KNOWLEDGE MATTERS

Twenty Years of Child Survival Programs in Concern (1998 – 2018)

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EXTREME POVERTY
WHATEVER
IT TAKES

If you have any contributions, ideas or topics for future issues of Knowledge Matters please contact the editorial team by email at knowledgematters@concern.net.

The views expressed are the authors' and do not necessarily coincide with those of Concern Worldwide or its partners.

Knowledge Matters basics

Knowledge Matters offers practice-relevant analysis relating to the development and humanitarian work of Concern Worldwide. It provides a forum for staff and partners to exchange ideas and experiences. The publication is committed to encouraging high quality analysis in the understanding of Concern's work. Concern staff and partners document their ideas and experiences through articles. Articles are very short – 500 – 1,500 words. Usually you only have space to make two or three interesting points. Here are some tips on writing a short feature article:

- Start by imagining your audience – a Concern colleague. Why are they interested – why do they want to read what you have to say? When you identify what your most important point is, say it straight away, in the title or first sentence.

- What can others learn from your story? Focus on this. Remember to back up your story with evidence. This can be got from evaluations.

- It's easier to get people reading if you start with the human perspective – mentioning real people and real-life events. (You don't have to give names).

- Use short sentences. Use Concern's style guide to help you.

- Keep paragraphs to a maximum of six lines long.

- Use clear language. Many of the readers of Knowledge Matters are non-native English speakers, so think carefully about using idioms or colloquial language that might not be easily understood by others.

- Always avoid assuming too high a level of knowledge of the topic you are writing about, on the part of the reader.

- Use active sentences ('we held a workshop' not 'a workshop was held by us')

- Use short and clear expressions.

- Keep your title short - no more than eight words.

- Where necessary use photos to accompany the narrative but ensure that you follow the Dóchas Code of Conduct on Images and Messages.

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Cover photo: Eight months ago, Nasibo Asuran (30) gave birth to a daughter - Ramah. Nasibo lives with her two other children – Samson (5) and Gumatho (10) and her mum and dad in Marsabit, Kenya. "I am happy I have a heathy child. I took her to the clinic and she has had all her vaccinations. I have been breastfeeding her and am now giving her food. The Community Health Volunteer visits us to check that everything is OK." Photo: Peter Caton / Concern Worldwide.

Contents

From the Issue Editor

The Child Survival Health Grants Program (CSHGP) was the largest USAID-NGO partnership for health and the second largest such partnership in the USAID portfolio. The program mobilized a diverse group of stakeholders including national and local governments, civil society organizations, and communities in 65 countries. The community of child survival grantees and community health practitioners set out to operationalize a vision of "health for all" – reaffirming and building on commitments made in 1978 as outlined in the Alma Ata Declaration. The child survival program engaged, empowered and linked communities with the health system, cultivated trust, and established cadres of volunteer community resources persons to strengthen systems. Projects supported families and empowered individuals and couples to make informed decisions about their health through improved health literacy. Child survival grantees - often referred to as "community health pioneers" made a

significant contribution to advancing global public goods and supporting governments to shape country strategies and priorities.

Concern entered the CSHGP with its first award in 1998 in Bangladesh as a two-year entry grant. Over the next 20 years, Concern submitted highly competitive applications and secured ten grants across seven countries: Bangladesh, Burundi, Haiti, Kenya, Niger, Rwanda, and Sierra Leone. With support from USAID, Irish Aid and other donors, Concern invested $31 Million USD over a twenty year period and reached 1.9 million extreme poor and vulnerable individuals including women, newborns, infants, children, their family members, other influential community members, and health workers. Collectively, we built cohesive communities that strengthened the local and national health systems, contributed meaningful evidence to advance global health best practices, and advocated for improved systems and policies that prioritize the poorest and most marginalized.

The Child Survival Knowledge Matters series is a compendium of five articles that attempts to capture the essence of this program, the achievements over two decades and learning generated through years of grassroots, community-based programming. The first article explores project design and results based management. This is followed by a second article that addresses how child survival projects strengthen community health systems with a focus on human resources for health and the frontline volunteer cadre. The third article is a review of the program approaches to social and behavior change communication and presents highlights of the key results; and the fourth article describes the operational research which was embedded in to the 2008 cohort of 'innovations' projects-onward. The fifth and final article is a reflection on sustainability and program elements that were scalable, replicable and generated high impact, low-cost and life-saving solutions.

Megan Christensen

Programme Design and Results-Based Management – Initiating the Child Survival programming in Concern Worldwide

The Child Survival Projects (CSPs) were, on average, five years in length and designed to implement low cost and high impact solutions to maternal, newborn and child health issues. USAID contributed between $1.5M to $1.75M to each of the projects and required a cost-share of at least 25 percent. However, Concern often matched USAID's contribution 1:1 – or a 100 percent cost-share[1].

*Project design***:** The project design and proposal development process was highly participatory and consultative in nature, evidence based, grounded in local and national policies, strategies and Ministry of Health work plans, and informed by current best practices. Concern's project design teams usually included a US-based Health Advisor, support from other SAL advisors, and sometimes an external consultant who all worked with the programs team in-country to design the project. Two to three weeks were usually spent in-country meeting with potential beneficiaries, other community leaders and stakeholders, district officials as well as Ministry of Health (MoH) staff at all levels. After which, the team had approximately three weeks to finalize and submit the proposal. The child survival projects focused on reducing preventable morbidity and mortality by strengthening the heath system to deliver healthcare to women

and children and in some cases, extending health services as close to their homes as possible.

The child survival projects were structured around four pillars:

1. Service delivery points or static health facilities (points of care) – the aim of this pillar was to improve **access to quality health services** through clinical skills upgrading and respectful patient-centered care.

2. Mobilizing communities using community health volunteers for **improved health-seeking** – this pillar focused on improving health knowledge at the household and community level to encourage adoption of optimal health practices for timely and appropriate care-seeking.

3. Local community health and development structures – this pillar focused on **building and strengthening the capacity** of local actors to increase management and accountability for health service delivery.

4. Advocacy for improved community health policies – this pillar worked at the micro, meso and macro levels using project evidence and learning to **advocate for improved community health policies for the extreme poor and vulnerable populations**, particularly women and children.

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1. The exception to this was Rwanda's Expanded Impact project in which USAID contributed $4M to a consortium of Concern Worldwide, International Rescue Committee and World Relief.
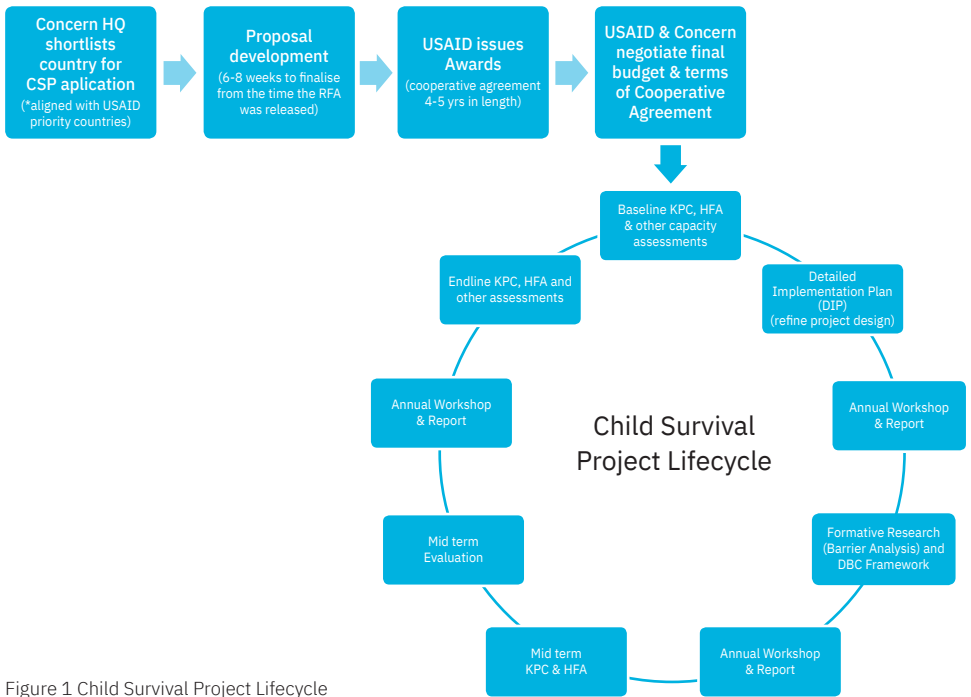
Figure 1 Child Survival Project Lifecycle

Project implementation and Results Based Management: The first three months of the projects were usually spent recruiting staff, establishing project reporting systems and preparing for baseline assessments. The team included a Program Manager (or Coordinator) to oversee the project as well as a team of anywhere from 5-13 national staff with specific expertise and skills in public health including social behavior change, monitoring and evaluation (M&E), community mobilization, and clinical skills for maternal, newborn and child health (MNCH) training, supervision and quality control. This country-based team was supported by a HQ based team in New York comprised of Health Advisor and Health Officer - both of whom were fully dedicated to Concern's child survival projects. The HQ based team was closely linked to and supported by a Washington D.C. based technical team established by USAID, referred to as 'backstopping'. Over

the years, this technical backstopping support changed from the Child Survival Technical Services (CSTS) to Maternal and Child Health Integrated Program (MCHIP) and finally the Maternal Child Survival Program (MCSP). This technical assistance mechanism was responsible for supporting grantees with project quality and providing global leadership to the whole USAID Child Survival program. Ultimately, this formed a network of high quality technical support and assistance to country teams on a continuous and on-demand basis.

Around the same time as Concern's first child survival project in 1998, CORE Group[2] was formed and initially funded by 10 international non-governmental organizations (iNGOs) working on child survival projects. CORE was formed to

2. Originally called The Child Survival Collaborations and Resources Group

create a community of practitioners working on CSPs and community health as a place to collaborate and share best practices and learning. Today, CORE Group has expanded into an international, membership organization with over 50 iNGOs, which Concern is a member of. An annual community health conference is held each year that facilitates conversations, development and dissemination of tools and resources through technical working groups, and sharing of evidence to advance community health.

Once project staff were on-board, the project began baseline assessments, which usually included a population-based coverage survey known as a Knowledge, Practice and Coverage (KPC) survey (similar to a Knowledge Attitudes and Practice survey) as well as a Rapid Health Facility Assessment (R-HFA)[3].

Some projects also included organizational capacity assessments, such as the Health Institutional Capacity Assessment Process (HICAP) to measure the change in capacity, which mainly targeted community level committees such as Health Management Committees and Development Committees.

Assessments

Baseline KPC and RHFA assessments usually took two to three months to complete, inclusive of data analysis and report writing. As with all CSP interventions, these surveys were participatory in nature and aimed to strengthen capacity of local stakeholders in the process. As such, MoH staff and members of community committees were often involved in data collection as enumerators and supervisors.

Mothers returning from the health facility in Parbatipur, Bangladesh. Photo: Concern Worldwide

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3. KPC surveys provided baseline data on beneficiaries' knowledge and health practice while the R-HFAs looked at the physical infrastructure and resources of health facilities as well as their caseloads, protocols, processes and supervision system

Occasionally academic institutions or independent consultants were hired to support with data collection and data analysis. USAID with assistance from the technical backstoppers[4] developed Rapid CATCH indictors – a list of more than 20 indicators that were tested and accepted internationally. All grantees were required to measure and report against these standard indicators in KPC surveys which still today have influenced Concern's standard indicators for health. A standardized tool was also developed for the RHFA and many of these indicators are still used in Concern's health programs.

Detailed Implementation Plans

A core part of the CSPs was the USAID requirement of a Detailed Implementation Plan (DIP). The DIP became the guiding document for how the project would be implemented which was updated periodically throughout the programs and was considered a form of best practice in terms of results-based management. A DIP workshop was held with all key project stakeholders including the project team, MoH and representatives from the community. Results from the baseline KPC and RHFA were presented, discussed and decisions made on overall project strategies and modifications to the original design, which was developed during the proposal phases. This was typically a weeklong workshop and outcomes from the workshop were aggregated by the project team in the DIP narrative. A detailed work plan as well as a comprehensive logframe with midterm and endline targets complemented the DIP narrative. The DIP was then submitted to USAID for review and following several rounds of comments from USAID, the

project leadership defended the DIP in Washington D.C. In subsequent years, efforts were made to reduce the workload and streamline this process and the DIP became known as a Strategic Workplan in the last CSP implemented in Kenya. When new staff joined the team or when evaluations were conducted, the DIP was a keystone to the project and a document against which the project was ultimately evaluated[5].

Memorandums of Understanding (MoUs) were important components of the projects. During the proposal phase these often took the form of a Letter of Support and were subsequently revised upon award to reflect roles and responsibilities of all implementing partners. This was especially important for MoH-District Health Teams and national level as well as other elected positions as it was not uncommon for a transition in leadership to occur over the life of the project and the MoUs provided a useful reference for new leadership. These were time bound and signed by Concern's Country Director and the District Medical Officer.

USAID also required annual reports and nearly all projects were required to conduct independent mid-term and final evaluations. Participatory annual report workshops were held and community representatives, local stakeholders including MoH and beneficiary representatives attended. These were led by the project team with support from the HQ based Advisor or Officer. The annual review workshops were designed to be fun, participatory and consultative; oftentimes these were two to three days and included a great deal of small group work and larger discussions with the whole group. Teams would review the year, highlighting key accomplishments and they would discuss

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4. Child Survival Technical Services (CSTS) to Maternal and Child Health Integrated Program (MCHIP) and Maternal Child Survival Program (MCSP)

5. Example DIPs and Annual Reports can be requested from the Programme Knowledge and Learning Adviser

challenges, barriers to implementation and make recommendations. The team also updated the logframe based on the data available for that year and submitted a revised work plan denoting activities that were on track and off track and any change for the coming year. When designing and planning these workshops, there was a high degree of sensitivity for the various capacity and literacy levels. Many of the tools were visual in nature and participants were sometimes paired to ensure everyone could actively participate.

Similar to the annual reports, the mid-term and final evaluations followed a participatory process that was inclusive of the stakeholders and beneficiaries the projects served. Mid-term and final evaluations for each project can be found in the Resources section. The evaluations typically required approximately 30 days of a consultant's time[6] of which 20 days was spent in-country. Concern mandated debriefing meetings with senior management in country as well as a debrief meeting with the MoH. For most final evaluations, large dissemination meetings were planned and co-facilitated with the MoH. Other iNGOs and implementing partners were invited as well as project stakeholders and beneficiary representatives.

Although this level of input for annual reports and evaluations required more time, effort and resources, the discussions were rich, insightful and increased community ownership of the project.

In fact, in Sierra Leone the community and MoH even referred to it as 'their project' and in Bangladesh, stakeholders noted that Concern's role was to be a 'catalyst'. Ultimately, this process of continuous engagement, local ownership, and partnership with communities and local stakeholders is felt to have contributed to and fostered more sustainable projects and health outcomes.

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6. As part of the cooperative agreement signed with USAID, the consultant selected by Concern had to be approved by USAID

Human Resources for Health – a focus on Child Survival Programs' experience with frontline health workers and community health system strengthening

Frontline health workers is the name given to community-based people who offer health services and/ or health information to community members. In the Child Survival Programs (CSPs), these individuals were volunteers and served as a link between individuals (usually a pregnant woman or the caregiver of a child under the age of five years), their households and the health system, including static health facilities. We use the term 'static health facility' to mean an actual building where a clinic or health service is housed. Over the 20-year period that Concern implemented child survival projects, a common thread among all the projects was engaging frontline health workers. In each country context and project the approach, organization, and mandate of these groups was slightly different, but was usually some form of a peer support group such known as Care Groups or modified

Nurse Betty at Malama community health facility in Sierra Leone uses a rapid diagnostic test to determine if a child has malaria. Photo: Megan Christensen/ Concern Worldwide.

Care Groups and more general networks or groups of health volunteers. They were called 'community health volunteers' (CHVs), 'youth volunteers', 'care group volunteers' 'Mother Leaders' and '*Binômes*' amongst other titles. Sometimes they were called 'community health workers' although they were actually volunteers. The frontline volunteers typically did not receive any payment for their work or training, but some incentives in the form of ID cards, t-shirts, notebooks, flashlights, water purification tablets and condoms were given, depending on the program. Regardless of what they were called[1], this network of volunteer 'health champions' was vital to the success of the projects and ultimately it was these people who drove better health outcomes in their homes and communities.

The frontline volunteer workforce was linked to and integrated with the health facility catchment area. This meant they worked with the health providers and support structures such as Health Facility Management Committees, Community Health Committees, Village (or Ward) Health Committees and Village (or Ward) Development Committees. Often times, frontline volunteers were supervised by health providers or extension workers, members of the support structures and/

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1. For ease of understanding, in this article we will refer to these as 'frontline volunteers' or the 'frontline workforce' and will refer to paid staff as 'health workers'.

or their peers. It was quite common for these frontline health volunteers to also perform other roles such as Traditional Birth Attendant or be a member of the Health Facility Management Committee.

Each project also had specific interventions at static health facilities to upgrade the clinical skills of health workers and to improve the quality of care provided which complemented the work of the frontline volunteers. Training for clinical staff usually included Integrated Management of Childhood Illnesses, Emergency Obstetric and Newborn Care and High Impact Nutrition Interventions in addition to trainings on management, data quality and use, and accountability. This was complemented by supervision, coaching and mentorship activities led by the Ministry of Health (MoH) with support from Concern.

Purposeful efforts were made to strengthen the community level platforms that existed in various formats, while also capacity building and organizing the health volunteers. This usually included first conducting capacity assessments followed by training and then routine on-the-ground support to these community groups. Building the capacity of these local committees or structures was important for increased participation and accountability for the overall functionality of the health facility, community health and community development. Developed in Bangladesh and then used in other country projects including the Sierra Leone CSP, the Health Institution Capacity Assessment Process (HICAP) tool[2] was created to systematically measure self-reported change in group capacity over time. In Burundi, Niger and Rwanda, the project developed curricula based on the community capacity assessments to strengthen the capacity of local committees.

Rather than creating parallel systems to the existing health systems, the projects focused on reactivating existing national policies and strategies, engaging local community-based organizations and strengthening community level resources. The frontline volunteers and health workers collected household level information and data for project monitoring which was also fed into national health information systems (usually DHIS-District Health Information Software) as well as back to the community for local decision-making. Beneficiary households were linked with these community platforms through community mobilization activities such as household visits, community events and health fairs that included their local community level committees, frontline volunteers and health workers. These linkages and integration within the community health platform were vitally important to the success of the projects and were a cornerstone to increasing social accountability for health as well as the sustainability of the projects.

As mentioned above, the structure and organization of the frontline volunteers varied by location, depending on current national policy and what was appropriate in each context. For most of the CSPs, there was some distinction between rural and urban setups. In rural areas, the Care Group model or a slightly modified version of this was typically the most appropriate and preferred format because of the ability of this approach to achieve high population coverage with proven results in geographically dispersed areas. In Kenya, although the project was implemented in a highly remote and rural setting, the project was guided by the community health strategy to operationalize the frontline volunteers so Care Groups were not set up in this project. During the Rwanda CSP, community health policies were being developed so the approach and model evolved overtime into a hybrid of the Care Group model and the Care Group criteria was not fully implemented in Rwanda.

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[2]   A link to the HICAP Toolkit is included in the resource section at the end of this issue

In urban settings, a household was harder to define compared to a village arrangement where a household was visually clearer. Often, multiple families were living under one roof in urban contexts and lifestyles varied considerably in urban set-ups due to different patterns of work, time and frequency of movement and availability of volunteers to attend group sessions. The CSP observed that in urban settings, organizing community health volunteers who had time for community service, and establishing peer supervision based on zones where volunteers resided worked better than relying on mothers who were already overburdened. As it turned out, in urban projects the volunteers were often, although not exclusively, young people and were both male and female volunteers.

Establishing and supporting frontline volunteers (whether or not this was a Care Group or other organized volunteer health peer group) required a significant investment in time and resources. More than a year or 20% of the project lifespan was allocated to identify, recruit, train and activate CHVs and their support system. Ongoing efforts to retain CHVs and refresh their skills continued throughout the life of the project.

Urban programs

In **Bangladesh**, the final evaluation of the first Child Survival Project (2004) noted that the success of the project was built on constructing a strong foundation based on human capital. The project reactivated existing community health and political structures such as the Ward Health Committee (WHC). Once the WHCs were formed, selection committees were developed to identify Community Health Volunteers (CHVs) from within the communities in which they would be working. Nearly 70% of the more than 4,000 CHVs were female, youth (usually secondary school level students) and unmarried.

Because the CHVs were young and a large majority of them women, WHC members met with the candidate's parents prior to their appointment as CHVs to explain what their responsibilities would be and that they would be doing work on behalf of their communities. This was considered very important in a conservative society like Bangladesh. A CHV was only allowed to work with the WHC if their guardian agreed.

The CHVs each worked with about 50 of their neighboring households to educate and encourage mothers and caregivers. The CHVs were supported and supervised by WHC members that were also living in their neighborhood. In addition to home visits for sharing health information and referring sick children and pregnant women for services, CHVs also collected and contributed household level data for the health information management system (HMIS). Deliberate efforts were made by CHVs to provide intensive support and assistance to poor and marginalized households. This strategy paid dividends and **the extreme poor benefited the most; overall, the project reduced the equity gap by 15%**. By endline those in the lowest wealth quintiles made stronger gains in improving maternal newborn and child health indicators compared to those in the highest wealth quintile. See Figure 2

Based on the experience in Bangladesh, the **Haiti** Child Survival Project trained over 900 youth volunteers between the ages of 16-18 from the neighborhoods in which the project was implemented. This included 70 youth distributers who served as a focal point for dispensing health products, and youth facilitators who played a key role in the coordination, leadership and training of the larger group of youth
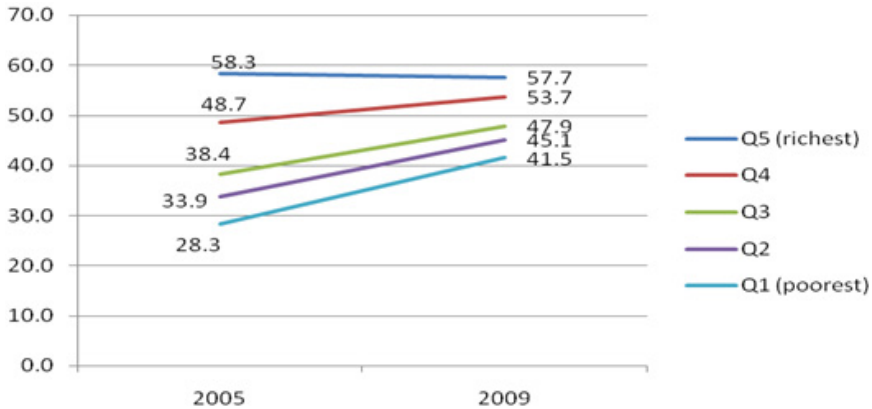
Figure 1: Composite Maternal, Newborn, Child Health Indicators by Asset Quintiles, 2005 vs. 2009

volunteers. Each of the youth volunteers were assigned to 15-20 households in a particular zone/ neighborhood and they used dialogue circles, home visits, health product demonstrations and distributions to engage caregivers and issued referrals to local health facilities.

The **Sierra Leone** Child Survival Project trained 1,206 CHWs (volunteers) and 96 Peer Supervisors (PS). The CHWs were the bridges between the community and the health system and each CHW was allocated about 25 households located near to where they lived who they visited at least once a month. The CHWs were the implementers of the behavior change strategy, using one-on-one counselling. Their referrals to the static health facilities formed the backbone of the community referral network and helped drive progress around improving the quality of care. Each PS was responsible to provide supervision and support to about 12-15 CHWs. The PSs were linked with the Health Management Committees (HMC) and Ward Development Committees (WDC), building a network among community level stakeholders that drove social cohesion and strengthened linkages between the community and the static health facility.

A group of urban Community Health Workers in Freetown, Sierra Leone. Photo: Michael Duff

Rural programs

The Child Survival Projects in **Burundi**[3] and **Niger**[4] followed versions of the Care Group Model. In Burundi, the CSP tested the traditional Care Group model versus an adapted model that was integrated with the health system. In Niger, the project followed

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3. In Burundi, 302 Care Groups with 3,021 Care Group Volunteers were trained and 317 CHWs were trained and provided 27,826 sick-child consultations and treated 12,291 children

4. In Niger, 48 Care Groups were established with 507 Mother Leaders (Care Group Volunteer). Of the 507 Mother Leaders, 56 were selected for additional training on integrated CCM (iCCM) and provide these services

a traditional Care Group arrangement however, illiterate or low literacy Care Group Volunteers (CGVs) were included and a cohort of these mothers were selected for training and the provision of curative care.

The Traditional Care Group Model (sometimes referred to as the NGO-led Care Group Model) utilized a hierarchical structure of paid NGO staff and community volunteers to disseminate health messages, training and encourage behavior change in mothers and caregivers of children. In Burundi, the Community Health Workers (volunteers), who were also part of the Care Group (in addition to the CGV), were also trained on integrated Community Case Management (iCCM) but only for malaria[5]. In Niger, a cohort of Care Group Volunteers known as Mother Leaders, were trained on comprehensive iCCM, which entailed home-based treatment for malaria, pneumonia and diarrhea, and screening and referral to a health facility for malnutrition. Typically, the materials used to train the Care Group Volunteers were pictorial in nature, to account for the low levels of literacy that most Mother Leaders/ CGVs had. Each Care Group met at least twice per month, had 10-15 volunteers and each volunteer would visit at least 10 neighbor women to disseminate messages and support her in practicing the new health behaviors she introduced. Supervision varied by model: either a paid staff member or a health worker and volunteer were to be supervised at least quarterly.

The Integrated Care Group Model (also referred to as the MoH-Led Care Group Model) was a variation of the Traditional Care Group Model where Care Group Volunteers were linked with the formal health system and trained and supervised by health workers (rather than paid Concern staff).
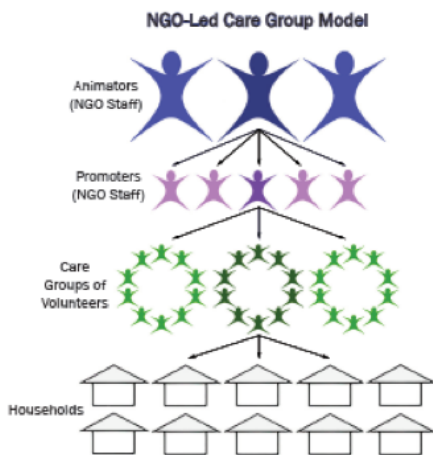

Figure 2: Traditional Care Group Model

Care Group Volunteer Fitina Honorate conducts a home visit in Mugina commune. Adèle Fox/ Concern Worldwide

Care Group volunteers in Bukinanyana Commune sing a song about malaria prevention and promoting early care-seeking. Adèle Fox/Concern Worldwide

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[5]. The CSP in Burundi had intended to include other illness such as pneumonia and diarrhea however policies were not approved prior to the end of the project which will allow home-based treatment for these illnesses.
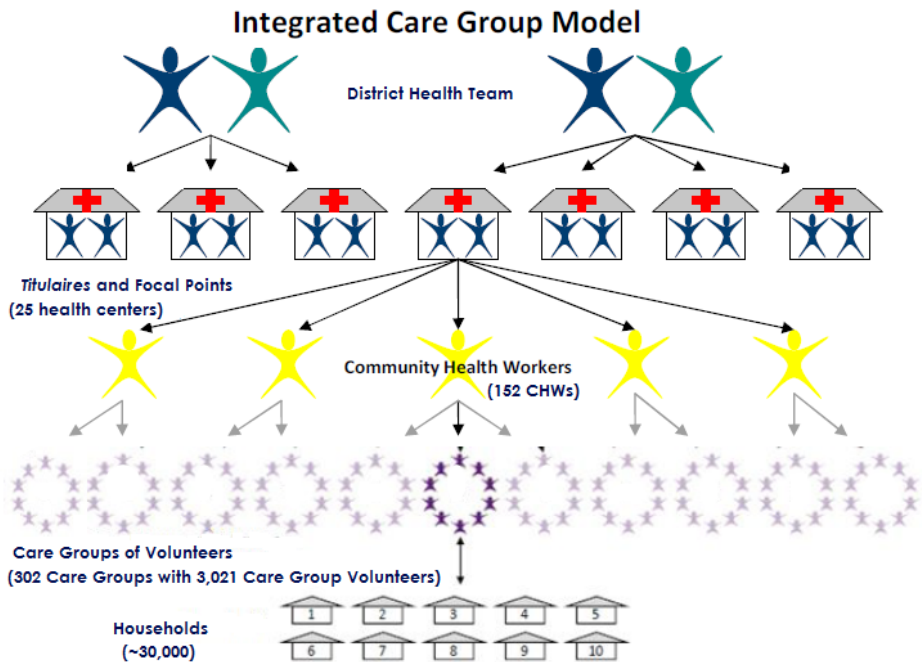
Integrated Care Group Model

Figure 3: Integrated Care Group Model example from Burundi

Regardless of the type of Care Group model used, the trainings were divided into modules of technical areas (for example: malaria, diarrhea, nutrition, acute respiratory infections and family planning) and each training was no more than 2 hours and very focused on one particular message or behavior. Counselling cards with drawings or pictures on the front (for the caregivers) and key messages on the back (for the CHWs or CGVs) were used which followed a technical curriculum developed by the program management with the Ministry of Health or District Health Teams where appropriate.

In **Rwanda**, the approach was adapted to fit with an already existing system in which each village had one male and one female volunteer community health worker known as *Binômes* who provided iCCM and served as liaisons with the health facility serving their village. Each *Binôme* was responsible

for monthly visits to 10-15 households. *Binômes* were supervised by Cell Coordinators, with each Cell Coordinator supervising 15-20 *Binômes*. The Cell Coordinators conducted peer supervision visits, compiled and submitted CHW reports including drug quantification and requisition to the health facility and represented the cell at the health facility level. Over 6,500 Community Health Workers were trained and 590,283 cases of fever treated (92% of cases within 24 hours of fever onset). These volunteers became the first point of care for caretakers of children with fever, respiratory symptoms and diarrhea. The project delivered about **30% of all community treatments in Rwanda** for pneumonia, diarrhea and malaria and data showed reductions in mortality following implementation of iCCM.

A Rwandese Community Health Worker, trained in iCCM feels the forehead of a child. Photo: Esther Havens

The Child Survival Project in **Kenya** utilized a model that was tailored to the newly established national Kenya Community Health Strategy. This approach included establishing 10 'Community Units' comprised of paid government staff as well as CHVs and community level committees (Community Health Committees and Village Health Committees). The network of more than 400 CHVs covered approximately 20 households in their community, providing information, advice and referrals for sick children and pregnant and lactating mothers. The CHVs were supervised by Community Health Extension Workers (CHEWs) who were recruited, hired and paid by the Ministry of Health.

Social Behavior Change Communication in Child Survival Programs

Each of Concern's Child Survival projects included a strategic outcome to improve health knowledge and practices. It was realized that simply providing information to beneficiaries would not be enough to evoke action and sustained change so Concern focused on using social and behavior change communication (SBCC) approaches. USAID developed Technical Reference Materials (TRM) for incorporating behavior change into program designs and developing behavior change strategies using the BEHAVE framework[1].

This refreshed approach reinforced actions that sustain positive health behaviors rather than simply passing information or communicating a message. The Designing for Behavior Change (DBC) approach was developed to help community development practitioners think more critically when developing and reviewing behavior change strategies. The approach starts with developing a DBC Framework which is built on the BEHAVE framework and serves as a strategy for SBCC.

All of the Child Survival projects had some form of a behavior change strategy. Projects implemented after 2002 used the BEHAVE framework and those implemented after 2008 used the DBC framework during project start-up and following the DIP when making revisions to the project design[2].

A well-rounded SBCC approach applies three key strategies:

1. Evidence-based behavior change communication that emphasizes action and supporting beneficiaries to adopt healthy practices not just the transfer of messages and information. (Action is what counts!)
2. Social mobilization
3. Advocacy at all levels to influence optimal health outcomes

As a first step, project teams would identify a problem. Often this was related to excessive but preventable morbidity and mortality of children. Results from the knowledge, practices and coverage (KPC) survey were used to identify low performing behaviors that may have been contributing to the problem identified. Project teams identified a subset of behaviors based on the technical intervention areas.

From this framework, each of the projects had identified the priority group (pregnant women, lactating mothers and caregivers of children under five years of age) and the key groups who influenced them (husbands, religious leaders, relatives and formal

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1. These have been updated and can be found at https://coregroup.org/child-survival-program-resources/

2. The DBC Framework could also be used at midterm if the expected behavior(s) were not changing or not changing at the expected rate. As was the case in Burundi, uptake of family planning was low and the team decided to conduct a barrier analysis survey. It revealed that there were many myths about family planning and the project team attempted to dispel these myths as well as involve religious leaders and husbands in conversations on family planning.

health workers). Several types of formative research were conducted including Trials for Improved Practices (TIPs) and Barrier Analysis or Doer/ Non-Doer Surveys. Data from these surveys were analyzed and used to inform SBCC materials that were context specific and addressed the particular factors that prevented or enabled the uptake of optimal behaviors. In later years as health system strengthening increasingly became a priority in Child Survival projects, the teams would use Ministry of Health (MoH) tools and adapt the messages to the project context, rather than creating new materials.

Project highlights:

Bangladesh

The graph below shows some of the main behavior change results of the Child Survival program in Bangladesh. Religious leaders, Imams, were part of the SBCC strategy. Imams were engaged and trained on maternal, child and newborn health issues and messages. At the endline, the Imams

reported providing health messages based on Quran verses in their Friday prayers. They provide information to people about where to get health services, as well as praying for them. Traditional healers and homeopaths were also trained and engaged. Rather than trying to alter care seeking from these sources, they were trained on how to identify danger signs in children and trained in referrals as a mechanism to improve quality case management.
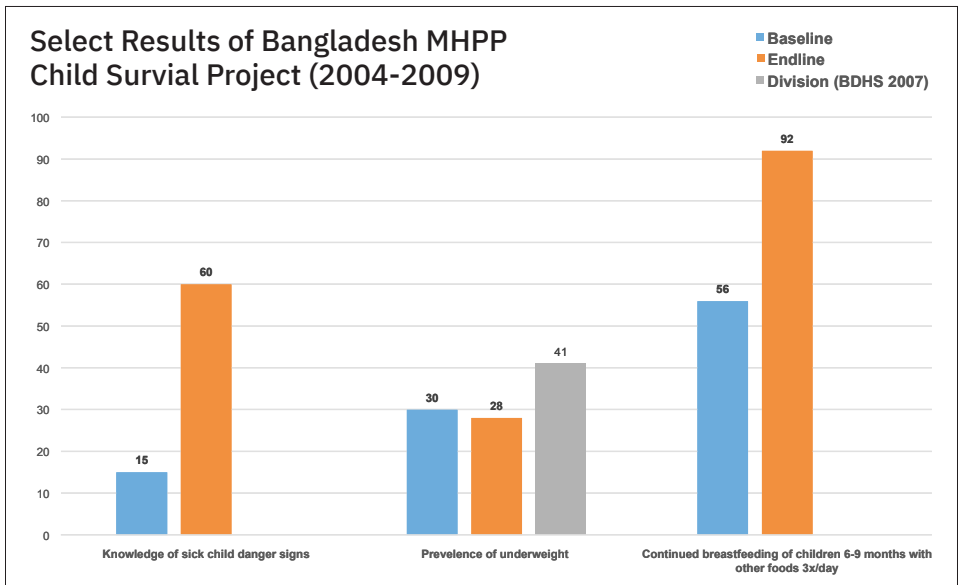

The Ward Commissioner and a Health Volunteer giving the polio vaccine to a child in Parbatipur, Bangladesh, 1999. Photo: Breda Gahan / Concern Worldwide.

Select Results of Bangladesh MHPP Child Survial Project (2004-2009)

- Baseline
- Endline
- Division (BDHS 2007)

Indicator	Baseline	Endline	Division (BDHS 2007)
Knowledge of sick child danger signs	15	60	
Prevelence of underweight	30	28	41
Continued breastfeeding of children 6-9 months with other foods 3x/day	56	92	

Haiti

The mass displacement and destruction caused by the earthquake in Haiti in 2010 meant that endline knowledge, practices and coverage (KPC) data could not be collected. However, a midline survey showed significant progress from baseline and it is likely that the end of project targets would have been met or exceeded. The following table shows the midline results for selected knowledge and behaviors:

Indicator	Baseline (%)	Midline (%)	Target (%)
Proportion of female youth aged 15-24 years who are using a modern contraceptive	28	51	55
Proportion of mothers with children aged 12-23 months who know at least two signs of childhood illness that indicate the need for treatment	33	54	60
Proportion of mothers of children aged 0-11 months who have been tested for HIV and know their serological status	37	51	n/a

Youth Volunteers in Haiti meet with a beneficiary mother and look at a calendar for scheduling a date to visit the health facility. Photo: Concern Worldwide.
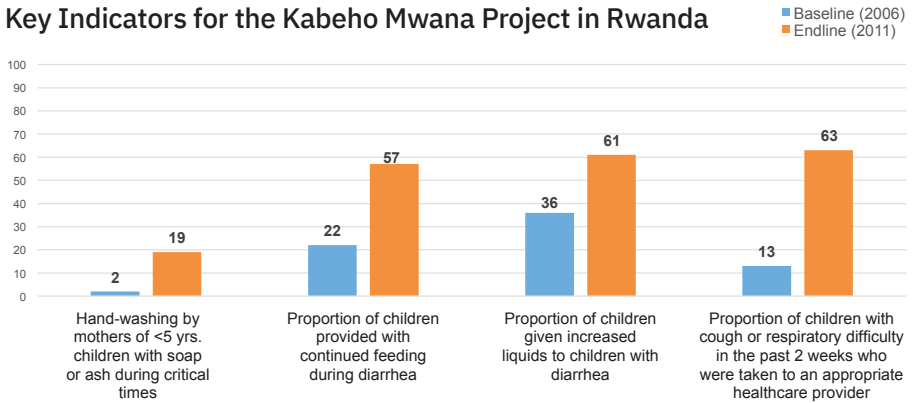
Rwanda

The project used the BEHAVE Framework to analyze determinants of health behaviors on pneumonia, maternal/newborn health (including family planning), malnutrition, diarrhea, malaria and HIV and AIDS. Behavior change communication was rolled out through a modified Care Group approach. The project developed behavior change communication visual aids for use at the community level. Messages were translated and field-tested and an artist created locally appropriate illustrations of these. The final products were approved by the MoH and used at district and national levels.

A young in Rwanda boy demonstrates how to use a tippy-tap that was set-up with the help of a CHV. Photo: Megan Christensen/Concern Worldwide.

Subsequently, the project organized training of master trainers on the use of these materials and cascaded the training along with distribution of materials to all CHWs and religious leaders. By endline, 41% of households visited by a CHV had a hand washing station. Other results achieved are presented in the chart below.

Key Indicators for the Kabeho Mwana Project in Rwanda

Legend: Baseline (2006), Endline (2011)

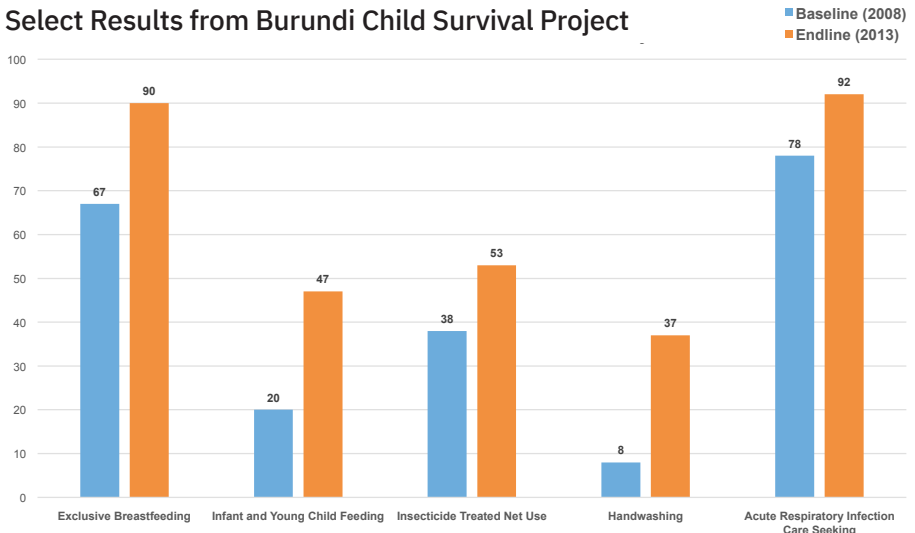|	Baseline (2006)	Endline (2011)
Hand-washing by mothers of <5 yrs. children with soap or ash during critical times	2	19
Proportion of children provided with continued feeding during diarrhea	22	57
Proportion of children given increased liquids to children with diarrhea	36	61
Proportion of children with cough or respiratory difficulty in the past 2 weeks who were taken to an appropriate healthcare provider	13	63

Burundi

Several methods of formative research including TIPs and Barrier Analysis surveys were used to inform the behavior change strategy along with Care Group materials and messages. Due to delays in establishing the Care Groups, there was pressure to accelerate the development of the BCC materials. It was noted in the final evaluation that perhaps sufficient time had not been allocated to training CGV and curriculum development because material placed more emphasis on communicating 'messages' rather than the action of adopting of new practices that optimize behavior change. Despite this, over 3,000 Care Group Volunteers were deployed and conducted over 30,000 household visits to caregivers twice monthly, contributing to the results presented in the table below.

Select Results from Burundi Child Survival Project

Legend: Baseline (2008), Endline (2013)

	Baseline (2008)	Endline (2013)
Exclusive Breastfeeding	67	90
Infant and Young Child Feeding	20	47
Insecticide Treated Net Use	38	53
Handwashing	8	37
Acute Respiratory Infection Care Seeking	78	92

The evaluation found that "with this level of coverage and intensity of the behavior change strategy it is quite clear that the results of the KPC survey are attributed, with confidence, to the Care Group strategy."

At midterm, the project team added a module on family planning because of interest among beneficiaries to know more about this topic. Religious leaders were not pleased about the community discussing contraceptive use and there was considerable push back. Project staff met with religious leaders on a couple of occasions and requested local authorities to help mediate. This learning reinforced the importance of developing well-researched behavior change frameworks, including influencing groups and key stakeholders before embarking on sensitive health-related messaging and BCC activities.

Niger

The project used the Care Group model to train Mother Leaders in BCC and community mobilization. The BCC strategies and ultimately the DBC framework were informed by Doer/Non-Doer Surveys and provided the basis for the selected key behaviors to promote. A thorough review of existing BCC materials was conducted to gauge the need for new materials. New materials were developed, tested, revised, and tested again. During project design and through formative research, it was determined that the radio was a significant source of information for communities[3] and

so radio was used to further disseminate key messages.

The project met targets for 15 of 23 outcome indicators in the areas of quality improvement, and essential family health knowledge or practices. Care-seeking behaviors improved significantly, as caregivers brought their sick child to a health facility instead of a traditional healer or other informal provider; and the rate of care seeking within 24 hours for all illnesses combined quadrupled. Complementary feeding practices for children 6-23 months increased from 6% to 30%. Care seeking for rapid breathing also increased from 51% to 82%.

Sierra Leone

Over 1,300 urban community health workers were trained and deployed to promote behavior change and support mothers and caregivers to adopt optimal health practice. With the MoH and community structures, the project team (including one fully dedicated BCC staff member) undertook extensive formative research. This included identifying low performing indicators and their corresponding behaviors, barrier analysis and preparing a DBC framework. This DBC framework was tailored extensively for Freetown residences. For example, when piloting the materials, the team observed that beneficiaries related better to and preferred actual photographs of someone similar to them doing the behavior rather than a drawing or a schematic.

Ten of the 13 practices covered by the CHWs BCC booklet increased significantly from baseline to endline, and the three that did not increased stayed constant[4]. Beneficiaries appreciated the tailored BCC materials and these were effective in promoting behavior change.

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3.   Before selecting radio or other media as mechanisms to disseminate messages, it is imperative to have gender-disaggregated data on literacy (if using print media) and radio ownership among the priority group (target beneficiaries) as well as influencing groups. If women are being targeted with radio messages, it is critical to understand at what times they are listening, who owns the radio and who makes the decisions on which station/broadcast to select, which stations are preferred and the format for information dissemination (ie. talk show, interactive/call-in, debate, dramas etc).

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4.   See pages 29 and 30 of the Sierra Leone final evaluation report in the Resources section of this issue.

The overall theme for the BCC materials was "You are the Mother, Do What's Best". In hindsight, this tagline was more gender exploitative rather than gender sensitive or gender transformative, which we now know is better practice. While messages in the Sierra Leone project did include and acknowledge men as caregivers, more deliberate effort could have been made to include men and boys in the DBC framework.

Community health worker (CHW) Nabie Kargbo explains the importance of breastfeeding to Fullah Sesay in Dwarzack community, Freetown, Sierra Leone. Photo: Michael Duff / Concern Worldwide.

Kenya

A slightly different and unique approach was rolled out in Kenya. A 'coalition' of frontline volunteers was mobilized to promote and support behavior change among pastoralists as well as make referrals to the health facility. At the same time, Community Conversation groups were formed to empower communities to undertake a transformative process that challenges social norms and long-held beliefs contributing to suboptimal health and development outcomes. In total, 79 Community Conversation Groups were established and linked to health volunteers-organized by Community Units.

Community conversations provided a platform for ongoing community discussions about MNCH issues and were vehicles for social cohesion among the community. Gender equality was enhanced through the groups and contributions made by Community Conversation group facilitators. During meetings, every effort was made to have a gender balance and the fact that men and women were coming together in the same group, sitting next to each other and discussing health issues was in and of itself transformative. Communities, project stakeholders and female beneficiaries noted that male engagement and responsibility for maternal and child health have increased. The communication between sexes and generations also improved through the all-inclusive approach of community conversations. Apart from introducing more gender sensitive approaches, the community conversations also addressed equity through ensuring people with disabilities, the elderly and other marginalized and vulnerable groups were reached and served by their community. When the community was linked with elected Ward Administrations and involved in the annual budget process, significant change with respect to health and development was observed; some communities were able to secure county funding for urgently needed resources at the health facility.

In sum, initially, social behavior change interventions are labor and resource intensive but the return on investment and value for money, are high. Remarkable progress has been achieved with proven impacts on accelerating maternal, neonatal and child health outcomes. These interventions and approaches, when paired with other system strengthening approaches, have cultivated environments that are more likely to sustain gains over time. Concern's commitment to partnerships, evidence-informed approaches, and use of data for decision-making is imperative to successful SBCC. Sufficient staff and project time and financial resources must be allocated to this process. Continued engagement with the CORE Group and participation in CORE's technical working groups including the SBC Working Group are also vital to the continued success of SBCC.

Operations Research

In 2008, USAID asked civil society to be 'innovative' and to test solutions to known problems by conducting high quality, rigorous research. It was known that health systems had recurring information gaps that led to a demand for new approaches that were supported by data and process learning. Prior to this time, there was a belief that civil society did not have a role or the capacity to conduct high quality operational research. Concern challenged this belief and produced high quality research with robust evidence that demonstrated promising practices and adaptations to current approaches. Below are summaries of the four operational research projects and the learning gained through their implementation. The full reports for each are available in the Resources section of this issue.

Burundi (2008-2013)[1]

Care Groups require a lot of management time and resources in order to function well. There were questions over the sustainability of this approach after the NGO project has finished and the Ministry of Health (MoH)

takes over. This study tested whether a MoH-led Integrated Care Group model functioned as well as the NGO-led Care Group model in achieving similar health knowledge and behavioral outcomes at the household level.

From 2011 to 2013, Concern implemented the Traditional and Integrated Care Group models[2] in two clusters of Bukinanyana Commune. Care Groups were established in the same way in both study areas using standard Care Group practices, including community sensitization to Care Groups, census of all households with pregnant women and children under five, and election of Care Group Volunteers (CGVs) based on census results. In both study areas, Care Group meetings were held twice per month and CGVs conducted home visits at least once per month, during which they provided targeted health promotion messages, screened for acute malnutrition, and collected vital events data.

In the Traditional Care Group study area, paid Concern project staff called Animators trained and supervised other paid project staff called Promoters, who in turn trained and supervised the CGVs. Each Promoter was responsible for between six to nine Care Groups and each group had 10-15 CHVs. In the Integrated area, CHWs directly supervised CGVs by conducting follow-up

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1. The dates in parentheses denote the entire project period and in the text, the study period is noted. Because the operational research was part of the projects, it often took a year or more for the research to commence once the core project activities were functional and Institutional Review Boards approval was secured. Thus, the research implementation period was a shorter timeframe than the full project period.

2. See the Human Resources for Health article for diagrams of both Care Group structures.

household visits, reviewing CGV registers, and troubleshooting problems during Care Group meetings. CHWs in both study areas were supervised by health facility-based *Titulaires*, as dictated in the Community Health Strategy.

Concern designed and tested the Integrated Care Group model to increase integration with the local MoH structure by shifting the Care Group facilitation and supervision duties from project staff to MoH structures. Concern provided technical support as needed over the course of the project to the District Health Team (DHT) and health facility staff in the implementation of Care Group activities.

At endline, there was sufficient evidence that the MoH-led Integrated Model performed as well as the NGO-led model for 36 of the 40 (90%) child health and nutrition indicators. The MoH-led Integrated model functioned similarly to the NGO-led model based on five operational indicators covering the areas of supervision, meeting frequency and attendance. This research provided important data demonstrating the ability of MoH to implement high quality Care Groups as a key child health strategy. Traditionally, Care Groups had been established and managed by iNGOs and functioned as a parallel structure to the health system. Using this modified approach, a lower cost model that was integrated with the health system was shown to work. This model also showed potential for increased sustainability and scale-up with government systems.

Niger (2009-2014)

The Niger Government invested heavily in local health posts staffed by full-time Community Health Agents (CHAs) who provided the national Integrated Community Case Management (iCCM) service package and other basic primary health services, as well as referred complicated cases to community health facilities. However,

distance from households to health posts and health facilities and lack of health personnel continued to be critical barriers to caregivers seeking timely care and children receiving appropriate services. For these young children to receive timely life-saving care, they needed basic preventative and diagnostic services and treatment options in or near their homes.

This operations research study examined the innovation of incorporating iCCM into Care Groups, whereby trained and equipped low-literacy volunteer Mother Leaders served as frontline health providers and were linked with the formal health care system to manage child illnesses. The study examined the acceptability, effectiveness, and quality of iCCM services provided by Mother Leaders. Concern conducted the operations research study from July 2012 to September 2014 in 12 villages of the Bambeye Commune of Niger's Tahoua Health District. Selected villages were more than five kilometers from the nearest health center, without access to other health services, and demonstrated interest in promoting village health.

Twenty Care Group Mother Leaders were selected by their community for these additional responsibilities and trained on iCCM, which consisted of a four-day theoretical course followed by a five-day clinical practicum. At the end of the clinical work, Mother Leaders were observed and certified by a senior nurse at the health center. Mother Leaders tended to have a minimum of four years of schooling, basic literacy skills[3], and an average age of 32 years. The study compared them with eight CHAs deployed to provide basic health services at seven rural health posts serving

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3. While the Mother Leaders selected for iCCM all had some level of literacy the majority had only completed primary school in a system where many children still can't read even after completing three to four years of formal education.

the same villages. The CHAs were MoH employees, had a minimum of 10 years of schooling, an average age of 36 years, a mean 9.6 years of clinical practice, and one week of iCCM training. Nurses from six local health centers provided supportive supervision and supplies to the Mother Leaders and CHAs.

The study's main findings confirmed that both MoH staff and communities consider iCCM services provided by low-literacy volunteer Care Group Mother Leaders an acceptable option for the initial treatment of sick children. The quality of Mother Leaders' work was comparable to that of the lowest cadre of paid facility-based community health workers in Niger (the CHAs). Community members were highly satisfied with the accessibility of services provided by trained Mother Leaders, who were consistently supported by health center staff. Significant improvements occurred in the timeliness of seeking care and treatment practices as significantly more sick children were taken for care in the first 24 hours, and seeking care from untrained providers nearly vanished. Community uptake of the iCCM intervention was successful and high enough that it facilitated some level of task-sharing between Mother Leaders and facility based providers. In communities where iCCM was available, Mother Leaders became the main providers for simple cases of malaria, diarrhea, and pneumonia whereas previously health facility staff, who are already overworked, had managed all cases. A majority of trained Mother Leaders provided correct classification and performed as well as CHAs in the quality of treatment. This data suggests than an iCCM model using Care Group volunteers, who are semi-literate, is a feasible strategy to enhance access to life-saving care and treatment in rural areas where children have increased instances of illness and death.

In Tahoua, Niger, a Care Group volunteer Mother Leader trained on iCCM asks another Mother Leader about the symptoms this young girl is experiencing. The Mother Leader determines the child is breathing too quickly, likely has pneumonia and proceeds to treat the child in the village. Photo: Megan Christensen/Concern Worldwide

Sierra Leone (2011-2017)

Community engagement has the potential to improve the impact of health interventions, facilitate responses to public health emergencies and disasters, and strengthen health systems. Despite this being promoted as a strategy for health systems strengthening, there is need for more evidence for effectiveness of this approach. Concern in collaboration with Johns Hopkins University and the Sierra Leone Ministry of Health assessed one form of community engagement; the development and implementation of a participatory community-based health information system (PCBHIS), in informal, urban communities in Freetown, Sierra Leone from July 2015 to March 2017. The objectives of the study were to assess the extent to which the PCBHIS facilitated local community structures[4] to use data to plan and implement actions for improving maternal, neonatal, and child health and to assess the extent to which this contributed to improved community-level maternal, newborn and child health outcomes.

The study was a cluster-randomized controlled trial[5], with communities randomly selected to either the intervention or control area. The intervention sites consisted of the routine project activities in addition to two additional activities:

1) Community Health Data Review (CHDR) meetings that were held every two months to support HMCs, WDCs, and Peer Supervisors to review household-level data collected by CHWs,

determine actions in response to this data and present and discuss the results of verbal autopsies

2) Verbal autopsies (VAs) for deaths of under-5 children that had been registered by CHWs were also conducted to identify the cause of death and develop an understanding of the circumstances around the time of death.

This study was implemented in challenging circumstances; the intervention was delayed because of interruptions in finalizing the national CHW policy, two separate cholera epidemics, and the Ebola epidemic lasting more than two years. Overall, communities conducting VAs and participating in bi-monthly meetings performed slightly better than communities who did not in measurements of CHW functionality, household behaviors, and care-seeking behaviors. According to the VA results, malaria and pneumonia were major killers of children in the area however, this information was not new and cause of death data alone was not sufficient for tangible, community led action. When VA results were combined with social autopsy findings, which explore other social determinants around the time of death, communities were better able to respond to these issues and develop local solutions. The social autopsies revealed challenges in care seeking practices, first point of care, and accessing appropriate care and a health facility. Weaknesses in the CHW intervention severely limited the extent to which the PCBHIS could be used to observe trends in mortality and morbidity. Nonetheless, the positive results achieved in the area of functionality of the CHW intervention and community structure capacity are encouraging. Results suggest there is value in further rigorous investigations into improving community-based health system functioning through a similar approach to community engagement.

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4. Ward Development Committees (WDCs) and Health Management Committees (HMCs)

5. This is a type of research where people are grouped into clusters (in this case, communities) and are randomly assigned whether they will receive the intervention or be the control. The communities chosen as 'controls' received only routine project activities and were observed at the same time as the intervention communities who received the additional intervention activities.

Kenya (2012-2017)

Less than 40% of women give birth with a skilled attendant in Marsabit County, Kenya[6]. This is a pastoralist region where access to quality health services remains challenging. Maternal waiting spaces (MWS) are a promising strategy to overcome geographic barriers, however, under-utilization of MWS is well documented. Concern in collaboration with Johns Hopkins University and the Kenya Ministry of Health assessed if a *package* of services including a MWS would increase facility delivery. The package was designed with local input, included skills building for health workers, community-led solutions and used community-based referral agents. This was one of the first studies to examine the contributions of a MWS for pastoralist women and nomadic communities.

A study was conducted comparing facility delivery rates between intervention sites (four facilities where MWS were established) and six comparison facilities. 480 Traditional Birth Attendants were retrained as Community Birth Referral Agents (CBRA) to refer pregnant women for antenatal care and to promote the MWS. Additionally, 104 Community Health Volunteers (CHV) were trained to provide health information and make referrals.

Between July 2015 and December 2016, 114 women utilized the MWS (23% of all facility-based births). There were no maternal deaths and no significant differences in neonatal outcomes and Apgar scores[7]. At baseline, there were 45% more deliveries at the intervention facilities than comparison facilities. By endline, there were 94% more deliveries in the intervention facilities – an absolute increase of 49 percentage points; or relative difference of 109%. There was a statistically significant higher rate of referral to higher-level facilities (District Hospital) in intervention facilities (5%) than in comparison facilities (1%). However, there were fewer maternal complications and referrals for women who used the MWS compared to those who did not utilize the space, but did deliver at an intervention facility. Among MWS-supported facility deliveries, 68% of women indicated their prior pregnancy resulted in home delivery. Nearly all users (98%) stated they would use the MWS again.

MWS within a package of health strengthening services increased facility-based births among the pastoralist women in the project areas. There was a high degree of acceptability for MWS among pastoralist women; and CBRAs and CHVs play a critical role in facilitating MWS use. More referrals to higher levels of care suggests that the MWS package (including clinical skills upgrading) improves timely referrals to comprehensive maternity care. The research showed that intervention packages should be designed with inclusive, community input especially that from women and mothers.

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[6]. Baseline KPC survey 2012 and KDHS 2014

[7]. The Apgar score is a test given to newborns soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed. The test is usually given twice: once at 1 minute after birth, and again at 5 minutes after birth. Sometimes, if there are concerns about the baby's condition, the test may be given again at 10 minutes after birth.

From Back-L, the Health Facility Nurse In-Charge, Mothers, Community Birth Referral Agents, and Community Health Volunteers outside the Maternity Waiting Space whereby these mothers recently stayed waiting for labor to begin. This formerly empty space was converted to resting area by Concern for pregnant women to come before labor began to ensure they had a safe delivery in Songa Health Facility, Marsabit County Kenya. Photo: Megan Christensen/Concern Worldwide

Sustainability, Lessons Learned and Ways Forward

Concern's Child Survival Projects collected a significant body of evidence, promising and best practices and lessons learned over the years. While new USAID funding for the Child Survival Health Grants Program finished-up around 2015, these approaches and learning have continued to influence Concern's understanding of health system strengthening and the new organizational health strategy that was finalized in 2019[1].

Furthermore, Concern continues to engage regularly with the CORE Group through the technical working groups and the network of community health practitioners for the annual CORE conference[2].

A hallmark of Concern's work in child survival programming was strategic partnerships with communities. The following is a reflection of the lessons learned and key 'ingredients' for what contributed to the success of these projects and perhaps stronger health systems with the capacity to sustain the gains achieved through meaningful partnerships with Ministries of Health and the communities themselves. All the evaluations show that appropriate consideration of contextual factors and continuous reinforcement are essential for understanding why some child survival interventions work and others fail to deliver improvements. There is a link between contextual awareness, responsiveness of the project to adapt to rapidly changing environments, and sustainability.

While there is no single determinant of sustainability, the Child Survival Projects aimed to strengthen the health systems with a set of proven, reinforcing elements to foster effective engagement and adaptations where necessary. Even in the post-project phase, the goal is that this approach will continue to improve health outcomes or sustain the gains made during the life of the project. Many of the on-the-ground investments such as training health workers and the community, strengthening capacity and measuring change in capacity, coaching and mentorship, social norm and behavior change will remain in the communities. In addition, because the projects aligned with national systems, strategies and priorities, and sought to operationalize these in partnership with the Ministries of Health and other implementing partners, the Child Survival Projects were often accelerators of more progressive, equitable and inclusive policies, which have been realized overtime.

Scale & Replication: Around 1998 and the beginning of Concern's Child Survival Program in Bangladesh, a fundamental decision was made which changed how Concern approached health programming.

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1. https://concern2com.sharepoint.com/:w:/r/sites/KExchange/_layouts/15/Doc.aspx?sourcedoc=%7B5F071FD6-EB8A-4151-9F74-1CE61F-F21F80%7D&file=Health%20Strategy%20Chapeau%202019.docx&action=default&mobile-redirect=true&DefaultItemOpen=1
2. https://coregroup.org/

Mother Leaders in Tahoua, Niger meet to review and discuss household level data with their Care Group. Photo: Concern Worldwide.

Concern shifted from a direct service delivery model to engaging local government and civil society to strengthen the health system with the community. In Bangladesh, this became a cost-effective, community-driven urban health model[3]. From the outset, there was a commitment to rigorously documenting the process and learning as well as establishing a robust monitoring system. Project evidence was systematically collected in order to acquire sufficient data and information that would be disseminated locally and nationally to convince stakeholders and other authorities that this model was worthy of their investment and further scale-up and replication.

One of the key successes in scaling and replicating this model within Bangladesh was the establishment of **Learning Centers**. Because Concern no longer provided tangible health services and focused more on building the capacity of local stakeholders to deliver health services, it was difficult for some local authorities and leadership to grasp the concept. The site visits to these Learning Centers provided the opportunity to turn abstract concepts such as 'mobilization', 'participatory' and 'capacity building' into something real and tangible. Stakeholders could observe activities and interact with other stakeholders in real-time. Often, after a site visit, officials returned home with a much clearer understanding and appreciation of what the approach is about and what is involved. These visits can be a truly eye-opening experience, as evidenced by their feedback. The Concern team received many comments like: "Now I understand!" and "Seeing is believing." Additionally,

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3. Additional information on the approach and the model can be found here: https://concern2com. sharepoint.com/sites/KExchange/Publications/ Breaking%20the%20Mold-A%20Toolkit%20 for%20the%20Replication%20of%20an%20 Effective%20Urban%20Health%20Model.pdf

the Learning Centers served as a technical resource to program implementers throughout the life of the project, as project staff were able to seek advice on how to resolve common issues.

Learning Centers or site/exchange visits as an approach were used in other Child Survival Projects as well. Project stakeholders would be taken to high performing areas to witness first-hand the action on the ground and these visits and discussions were often cited as motivating factors to adopt similar approaches in their communities. Principles of the Bangladesh urban health model were subsequently applied in Haiti and Sierra Leone and with some contextual adaptations, the model was replicated.

In Rwanda a similar approach to scale-up was applied whereby the project prioritized and **rigorously documented** a pilot for home-based treatment of malaria. Together with other implementing partners and donors, Concern arranged exchange visits and eventually the *Kabeho Mwana* consortium was formed that scaled-up home-based treatment of malaria to include treatment for pneumonia and diarrhea as well as home-based screening for malnutrition. Concern's reputation of a **strong field presence**; **mentoring** and providing technical support to health workers and local health teams; **strengthening community capacity**; and fostering innovation by adapting national policies on community health to reach the last mile[4] contributed to the consortium's ability to scale-up a promising practice which is now known as integrated Community Case Management (iCCM).

Creating Ownership: The second phase of the child survival project in Rwanda '*Kabeho Mwana*' and to a large extent the projects that preceded it, showed that building from

the ground-up: a grassroots approach, does work. During the evaluation, the MoH praised project staff for being present on the ground. The project team embedded themselves within the communities and the health system. This presence from the project team nurtured relationships and built trust at the most fundamental levels. Beneficiary households, frontline volunteers, health workers, and community structures came together with the project team around a shared vision.

In Kenya, the Community Conversations approach of participatory community dialogue generated evidence that this mechanism was essential to establishing Community Units. The MoH noted that by the project bringing communities together to discuss health issues and local solutions through Community Conversation groups, this increased ownership and led to sustainability of the project. Even though initial investments may be higher by choosing routine community engagement approaches, in the long term, this can decrease costs associated with attrition.

A Community Conversation group in Somare, Moyale in Marsabit County, Kenya. Photo: Megan Christensen/ Concern Worldwide

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4.   The 'last mile' means the beneficiaries at the village, community or household level, and in this case was children and their caregivers.

In Sierra Leone, the project sought to engineer local ownership so that sustainability would be a significant pillar of the interventions. To do so, the team involved the community from project inception and each community held a project launch event with the support of the project team. A Community Development Officer (paid Concern staff), was assigned to each community and spent a significant amount of time (80% or greater) in their assigned community working hand-in-hand with local stakeholders. The community and MoH referred to the '*Al Pikin fo Liv*' project as 'their initiative' and spoke of Concern as a facilitator or catalyst - clearly demonstrating their ownership over the project and its objectives.

Capacity building: In Rwanda, Concern demonstrated that **field presence does not mean substitution**; instead, **capacity building requires coaching** and accompanying health workers when conducting their day-to-day tasks. A key lesson identified in the first child survival project was that community capacity building and mobilization is not something that can be tacked on to a project or embedded in a work-plan. Capacity building must be an integral part of a project strategy and something that can and should be planned and measured over time. Using the HICAP, projects in both Bangladesh and Sierra Leone showed considerable improvement in self-assessed capacity areas[5,6].

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5. In Sierra Leone, the average HICAP score across all self-assessed indicators rose by 22%. The Health Management Committee and Ward Development Committee members rated themselves most highly on leadership, followed by participatory planning and collaboration and coordination. Both groups improved their resource mobilization and management skills. Gains of 33% or more were shown for monitoring and evaluation, supervision, and resource mobilization.

6. The HICAP in Bangladesh aimed to have at least 75% of the municipalities have a one-step increase in their capabilities; this was greatly exceeded. Each of the municipalities reported increased capacities over a three-year period (2006-2009) in human resources, leadership, planning and implementation, coordination and resource mobilization and M&E.

Political Will/Political leadership:
Successes achieved in the Child Survival Projects can partly be attributed to the fact that when **local leadership and government were mobilized**, meaningfully **engaged as partners** and connected to their constituents, collectively the projects performed better, health outcomes improved and the likelihood these gains would be sustained increased.

In Kenya, linking Community Conversation groups to the decentralized governance structure of the Ward Administration led to many successes including improved water supply, roads and inputs to the health facilities. Paramount to this, communities participated in county planning and budgeting processes led by the Ward Administrator; this allowed communities to articulate their priorities and for these to be funded.

In Bangladesh, municipal and ward leaders saw evidence that their involvement, on behalf of their constituents' health had positive political dividends. They realized it was possible for them to "do well by doing good".

In Burundi, Rwanda and Sierra Leone, buy-in from the MoH at all levels and their desire for stronger community health systems fostered uptake of progressive, community health policies. These policies, operationalized with Concern, increased task-sharing, reduced workloads at static facilities and brought life-saving health services to the last-mile.

Advocacy: Application of **evidence and learning resulted in successful advocacy** to influence the Rwandan government to adopt iCCM as national policy and the integration of Community Management of Acute Malnutrition (CMAM) into the national nutrition protocol in Rwanda. Similarly, in Burundi and Niger, evidence from two pilot projects were used to transform community health policies by contributing learning on scaling up community case management for childhood illness. The District Health Team in Burundi expressed interest in

incorporating the Integrated Care Group Model into the National Community Health Strategy; and in Niger, it became clear that mothers, with very low levels of literacy, could provide basic curative care for children in their homes.

In Kenya and Sierra Leone, Child Survival Project learning was used to influence the community health strategy through its contributions to establishing and maintaining the frontline Community Health Volunteers and Community Health Assistants.

Partnership: When community members **participate in decision-making**, they are more likely to respond positively to health services; contribute individual and collective resources (time, money, energy, materials) for health improvement; positively change health behavior, and be empowered with information and skills that enable them to take control over their health and demand for accountability[7]. Even though participatory community approaches initially require greater investment, the child survival projects demonstrated that slowly these investments take root and pay dividends for years to come. As such, partnerships with communities became the hallmark of this portfolio.

In Bangladesh, the team sought to achieve sustainability by ensuring that civil society and the health sector worked collaboratively to achieve better health outcomes for children. This approach sought to turn hesitant leaders into supporters by demonstrating to them the commitment and capability of the Ward Health Committees.

In Sierra Leone, the participatory community-based health information system was developed hand-in-hand with the community. At the end of the project, the community members were leading the health data review meetings and discussing community actions and local solutions to improve health outcomes and their health system.

Equality and Equity: Concern and community stakeholders in Bangladesh identified and created community maps with notations for extreme poor households which were known as the Least Advantaged Group (LAG). In this way, the project with other local stakeholders could increase or direct project resources to those households in greatest need. These maps and lists also allowed project staff and Community Health Workers (CHWs) to link the extreme poor with other social services. By establishing criteria and aligning **pro-poor project strategies** with government policies, the project made huge strides in reducing the equity gap and ensuring the extreme poor could access quality health services.

Community Conversations in Kenya introduced dialogue that led to community actions, spearheaded by community members, to build houses and latrines for poor or other vulnerable community members.

Over time, Concern learned the **importance of engaging men and boys in health issues**. This was particularly apparent in Burundi and Niger where engaging husbands was essential to women's participation in project activities. Furthermore, project learning pointed to the fact that in order to sustain gains and reach those who are most vulnerable, men must be involved in health decision-making as they are often the gatekeepers to women and children accessing health services.

Conducting good research: The initial operational research studies in Burundi and Niger were difficult to get up and running in the absence of an academic partner and without the presence of an experienced, full-time Research Coordinator in country. However, with the **support of a Principle Investigator** assigned to each project who had experience in field research and peer-reviewed publication, the projects benefitted from more rigorous designs and comprehensive analysis at endline.

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[7]. Rifkin, S. B. (2009). Lessons from community participation in health programmes: a review of the post Alma-Ata experience. International Health 1(1): 31-36.

It is highly recommended therefore to include a **full-time Research Coordinator** based in the study location. Preferably, this person should have experience with writing research protocols and Institutional Review Board (IRB) submissions as well as leading on peer-reviewed publications.

A thorough analysis and **literature review** was conducted prior to finalizing the research question/s and a research protocol. This process guided teams in determining what the most pressing health issues were, the knowledge and practice gaps at that time and the needs for additional information and solutions. Operational research undertaken in these projects was informed by a need for more evidence and through consultations with stakeholders. These research studies were all embedded in larger projects and were not stand-alone research initiatives. This ensured the relevance of the research and that solutions developed through it were applicable in real-world situations.

Depending on the nature of the research and complexity of the research question/s, **adequate time** needs to be budgeted to not only set-up the project but also to allow time for the study to be conducted and to generate evidence. Using population-based surveys like Knowledge, Practice and Coverage (KPC) or Knowledge, Attitudes and Practice (KAP) to measure change in behaviors, knowledge, practice and attitudes, requires time not only for the intervention to run, but also for change to occur and to be measured in the population. Therefore, a minimum of two years from the time the intervention starts is recommended.

Rigorous research requires a **sufficient budget**. It is recommended to ensure that there is adequate budget, based on the research design and methodology, to yield results with sufficient power so that meaningful conclusions can be produced. It is also advisable to set aside funds for open source, peer-reviewed publication of the research. This process can take 1-2 years post-intervention.

Way Forward

For twenty years, Concern's Child Survival Program work has led to improvements in the health system as well as survival of children, mothers, and newborns. Globally, illness and death among children under 5 years of age have declined dramatically, and improvements in health and survival of mothers and newborns have taken root. More importantly, as this article has shown, many countries are increasingly able to effectively sustain gains in child, maternal, and newborn health on their own when communities are meaningfully involved. The latter is happening because contextual factors were considered in the design and implementation phases. Local ownership and engagement has proven critical to enhance sustainability of program outcomes. Even with various innovations and adaptations to old but proven models, Concern's foundation remains the same: building participatory, community-based projects from the ground-up.

In the years since the child survival program ended, Concern's work has expanded from a focus on maternal newborn and child health to an increased emphasis on addressing a continuum of care that deliberately engages men and boys, adolescents and sexual reproductive health, and inclusive, community-based primary healthcare. More than ever, digital health technology is increasingly relevant to scalable, timely health responses that achieve coverage and increase resilience. However, in many resource-poor settings, infrastructure is a limiting factor to the uptake of new technology. There are still gains to be made in using data for decision-making at all levels. To prevent outbreaks and epidemiological catastrophes, the use of timely surveillance data is vital for more resilient health systems and to improve preparedness, appropriateness and timeliness of responses. Concern is also piloting innovative financing mechanism for health care, which will be paramount to driving universal healthcare and universal health coverage and advancing Sustainable Development Goal (SGD) 3: Ensure healthy lives and promote well-being for all at all ages.

Resources

Resources for Concern's Child Survival Programs

Note: most of the links below are for documents on Concern's Knowledge Exchange platform, for which a Concern username and password are required.

Bangladesh

Concern Worldwide Bangladesh Child Survival Partnership Program 2000 – 2004 Final Evaluation Report

Municipal Health Partnership Programme (MHPP) 2004 – 2009 Final Evaluation Report

Sustainability of the Saidpur and Parbatipur Urban Health Model (Bangladesh) Five Years after the end of Concern's Child Survival Project Final Evaluation Report 2010

Burundi

Community Health Systems Strengthening in Cibitoke Province, Burundi: Mabayi Child Survival Project Final Evaluation Report 2013

Mabayi Child Survival Project Cibitoke Province Burundi, Midterm Evaluation Report 2011

Burundi Operations Research Brief: Shifting the management of a community volunteer system (Care Groups) from NGO staff to Ministry of Health staff in Burundi

Burundi Operations Research Final Report: Testing the Effectiveness and Sustainability of an Integrated Care Group Model as Compared to the Traditional Care Group Model

Implementing Community Case Management for Malaria in Burundi 2012

The Implementation and Functionality of Care Groups in Burundi 2012

Haiti

The Urban Health project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince (Child Survival Project), Haiti Midterm Evaluation Report 2008

The Urban Health project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince (Child Survival Project), Haiti Final Evaluation Report 2010

Kenya

Evaluation of the Child Survival Program Improving Maternal, Neonatal and Child Health for Pastoralists in Moyale and Saku Sub-Counties, Marsabit, Kenya 2017

Kenya Child Survival Operations Research Results: Do Maternity Waiting Spaces Increase Health Facility Births for Pastoralist Women in Marsabit County, Kenya?

Niger

Lahiya Yara Child Survival Project Niger Midterm Evaluation Report 2012

Lahiya Yara Child Survival Project Niger Final Evaluation Report 2014

Niger Operations Research Report: Can Low-literacy Mothers Deliver Essential and Life-saving Care to Young Children in Rural Niger?

Rwanda

Rwanda Child Survival First Project 2001 – 2006 Final Evaluation Report 2006

Rwanda Child Survival Program 2006 - 2011 Kabeho Mwana Midterm Evaluation Report 2009

Rwanda Child Survival Program 2006 – 2011 Kabeho Mwana Final Evaluation Report 2011

Plausible role for CHW peer support groups in increasing care-seeking in an integrated community case management project in Rwanda: a mixed methods evaluation

Nationwide implementation of integrated community case management of childhood illness in Rwanda

The Rwanda Expanded Impact Child Survival Program Booklet

The Rwanda Expanded Impact Child Survival Program: Lessons from Working in Consortium

Sierra Leone

Sierra Leone Child Survival Program Al Pikin Fo Liv Final Evaluation Report 2017

Sierra Leone Operations Research Brief: Testing a Participatory, Community-Based Health Information System

Engaging communities in collecting and using results from verbal autopsies for child deaths: an example from urban slums in Freetown, Sierra Leone

Piloting a participatory, community-based health information system for strengthening community-based health services: findings of a cluster-randomized controlled trial in the slums of Freetown, Sierra Leone

Other resources

USAID Designing for Behavior Change: A Practical Field Guide 2017

Designing for Behavior Change for Agriculture, NRM, Health and Nutrition Training Curriculum

CORE Group Resource Library

An Overview of Approaches to Social and Behaviour Change (Concern Worldwide 2013)

Review of Barrier Analysis on Common Behaviours Learning Brief (Concern Worldwide 2018)

Engaging Men in Maternal, Newborn and Child Health and Nutrition: A Concern Worldwide Technical Brief 2017

Child Survival Toolkit Concern Worldwide 2012

Breaking the Mold: A Toolkit for the Replication of an Effective Urban Health Model 2011

Breaking the Mold: Annexes

New Frontiers in Child Survival: Reaching the Most Vulnerable

Integrating Care Groups into MoH Systems: A User's Guide for Implementation

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

Health Institutional Capacity Assessment Process (HICAP) Toolkit for Concern staff

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THANK YOU

These past two decades would not have been conceivable without a tremendously dedicated network of colleagues and community health champions. First and foremost, we salute the frontline volunteers – who were mostly women and mothers and selflessly gave of themselves to improve the lives of their friends, neighbors and family members. We are deeply grateful for their commitment – without them, this would have never been possible. Thank you to our community volunteers. Also, a sincere thank you to the communities themselves, health workers, government institutions and civil society partners for their undying commitment to improving community health for all. They generously sacrificed their time and contributed other resources to prevent women, newborns and children from dying of preventable causes and to ensure their community would benefit from stronger and more accountable health systems.

We would also like to recognize and commend each of the country programs, the child survival teams, and the leadership who were heroes and community health champions, in their own right. The remarkable achievements of this program are a testament to their on-the-ground presence, strategic partnerships and relationships and relentless commitment to working with communities to improve health outcomes.

To the headquarters based teams and all of the likeminded colleagues who provide support over the years – thank you for working with and

Eager children in Burundi thriving in child survival project area. Photo: Megan Christensen/Concern Worldwide

20-year-old Fatuma Mohamed and husband Abdulahi Osman (25) with their two boys - Yusuf, who is only three-and-a-half weeks old, and Mohamed (2½) in Marsabit, Kenya. Photo: Peter Caton / Concern Worldwide.

alongside us. Finally, to USAID, Irish Aid and our donors: thank you for your partnership, technical assistance and vision. We did it!

For whom is the publication?

All staff involved in designing, implementing, managing, monitoring, evaluating and communicating Concern's work. This publication should also be shared with partners.

What this publication includes:

- Promising practice
- Organisational learning
- Promotion of multi-sectoral and integrated approaches to programming
- Links to full reports

What it doesn't include:

- Targeted recommendations
- Additional evidence not included in the papers cited
- Detailed descriptions of interventions or their implementation

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Key words

Child survival, Health, Care Groups, Maternal, Newborn and Child Health, Results-based Management, Social Behavior Change Communication, Operations Research, Health System Strengthening, community health

KNOWLEDGE MATTERS

Issue 26 | December 2019

CONCERN worldwide

ENDING EXTREME POVERTY WHATEVER IT TAKES