CAPABILITY STATEMENT
COMMUNITY GOVERNANCE
AND MOBILIZATION

For over 50 years, University Research Co., LLC (URC) has provided technical assistance in quality improvement (QI) and health systems strengthening at the national and subnational levels to expand coverage and quality of high impact, evidence-based health and social services in over 50 low- and middle-income countries. Given that much of a patient’s care takes place at the household and community levels, strong linkages and communication between community members and health care workers are key to improving health outcomes. As such, URC has empowered communities to take ownership and action over their health and become more resilient across various projects.

USE OF QI METHODS

The USAID Applying Sciences to Strengthen and Improve Systems (ASSIST) Project (2012-2020) worked alongside local groups and partners to apply QI methods within the community health system. URC implemented community system strengthening activities to strengthen community level impact of community health workers (CHWs) and other service providers and increase the sustainability of programmatic impacts. URC implemented community system strengthening activities in Botswana, Burundi, Ethiopia, Haiti, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Tanzania, and Uganda and in 13 Latin American and Caribbean countries as part of the USAID response to the Zika epidemic.

Lessons Learned about Community Engagement in Service Improvement

• Communities can successfully adopt an improvement approach to improve community-wide support for health and direct service provision.
• Community QI teams can be effective in promoting health care-seeking behaviors, improving access to and uptake of services, strengthening referral and follow-up systems, and improving data collection, analysis, and use.
• Community QI are feasible and sustainable and can be strengthening with frequent coaching and mentoring.

Through the ASSIST Project and in current projects like the Mali Household and Community Health (HCH) Activity (2020-2025), URC has been applying a Community Health System Strengthening (see Figure 1) model to engage existing community groups in the health system, identify local health gaps, and test strategies tested to overcome those gaps. Through ASSIST and other projects, URC has worked alongside national, district, and community level leaders to select and train coaches with supervisory or oversight responsibility for CHWs or community health activities on how to support community
groups to improve the care they provide. URC supports these coaches to establish community QI teams consisting of leaders and representatives from the communities, facilities, and local governments. Together, the coaches, these teams, and health care workers collect and aggregate data for decision-making and maintain ongoing communications between community groups, the community team, and the facility. The community improvement team applies QI principles to address how participating groups and structures function together toward providing integrated, seamless care. Through URC’s coaching and guidance, community health system elements are harmonized, coordinated, and function well with the CHWs’ efforts. As a result, quality health services are more accessible to community members. Health facilities and households experience a more effective information exchange.

**WORK WITH CIVIL SOCIETY ORGANIZATIONS**

The USAID Regional Health Integration to Enhance Services in East Central Uganda (RHITES-EC) Activity (2016-2021), URC awarded grants to civil society organizations (CSOs) to promote community governance toward uptake of health services in nine districts and 34 sub counties. Key achievements include:

- Reached 11,440 eligible households and 45,952 individuals with messages on integrated health services. Of these, mobilized and referred 5,981 and 4,231 received services;
- Screened 301 community members for TB through home visits and referred suspected cases for TB testing, of which 122 were tested positive and initiated on treatment;
- Supported implementation of activities targeting adolescent girls and young women (AGYW) leading to formation of 34 Stepping Stones groups benefiting 850 AGYWs with relevant sexual and reproductive health services, and initiation of 22 groups into Savings and Credit Cooperatives; and
- Built the capacity of three CSOs to successfully compete and win grants from USAID.

In addition, the RHITES-EC project saw an 18% improvement in first trimester ANC visits and a 24% increase in institutional deliveries across 27 CSO targeted sub-counties between Q3-Q4 of FY20.

**USE OF COMMUNITY SCORECARD**

USAID Systems for Health in Ghana (2014-2019) supported Ghana Health Service (GHS) to implement its Community-based Health Planning and Services (CHPS) policy and implementation guidelines aimed at reducing health inequalities and improving the delivery of high-quality primary health care services. The project helped to remove geographical barriers and increase community participation in health decision making across five regions. Furthermore, Systems for Health used the Ghana Community Scorecard to enhance community empowerment to improve the quality of and access to CHPS services. The scorecard provided the platform for ongoing
dialogue between communities and CHPS zones to continuously improve the quality of and access to primary health care. At quarterly community meetings with multi-sectoral representation, communities assessed each facility using nine process indicators. Community stakeholders used scorecard results to prioritize and discuss the indicators that needed improvement and made action plans to mitigate concerns. National GHS personnel reported that scorecards have enhanced data-driven decision making, have illustrated community perceptions about service delivery, and have given leaders pragmatic actions for their QI initiatives. Community Health Management Committees and frontline health staff use the scorecards to find local solutions to challenges and to make regional and district decisions.

In Mali, URC is using a similar scorecard as part of its community interventions in the Mali Household and Community Health (HCH) Activity (2020-2025). The scorecard, developed in conjunction with the existing community structures, will support community members in holding community health structures and health facilities accountable for the provision of quality health services. The tool also will guide the community members in maintaining an open dialogue with the health system at all levels.

COMMUNITY MOBILIZATION FOR CHPS

The USAID Systems for Health project aimed to support to regions, districts, and communities to strengthen community participation in health service delivery and empower individuals, especially women and girls, to seek and access quality health care. The project supported the CHPS strategy and increased stakeholder engagement in improving CHPS functionality by providing ongoing coaching visits to 483 CHPS zones. This support included follow-up to previously trained Community Health Officers and Community Health Management Committees (CHMCs) as well as coaching on health services, community mobilization and empowerment, community decision making, home visits, and outreach services. See key services provided in the 483 project-supported CHPS zones in Figure 2.

*Figure 2: Key services provided in project-supported CHPS zones in Ghana, a comparison of Year 2 to Year 5*

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CREATING AWARENESS ON GENDER-BASED VIOLENCE THROUGH ENGAGING COMMUNITY STRUCTURES (RELIGIOUS AND CULTURAL)

Through the Regional Health Integration to Enhance Services in Northern Uganda (RHITES-N, Acholi) Activity (2017-2022), URC works with role model men, case managers, para-social workers, and police officers to create awareness on gender-based violence (GBV) among the communities. URC conducted 62 community awareness activities, including household dialogues, and reached 16,420 (M=13,210, F=3,210) people with GBV targeted messages. The role model men conducted household dialogues focused on breaking social norms and addressing behavioral barriers to uptake of health services and products with members of the participating households and reached 2,320 (M=107, F=166) people during the period. They also mapped 64 GBV cases, both physical and sexual violence, and referred 24 sexual violence cases for clinical care including PEP to all victims of sexual assaults and legal redress. The awareness has improved in reducing GBV cases in the community.

CONNECTING VHTS WITH COMMUNITIES THROUGH SOCIAL AND BEHAVIOR CHANGE TOOLS

The RHITES-EC Project adapted The Wheel of Good Practices for Better Living (The Wheel) to improve health outcomes during the first 1,000 days of life in East Central Uganda. URC has supported the use of this tool, which lays out six practices for pregnancy, seven for newborn and childcare, and seven for WASH, FP, and Malaria, by CHWs and village health workers (VHTs) to support negotiated counseling during monthly home visits. Figure 3 describes the
steps taken to implement The Wheel at the household level. Originally, there were negative community perceptions toward maternal, neonatal, child health (MNCH) services uptake and a widespread preference for home delivery or for delivery with traditional birth attendants. There was also a weak bond between VHTs and community leaders due to disjointed community mobilization interventions. The tool was piloted in two sub-counties in Mayuge district between April and August 2018, showing a 24% average increase for the pregnancy practices and a 33% increase in attending at least four ANC visits. In addition, feeding children appropriately for age increased 25%. Between March and June 2019, the project worked with nine CSOs and 419 VHTs and volunteers to expand the use of the Wheel into 34 sub-counties. This enabled better targeting of pregnant women most likely to not attend early ANC visits and 9,300 households with pregnant women and/or caregivers of children under 24 months. As a result, the number of pregnant women attending at least four ANC visits tripled from 849 to 3170 women, the number of women taking their children for immunization more than doubled from 759 to 1922 individuals, and the number of individuals sleeping under a mosquito net doubled from 996 to 2013 individuals.

*Figure 3: Steps Taken to Implement the “Wheel” at Household Level*

1. Orientation of key stakeholders: CSOs, DHT, health facilities, and partners
2. CSOs, DHT, health facilities and partners orient VHTs/CHWs
3. VHTs/CHWs identify and register priority households with pregnant women and/or children below 2 years
4. VHTs conduct monthly home visits to conduct negotiated counseling and track progress on adoption of practices
5. Audience adopts desired practices and behaviors (or does not)
6. Evaluation, learning, and adaptation