MCSP Community Health Contributions Series: Summary

Background

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) supported 32 countries to prevent maternal and child deaths and to empower host country governments to achieve locally sustained results. To support these efforts, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers, and supporting partnerships with country governments and civil society organizations (CSOs).

MCSP undertook a review to identify how various community health approaches contributed to changes in health service uptake and behavioral outcomes in seven MCSP-supported countries. The six MCSP countries included in the series are Ethiopia, Guatemala, Haiti, Kenya, Mozambique, and Rwanda; the series also includes Bangladesh, implemented through the USAID Bureau for Global Health's flagship Maternal and Child Health Integrated Program (MCHIP) MaMoni Health Systems Strengthening Associate Award (AA). The series is focused on reproductive, maternal, newborn, and child health (RMNCH) and, in some countries, adolescent health, malaria, nutrition, and water, sanitation, and hygiene (WASH).

Community Approaches

MCSP provided support and assistance to governments at national, district, and subdistrict levels, and to communities and CSOs to increase high-quality public-sector service delivery and significantly streamline approaches to community mobilization. By strengthening existing community platforms, MCSP engaged communities to mobilize resources and strengthen community response for a range of health topics. MCSP's global community health strategy combined community service delivery with community capacity strengthening and social and behavior change focused at the community level.

Examples of MCSP's Community Health and Civil Society Engagement Approaches

	Service Delivery	Capacity Strengthening	Social and Behavior Change
Training	Train members of civil society at the subnational and district levels to strengthen primary health care services and community health interventions.	Train and provide follow-up support to build the capacity of community health workers (CHWs) and local government institutions to contribute and monitor health services.	Train faith-based leaders on key RMNCH topics so they can work with the community and train other faith-based leaders to support positive health behaviors.
Coordination	Establish or strengthen local governance and oversight of community structures, such as community action groups and community health committees.	Implement social accountability activities to increase citizen participation in identifying quality of care concerns and developing solutions in partnership with health facility staff.	Organize community-level education events, health screenings, and demonstration sessions to increase community awareness about the availability of health services.
Materials	Update or develop, print, and disseminate guidelines, standards, protocols, job aids, and other technical tools related to RMNCH and service delivery.	Create portable community health bulletin boards and scorecards to aid in decision-making for improved community planning.	Develop and adapt social and behavior change materials, including scripts for radio and posters for use in the community.

Community Health and Civil Society Engagement

Effective community-based approaches are necessary to improve RMNCH outcomes. They require strengthening the capacity of health systems to engage with communities, provide accessible services, and promote social and behavior change in support of positive health practices, including appropriate care seeking.

The seven countries reviewed for this series varied in terms of their programmatic areas of focus—adolescent health (AH), malaria (M), nutrition (N), RMNCH, and WASH—as well as type of community health approaches used. All seven countries employed community capacity strengthening and social and behavior change activities.

Country and focal areas examined for the series	Capacity-building for CHWs	Capacity-building of local CSOs	CHW policy and planning	Community capacity-strengthening approaches	Community health technical working groups	Demand generation and social and behavior change	Social accountability	Strengthening government-civil society partnerships	Support for community health management information systems
Bangladesh (MCHIP AA) (N/RMNCH)	•	•		•		•			
Ethiopia (MNCH)	•		•	•	•	•	•		•
Guatemala (AH/N/RMNCH)		•		•		•	•	•	
Haiti (N/RMNCH)	•		•	•	•	•		•	•
Kenya (N/RMNCH/WASH)	•		•	•	•	•			•
Mozambique (M/N/RMNCH)	•	•	•	•	•	•	•	•	•
Rwanda (RMNCH)	•		•	•	•	•	•	•	•

Achievements

MCSP's community health approaches mobilized local assets, increased transparency regarding local resource use, and enhanced accountability. Engagement of local government in health service delivery and the activation and revitalization of existing community health structures were among MCSP's significant achievements. Use of community platforms facilitated the institutionalization of community engagement approaches and collective ownership. Moreover, MCSP's collaboration with national governments showed that implementation of community engagement and demand creation activities at scale is possible. Examples of MCSP's achievements include:

- **Strengthened community platforms and structures:** In several countries featured in this series, MCSP used the Community Action Cycle (CAC) process to mobilize communities around RMNCH. Specifically, the CAC fosters individual and collective action to address key health program goals and improve health outcomes. In Rwanda, the CAC process was used to reinforce the capacity of communities to resolve their own health-related challenges, particularly around utilization of high-quality health services and healthy behaviors at the household and community levels.
- **Institutionalized community health:** Governments from several countries featured in this series are taking steps to embed community health and civil society engagement approaches into routine programming. The Government of Guatemala, for instance, has adopted the Partnership Defined Quality approach—which links quality assessment and improvement with community mobilization—locally in several districts.
- **Increased demand and access to health services:** In all seven countries featured in this series, MCSP worked closely with ministries of health to strengthen the capacity of frontline health workers to improve diagnosis and referral. A new approach for improving RMCNH referrals and counter-referrals in Nampula Province, Mozambique, decreased the period between effective referral (leaving the peripheral health facility) and arrival at the referral health facility. The Ministry of Health in Mozambique is now replicating this system in other provinces. In addition, MCSP mapped community emergency transportation options in communities in Mozambique and mentored community health councils to develop village community banks that raised funds to maintain and fuel motorcycle ambulances.

The briefs from this series can be found on the MCSP website.

Results: By the Numbers

Service delivery data indicate improvements in maternal and newborn health service utilization in project implementation areas that employed community health and civil society engagement approaches.

Improved Maternal Health

↑19%

In **Bangladesh**, facility deliveries increased by 19% during project implementation (2014–2016).

↑29%

In **Ethiopia**, home visits during early pregnancy (first 12 weeks) more than doubled from baseline to endline, from 23% to 52%.

↑10%

In **Haiti**, CHWs accompanied women to facilities when it became time to deliver. The rate of institutional delivery at MCSP project sites increased from 10% to 20% in 1 year.

Improved Newborn Health

↑12%

In **Kenya**, CHWs promoted health services at the community level. Timely first antenatal care visits (i.e., before 12 weeks of pregnancy) increased from 48% to 60% in three subcounties of Baringo and Meru.

↑46%

In **Rwanda**, the percentage of newborns who received postnatal care within 2 days of birth increased from 38% to 84% in just under 3 years of implementation.

↑8%

In **Ethiopia**, the project promoted facility delivery in the community using various techniques. Facility delivery increased by 8% from baseline to endline (June 2015–June 2017).

This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Project and do not necessarily reflect the views of USAID or the United States Government.