landscape in which community health remains undervalued and underfunded—drove its impact within countries and globally. The program operationalized the vision of “health for all” by strengthening systems for primary health care by engaging, empowering, and linking communities with the system.<sup>§</sup> The CSHGP empowered families and communities to make informed decisions about their health by improving health literacy and engaging community members as resources to strengthen health systems. For three decades, the CSHGP’s INGO partners pioneered the field of community health by developing global public goods (data and evidence, state-of-the-art technical resources) and supporting governments to shape country plans and priorities. The CSHGP’s INGO partners remain valued allies of country governments, national and local nongovernmental actors, and communities in advocating for and building local capacity to operationalize diverse roles of communities, supported by systems and policies.

In 2015, global leaders committed to 17 [Sustainable Development Goals](#) (SDGs),<sup>1</sup> with a focus on multistakeholder partnerships, including government, civil society, and the private sector, for achieving success by 2030. In support of the SDGs, renewed global health strategies\*\* prioritize individuals, families, and communities as beneficiaries and valued actors in health systems that are responsive to their needs and characterized by trusting partnership to improve health, well-being, and development. For example, key

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\* “Primary health care, as defined by the Declaration of Alma-Ata (1978), involves providing preventive, promotive, curative, rehabilitative health care services as close to community as possible by members of a health team, including community health workers and traditional practitioners, and it broadened the concept even further by calling for primary health care to also address the primary causes of ill-health through inter-sectoral collaboration, community participation, and reduction of inequities.” [Source: 2017. *Engaging Communities for Improving Mothers’ and Children’s Health, Reviewing the Evidence of Effectiveness in Resource-Constrained Settings*. Perry H, ed.]

† USAID’s goals in health include preventing maternal, newborn, and child deaths; combating infectious diseases (including TB, malaria, and emerging threats); and controlling the HIV/AIDS epidemic.

‡ In the US Government lexicon, INGOs are known as private voluntary organizations (PVOs). USAID defines PVOs as “tax-exempt nonprofits that leverage their expertise and private funding to address development challenges abroad.” <https://www.usaid.gov/pvo>. The term PVO does not apply to foundations, universities, or churches. To be classified as a PVO, an INGO must meet eight conditions, including soliciting and receiving cash contributions from the general public. *Conditions of Registration for U.S. Organizations, USAID*, [https://www.usaid.gov/sites/default/files/documents/1880/PVO\\_Conditions\\_US\\_Organizations.pdf](https://www.usaid.gov/sites/default/files/documents/1880/PVO_Conditions_US_Organizations.pdf). This document uses the term “INGO,” which is more globally recognized, rather than “PVO.”

§ Systems support to primary health care at the community level encompasses a range of terminologies for community health (community-based primary health care, community health platform, community centered, community oriented, community health systems, etc.) that support a range of roles of community members, including delivery of services at the community level, oversight and governance for delivery, household production of health and behavior change, and voice and accountability.

\*\* These strategies include: [Global Strategy on People-Centered and Integrated Health Services](#); [Global Human Resources for Health Strategy](#); the [Roll Back Malaria Partnership to End Malaria](#); the [End TB Strategy and the Stop TB Partnership Global Plan to End TB](#); [Feed the Future](#), the [Multi-Sectoral Nutrition Strategy](#), and [Scaling Up Nutrition movement](#); [Family Planning 2020](#); and the [Global Health Security Agenda](#).

action areas to accelerate progress—such as individual potential, community engagement, accountability, multisectoral action, and health system resilience—are essential to achieving the goals (survive, thrive, transform) of the [Global Strategy for Women’s, Children’s and Adolescents’ Health \(2016–2030\)](#).

CSHGP-supported INGO partners have played a key part in maintaining focus on the role of communities in primary health care and development in the [Alma-Ata Declaration \(1978\)](#). These efforts culminated in a call to action to make people and communities central to achieving high-performing primary health care to reach universal health coverage (UHC) and attain the SDGs by 2030. The sustained efforts of the CSHGP’s INGO partners over the past three decades have elevated the focus on people and communities in the renewed vision for primary health care articulated in the [2018 Declaration for the Global Conference on Primary Health Care](#).<sup>2</sup> This legacy document highlights the CSHGP’s major achievements from 1985 through 2017—in some of the hardest places in the world to reach—through multistakeholder partnerships at the subnational level, including key primary health care system actors and communities. This document will provide useful evidence and lessons to define the path forward.<sup>††</sup>

### **Text Box 1. Celebrating progress, acknowledging challenges**

The tremendous global strides made in improving the health of women and children worldwide during this 30-year period has been welcome progress. The number of deaths among children under 5 fell—from almost 13 million in 1985—to about 6 million in 2015, despite population growth. The under-5 mortality rate (deaths among children under 5 per 1,000 live births) were halved, saving the lives of 48 million children since 2000. Progress in maternal health resulted in far fewer women dying during pregnancy, childbirth, and the first 6 weeks after delivery in 2015 (estimated at 303,000) compared to 1990 (estimated at 523,000). In addition, increases were seen in the percentages of women and children who received or accessed lifesaving health interventions, ranging from pregnant women making four or more prenatal care visits to children ages 0–59 months with symptoms of pneumonia receiving antibiotics.

Despite these advances in global health, women and children are still dying in alarming numbers from preventable causes. Each year, 303,000 women die of pregnancy-related causes, and 5.6 million children die before their fifth birthday—nearly half of them in their first month of life. The vast majority of these maternal and child deaths are preventable. With a smart, focused, innovative approach, we can save millions of mothers and their children and create ripples of change that transform the futures of families and their countries. Please see Text Box 2 for estimates of lives that could be saved by scaling up CBPHC.

CBPHC is a core strategy for achieving the SDGs for health and is foundational to high-performing health systems in partnership with empowered communities. CBPHC is a process through which health programs and communities work together to improve health and control disease. CBPHC allows for the promotion of key behaviors at the household level and the provision of health care services outside of facilities at the community level. Through this approach, the health of geographically defined populations can be improved. CBPHC does not include health care provided at the health facility unless there is community involvement and associated services that extend beyond the facility. CBPHC also uses multisectoral approaches to address health disparities, including programs that improve (directly or indirectly) education, income, nutrition, living standards, and empowerment.

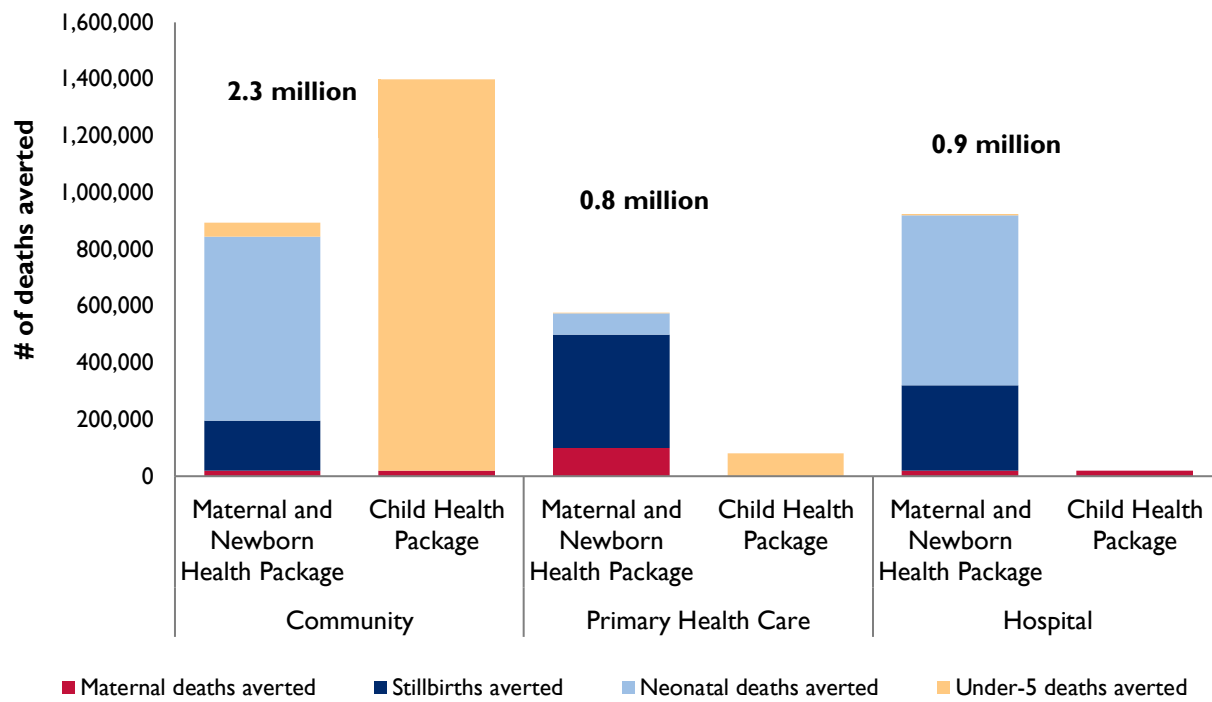
The data highlighted in the CSHGP legacy report are from baseline and end-of-project measurements of key indicators, an evaluation requirement of the CSHGP from the program outset. This dataset is a noteworthy contribution to USAID’s global health evidence-based results monitoring, given that few other USAID health programs consistently documented outcomes<sup>3</sup> before the 2011 [Agency evaluation policy](#).<sup>4</sup> The USAID CSHGP is a major contributor to the evidence that forms the foundation of [one of the most comprehensive in-depth current reviews of the effectiveness of community-based primary health care \(CBPHC\) in improving maternal, newborn, and child health](#).<sup>5</sup> The review also concludes that stronger CBPHC programs can create entry points and synergies for expanding the coverage of family planning (FP) services and for accelerating progress in the detection and treatment of HIV/AIDS, TB, malaria, hypertension, and other chronic diseases.

<sup>††</sup> Although the CSHGP cycle continued through 2017, this document focuses on the 30-year period from establishment through 2015.

**Text Box 2: Estimates of the number of mothers' and children's lives that could be saved by scaling up primary health care in partnership with communities**

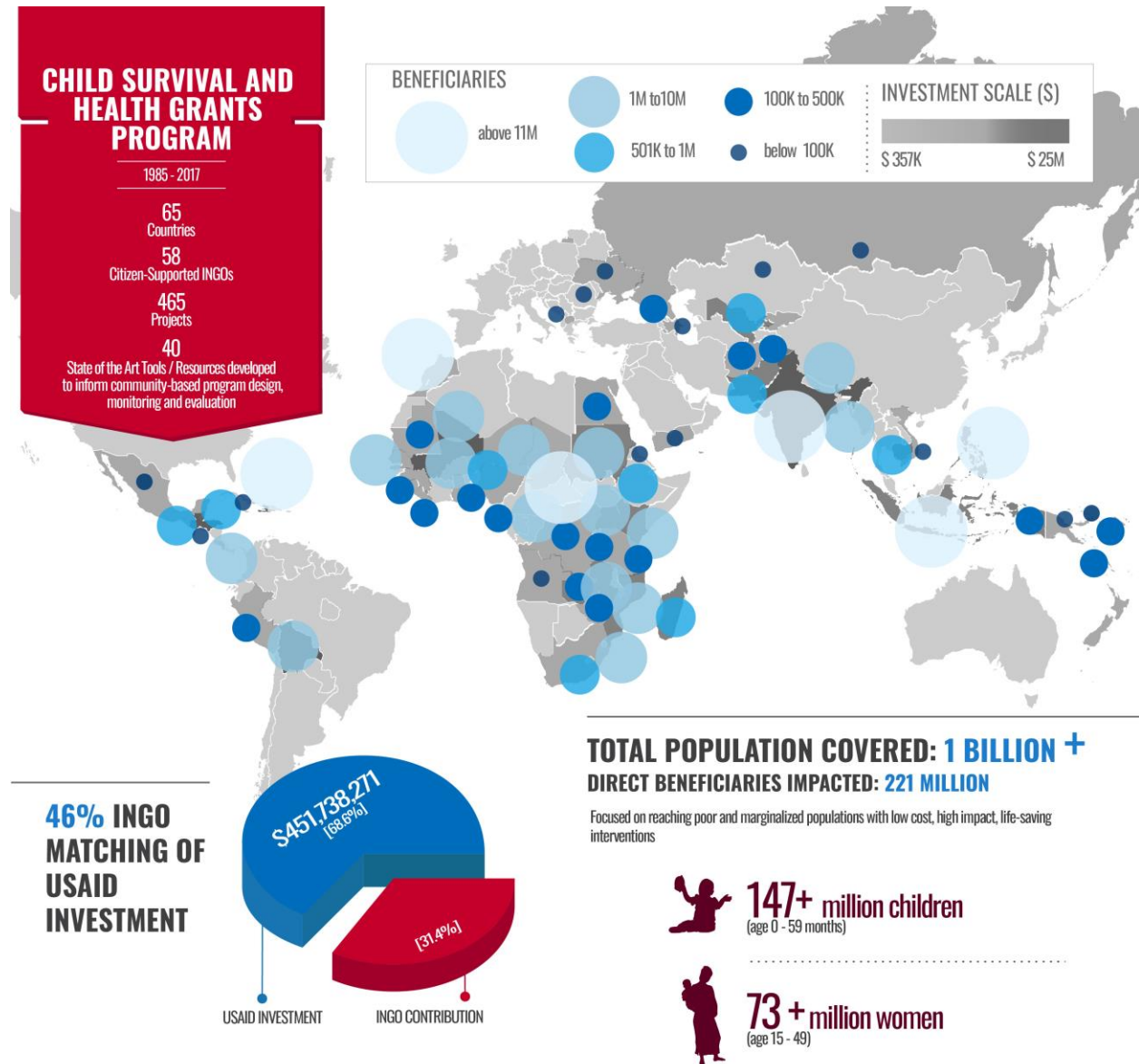
The [best current evidence](#) indicates that if the complete package of evidence-based interventions for mothers and their children that can be provided at the community and primary health care levels reach all those who need them, 3.1 million deaths would be averted each year. This is approximately 77% of the total number of deaths. Governments, government health programs, and NGOs should develop health systems that respect and value communities as full partners and work collaboratively with them in building and strengthening CBPHC programs.

**Figure I. [Maternal, perinatal, newborn, and child deaths that can be averted by health care packages through three service platforms](#)**

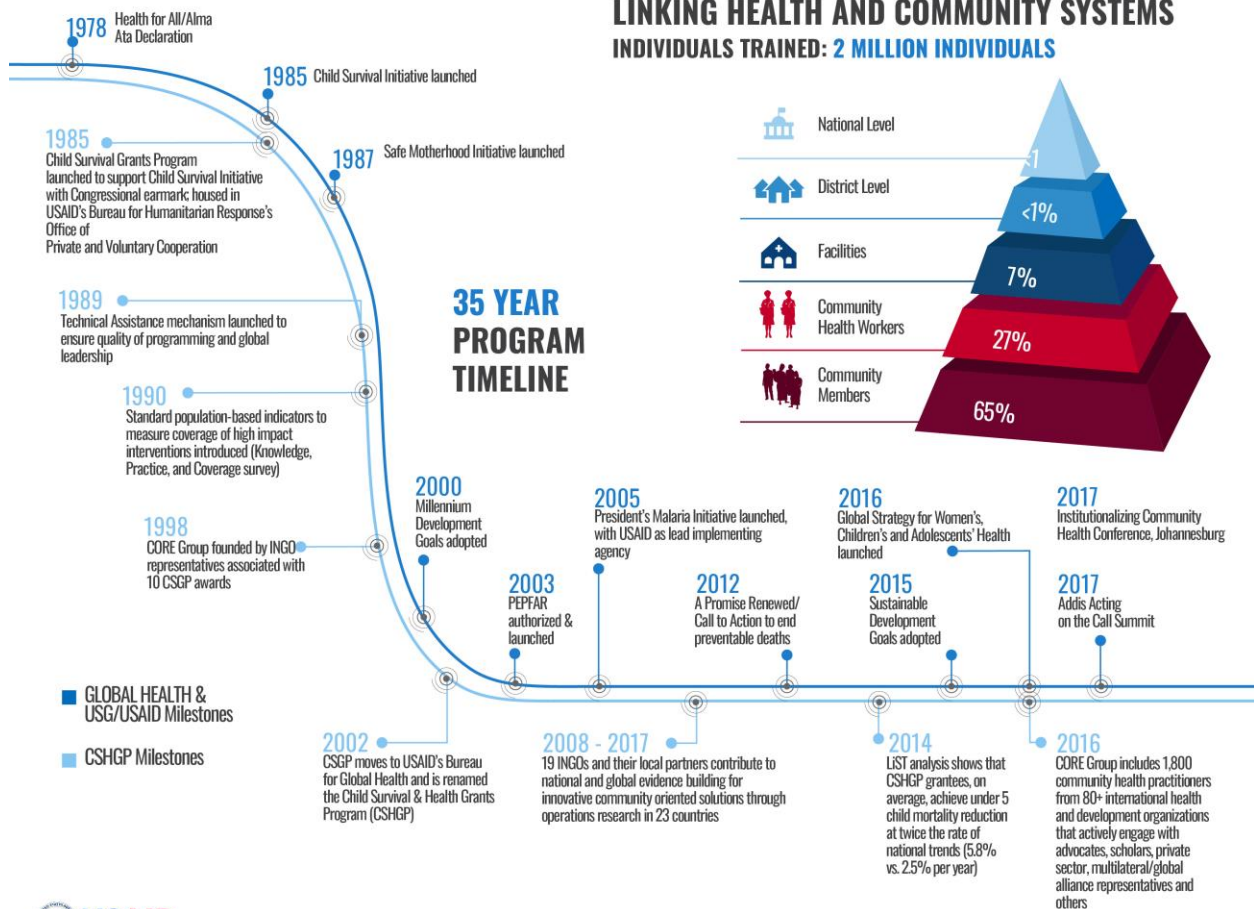
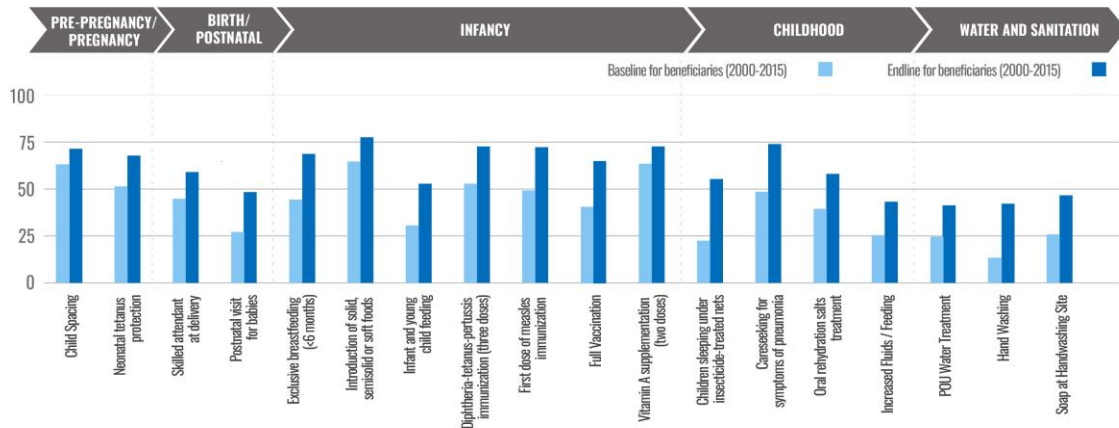




**Figure 2. CSHGP: An Overview**



# A TRACK RECORD FOR CONSISTENTLY IMPROVED COVERAGE FOR LIFE-SAVING INTERVENTIONS



## A. Major Contributions of the CSHGP to Global Health

Public opinion polls show that Americans consider improving the health of populations in low- and middle-income countries to be a top priority for US engagement. They rate interventions such as providing access to clean water, reducing hunger, improving child health, and increasing vaccinations as important.<sup>6</sup> Citizen-supported NGOs—those with multiple sources of funding, including private US citizens—make up the INGOs supported through the CSHGP. In 2014, approximately 600 NGOs (485 US and 106 international) registered with USAID [reported](#) that they dedicated almost \$8 billion in private contributions to improve health.<sup>7</sup> In 103 countries, these NGOs are collaborating with 10 or more local NGOs.

The CSHGP leveraged not only other funding in these INGOs but also their accumulated knowledge, experience, and social capital that contribute significantly to reaching development goals shared by both government and civil society.<sup>8</sup> This program influenced the development of INGO health-sector programming by improving the capacity for partnerships that address constraints to global health success.

Since its establishment, the CSHGP supported 465 grants to 58 INGOs, 30% of which are faith-based organizations, in 65 countries (see Figure 2). Between 1985 and 2017, USAID's total contribution of \$451,738,271 was matched by INGOs in the amount of \$206,491,029—a contribution of \$45 for every \$100 invested in the program. INGO resources were leveraged from private sources, such as citizen support or for-profit entities and other non-USAID/US Government (USG) resources.





From 1985–2017, the CSHGP contributed significantly to the development and strengthening of systems for primary health care with robust community engagement and empowerment. The CSHGP demonstrated that building a strong primary health care platform can 1) save lives, 2) improve health care equity and accountability, 3) strengthen relationships among various actors within countries and globally, and, through these collective achievements, 4) influence policy and program directions. Examples of these achievements, which are expanded upon in subsequent sections of this report, are:

**1) Saving lives through increased coverage of essential health services and household practices.** With an eye toward ensuring access to a small set of lifesaving behaviors and health interventions critical to the achievement of overall global health goals (see Figure 1),<sup>9</sup> CSHGP-supported INGO partners brought basic health care to remote communities, often beyond the reach of the formal health care system. They encouraged healthy behaviors and appropriate care-seeking at the household level across the life cycle (from pre-pregnancy through childhood), and enhanced the skills of mothers, caregivers, and community health workers (CHWs). The program reached 221 million direct beneficiaries (73 million-plus women aged 15–49 years and 147 million-plus children under 5), serving a total population estimated at 1 billion individuals. An analysis of 129 CSHGP projects completed from 2000 to 2015 showed consistent improvements in coverage for critical intervention and health status indicators.<sup>10</sup> *Note: The program was leveraged by USAID to strengthen systems for primary health care at the community level for improving the diagnosis, case finding, and management of infectious diseases (TB, HIV/AIDS), but this information has not been included in this report.*

Even though the projects typically worked in districts and regions of a country with levels of coverage that were lower than national averages, the CSHGP-supported INGOs and their local partners successfully increased coverage so that it exceeded national averages in these areas.<sup>11</sup> The CSHGP was one of the first USAID programs to adopt a methodology—the [Lives Saved Tool \(LiST\)](#)<sup>12</sup>—to estimate the number lives of children saved by its projects through increased coverage of high-impact health and nutrition interventions. Across the [12 projects analyzed](#) (which were typical of all CSHGP projects from 2002 to 2007), average under-5 child mortality rates in the CSHGP project areas declined by 5.8% per year, compared to average declines of 2.5%, measured for the surrounding regions.<sup>13</sup>



**Figure 3. Illustrative lifesaving, low-cost technical interventions used in the CSHGP <sup>14</sup> ‡**

 Pre-pregnancy/ Pregnancy	 Birth/postnatal	 Infancy	 Childhood
Nutrition counseling	Skilled birth attendant at delivery	Infant and young child feeding counseling	Nutrition counseling; treatment of malnutrition
Newborn tetanus protection	Essential newborn care	Routine and full immunization	Prevention and treatment of pneumonia
Malaria prophylaxis	Immediate breastfeeding	Vitamin A supplementation	Prevention and treatment of malaria
Child spacing	Postnatal visits for mother	Sleep under treated bed nets	Oral rehydration salts, zinc, and increased fluids/food for diarrhea
Antenatal care	Postnatal visits for newborn	Exclusive breastfeeding under 6 months	Sleep under treated bed nets
Handwashing with soap			
Improved drinking water sources and improved sanitation facilities			

**2) Improving equity and accountability by strengthening systems support for primary health care engages and empowers communities to better respond to the needs of the most vulnerable populations, particularly women as drivers of change in their communities.** The CSHGP took on the challenge of connecting health systems to the frontlines, choosing to focus on the district level and below (facility, community, household/family), which is where the strengthening of the system often loses steam. Under-resourced and overburdened district- and community-level health systems have long faced great difficulties in ensuring the health and survival of vulnerable populations in marginalized communities. The CSHGP partnership leveraged INGO expertise about processes that engaged and linked communities with health systems that were more responsive to their needs by building capacity to enable participation and elevation of community voices in systems. For example, the CSHGP supported INGOs and their local partners in the following ways:

- Developed systems to provide frequent interpersonal contact with households, which helped to replace ingrained cultural beliefs and harmful practices with recommended healthy behaviors.
- Created more client-friendly health services, which resulted in greater use.
- Established community-based health information systems, which enabled targeting of high-risk families with high-impact interventions against prevalent diseases.
- Mobilized communities for citizen participation in defining, developing, demanding, and monitoring appropriate services.

‡ The CSHGP also included TB and HIV integration (prevention of mother-to-child transmission of HIV) interventions.

CSHGP-supported INGOs and their local partners trained more than 2 million individuals (approximately 75% of whom were women) in the health system, including 540,000 CHWs and over 1,300,000 community members.

**3) Building relationships in systems and establishing vibrant, skilled partnerships for advancing global community health.** The CSHGP served as a vehicle for INGOs to nurture partnerships among a diverse range of local institutions, governments, academia, civil society organizations, and underserved communities. INGOs helped to build the sustainable capacities that allow local partners to increase access to lifesaving interventions, improve health systems, obtain political commitment for community health, and manage donor funds directly. Many CSHGP-supported INGOs and their local partners leveraged their experience and funding from the CSHGP to attract additional millions in funding from other donors. The CSHGP encouraged INGOs to collaborate with universities and professional service agencies to integrate research with local capacity-building efforts and program implementation, focusing on solutions for addressing persistent challenges faced by underserved populations. For some INGOs, the results of their first grants gave impetus to further grow their organizational health portfolios. Others made their project sites into learning sites for integrated primary health care programs, where key stakeholders within and across countries were introduced to innovations and operationalization of new policies in global health. The collaboration and learning of a network of more than 80 INGOs, universities, and private-sector organizations, and 1,800 community health practitioners around the world that make up [CORE Group](#) also served as a partnership platform for technical knowledge development, capacity-building at global and country levels, and diffusion of evidence-based community health strategies.

**4) Influencing global and country practice and policy.** The CSHGP served as a vehicle to support, strengthen, and influence global and national policies focusing on community health. CSHGP-supported INGOs and their local partners tested, developed, adapted, and expanded—within countries and to other countries—replicable approaches that filled the gap between communities and the health systems. Through CORE Group collaboration, their experiences contributed to updates in global standards of practice that made community health care more effective through state-of-the-art tools and resources to advance community health. They supported governments in implementing policy shifts to improve equitable access to lifesaving health interventions. CSHGP-supported INGOs and their partners piloted, documented, and refined packages of community-centered health care, such as household and community integrated management of childhood illness (HH/C-IMCI), integration of zinc into the treatment of diarrhea, integrated community case management (iCCM), and community packages tailored to promote prevention and care to support national infectious disease control strategies. In this way, they provided the evidence, experience, and expertise to inform policy and the practice guidelines that followed. In addition to introducing or influencing the delivery of technical interventions, CSHGP-supported INGOs contributed to processes that improved uptake and use of the interventions. These processes included creating guidance for organizing women’s and other peer groups, improving performance of CHWs at scale, defining roles and improving capacity of community structures to support systems, encouraging use of maternity waiting homes, establishing home management practices for newborns, and implementing community-based directly observed therapy. They developed or refined national tools, protocols, curricula, and other technical resources, and, by working in technical government working groups along with other partners, contributed to their national scale-up.<sup>§§</sup>

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<sup>§§</sup> [CORE Group Resource Library](#) contains many national tools, protocols, curricula, and other technical resources that can be used by global and national health and development actors.



Traditional birth attendant who now serves as a community-based referral agent for skilled delivery in Kenya. *Photo by Daniel Jack Lyons, HealthRight International*



## II. Origins, Evolution, and Features of the CSHGP

In 1984, the US Congress enacted the [Child Survival Act](#), which required that a program be designed to address child health and malnutrition, as an amendment to the Foreign Assistance Act,<sup>15</sup> responding to UNICEF's call for a "child survival revolution." The US Senate added the stipulation that "such assistance [shall] be provided through private and voluntary organizations and international organizations whenever appropriate."<sup>16</sup> INGOs had the reputation of competent and committed organizations already embedded in the most challenging corners of poorer countries, with strong ties to communities that could ignite behavior and social change. INGOs were viewed as [efficient and effective channels for distributing resources to deliver primary health care](#), and their general development work in communities provided a platform to support strengthening health systems.<sup>17</sup>

### Text Box 3. [Comparative advantage of INGOs](#)<sup>18</sup>

- Established partnerships with local populations:
  - Decades of work with local communities, governments, private sector, and networks based on trust
  - Close relationship with US civil society and local civil society
- Global reach:
  - Work in every developing country, including many where USAID has no presence
  - US resources contributed to achieve worldwide development priorities
- Innovation and best practices:
  - Focus on applying best practices and incubating innovations that address persistent development constraints
  - Freedom to experiment, make changes, and innovate in ways that are difficult for the USG and publicly funded institutions
- Proven expertise in capacity-building:
  - Partnerships with local community organizations, NGOs, government, and private-sector organizations
  - Skills and know-how for bolstering ability of local organizations to deliver development results
- Support and resources from the American people:
  - Billions of dollars raised from private sources of funding
  - Demonstrated commitment of American citizens, foundations, and corporations to development assistance and to the INGOs they trust to implement this work

### A. Origins and Evolution of the CSHGP

[USAID created the CSHGP](#) as one of several measures to carry out the mandate of the congressional legislation.<sup>\*\*\*</sup> Every year since its founding, the CSHGP issued a competitive annual request for applications around the common goal to focus global health efforts where impact could be greatest—on the frontlines, with communities. While focusing on the particularly pressing public health needs in specific countries, the CSHGP maintained a consistent goal of accelerating progress toward achieving improved outcomes (mortality, morbidity, nutrition status, equity) in vulnerable populations through the provision of 4- or 5-year grants/cooperative agreements.

The focus of the CSHGP mirrored the focus of other global efforts to improve the health of vulnerable populations in low- and middle-income countries. Although it was the "[child survival revolution](#)" that sparked the establishment of the CSHGP, INGOs had been contributing to USAID's earlier programming in developing new approaches for working at the community level, in support of the [groundbreaking 1978 Alma-Ata Declaration](#). This milestone identified primary health care—essential health care as close as

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<sup>\*\*\*</sup> The CSHGP began in the Office of Private and Voluntary Cooperation in the Bureau of Food for Peace and Voluntary Assistance. It transitioned to USAID's Bureau for Global Health's Office of Health, Infectious Diseases and Nutrition in 2002.

possible to where people live and work in the community—as the key to attaining the goal of “[health for all](#).”<sup>19</sup> The key principles of the declaration, such as equity, accountability, and community participation in health, shaped the CSHGP throughout its lifespan.

Within the child survival movement, a few low-cost interventions directed at the child were singled out from the primary health care package, notably immunization, oral rehydration therapy (ORT), growth promotion, and breastfeeding.<sup>20</sup> The CSHGP modeled its early projects accordingly. With the launch in 1987 of the World Health Organization (WHO)’s Safe Motherhood Initiative, which called attention to the links between reducing maternal deaths and improving newborns’ and children’s survival and health, maternal health was added to the scope of the CSHGP. In this first decade, CSHGP-supported INGOs [sought to develop innovative solutions](#) to common maternal and child health (MCH) challenges. For example, **Project HOPE** partnered with tea estates in **Malawi** to establish employer-based child survival and maternal care clinics; **La Leche League** established a community network of mother-to-mother support groups in poor peri-urban areas of Guatemala City; and **Project Concern** helped provincial and district departments of health in **Indonesia** to improve performance of immunizers with an on-the-job peer training program.<sup>21</sup>

Over the next two decades, the number of high-impact health and nutrition interventions in the primary health package grew, as evidence that supported their effectiveness and feasibility at the community level came to light, and CSHGP-supported INGOS and their local partners incorporated them into practice. These included medical interventions, such as zinc for diarrhea, antibiotics for childhood pneumonia, chlorhexidine to prevent sepsis in newborns, and misoprostol to protect women from bleeding to death after giving birth at home, as well as social and behavior change (SBC) approaches, such as participatory women’s groups. Voluntary FP, with a focus on the healthy timing and spacing of children, an effective and well-tested strategy for saving women’s and children’s lives and improving health, also became part of the CSHGP portfolio. With the establishment of the United States [President’s Emergency Plan for AIDS Relief](#) in 2003, the launch of the [President’s Malaria Initiative](#) in 2005, and the USG’s increasing efforts to address TB, the CSHGP expanded its focus to include HIV/AIDS, TB, and malaria. Programming shifted to a broader focus to include integrated interventions and those affecting the mother, child, and wider family. National and global stakeholders recognize the importance of strengthening systems for primary health care through community engagement and empowerment, and building capacities to sustain changes gained momentum.

Community-centered solutions of INGOs gained greater visibility and momentum in a changing strategic landscape as part of [USAID Forward reforms](#) and the [Global Health Initiative](#), which aimed to strengthen and transform the agency by embracing new partnerships, investing in the catalytic role of innovation, and demanding a relentless focus on results.<sup>22</sup>

CSGHP-supported INGOs collaborated with USAID, UNICEF, and country governments to support the common goals of preventing child and maternal deaths ([Acting on the Call: Ending Preventable Child and Maternal Deaths](#)) and achieving the SDGs,<sup>23</sup> bringing their expertise and comparative advantages to these national, USG and UN commitments.

## **B. CSHGP Operational Features and Partnership Structure**

The multifaceted CSHGP partnership combined a number of attributes and practices, which individually are not unique to global health efforts but together distinguish the CSHGP from other programs. All CSHGP-supported projects demonstrated these attributes and practices, although their emphasis varied over time, according to country-specific needs and the evolution in global public health practices. These aspects included:

A **strategic partnership model** to build the capacity of civil society and communities with host country governments and the private sector to accelerate improvements in health outcomes in priority countries and at the global level. The partnership had three linked components: 1) USAID direct cooperative agreements to support the work of citizen-supported INGOs and their local partners; 2) technical assistance (TA) and support components to ensure programmatic rigor and quality; 3) and a learning network to foster

communities of practice and amplify relevant findings to other INGOs and partners, promoting leadership and collaboration for further action.

**The engagement of US civil society through INGOs.** This approach linked a foreign assistance objective and a priority issue for Americans—that the United States is a leader in reducing hunger and poor health among vulnerable populations, including children and women, worldwide.

**A focus on the lowest tier of health systems and disadvantaged populations and subgroups.** The CSHGP directed its efforts at the poorest, the least educated, and those residing in rural areas. These are populations with lower health intervention coverage and worse health outcomes than more advantaged subgroups.<sup>24</sup> The program addressed leading causes of death in these populations and the empowerment of all health systems actors, including women and communities more broadly.

**A commitment to communities as resources and partners.** CSHGP-supported INGOs and their local partners systematically engaged communities as: 1) beneficiaries; 2) means to deliver services at the community level and contribute to oversight and governance; 3) primary agents of health production in the household and community; and 4) influencers of positive change for their residents and for holding government health systems accountable for services.

**Innovation in practice and policy.** Since its inception, the CSHGP provided a flexible space to INGOs to collaborate with local partners in developing creative solutions to address common health problems and tailor interventions to local settings and national strategies.<sup>25</sup> [The Diffusion of Innovations initiative](#) (CORE Group, 2003) enabled the transfer and spread of evidence-based community health innovations developed by CSHGP-supported INGOs to other global and national stakeholders.<sup>26</sup> The addition of an operations research portfolio in 2008 allowed these INGOs and their partners (global and local) to build evidence for and improve measurement of community health innovations, typically in partnership with an academic institution, to respond to the policy and program decision-making needs of country governments. From 2008 to 2012, [19 INGOs in 24 countries received operations research awards](#),<sup>†††</sup> formalizing 151 partnerships with northern and southern research institutions and national and local organizations to address issues of local relevance as shown in national strategic priorities or global priorities.<sup>27</sup> The evidence and lessons generated by the [CSHGP's innovation and research portfolio](#) were published in peer-reviewed journals.<sup>28</sup>

**Scientific rigor in interventions and data.** The program delivered evidence-based, lifesaving interventions in line with the relevant knowledge at the particular point in time. Rigor and consistency in data collection fostered analysis, documentation, dissemination, adaptation, and replication of learning. Early in its lifetime, the CSHGP established standardized indicators across the portfolio of projects and a systematic approach to capturing the baseline and endline coverage rates of key indicators through knowledge, practice, and coverage (KPC) surveys.<sup>29</sup> Indicators were regularly updated to ensure that they were current with the state-of-the-art knowledge and compatible with other widely used health surveys (population-based surveys such as Demographic and Health surveys, Multiple Indicator Cluster Surveys, etc.).

**Strategic TA and support to INGOs.##** The technical support function, led initially by the Johns Hopkins School of Hygiene and Public Health (1985–1997), now known as the Johns Hopkins Bloomberg School of Public Health, and later by ICF International (1997–2017), created 40 guidance tools and resources in collaboration with CORE Group and CSHGP-supported INGOs to inform community-centered health program design, monitoring, and evaluation in addition to several tools created by CORE Group. This technical support has contributed to greater capabilities and consistency among the CSHGP-supported INGOs and their local partners, as well as high-quality program design, implementation, monitoring, and

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††† Read findings from the operations research in 24 countries on [the MCSP website](#).

## [CORE Group web resources](#) include tools that the CSHGP-supported INGOs created; [KPC survey modules](#) and [Taking the Long View](#) sustainability manual are examples of tools and guidance provided as part of technical assistance to CSHGP-supported INGOs.

evaluation. The requirement for each project to have technical staff based at headquarters strengthened the INGOs' role in global health leadership.

**A network of INGOs for learning and exchange.** [CORE Group](#) and its network of INGOs have provided a forum for collaborative action and peer-to-peer support for learning and diffusion of community health best practices through conferences, listservs, websites, webinars, technical advisory group meetings, and tool creation and dissemination. Incorporated as an NGO in 2000 by 10 CSHGP-supported INGOs, this network was a pioneering effort in global health knowledge management, as few health and development organizations had incorporated such a practice at that time. In 2014, CORE Group's knowledge management platform was supported by more than 9,000 volunteer hours,<sup>30</sup> and the network had grown to over 80 international health and development organizations, including universities and the private sector.

Through CORE Group, INGOs increased their participation in collaborative processes at the global and national levels to develop and disseminate relevant policy tools and resources, and represented civil society in diverse international fora, such as [GAVI](#) (a global vaccine alliance), [Scaling Up Nutrition](#), the [Stop TB Partnership](#), [Roll Back Malaria](#), and the [Humanitarian Pandemic Preparedness initiative](#).<sup>31</sup> Through the [CORE Group Polio Project](#), several CORE Group member organizations established in-country secretariats, made up of small teams of neutral technical advisors, independent from any one implementing partner, in countries and regions still struggling to eradicate polio. These teams facilitated communication, coordination, and transparent decision-making among all partners—unifying the community-level expertise of INGOs and local NGOs with the international knowledge and strategies of the Global Polio Eradication Initiative partners.<sup>32</sup>

As the CSHGP evolved over its 30-year history, the INGOs also evolved, building their organizational capacity and that of their local partners (NGOs, governments), expanding partnerships with governments, multilateral institutions, and other donors to disseminate best practices initially developed in this program.

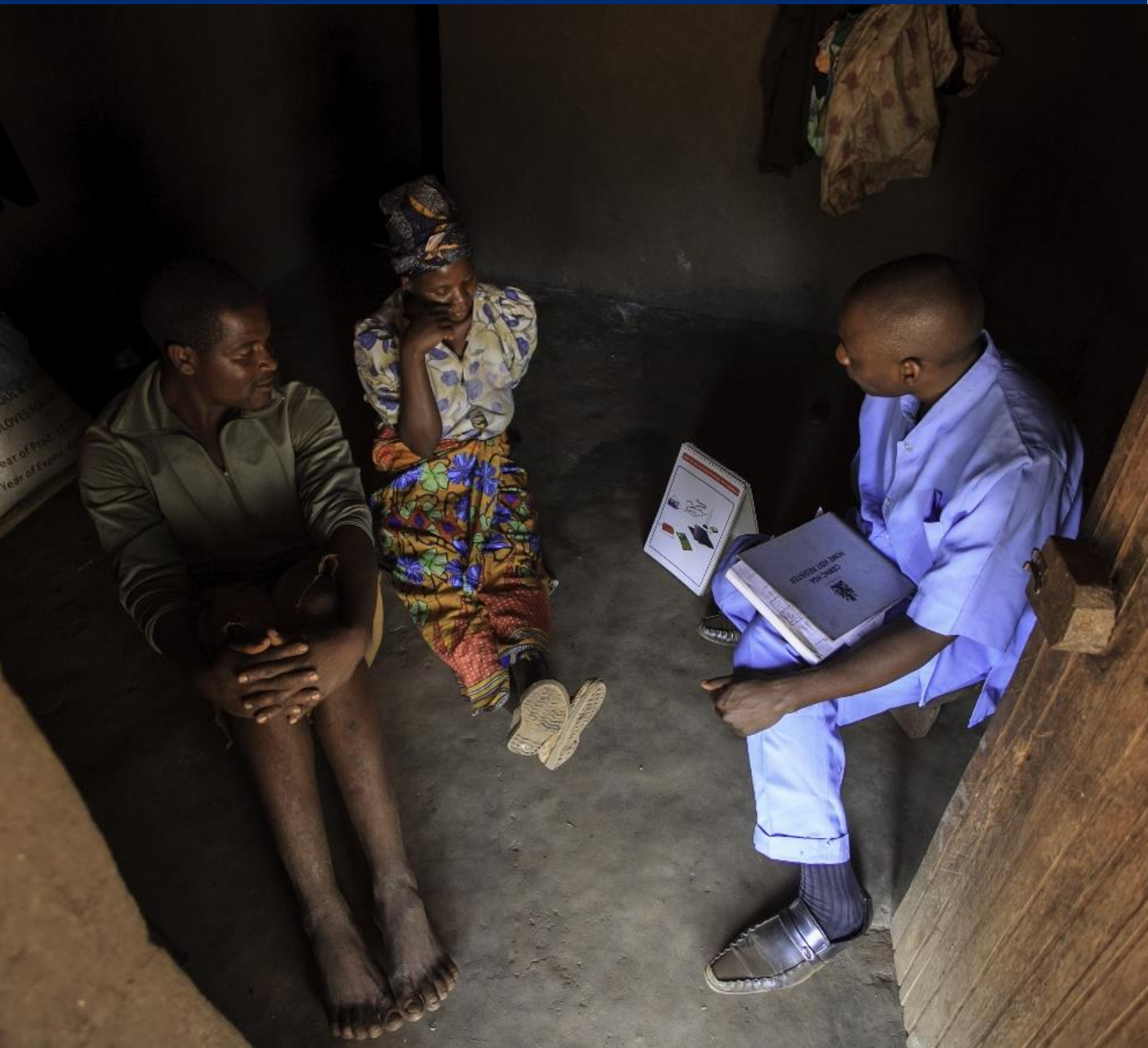
#### **Text Box 4. Expanding partnerships, expanding capacity**

**World Renew** (formerly the Christian Reformed World Relief Committee) **Bangladesh/India** leveraged support from the CSHGP (including CORE Group) to expand partnerships and its CSHGP project model, an experience similar to many other CSHGP-supported INGOs.

The first project (2004–2009) collaborated with three Bangladeshi NGOs (SATHI, PARI, and SUPOTH); a second project (2006–2011) replicated the model in a district in India, with an Indian NGO partner (EFICOR); and the third (2009–2014) expanded the model to new areas in Bangladesh with two of its NGO partners (SATHI and PARI) from the first grant. In each project, other local NGOs provided training and assessment support, and self-help community-based organizations at the village level worked with government health officials from the ministry of health (MOH), facilities, and volunteer CHWs.

Over time, World Renew and its local NGO partners gained the skills and capacity to expand their in-country networks, and link with and learn from other CSHGP-supported INGOs. They also shared the activities and learning from the projects with global partners outside of Bangladesh and India. Implementing NGO partners in Bangladesh and India received non-USG funding sources to serve new areas and/or add health and nutrition interventions, modeled on the CSHGP projects, thanks to connections made through the three CSHGP projects. In addition, local NGO implementing partners in **Kenya** and **Malawi** received grants for similar programs based on effective CSHGP program strategies. Sources of support have included: Enfants du Monde (Switzerland); the European Union through Kindernothilfe (Germany); Department of Foreign Affairs, Trade and Development (Canada) through HealthBridge Canada; Tear Fund (Australia); ERIKS (Switzerland); the Canadian Foodgrains Bank; and private donors.<sup>33</sup>





A day in the life of Community health worker Chisomo: Community health worker, Chisomo visits Emilda Kennedy in Malawi in September 2012. During his visit, he shared information with the couple about making a birth plan, having a safe delivery, immediate newborn care and correct and proper attachment and positioning of the baby to the breast. *Photo by Save the Children, Malawi*

# III. Improving Health and Saving Lives through Increased Coverage of Essential Health Services and Household Practices

At the most fundamental level, the CSHGP focused on saving lives in resource-constrained settings with high mortality. This section summarizes the program’s impact on improving health and related outcomes.

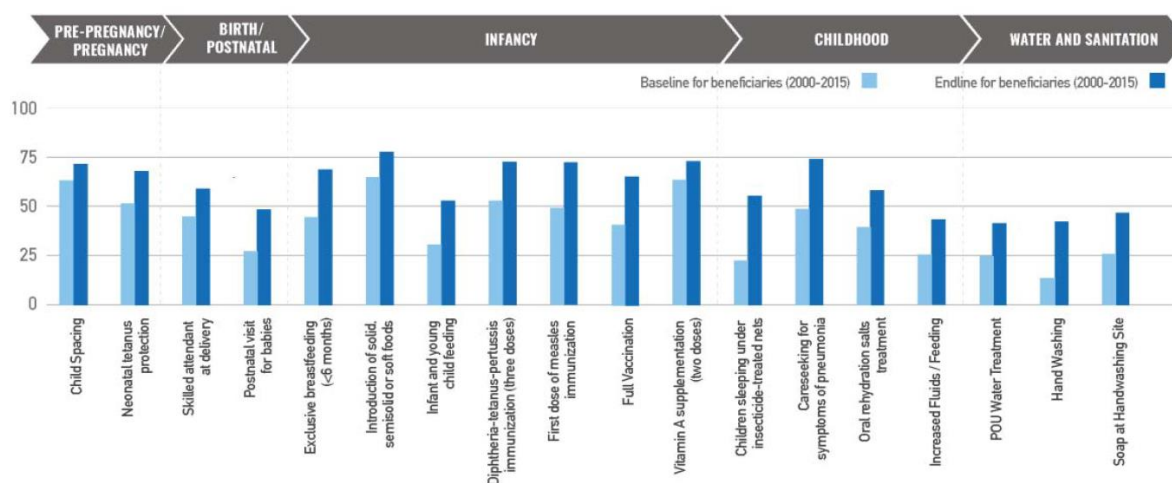
## A. Increasing Coverage of Essential Health Services and Practices

Delivering existing lifesaving interventions to the children, mothers, and families who need them is and has been a critical challenge to reducing MNCH deaths and tackling the burden of infectious diseases.<sup>34</sup> There is a close relation between higher intervention coverage and lower mortality. The positive effects of increased coverage typically exceeded those resulting from national economic growth in countries with the highest mortality burdens.<sup>35,36</sup>

Figure 4 illustrates the consistent increases 129 CSHGP projects achieved in coverage of critical interventions from 2000 to 2015.<sup>37</sup>

**Figure 4. Increases in coverage of lifesaving interventions** §§§

### A TRACK RECORD FOR CONSISTENTLY IMPROVED COVERAGE FOR LIFE-SAVING INTERVENTIONS



Moreover, further analysis of these data shows that increased coverage in the geographic areas of CSHGP projects often surpassed average national coverage increases over a comparable period. The improvements in coverage of exclusive breastfeeding (EBF)—a practice that provides protection to infants and mothers and could prevent 13.8% of all deaths of children under 2 in low- and middle-income countries<sup>38</sup>—illustrate the comparative performance of CSHGP projects regarding this practice in multiple countries (see Figure 3).<sup>39</sup> Other analysis showed similar improvements in diet quality and diversity for children between 6 and 23 months of age, leading to a reduction in the percentage of children underweight for age,<sup>40</sup> an important indicator since undernutrition is related to one-third of child deaths.<sup>41</sup>

§§§ This chart is focused on continuum of care and is not inclusive of all indicators collected (TB, HIV), nor of a more comprehensive set of indicators that individual projects collected due to the inclusion criteria at the portfolio level.

**Figure 5. Trends in EBF: CSHGP project areas versus national trends (2001–2007)**

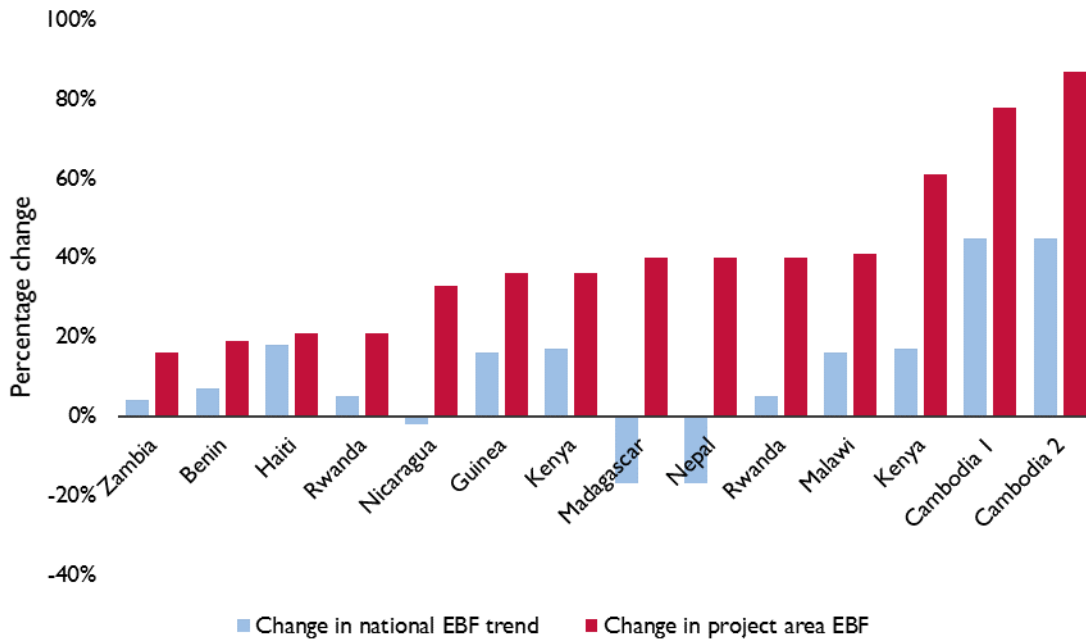
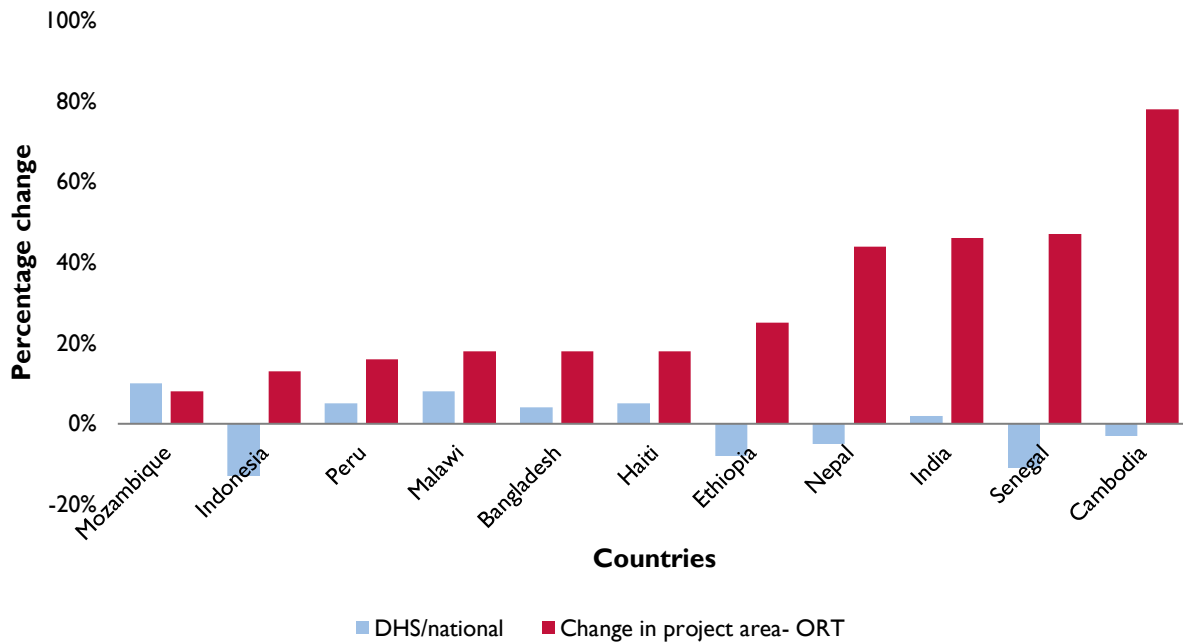


Figure 6 shows the comparative results in coverage of ORT for diarrhea, one of the leading killers of children under 5, demonstrating that CSHGP-supported INGOs and their local partners again outperformed national trends, despite working in poorly performing regions of countries.<sup>42</sup>

**Figure 6. Trends in ORT: CSHGP project areas versus national trends (2004–2007)**



## B. Estimating Lives Saved

The systematic capture of baseline and endline coverage rates of high-impact health and nutrition indicators made it possible to estimate children's lives saved with the increased coverage achieved by the CSHGP projects, using LiST.<sup>43</sup> Some projects also measured mortality directly.

Although maternal and child deaths as well as morbidity rates have been decreasing globally, the actual number of deaths *prevented* is impossible to calculate with certainty. That said, however, LiST makes it possible to determine defensible estimations of the impact of CSHGP-supported INGO projects in terms of lives saved. USAID's [Acting on the Call series of reports](#) have used LiST to estimate the potential impact of mortality reduction as a result of expanded coverage of selected maternal and newborn health interventions, as well as the impact of key delivery strategies, such as focusing on equity and addressing bottlenecks in health systems.<sup>44</sup>

For the CSHGP, [experts analyzed population coverage data](#) at the baseline and endline for key child health interventions in 12 CSHGP projects, estimated the under-5 mortality rate by modeling coverage changes in LiST, and compared findings with concurrently measured mortality data from a national survey. This analysis covered a population of 2,669,103 and was typical of all the CSHGP projects at the time (2002–2007). The average under-5 mortality rate in the CSHGP project areas declined by 5.8% per year compared to declines measured for the surrounding regions, which averaged only 2.5%.<sup>45</sup> The analysis determined that most of this decrease in under-5 mortality was accomplished through CSHGP-supported INGO project interventions delivered at the community and household levels through approaches that enabled frequent interpersonal contact with families and households.

LiST was also used to demonstrate that the Care Group model—a community-based model for educating and empowering families, fostering behavior change in positive health practices, and monitoring health status through mothers' groups and systematic home visitation—was associated with reductions in under-5 mortality. The [average estimated decline in under-5 mortality among eight Care Group projects](#) was 32%. In comparison, among the 12 child survival projects that were not part of the Care Group, the under-5 mortality declined, on average, by an estimated 11%.<sup>46</sup>

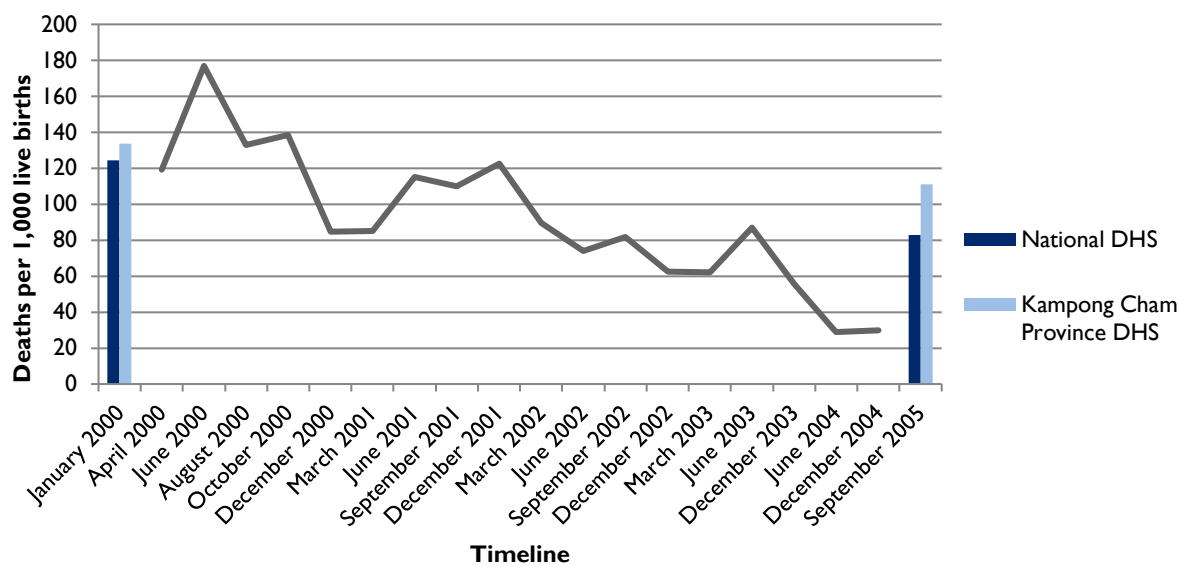
Such accelerations in child mortality reduction (doubling and almost tripling the rate of reduction) in districts that had previously performed poorly are precisely what countries would need to achieve to reach the SDGs and the ambitious objectives of *Acting on the Call*.

Although the coverage data changes and LiST made it possible to estimate changes in mortality rates, several CSHGP project teams purposively tracked mortality rates over time and compared these during their evaluations to national-level improvements. These direct mortality reduction measures were consistent with trends calculated through LiST.

**World Relief's** work in **Cambodia** illustrated how a vital events tracking system, in which Care Group community volunteers captured births and deaths through monthly household visits, was able to demonstrate a reduction in the child mortality rate that exceeded the reduction in the national and province-wide rates in just 4 years of project implementation, as shown in Figure 7 below.<sup>47</sup>



**Figure 7. Rapid decline in under-5 mortality with monthly home visits by Care Group volunteers (Cambodia, 2000–2004)**



## C. Reducing Inequities in Coverage

Despite steady improvements in global health indicators, disadvantaged population subgroups—the poorest, the least educated, ethnic minorities, and those residing in rural areas—still experience the lowest health intervention coverage and worse health outcomes than more advantaged groups.<sup>48</sup> Influenced by the Alma-Ata Declaration, which recognized inequalities in health among and within countries,<sup>49</sup> the CSHGP has always deliberately targeted equity and improved outcomes in areas with the poorest health indicators. In addition to focusing on the most socioeconomically deprived communities, CSHGP-supported INGOs and their local partners addressed inequities in coverage found across gender, ethnic, and other marginalized population groups. Mathematical modeling, using LiST and other tools, found that equity-focused approaches that prioritize information and services for the poorest and most marginalized [can be more effective and cost-effective](#) than approaches that gradually increase coverage from the easier- to the more-difficult-to-reach populations.<sup>50</sup>

**Curamericas** (formerly Andean Rural Health Care) piloted a [census-based, impact-oriented \(CBIO\) approach](#) to primary health care in **Bolivia**. The pilot demonstrated that high levels of coverage of basic health services can be achieved through a system of “epidemiographic” surveillance of all families with priority services to those most at risk, thereby reducing infant and child mortality. The [CBIO approach](#) includes a complete community census followed by routine systematic data collection by CHWs of all vital events (pregnancies, births, deaths) during home visits to provide services. One early example of the CBIO approach in Bolivia resulted in a significant improvement in child survival rates when compared to adjoining districts with similar baseline figures and constraints. From 1992 to 1993, the annual rates of child mortality of children were 98.5 per 1,000 live births in the Curamericas project area compared with 205.5 per 1,000 in the comparison district.<sup>51, 52, 53</sup>

**Concern Worldwide** in **Bangladesh** measured its results across wealth quintiles, using the information to reach the poorest communities and households and those most in need of services. [Guidelines](#) on how to systematically incorporate health equity into program design and [evaluation](#), developed by the CSHGP’s TA team, further strengthened equity programming in the CSHGP.<sup>54</sup>

[Elements of health equity programming](#) in projects included:<sup>55</sup>

- Increasing access by **targeting the most vulnerable** children and women, using a variety of data sources and participatory methods to identify populations
- Increasing access by **tackling social norms**, such as those that discourage women from seeking care for particular services or that result in providers delivering poor-quality, disrespectful, and sometimes even abusive care
- Improving community-based service delivery through **use of CHWs**, which enables those without access to facility-based services to receive high-impact intervention packages
- **Strengthening the community's voice** so that community members can express their health care preferences and needs, and hold service providers accountable for delivering high-quality, equitable care
- **Empowering women** through education, savings and loan clubs, mutual support, and leadership positions so they can maximize the quality of their health care and that of their children
- **Measuring and learning** to monitor and evaluate for equity

#### **Text Box 5. [Increasing coverage for the poorest and most remote communities](#)**

To reduce geographic and financial barriers to access community health care in Honduras, ChildFund conducted a Global Positioning System (GPS) mapping exercise and, taking into account factors such as transport and community resources, identified 20 least-served locations to target with community-based health care. The project supported the establishment of financially self-sustaining, community-managed community health units (abbreviated as UCOs in Spanish). These units are freestanding structures in remote areas that are equipped with essential drugs, basic equipment, and health education materials. Volunteer CHWs staff the units, and the MOH supervises them. More than 50% of UCO clients were from the lowest socioeconomic quintile (versus only 5% of clients at regional MOH facilities in more densely populated areas). Comparison of endline to baseline data found significant increases in five of seven indicators in the UCO implementation zone. The data indicated the following: a 200% increase in pregnant women registered by the UCO, a 46% increase in the number of women who received at least five prenatal care visits, a 109% increase in the number of women who had a birth plan, a 100% increase in postnatal care for newborns by a health volunteer within 3 days after birth, and a 171% increase in proper treatment of sick children under 5.<sup>56</sup>

Many CSHGP-supported INGO partners used participatory processes to address health inequities and improve health practices among marginalized populations. For example, in **Nepal**, **Plan International** and **CARE** supported projects under the government's Community-Based Newborn Care Program by forming women's groups to improve self-care and care-seeking, and increased use of health services during childbirth. These groups included mothers' groups, pregnant women's groups, and groups that engaged mothers-in-law, who are key household decision-makers. In **Sierra Leone**, **CARE** formed community health clubs (CHCs) to foster inclusiveness and respect for men and women (see Text Box 12). Members of the CHCs discussed health issues from male and female perspectives. These discussions led to the construction of birthing huts, birth waiting rooms, and wells, and established stronger community linkages with the formal health sector. Equally important was the increased sense of community cohesion and broader community development actions, such as improved governance and leadership.

## **D. Achieving Sustained Health Outcomes**

INGOs are valued partners of national governments of countries at different stages of development. Given their strong track record in building capacity at all levels of the system and forging inclusive partnerships, INGOs have supported country ownership and leadership to drive community health policies and strategies as a part of primary health care.

From the outset, CSHGP projects began planning for sustained demand for and effective delivery of services at the end of a project. Early reviews of CSHGP projects found evidence for various types of sustainable achievements by empowering and building the capacity of local systems actors to continue activities and

achieve results with local resources after project end.<sup>57</sup> Several CSHGP INGO partners also linked CSHGP projects with opportunities to participate in national decision-making through technical working groups and/or relationships with the national government. Although projects were committed from the start to sustainability, there was no agreement on definitions, valid indicators, and models of sustainability for primary health care. The CSHGP's TA team conducted a participatory process of research and dialogue on sustainability with CSHGP-supported INGOs from 2002 to 2004, resulting in a [peer-reviewed publication](#) of findings.<sup>58</sup>

### **Text Box 6. Sustainability defined**

Sustainability in community-based health projects was defined as a contribution to the development of conditions enabling individuals, communities, and local organizations to express their potential, improve local functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure resources (financial, human, technical, informational). With such an approach, local stakeholders could negotiate their respective roles in the pursuit of health, wellness, and development, beyond a project's intervention.<sup>64</sup>

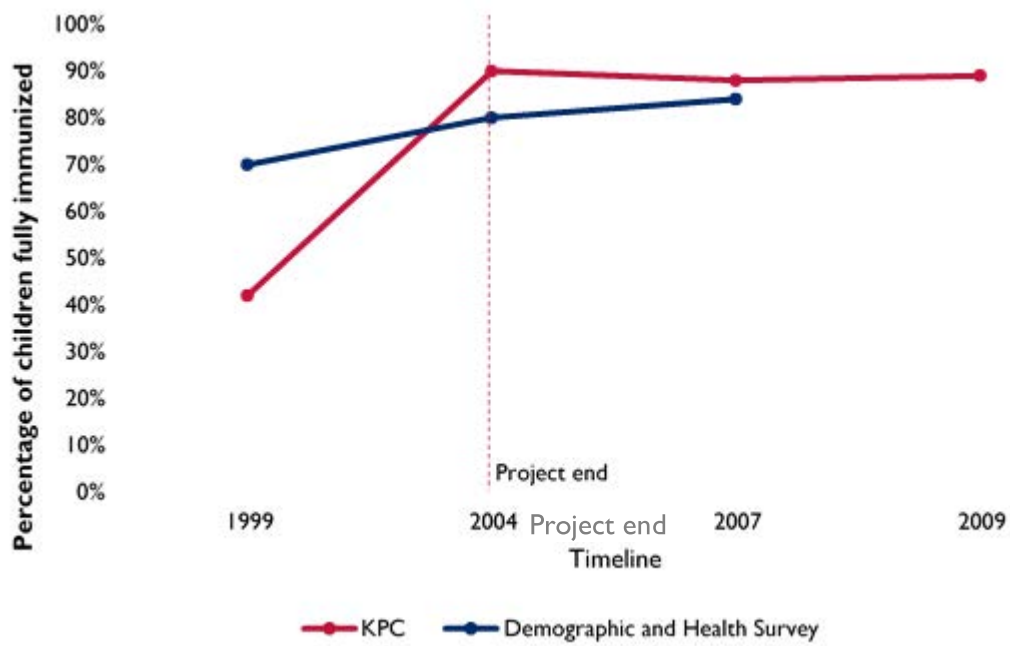
A definition of sustainability was developed and [published](#) along with a locally driven, participatory sustainability assessment framework for three critical dimensions: health outcomes, approach, and quality; organizational capacity and viability; and community competency/capacity and the social ecological environment.<sup>59</sup> The CSHGP, with its technical support mechanism and CSHGP-supported INGOs input, developed a sustainability framework with an accompanying [user's guide](#)<sup>60</sup> to aid CSHGP-supported INGOs and their local partners in consciously selecting approaches that built local capacity to maintain gains and continue processes that supported improved health outcomes. The tool's success led to USAID's Division of Population and Reproductive Health adapting it as part of its [Flexible Fund program](#).<sup>61</sup> In 2014, the CSHGP supported use of the tool to review [sustainability factors of iCCM in Rwanda](#) at the district level, identifying possible and plausible effects on other determinants, through a causal loop analysis.<sup>62</sup>

### **Text Box 7. [Sustainability through community and local government ownership of health](#)**

In **Bangladesh, Concern Worldwide** used the sustainability framework to plan and monitor its sustainability strategy, which centered on building the capacity of two municipal health departments to reinvigorate ward health committees for better management and coordination of health activities during the project (1999–2004). The revitalized health committees recruited, trained, and supported a network of community health volunteers and became a focal point for community mobilization for health. With their strengthened capabilities, the municipal health departments improved Maternal and Child Health planning and coordination systems, increased appropriate prevention and care practices for sick children, and created more responsive maternal and newborn care services. The two municipalities became learning centers at the end of the project, and Concern Worldwide scaled up the capacity-building model to seven additional municipalities.

Concern Worldwide measured capacity-building efforts and results in terms of immunization coverage during and years after project end. Figure 8 below shows that not only did coverage rates in the project area increase more quickly than those at the national level, but the areas covered also maintained over a 90% immunization coverage rate even 5 years after project end.<sup>63</sup>

**Figure 8. Sustaining health outcomes: 2009 post-project analysis: Concern Bangladesh (1999–2004)**



Compared estimates of percentages of children fully immunized (KPC survey 1999, 2004, 2007, 2009) and national urban average (Bangladesh Demographic and Health Survey 1999, 2004, 2007).





In Bambeye Commune, Tahoua Region, Niger, a *Care Group Mother Leader* who was trained in community case management interviews a caregiver with a sick child. Concern demonstrated that semi-literate volunteer mothers can deliver life-saving care to children, extending access of Ministry of Health treatments for childhood malaria, diarrhea and respiratory illness. Photo by Megan Christensen, Concern Worldwide



## IV. Strengthening Health and Community Systems to Respond to the Needs of the Most Vulnerable

Achieving and sustaining good health outcomes in poor and underserved populations depends on more than just the delivery of proven, life-saving interventions and includes a broader social context of health and well-being. Social norms that foster healthy behaviors and strong, functioning health systems that can promote uptake of interventions and support their delivery are essential. As the CSHGP evolved, building the capacity of district health systems in partnership with civil society, community groups, local NGOs, frontline health workers, and the private sector became central. [Integrated, Community-Based Primary Health Care](#) (CBPHC) and community engagement in local systems have been the drivers of health systems strengthening. Unlike in many other programs, in the CSHGP, the solutions to obstacles to stronger health systems often arose from the periphery (the community level), rather than from the “top” (e.g., national or regional levels). This section outlines the CSHGP’s pioneering roles and approaches in defining and strengthening more inclusive health systems at the district level and below through cross-cutting components of the HH/C-IMCI framework (see Text Box 8 for more details). These components served as a bridge to the current discourse focusing on engaged and empowered communities as resources in health and local systems.

### Text Box 8. [HH/C-IMCI: a framework for implementation](#)

Early in the CSHGP’s second decade, INGO partners adopted the WHO/UNICEF integrated management of childhood illness (IMCI) strategy.<sup>64</sup> However, they quickly recognized the need for a descriptive framework that drew on their experience with child health and nutrition programs at the household and community levels. Existing IMCI frameworks and tools had limited application in a household and community context, particularly where INGOs had a long-standing presence. In 2001, after several years of inquiry and development by CORE Group members and experts from Johns Hopkins University (JHU), INGOs developed and endorsed the HH/C-IMCI framework. CSHGP-supported INGOs and other NGOs have found the framework to be a valuable tool, and it continues to evolve through new applications and insights.<sup>65</sup> CORE Group held regional trainings in HH/C-IMCI and developed a curriculum and PowerPoint slide deck for NGOs to work with their governments to develop appropriate in-country tools and strategies for community health approaches to improve MNCH outcomes.

Applied to a broad spectrum of public health interventions, the framework categorized household and community health activities according to three interlinking elements:

- **Integrated promotion** of key family practices critical for health and nutrition
- **Appropriate and accessible health care and information** from community-based providers
- **Partnerships** between health facilities and the communities they serve

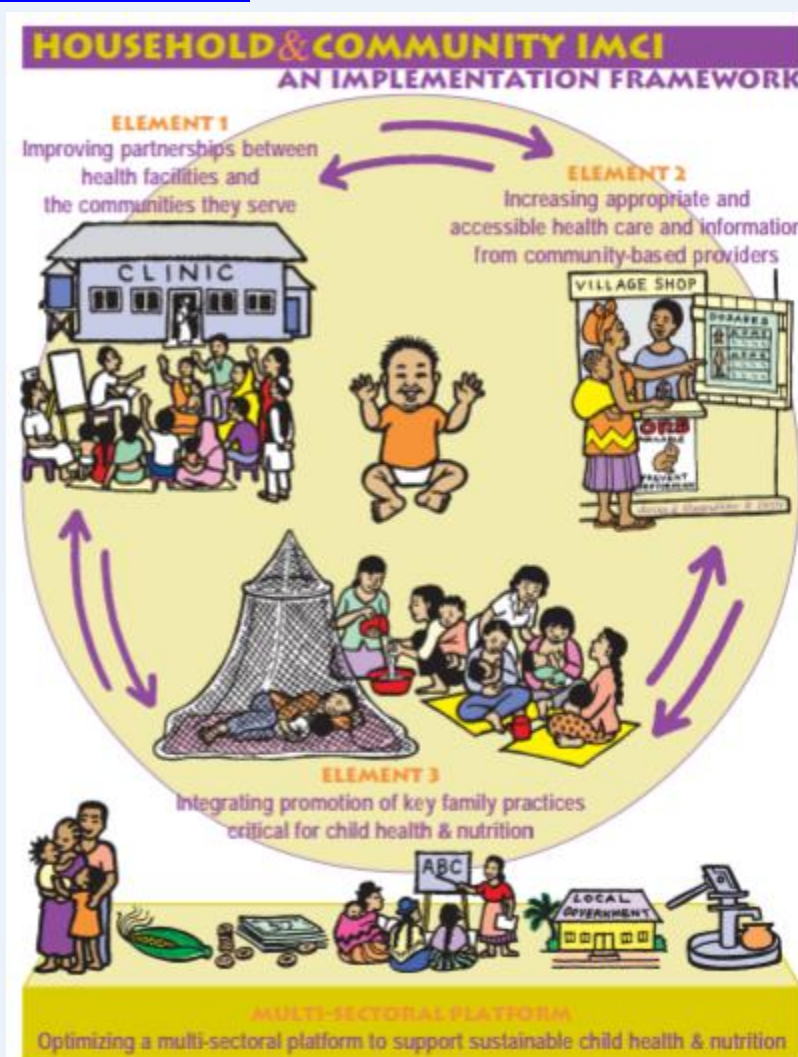
A **multisectoral platform** at the base of the framework represents the importance of addressing determinants of ill health, such as poverty, illiteracy, and water and sanitation, to achieve sustained improvements in health.

**CHWs** are integral to all three HH/C-IMCI elements and the multisectoral platform as well as an important link between communities and the health system.

**Capacity-building** enhances the knowledge and skills of community structures, community- and facility-based health care providers, and program managers.

**Community-based monitoring and evaluation** efforts, including participatory research, serve as important tools for learning, accountability, and creating a sense of community ownership and span across all elements.

Figure 9. [HH/C-IMCI framework](#)



Source: CORE Group, 2001

## A. CHWs: Linking Communities with the Health System

The shortage of human resources for health, expansion of health services to the poorest segments of the population, and urgency in achieving global health goals have stimulated [interest in CHWs](#) as educators, counselors, and, in some cases, providers of essential services.<sup>66</sup> There is [compelling evidence](#) that CHWs can be particularly effective in delivering basic and essential lifesaving health services to a broad range of people regardless of income.<sup>67</sup> They provide a critical and essential link with health systems and are a powerful force for promoting healthy behaviors. CHWs have [frequent interpersonal contact](#) with the majority of a target population, which is likely to be an important determinant of accelerating improvements in health outcomes.<sup>68</sup> Empowering CHWs can also facilitate change toward greater [gender equity, empowerment, and social accountability](#) within communities.<sup>69</sup> However, integration of CHWs in the health system and communities remains uneven across and within countries. In recognition of the potential of CHWs to improve primary health care to achieve UHC, countries are increasingly engaging in dialogue and developing plans to optimize CHW policies and programs. WHO's new CHW guidelines have been informed by the evidence, [technical resources](#), and input of the CSHGP's INGO partners.

Supporting countries to extend the reach of their health systems through a trained and supported community health workforce has been a common feature of CSHGP projects. The nature of the CHWs deployed in each project varied according to the features of a country's national health system as well as community context and needs. In some projects, CHWs were local volunteers such as volunteers from more than 900 civil society organizations who collaborated with **Plan International, Helen Keller International, and Population Services International** to promote and counsel on HH/C-IMCI behaviors in **Cameroon**. In others, they were

full-time, salaried workers who made up part of a national government's personnel, such as health extension workers (HEWs), in several projects in **Ethiopia**. Through the CSHGP, INGOs provided training and support to more than 540,000 CHWs, the majority of whom were women, to deliver essential health services and behavior change education through outreach at facilities and community support meetings (such as participatory women's groups) and during household visits.

CSHGP-supported INGOs and their local partners employed community-centered processes across the various HH/C-IMCI elements, including supporting communities to identify culturally appropriate CHWs, devise their roles and responsibilities, and participate in their training and supervision. For example, rather than having a local authority appoint CHWs, communities participated in the selection process. This facilitated the work of CHWs across socioeconomic boundaries in a community. CSHGP-supported INGOs and their local partners often trained illiterate women to counsel mothers and other caregivers, and to mobilize their communities, empowering them to serve as future community leaders.

A frequent challenge in programs that deploy CHWs is ensuring the adequate performance of this cadre of worker over time.<sup>70</sup> Problems include inaccurate or incomplete recordkeeping, delivery of incorrect information, and high turnover. In addition to training and other support, CSHGP-supported INGOs and their local partners used a variety of innovative approaches to strengthen the performance of this essential cadre of worker. **World Vision** in **Uttar Pradesh, India**, developed a “[timed and targeted](#)” approach to enable CHWs to “[reach the right people at the right time with the right message](#)” to communicate information dependent on a woman's stage of pregnancy, intention to become pregnant, and the age of her children to integrate FP into its MCH program. The government adopted this approach for its nutrition program in all Uttar Pradesh districts.<sup>71</sup>

### **Text Box 9. [Community supportive supervision of CHWs](#)**

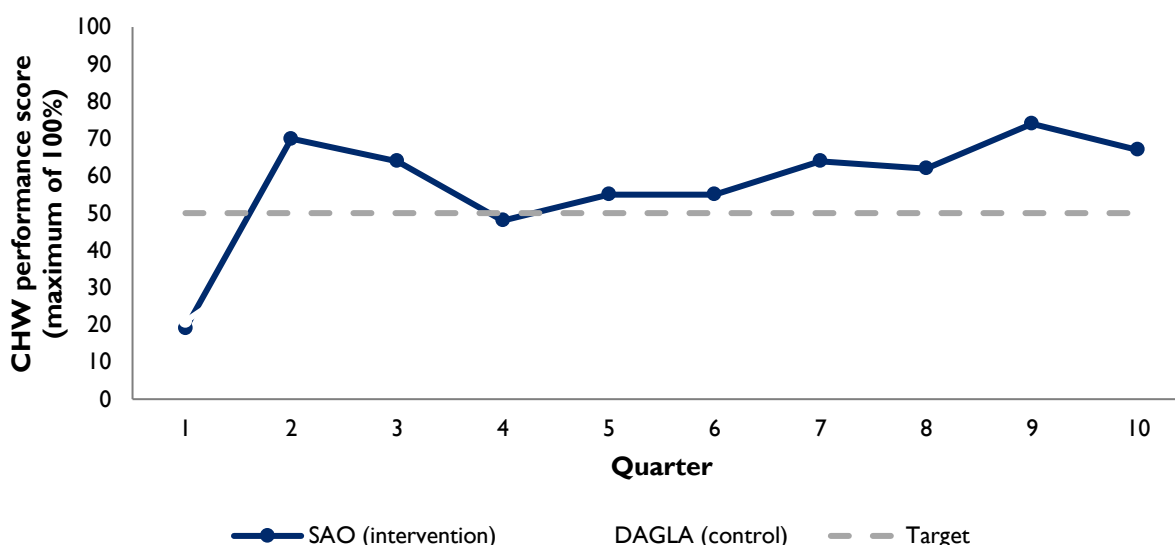
Warrap State in **South Sudan**, where 64% of the population live below the poverty line, more than 80% of adults are illiterate, and almost all live in remote rural villages, is one of the poorest states in the nation. To address the national health workforce shortage, the government created a new cadre of CHWs known as the home health promoters (HHPs). All HHPs are female, illiterate, and chosen by their communities. **World Vision** tested a supervision model focused on community resources to support the iCCM implementation by HHPs. The pilot project found that supportive supervision, particularly during the first 6 weeks following training, proved critical in supporting the acquisition of skills such as management of registration and reporting forms, correct disease identification, and treatment.<sup>72</sup>



### Text Box 10. [Community quality improvement \(QI\) collaboratives improve CHW performance](#)

The performance of CHWs in **Benin** has been a challenge for many years. Challenges with strengthening the roles of communities in systems, including a lack of community engagement in the work of CHWs and a lack of non-monetary incentives, contributed to problems with CHW retention and low performance. **University Research Co./Center for Human Services** investigated whether community-level QI collaboratives, in addition to performance-based financial incentives, could improve performance and retention of CHWs more effectively than monetary incentives alone. The QI collaborative engaged CHWs, village health development committees, CHW supervisors, and others in continuous community feedback loops. The study found that CHWs who participated in the combined intervention were more likely to achieve a high performance score than those who received only financial incentives (see Figure 10). In addition, community support and engagement proved to be a key determinant of high CHW performance.<sup>73</sup>

Figure 10. [CHW mean performance scores over time](#)<sup>74</sup>



## B. Integrating Promotion of Key Family Practices Critical for Health and Nutrition

[Promoting key family practices](#) for individual caregivers, households, and communities, and increasing demand for health services have long been and remain the cornerstone of strengthening systems for primary health care at the community level.<sup>75</sup> To promote such practices and increase demand requires understanding social norms, listening to community perspectives, involving communities in planning and implementing health projects, strengthening community knowledge, and reducing barriers to care. CSHGP-supported INGOs and their local partners designed and implemented evidence-informed social and behavior change components, which aimed to not only change individual behaviors but also create a social environment that supported and reinforced the behaviors. Investigation of the determinants of and influences on practices—from the point of view of families and communities—preceded development of these components. CSHGP-supported INGOs and their local partners engaged communities in the selection of practices to be promoted and identification of actions to be taken.

**Figure 11. Illustrative creative SBC materials and job aids**

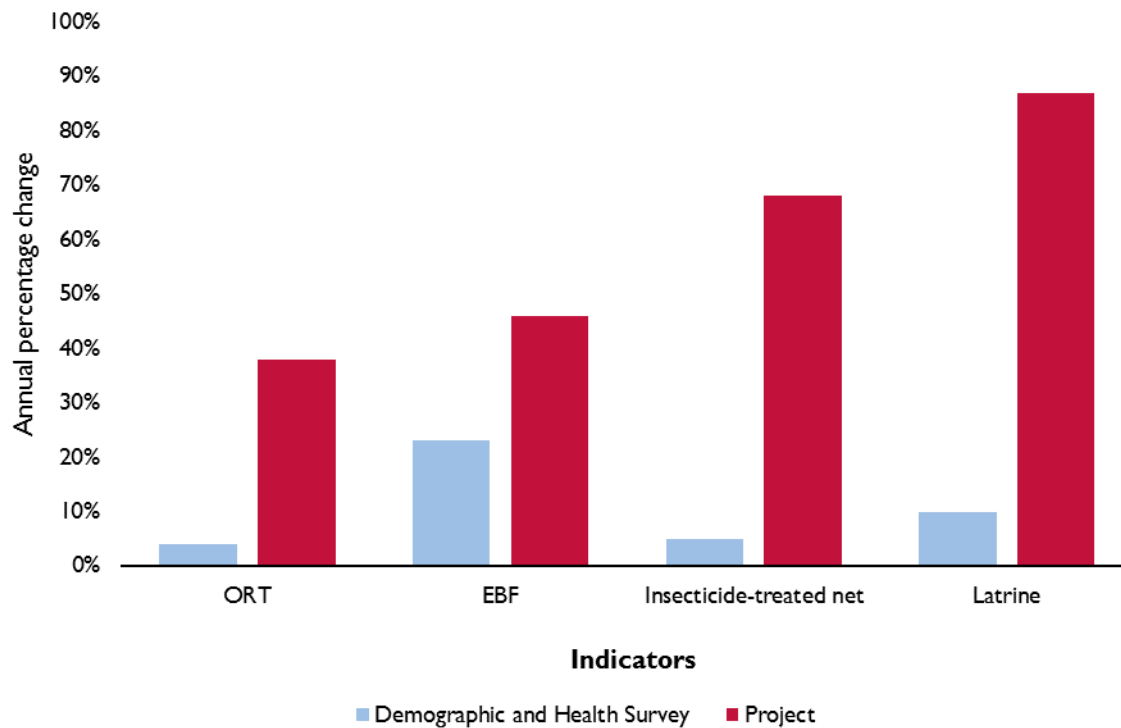


The SBC content and approaches used were context specific, taking into account cultural practices, community assets, capacities, and dynamics as well as epidemiological data. Nevertheless, they all linked with other CSHGP-supported project activities, such as training, health systems support, and service improvements. Typical activities focused on frequent interpersonal contact with mothers, other caregivers, and household members through home visits, outreach from facilities, and community support meetings (e.g., participatory women’s groups, CHCs, and village health committees). Trained CHWs were the most frequently deployed “change agents,” but model mothers, religious leaders, and influential community members (e.g., village elders) also encouraged healthy practices. For example, in **Tajikistan**, **Mercy Corps** worked with mothers-in-law and men to address poor household nutritional practices of mothers and children. Dramatic changes ensued—pregnant women increased their food consumption during pregnancy from 9% to 85%, and extended breastfeeding for infants became the norm (from 38% to 82%).<sup>76</sup> In **Guinea**, the **Adventist Development and Relief Association (ADRA)** trained Muslim religious leaders to become family planning and safe motherhood allies by training them on the importance of spacing pregnancies 2 to 3 years apart to protect the health of mothers and children.<sup>77</sup> Counseling cards, posters, videos, radio drama, local media, technology, and other communication channels often supplemented these efforts. CORE Group’s SBC Working Group developed curriculum and guides on [designing for behavior change](#); provided numerous US, regional, and country workshops; and later helped adapt the curriculum for use in agriculture and natural resource management in addition to health and nutrition.<sup>78</sup>

Together with the other elements of community health system strengthening, not only did household behaviors improve, but communities also developed a sense of ownership over the practices—assuming

responsibility for promoting and sustaining them. Figure 12 below, with data from the expert [analysis of 12 typical CSHGP projects](#), compares project findings on several key family practices promoted in projects with concurrently measured coverage data from a national survey.<sup>79</sup>

**Figure 12. Average annual change in four high-impact indicators vs. secular trend**



## I. Empowering Communities to Improve Health Outcomes and Agency

The CSHGP partners often mobilized communities to help communities identify and address pressing health care issues. The [definition of community mobilization](#) is a “capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.”<sup>80</sup> CSHGP-supported and other INGOs demonstrated diverse community mobilization approaches—such as participatory women’s groups, participatory learning and action cycles, and other similar approaches—to promote awareness, foster healthy behaviors, and strengthen the agency of women, families, and communities. In 2014, [WHO recognized these approaches](#) as effective strategies to improve maternal and, most notably, newborn health and survival, particularly in rural settings with low access to health services, placing the CSHGP at the forefront of addressing this challenge. These groups engage women in the cycle of collectively identifying priority problems and advocating for local solutions. Other perceived benefits include increased community openness and concern about women’s and children’s health, increased community capacity to address health problems, and strengthened linkages among communities, frontline workers, and health services.<sup>81</sup>

**Text Box 11. Care Groups: the power of women working together to transform their communities**

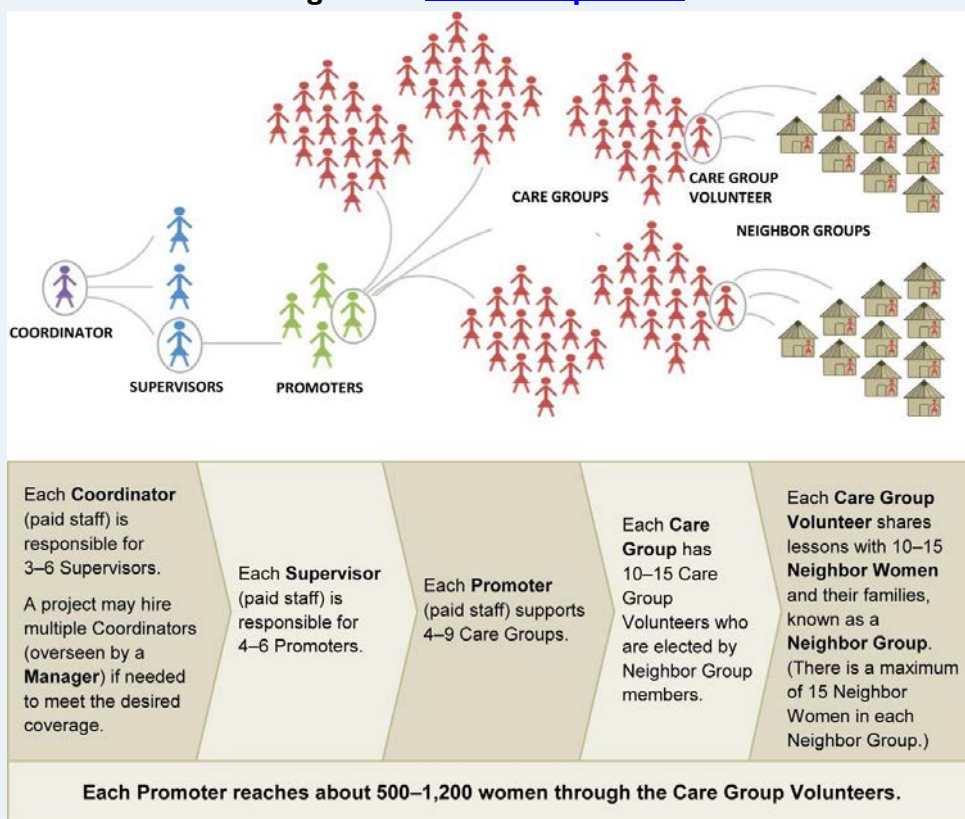
A Care Group is a group of 10–15 volunteer, community-based health educators who meet regularly with project staff or local MOH counterparts for training and supervision. They are different from typical mothers' groups in that each volunteer is responsible for regularly visiting 10–15 of her neighbors, sharing what she has learned, and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. They also provide the structure for a community health information system that reports on new pregnancies, births, and deaths detected during home visits.<sup>82</sup>

Care Groups motivate female volunteers to assist their neighbors in adopting positive behaviors and encourage them to seek health care from the formal health system when needed. Facilitators use participatory learning (role-play, composition of songs and skits) and storytelling to convey messages and stimulate dialogue.

Care Groups have reached an estimated 1.3 million households, almost entirely in rural areas, and more than 25 INGOs in 28 countries have trained at least 106,000 female volunteers using the approach. INGOs have adapted the Care Group model in some settings to integrate with MOH systems, optimize CHW performance in the form of CHW peer support groups, and incorporate nutrition, agriculture, FP, and even TB control into the Care Group platform. The INGOs that have implemented the Care Group approach in a variety of field settings throughout the world have been uniformly enthusiastic about the effectiveness of the approach in changing behaviors, improving health care utilization, achieving demonstrable benefits in vulnerable populations, and empowering women and their communities.

Care Groups are among several high-impact, low-cost innovative approaches developed by INGOs that hold great promise for achieving ambitious goals in health by the year 2030. USAID has been the primary donor supporting INGOs and local partners (government, civil society) to build the evidence and experience to enable countries to adapt, integrate, and scale up the Care Group model through the CSHGP, Food for Peace, Office of US Foreign Disaster Assistance, and bilateral assistance.

**Figure 13. Care Group model<sup>83</sup>**





## **Text Box 12. [Community Health Clubs enable an environment where everyone's ideas are valued](#)**<sup>84</sup>

In 2003, some of the world's highest rates of child and maternal mortality were found in Koinadugu District in **Sierra Leone**. **CARE** organized CHCs as forums in the district for participatory learning and action around health promotion as a means to strengthen community participation in health and development—including women's participation in decision-making processes—through integration with village development committees. CHCs created a culture around the importance of health in communities, advancing community roles in health promotion, community management of health programs, and community development initiatives. The CHC approach was gender neutral: It fostered inclusiveness and raised sensitivities and respect for men and women. This mechanism led to discussions that looked at issues and problems from male and female perspectives. Although many CHC activities benefited women directly (e.g., construction of birthing huts, birth waiting rooms, and wells, and stronger community linkages with the formal health sector), an equally important outcome was an increased sense of community cohesion. A CHC member expressed this view: "Coming together improves unity, and it creates ideas, not just improved health." This collective spirit improved gender relations and contributed to women's empowerment. Women said that CHCs gave them the capacity to ask questions and to organize, and taught them about gender equity. Over time, CHCs evolved into a space for broader community development actions, such as better governance, the emergence of new leadership, and self-initiated plans to facilitate emergency transportation for pregnant women with complications. In short, CHCs created an environment where everyone's ideas were valued, resulting in effective linkages between communities and the formal health system, and improved community health knowledge and behavior, community empowerment, and gender equity.

CSHGP-supported INGOs and local partners adapted innovations in social and behavior change approaches following the invention of new technologies. For example, mobile health (mHealth) approaches used in the CSHGP newborn health programs supported the referral and tracking of mothers and infants, decision support for CHWs, CHW supervision, scheduling and tracking postpartum and postnatal visits, and teaching and counseling for mothers and families.<sup>85</sup> In **Timor Leste**, for example, **Health Alliance International** implemented [the first mHealth project in the country](#) to assess the impact of mobile phone technology to improve maternal health outcomes by improving community understanding of better ways to assure a healthy pregnancy. Called [Mobile Moms](#), the project delivered weekly health messages to pregnant women, doubling antenatal care visits and increasing caseloads of midwives. The project received the [US Global Development Lab's Turning Data into Action award](#). The Australian Department of Foreign Affairs and Trade provided funding to expand the project to other districts.<sup>86</sup>

## **Text Box 13. [Overcoming barriers to care with mHealth](#)**

Herat Province has the highest maternal mortality ratio in **Afghanistan**. Women have limited access to maternal and newborn care services due to geographic barriers, security problems, cultural concerns about women leaving the home without a male companion, and women receiving care from male health workers. **World Vision** and **Dimagi** developed and tested a mobile phone application of home-based lifesaving skills modules for the first time in Afghanistan and demonstrated that it supported CHWs in counseling and coordinating referrals for pregnant women, while improving knowledge and behaviors of women and families during pregnancy. Integrating mHealth technology to enhance communication within a family- and community-centered maternal and newborn health care approach holds promise for addressing geographical and cultural barriers that impede access to basic health services in Afghanistan and similar post-conflict settings.<sup>87</sup>

## **C. Increasing Appropriate and Accessible Health Care and Information from Community-Based Providers**

Integrated Management of Childhood Illness (IMCI) relies on health workers in clinics or other facilities to provide treatment for pneumonia, malaria, and dysentery or diarrhea; however, these services do not bring curative care to households and communities that may be far from a facility.

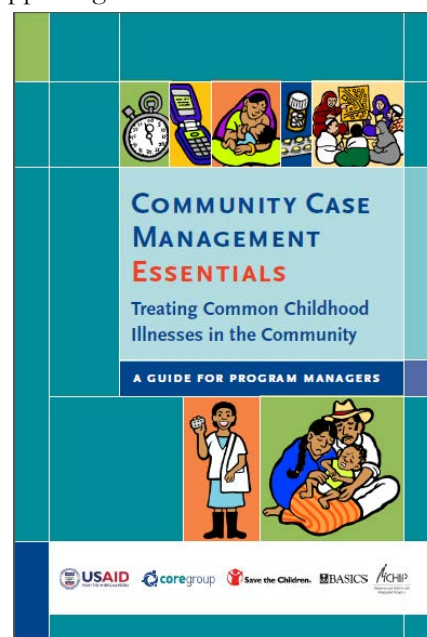
## I. iCCM: An Equity-Focused Strategy for Children Brings Services and Information to Communities

The implementation of iCCM as an equity-focused strategy amplified the treatment arm of HH/C-IMCI to deliver lifesaving, curative interventions for common childhood illnesses and provide information to their caregivers, in particular where there was little access to facility-based services.

Evidence and program experience from multiple countries demonstrated that well-trained, supervised, and supported CHWs, whether literate or not, could successfully diagnose pneumonia, malaria, or diarrhea, and provide effective treatment.<sup>88</sup> From 2000 to 2012, 12 INGOs implemented 22 iCCM projects, reaching 1.75 million children in 18 countries. iCCM continues to be an evolving strategy, subject to ongoing learning. For example, when WHO found that zinc supplementation effectively reduced the duration and severity of diarrheal episodes and likelihood of subsequent infections for 2 to 3 months, CSHGP projects piloted its delivery by CHWs. **Save the Children** (SC) partnered with JHU to embed research into its CSHGP project in **Mali**, [introducing zinc in village drug kits managed by CHWs](#). They disseminated research findings widely until zinc became nationally recognized as a treatment strategy by the MOH.<sup>89</sup> Similar operations research and policy advocacy was done in other countries, including by **Food for the Hungry** in **Mozambique** and **Helen Keller International** with **Plan International** and **Population Services International** in **Cameroon**, which also led to new national policies.

iCCM started with trained and supported CHWs providing oral rehydration solution and zinc for diarrhea. The strategy eventually grew to include the diagnosis and provision of antimalarials for malaria, antibiotics for pneumonia and dysentery, ready-to-use therapeutic foods for malnutrition, and postnatal visits to assess newborn danger signs. CSHGP-supported INGOs, alongside national NGOs, UN agencies, and other development actors, have been at the forefront of generating, disseminating, and promoting the use of new, locally derived evidence and lessons to advocate for iCCM at the national and global levels. At the global level, INGOs championed iCCM and contributed to leadership while supporting national and local governments to introduce and scale up iCCM as an element of their community health programs. In just 5 years, from 2005 to 2010, the number of countries in sub-Saharan Africa with policies supporting iCCM increased from 10 to 23.<sup>90</sup> Through the CSHGP, at least nine INGOs (either in collaboration or individually), as trusted partners of national MOHs, influenced policy to enable the introduction of iCCM in at least seven African countries (**Cameroon, Ethiopia, Madagascar, Mali, Mozambique, Rwanda, and Sierra Leone**).

In 2010, CORE Group and other organizations published [Community Case Management Essentials: Treating Common Childhood Illnesses in the Community](#) (see Figure 14), updated in 2012.<sup>91</sup> Over a 5-year period, INGOs (including several CSHGP-supported INGOs) and other organizations implementing community case management programs collaborated to draft, field-test, and disseminate the guide. It provides practical guidance and reconciles diverse input and expert community child health experience from around the world. In 2012, WHO/UNICEF made a [joint statement](#) on iCCM, laying out actions that countries and partners could take to support the implementation of iCCM at scale and highlighting the guide as one of two implementation support resources.<sup>92</sup>



**Figure 14. Community Case Management Essentials**

## Text Box 14. Influencing iCCM national rollout through INGO collaboration

**Concern Worldwide**, in partnership with the **International Rescue Committee (IRC)** and **World Relief**, [combined IMCI with iCCM in Rwanda](#) to increase access to treatment for malaria, pneumonia, and diarrhea among a population of approximately 1.7 million people. They helped the MOH to train and support over 6,100 CHWs in iCCM and train over 13,000 CHWs to mobilize the community and conduct monthly home visits. The final evaluation showed significant increases in care-seeking for illness when compared to non-intervention areas. This held true for use of services provided by CHWs as well as those within the formal system contributing to Rwanda's decision to roll out iCCM nationally.<sup>93</sup> By working with other development actors (UN agencies, the National Malaria Control Program with support from the Global Fund, and other INGOs, including World Vision, IntraHealth, and Management Sciences for Health), CSHGP-supported INGOs and their local partners contributed to the nationwide rollout of iCCM. [A study found](#) that the number of children receiving community-based treatment for diarrhea and pneumonia increased significantly in the year after the introduction of iCCM nationally. In addition, on average, total under-5 mortality rates declined significantly, by 38%, which was significantly greater than would have been expected based on baseline trends, although the study design did not allow for direct attribution of these changes to iCCM.<sup>94</sup>

**IRC** used its CSHGP experience in **Rwanda** as a learning lab and center of excellence for iCCM, influencing six country programs and attracting roughly \$20 million from other funding sources, including the Canadian International Development Agency, Department for International Development of the United Kingdom, Crown Family, and UNICEF.<sup>95</sup> One example is the expansion of iCCM in **Sierra Leone**. About 1 year after peace was declared in Sierra Leone in 2002, the CSHGP supported **IRC** in the introduction of IMCI, strengthening the quality and performance of the health system and its linkages with communities in a district that had been at the epicenter of the conflict. When it became clear that educating the community and strengthening the health system would be insufficient to improve health outcomes for children in this resource-constrained environment, IRC introduced iCCM. The project leveraged additional funding to train 345 community-based distributors and buy medications, developed a community-based distributor supervision system, and implemented widespread community-based treatment of the three most common causes of child mortality: malaria, pneumonia, and diarrhea. In less than 3 years, the mortality rate for children under 5 was reduced by almost half (from 6.1 to 3.2/1,000/month).<sup>96</sup>

## Text Box 15. Influencing iCCM national policy with CSHGP project sites as learning labs (or Centers of Excellence)

In **Ethiopia**, **SC** developed strong partnerships with the MOH at all levels through three CSHGP-supported projects from 1997–2012. Before the rollout in 2004 to 2005 of the country's pro-poor Health Extension Program, which deployed HEWs widely, the MOH consented to a pilot test of antibiotic treatment for pneumonia by HEWs. The pilot played an important role in SC's broader advocacy efforts at the national level, along with WHO and UNICEF, to introduce community treatment for pneumonia within an iCCM package. The package included treatment of diarrhea with low-osmolarity oral rehydration solution and zinc, rapid diagnostic tests for the assessment of fever and treatment of malaria with artemisinin-based combination therapies, and home visits for postnatal care to identify newborns with danger signs. SC's advocacy strategy embedded implementation within a broader policy engagement process alongside other development actors. CSHGP-supported project site became an iCCM learning district, serving as a demonstration site for government officials. SC, along with other partners, participated in the iCCM Technical Working Group convened by the MOH's Child Survival Working Group, and supported the national-level dialogue and subsequent policy shift to allow treatment of pneumonia with antibiotics to be added to the iCCM package. SC contributed to a [special supplement of the Ethiopian Medical Journal](#)<sup>97</sup> on Ethiopia's iCCM policy and implementation. SC's leadership role and the opportunity afforded by the CSHGP to develop a rigorous demonstration and training site enabled the expansion of community case management for pneumonia at scale, with nearly 30,000 HEWs trained and supported to provide iCCM services in over 14,000 health posts in Ethiopia.

## D. Improving Partnerships between Health Facilities and the Communities They Serve

Bridging the knowledge gap and cultural divide between more biomedically oriented health facilities and the socially constructed world of community members was an important strategy to increase demand for and use of culturally appropriate services. Encouraging the use of services, whether at the community or clinic level, was a key aspect of the CSHGP's overall efforts to bridge the divide between the community and the health system. Community members need to value and appreciate the services provided, and they should expect respectful and competent care when they do use those facilities.

### I. Increasing Skilled Birthing Care

Linking communities to facilities is of particular importance in reducing maternal and newborn morbidity and mortality. Many lifesaving interventions for women and their newborns depend upon the presence of a skilled birth attendant (SBA) with access to emergency medical care during labor, birth, and the 24 hours following birth. The majority of SBAs are found in health facilities. [A summative description of 129 CSHGP projects implemented between 2000 and 2010 reported an overall increase in use of an SBA](#), going from 43% to 56%.<sup>98</sup> Five projects saw SBA coverage more than double over the life of the project, including **CARE** in **Sierra Leone**, **Health Alliance International** in **East Timor**, **Haitian Health Foundation** and the **African Methodist Episcopal Church Service and Development Agency** in **Haiti**, and **Amref Health Africa** in **Kenya**.<sup>99</sup> Where access to government facilities remained difficult, CSHGP-supported INGOs and their local partners developed alternative approaches for provision of skilled birth care. For example, the **Aga Khan Foundation** developed a [community-based midwifery practice model in a mountainous district of Pakistan](#), increasing SBA delivery from 33% to 82%.<sup>100</sup> **Africare** in **Liberia**<sup>101</sup> demonstrated that [engaging communities in the construction and staffing of maternity waiting homes](#) significantly increased team births at delivery by SBAs and traditional midwives. **Curamericas** in **Guatemala**<sup>102</sup> [engaged indigenous communities to operate local, culturally appropriate birthing facilities](#) to achieve high and equitable utilization of skilled birth care in isolated, mountainous areas.

CSHGP-supported INGOs and their local partners cultivated trust that previously was lacking between health facilities and communities through a capacity-building approach and frequent dialogue. INGOs implemented various types of outreach services to increase use of facilities, including the linkage of CHWs with health centers, supervision of health services by community health committees, quality improvement approaches to improve the responsiveness of facility-based care, and community feedback mechanisms.

#### **Text Box 16. [Network of public and private facilities linked with communities increases access to quality care](#)**

Maternal and newborn mortality rates in **Ecuador's** Cotopaxi province are among the highest in the country, where indigenous and poor families bear the heaviest burden. When the project began in 2010, few women had access to a skilled birth attendant, and there were almost no links between community systems used by most indigenous women (traditional birth attendants) and facilities that could manage childbirth complications. **University Research Co./Center for Human Services** supported the MOH in piloting a new model, an Essential Obstetric and Newborn Care Network, in rural parishes with the highest percentage of indigenous and/or poor families. This province-wide network links hospitals with community-level services and includes micronetworks in each district that integrate public providers (MOH and Social Security programs) with NGOs, hospitals, traditional birth attendants, and community leaders. This was all part of an effort to increase referrals and ensure quality care, including respectful, client-centered, and culturally responsive care at facilities. The model also strengthened and expanded the MOH's Basic Health Team approach to provide early postpartum home-based care interventions through traditional birth attendants and skilled providers. Data from Ecuador's National Institute of Statistics and Census demonstrated that newborn deaths decreased by half (from 15 in 2009 to seven each in 2010 and 2011), and maternal deaths from childbirth were eliminated (from three in 2009 to two in 2010 to zero in 2011). The MOH announced plans to expand the model nationally.<sup>103</sup>



## 2. Increasing Community-Friendly Outreach Services

One strategy to increase the use of formal health services is to bring these services closer to underserved populations, with input from the community on how best to make the services culturally acceptable. Several CSHGP-supported INGOs and their local partners trained CHWs and established mechanisms to link them more closely with the formal health system, helping to revitalize primary health care.

### **Text Box 17. Rebuilding an integrated community health system with partners**

In **Senegal**, **ChildFund** implemented two CSHGP grants (1998–2006) that led to the development of a still-unfolding national community health system, transforming primary health care in that country. The projects built on the “health hut” initiative of the late 1970s, which aimed to provide basic health promotion and selected curative services in areas without access to health facilities; however, this initiative was abandoned in the mid-1980s. ChildFund began a CSHGP project to resuscitate health huts in three districts, in partnership with the MOH, the USAID-funded Basic Support for Institutionalizing Child Survival (BASICS) project, Management Sciences for Health, and a World Bank-funded government childhood nutrition program. Health huts are community-based structures staffed by trained community volunteers who are supervised by MOH facility-based staff.

This work set the stage for the 2006 launch of the large-scale, [USAID/Senegal-funded Community Health Program \(PSSC by its acronym in French\)](#) to rapidly expand primary health care through health huts nationally, reaching more than 25% of the nation’s 12 million people by 2011. Additional INGO partners—**Africare**, **Catholic Relief Services**, **Counterpart International**, **Plan International**, and **World Vision**—joined ChildFund in a consortium to support PSSC. The MOH at all levels ensured increased standardization of health interventions; the addition of more health interventions, including child nutrition, malaria, and FP; and fuller integration of health huts within the overall national health strategy. PSSC II continued through 2016, with many additional national and local partner agencies, covering over 70% of the national population. The partnership helps to increase national coverage and coordinate data collection and management of health services by standardizing training, implementation, staffing, monitoring, and reporting systems across multiple actors.

In 2013, Senegal’s MOH approved a national Community Health Policy, which recognized health huts as an integral part of the national health system and formalized the [community health model](#). In 2014, the MOH launched a Strategic Plan for Community Health that set out the process for operationalizing the Community Health Policy for the next 5 years.<sup>104</sup>

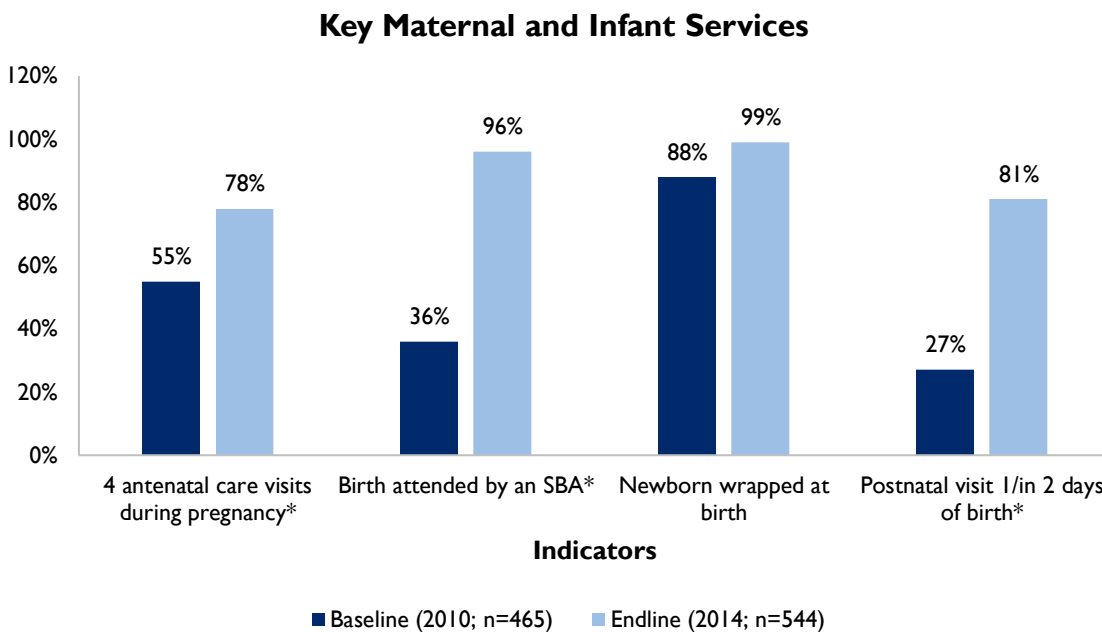
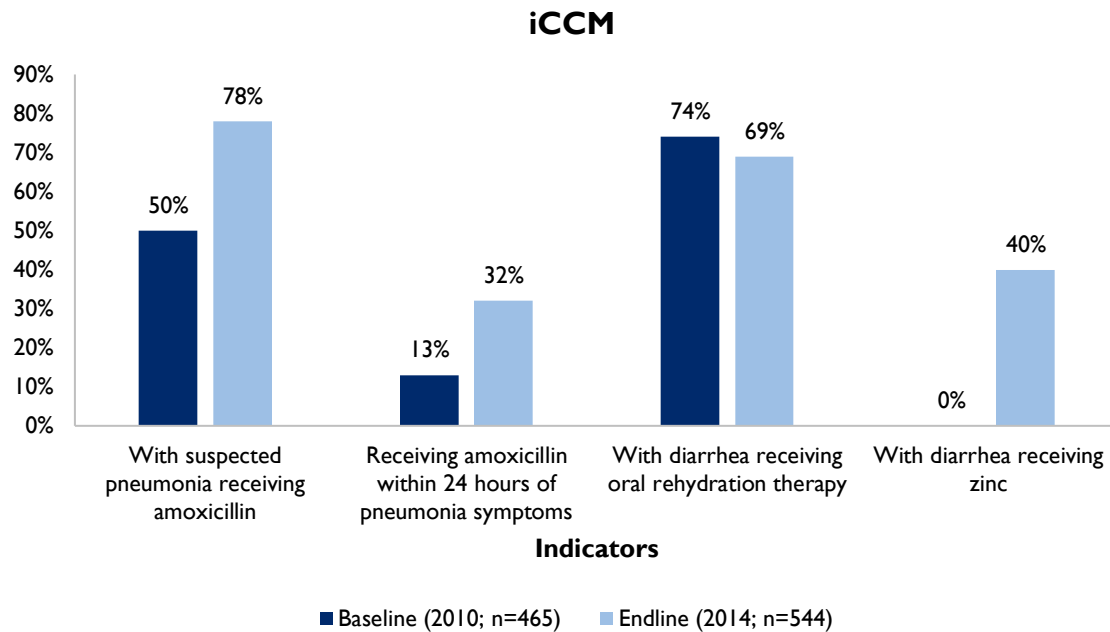
## 3. Partnering with Community Health Committees

Other CSHGP-supported INGOs and their local partners increased use of health services by building the capacity of community health committees to contribute to, manage, and/or supervise local services in partnership with the government. In **Peru**, the community co-manages government primary health care services through local health administration committees (CLASs). **Future Generations** [trained local community leaders](#) in CLAS law, budgeting, and planning, increasing facility management by CLASs from 41% to 70% in a rural area, enabling community links, and decentralized financing that improved health outreach and promotion in that area.<sup>105</sup>

### **Text Box 18. [Team approach to address missed opportunities](#)**

**Zambia** has a strained health care system, especially in rural areas. Traditional birth attendants and CHWs provide basic health services, with traditional birth attendants providing care for pregnant women and CHWs providing care for children 6 months and older. This leaves a gap in care for infants, and postnatal care coverage is low. **SC** [trained Neighborhood Health Committees to use a participatory community action cycle for action planning to address this gap](#). Through this initiative, the approach of teaming male CHWs with trained female was traditional birth attendants identified to strengthen continuity of care for newborns and infants, and improve community-based referral systems to enable better responses to obstetric, newborn, and child health emergencies. These teams, supported by Neighborhood Health Committees, performed joint postnatal care home visits; resolved problems; facilitated referral of mothers, newborns, and children with danger signs; and closed the gap for young infants. Figure 15 highlights some of the results of the community action cycle/team approach.<sup>106</sup>

**Figure 15. Traditional Birth Attendant/Community Health Worker teaming to improve services**



\*indicates statistical significance at p<0.05

#### 4. Working Together to Improve Quality of Care

CSHGP-supported INGOs and their local partners developed and/or used different QI processes to bridge the gaps between community needs and perceptions of health services, and how health care providers deliver care and their own biases toward the community. By engaging community members in defining quality, setting objectives, and monitoring their achievements, QI processes also contributed to accountability of services and reducing inequities in coverage. Improvements in the quality of care at health facilities also resulted from IMCI training and monitoring, supportive supervision, establishment of drug revolving funds,

and provision of equipment and supplies to projects. One of the methods used by many INGOs is that of [partnership-defined quality \(PDQ\)](#).<sup>107</sup> Developed by SC, it is a systematic method to bring health care providers and community members together to identify and address high-priority problems. The method emphasizes QI as a joint activity and takes steps to secure buy-in from all stakeholders and ensure a common vision for quality care.<sup>108</sup> CORE Group compiled [promising INGO-developed, community-centered approaches that enable communities to contribute to quality and social accountability in health systems](#).<sup>109</sup>

### **Text Box 19. Partnership-Defined Quality**

In **Afghanistan**, **SC used PDQ to increase access to and quality of safe motherhood services**. The process involved community *shuras* (consultative councils), religious leaders, teachers, community representatives, and health care providers from communities with low service coverage. After creating a joint definition of quality, action plans with clear indicators, roles, and responsibilities were developed. Results from carrying out the action plan from 2004 to 2006 included: an increase in antenatal care coverage from 45% to 62%, an increase in deliveries by SBAs from 19% to 25%, and an increase in postnatal care from 29% to 41%. The government recognized PDQ as a national quality assurance standard, and the USAID-funded Health Services Support Project scaled this up to five provinces, with plans for an expansion to 13 provinces.<sup>110</sup>

## **5. Creating Feedback Mechanisms to Promote Citizen Participation, Build Accountability, and Improve Governance**

Accountability requires objective measures of progress and measurement of that progress against mutually agreed-upon goals.<sup>111</sup> Community-based health information systems were a central feature of CSHGP feedback and accountability mechanisms, allowing health data to be analyzed in and reported directly to communities, rather than typical systems that only report to higher levels in the national health information system. Moreover, many district health information systems (DHISs) do not capture essential health-related community events, such as births and deaths. DHISs also do not shed light on health behaviors in the population at large, about the quality of health services provided in health facilities, or by individual providers. Adding community-based information to existing routine health information has the potential to create a robust community-based health information system that also promotes local buy-in, improves utilization of information for decision-making and planning, and increases government and private-sector health service accountability to communities. Such a system could also serve as a platform for national evaluation.<sup>112</sup>

### **Text Box 20. A bottom-up approach to DHIS**

In Grand Cape Mount County, **Liberia**, **Medical Teams International** enhanced the DHIS by helping to provide community-based information that is typically missing from such systems, particularly on indicators of progress needed for accountability, including coverage of key behaviors and interventions, and the measurement of mortality.<sup>113</sup> The project used data collected by CHWs on vital events. LIST provided model estimates of child deaths averted, under-5 mortality rates, and maternal mortality ratios. Other additions to the DHIS that filled identified gaps included:

- Rapid health facility assessments and a Health Facility Supervision Checklist to provide information on the quality of MCH services at health facilities
- KPC surveys and annual lot quality assurance surveys (standard practices in all CSHGP projects) for measurement of population-based coverage measurement of health interventions and nutritional stats
- [Community feedback sessions, focus groups, and doer/non-doer analysis](#)<sup>114</sup> to assess community perceptions of quality of care and barriers to care
- Community profile and institutional assessment for a situational analysis of community resources
- CHW monthly reports and training reports to track other health inputs at the district level

Together with the routine data at the district level, these efforts created a “bottom-up” DHIS that could be used first for decision-making and priority setting by health workers in the district, before the data are aggregated and analyzed at higher levels.

Guidance on [sampling techniques for intervention coverage surveys](#) and also [for documenting vital events](#) is available from CORE Group.<sup>115, 116</sup>

In addition to improving data availability and use at the community and district levels, all CSHGP projects began by seeking input from the community and other stakeholders. They participated in appraisals and focus group discussions, which yielded insights into health system functioning, resources and assets, gaps and frustrations, and social dynamics—information used to refine project design and implementation planning. These applications of data for decision-making were one of the first and most valuable exercises to strengthen the capacity of the district health system for future planning to be accountable to community health needs.

Community input did not stop at design. The CSHGP projects used a number of mechanisms to create a level of co-accountability for health care quality and health outcomes, wherein community members, providers, and district health leadership played critical roles. These mechanisms created processes and safe spaces for dialogue about how health is achieved at the community level and who is responsible for it, promoting citizen participation and democracy, and contributing to local (and higher-level) ownership.

### **Text Box 21. [The wall of good health: a community scorecard](#)**

The experience of CSHGP-supported INGOs and their local partners has shown that community-based information systems allow data to be analyzed at the level where they are collected. Nevertheless, presenting health data to communities where literacy levels, especially among women, are low can be a challenge. In **Ghana**, **Catholic Relief Services** found a solution in erecting *Alaafia Goomni*, which translates to “wall of good health” or community giant scoreboards, in most project communities. The wall displays data on two health indicators, chosen from a menu of indicators by the Healthy Mothers and Newborn Care Committee. At the top of the wall, 10 holes hold 10 colored sticks—green for percentage achieved, and red for the percentage remaining to achieve 100%. For example, if the percentage of births attended by skilled providers (a commonly selected indicator) is 60%, six green sticks and four red sticks are on the wall. The walls demonstrate to the community to what degree their contributions have been successful, foster spirited discussion, and motivate communities in their role as advocates for mothers and babies. The high visibility of the walls also promotes friendly competition among communities. Health facilities have also adapted the community giant scoreboards to monitor MNCH indicators.<sup>117</sup>

## **E. Working along a Multisector Platform**

Most CSHGP-supported INGOs integrated health into their broader human and community development programming. These multisectoral efforts bolstered community health investments, while reinforcing the work of other sectors. Water and sanitation programs reduced the incidence of diarrhea; village savings and loan programs provided additional incentives for women’s groups to meet; literacy programs conveyed health messages, while also empowering girls and women; home gardening interventions ensured that families had essential micronutrients and low-cost foods to prevent malnutrition; and income-generating activities, such as soap-making and animal husbandry, boosted family earnings. Other CSHGP-supported INGOs integrated FP into their CSHGP projects. For example, the **American Red Cross** partnered with the **Armenian Red Cross** to integrate FP at the village level into the MOH’s community IMCI platform and doubled contraceptive use.<sup>118</sup> In many of the CSHGP projects, CSHGP-supported INGOs and their local partners developed governance models that strengthened national, community, and local government capacity to manage multisectoral initiatives. For example, **Helen Keller International** in **Nepal** brought together decision-makers from multiple ministries (notably Health, Agriculture, and Local Development) to strengthen planning and coordination of [nutrition and food security initiatives](#).<sup>119</sup>



### **Text Box 22. Savings and loan programs empower women, improve health practices**

Women living in rural poverty must overcome numerous hardships to earn money and feed their children. **Freedom from Hunger** developed a Credit with Education program in **Ghana** in partnership with local banks. It offered an integrated program of microfinance, combined with dialogue-based adult education. Joining a Credit with Education group connected women in the same village. These groups received loans and jointly guaranteed repayment. At regular meetings, the women gathered to make repayments and deposit their savings. An [impact evaluation](#) found that credit and education services, when provided together to groups of women, can increase income and savings, improve health and nutrition knowledge and practice, empower women, and ultimately improve household food security and children’s nutritional status.<sup>120</sup>

### **Text Box 23. Child-friendly villages link health and community development**

To be formally declared a child-friendly village in the ADRA project in **Cambodia** (2001–2006), a village had to meet seven village-wide MCH indicators, covering immunization, pregnancy spacing, and maternal and newborn care. A village steering committee coordinated efforts to obtain this honor. The committees endeavored to ensure that complementary community development activities linked with health efforts. A home gardening program provided agriculture and nutrition training to families, along with incentives such as seeds to encourage gardens that meet family nutritional needs and provide a source of income. Increasing access to improved water and sanitation facilities complemented the home garden and nutrition work. Some families received training in fish farming, and women’s groups gained literacy skills to better address community concerns, including health.<sup>121</sup> A final survey found that villages that achieved “child-friendly status” generally outperformed those that did not, although improvements in health indicators were found in all villages that were part of the project.<sup>122</sup>



People in Jawani village, northern Ghana, attend a community event around their local "scoreboard" or Aloofia Goomni, which translates to "wall of good health." The scoreboards were a component of Catholic Relief Services' USAID-funded Encouraging Positive Practices for Improving Child Survival (EPPICS) Project that helped to ensure vulnerable populations, especially pregnant women, newborn babies, and lactating mothers had increased access to health care. The walls demonstrated to the community the degree to which their contributions have been successful, fostered spirited discussion, and motivated communities in their role as advocates for mothers and babies. The high visibility of the walls also promoted friendly competition among communities.

*Photo by Catholic Relief Services, Ghana*



## V. Care Groups: An Illustration of the CSHGP Evidence, Learning, Innovation, and Diffusion

The Care Group model educates families and improves coverage of lifesaving interventions by promoting behavior change, empowering women, and monitoring health status through mothers' groups and systematic home visitation. The model has proven to reduce child mortality and has been scaled up in some countries as a "best bet" to improve coverage of lifesaving interventions (see Figure 7 earlier in report). The diffusion and adaptation of the Care Group model (e.g., across INGOs, countries, integration of evidence-based interventions) exemplifies how the key features of the CSHGP have merged to achieve improvements in MNCH and infectious diseases in multiple countries. The model responded to the need for a more comprehensive approach to engaging community members in volunteer service to reduce the threat of common problems in community health programming: volunteer attrition and burnout.<sup>123</sup>

CSHGP-supported INGO **World Relief** [created and tested the model from 1996 to 1999 in Mozambique](#), demonstrating impressive gains in rural women's caregiving knowledge and behaviors.<sup>124</sup> Technical support from the CORE Group and funding from donors (USAID and other donors) catalyzed further adaptation, and, as mentioned previously, as of 2015, [more than 25 organizations \(INGOs and government agencies\) in over 28 countries had used the model to train 106,000 peer educators and reach an estimated 1.3 million households](#).<sup>125</sup>

The model is adaptable to a wide range of lifesaving interventions, cultures, and countries. **Food for the Hungry International** was an early adapter, using it to improve health and nutrition in the context of a Title II food security program in **Mozambique**, beginning in 1997. **World Relief** further applied it in CSHGP projects in **Cambodia, Malawi, Rwanda, and Burundi**, and **Curamericas** used it in **Guatemala**.<sup>\*\*\*\*</sup> In **Burundi** and **Niger**, operations research conducted by **Concern Worldwide** determined that responsibility for supervising Care Groups could shift from paid INGO staff to MOH staff and CHWs trained in the approach, without compromising results. This finding paved the way for greater likelihood of sustaining Care Groups within the health system and strengthened government leadership and ownership of the groups.<sup>126</sup>

The promising evidence supporting the effectiveness of Care Groups, as well as CORE Group's Diffusion of Innovations effort, with its focus on learning and the spread of proven program approaches, and TA and the support of USAID advanced the scale-up of this strategy.

Data from KPC surveys conducted in several **World Relief** sites using Care Groups found changes in health practices similar to those seen first in Mozambique, ranging from increases in EBF to more children with up-to-date immunizations. Analysis of mortality data from the community health information system in **Mozambique** also showed a [marked decline in both infant and child death rates](#).<sup>127</sup> [An independent mortality assessment](#) carried out with researchers from JHU through funding from CORE Group corroborated these findings, showing reductions of 49% and 42% in infant and under-5 mortality, respectively.<sup>128</sup> **Food for the Hungry's** food security and nutrition projects also [demonstrated important gains](#) using Care Groups.<sup>129</sup>

In light of the track record of Care Groups in improving child health, CORE Group's Diffusion of Innovations initiative documented and disseminated the model, jointly producing with CSHGP-supported INGOs a variety of learning products, which included training curricula and implementation guides in multiple languages. This collaborative effort refined the model and facilitated diffusion to more INGOs and application in other health areas (maternal health, FP, TB, nutrition/agriculture). The model also received recognition from international entities such as UNICEF<sup>130</sup> and USAID.

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\*\*\*\* Details on World Relief's work available on the [MCSP website](#).

As the number of CSHGP-supported INGOs implementing Care Groups with their local partners grew, so did the evidence base backing the model. Analysis of KPC survey data from a 2005–2010 **Food for the Hungry** project in **Mozambique** (a follow-on to previous projects) found that Care Group volunteers (peer leaders) reached almost every mother with a young child in the communities served (total population of 1.1 million). The volunteers reached an average of 91% of mothers with children ages 6–23 months and 94% of mothers with children ages 0–5 months in the previous 2 weeks. Numerous household behaviors promoted by the project showed statistically significant increases when comparing endline with baseline measures, including EBF, appropriate complementary feeding, appropriate treatment of diarrhea, and handwashing, among others. [Malnutrition among children under age 2 fell by 8.1 percentage points \(from 25.9% to 17.8%\) in one area covered and declined by 11.5 percentage points in a second site that replicated the methodology \(from 27.1% to 15.6%\), at a cost of \\$2.78 per beneficiary \(mothers with young children\) per year.](#)<sup>131</sup>

With the continuing diffusion of Care Groups, [CSHGP-supported INGOs have produced new learning and guidance materials](#), and researchers have conducted a [cross-country analysis of the impact of Care Groups](#). The latter, recently published, concludes that the Care Group model may provide a promising approach to significantly expand key child survival interventions and increase reductions in under-5 mortality.<sup>132</sup> The model's system for integrating several high-impact interventions with a high volunteer-to-community-member ratio resulting in frequent and consistent interpersonal contact that reaches everyone in the population is likely to have contributed to the positive outcomes. Expanding the model could help to accelerate the adoption of the highest impact interventions known to improve the health of households and communities.

The Care Group model is only one of the approaches arising from the CSHGP that started small, gathered experience and evidence, and went on to have larger effects, putting the lives of women, children, and communities most in need around the world at the center.





A couple enrolled in the mHealth program Liga Inan ("Connecting Mothers" in the local Tetum language) read one of their twice weekly health messages that continue until the baby is six months old. Skilled birth attendance -- one of the most inequitable health indicators -- more than doubled over the life of the CSGHP-supported HAI project in Timor Leste that introduced mhealth to the country. *Photo by HAI, Timor Leste*

## VI. Conclusion

For more than three decades, USAID's CSHGP served as an important development tool to advance the mission of the agency and reinforce the values of the American people as a high-impact partnership among INGOs, governments, local civil society organizations, and vulnerable communities. The CSHGP supported 465 grants to 58 INGOs and their local partners in 65 countries. The partnership made several noteworthy contributions to improving primary health care and the national and global progress toward improved health and survival of vulnerable populations in low- and middle-income countries. Most important, the CSHGP **saved lives and improved the health and nutritional status of vulnerable populations** through increased coverage of essential health services and behavior change that markedly improved household practices in some of the most challenging places to work in the world. INGOs lived up to the belief, marked in congressional records at the program's inception, that INGOs' strong connections with communities would position them to help countries address their primary health care priorities and benefit from a "child survival revolution."

The program saved lives while also **strengthening the ownership, collaboration, and capacity of country health systems actors, local civil society, and communities to sustain impact** over time. The INGOs approached the community as a valuable resource and partner, and demonstrated repeatedly that integrated, community-centered primary health care is a low-cost and effective systems strategy in high-mortality settings for improving population-level health outcomes, particularly for women and children. Extending the reach of the health system through a trained and supported community health workforce to address health priorities across the continuum of care was a common feature of CSHGP projects. INGOs empowered local and community-based organizations and groups, including women's and adolescents' groups and diverse community stakeholders, such as religious leaders, to participate in strengthening the primary health care system and hold the system accountable for high-quality services. In particular, they ensured that services were responsive to those most in need, creating the social change necessary for sustained and improved health practices as well as the foundations of self-sufficient communities and resilient health systems.

Over time, the CSHGP also **influenced global and national policies and standards of practice** by testing, documenting, and disseminating innovative strategies that addressed persistent access and delivery challenges. **INGO contributions to strengthening community health policies and programs to achieve "health for all" have formed the backbone of today's community health programs in several countries.** INGOs continue to support country governments in developing and refining policies and strategies, and leveraging domestic resources to institutionalize community health as an integral part of primary health care. For example, INGOs contributed evidence and advocacy for: a community component of the global IMCI strategy, global and national policy for using iCCM to treat common childhood illnesses at the community level, national policies of community delivery of zinc as an effective supplement for treatment of diarrhea, and global endorsement of participatory women's groups for improving health, among others.

The CSHGP was dynamic and evolved significantly over its three decades, with INGOs demonstrating their flexibility and responsiveness to shifting USAID and country government policies and strategies. In the 1980s, the CSHGP began as a competitive program to develop **partnerships** with INGOs to roll out the priorities of the Child Survival Initiative in **underserved, high-mortality areas where health systems were extremely weak or non-functional**. As the program evolved, INGOs shifted their roles from providing direct service delivery to building local capacity. They integrated new interventions into their programs as evidence increased, partnered with global initiatives as they evolved, collaborated with academic institutions to undertake operations research and jointly published findings, and nurtured and expanded collaborations at the global level through CORE Group and in countries, working with civil society, governments, and the private sector, toward greater scale and sustainability. Ten CSHGP-supported INGOs founded a collaborative learning and knowledge management network that improved the field of community health and opened the door to new organizations and partnerships outside the CSHGP INGO partners. This collaborative is now a vibrant global coalition for community health, known as CORE Group, with a reach in 120 countries through



84 members. This coalition has enabled USAID to effectively engage and coordinate with INGOs to respond to emerging health and nutrition needs, including polio eradication (CORE polio) and pandemic flu preparedness. The program structure enabled high-quality results to be replicated across districts and countries through the three program components working in synergy: TA, global program learning and exchange, and strong partnerships at the local level.

Despite the significant progress countries have made in reducing child and maternal deaths and increasing government health expenditures to address the needs of citizens, approximately 303,000 mothers and 5.6 million children will continue to die globally each year from preventable causes. The toll of infectious diseases will remain significant (216 million cases of malaria in 2016, with 445,000 malaria deaths; 1.5 million deaths from TB; and 400,000 deaths associated with 1.2 million people with HIV who develop TB). The majority of these deaths can be averted by scaling up a package of high-impact health and nutrition interventions through stronger systems to support primary health care, with community engagement and empowerment as essential components. Progress can be accelerated by focusing efforts on the [poorest 40% of the population](#)<sup>133</sup> and through [stronger health systems, inclusive of communities](#).<sup>134</sup>

The policies and strategies of countries and the evidence base to support and expand the roles of communities and nongovernmental actors in strengthening [inclusive primary care systems at the community level](#) become more important in the SDG era in the context of achieving universal access to health or “health for all.”<sup>135</sup> In 2017, USAID and UNICEF (in collaboration with WHO and the Bill & Melinda Gates Foundation) brought together 400 champions of community health from 44 countries, representing multiple sectors, for the [Institutionalizing Community Health Conference](#) in Johannesburg, South Africa. At this forum, participants outlined [10 critical principles to institutionalize community health through stronger community health systems](#) that countries must focus on to accelerate progress in health.<sup>136, 137</sup> Soon thereafter, ministers and heads of country delegates from 26 countries gathered for the 2017 Acting on the Call Summit in Addis Ababa, Ethiopia, during which they reiterated the commitment made in adopting the SDGs. They committed to the 2030 targets to reduce mortality and to “[strengthening the community level of \[our\] health systems as a critical step in revitalizing universal health coverage](#).”<sup>138</sup>

#### **Text Box 24. [Ten principles to institutionalize community health](#)**<sup>139</sup>

1. Engage with and empower communities to build viable and resilient community health systems with strong links to health and other relevant sectors.
2. Empower communities and civil society to hold the health system accountable.
3. Build integrated, resilient community health systems based on recognized frontline health workers.
4. Implement national community health programs at scale, guided by national policy and local systems context, to ensure effect.
5. Ensure sufficient and sustainable financing for community health systems that is based on national and international resources, includes the private sector, and contributes to reducing financial barriers to health.
6. Establish programs that reduce health inequities and gender inequalities.
7. Ensure that communities facing humanitarian crisis receive essential health care, particularly at the community level.
8. Invest in the development of inclusive partnerships to leverage and coordinate diverse civil society and private-sector actors to support national acceleration plans and enable communities to shape and support the implementation of policies.
9. Integrate community data into the health information system, including investment in innovative technologies.
10. Employ practical and participatory learning and research to identify, sustain, and scale up effective community interventions while providing opportunities for country-to-country lesson sharing and informing a shared global learning agenda.

The [2018 Global Conference on Primary Health Care](#) will enable countries and global health and development institutions and actors to renew political commitment and build consensus around an implementation strategy to position communities at the center of primary health care, achieve UHC, and reach the SDGs. This moment presents an unprecedented opportunity for reflection and coordinated,

country-driven action—on the part of national governments, NGOs, development aid organizations, and the private sector—to realize a significant paradigm shift. This shift envisions systems of the future achieving the SDGs by 2030 and operationalizes high-performing primary health care with communities as the foundation. [Success will require strategic, action-oriented partnerships, unprecedented coordination across sectors, and a focus on prevention through locally led community-centered approaches.](#)<sup>140</sup>

As the momentum continues to build globally and countries mobilize key partners to meet the SDG goals by 2030, it is clear that citizen-supported INGOs—which have supported governments at the national and subnational levels in rolling out pro-equity policies and delivering results at low cost to those most in need—will remain trusted thought leaders, collaborators, and advocates. They will continue to build upon their strong track record as champions of inclusive primary health care systems that engage and empower communities and local civil society. USAID’s partnership with INGOs through the CSHGP is testimony to the leadership role and adaptability of INGOs to chart new frontiers and redefine roles and relationships to make the SDG era successful, while maintaining a strong and steady focus on serving and empowering the most marginalized and vulnerable communities to contribute to the progress of their nations.



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