World Vision

Health & Nutrition Technical Brief

Community Health Committees (COMM) Project Model

THE ISSUES

There is extensive literature advocating for and providing evidence to support the importance of community participation as a means of improving community health outcomes, and community participation is also understood as a vital element of a human rights-based approach to health.[1] The 2008 World Health Report called for renewal of the Alma Ata Declaration, which "brings balance back to health care, and puts families and communities at the hub of the health system. With an emphasis on local ownership, it honours the resilience and ingenuity of the human spirit and makes space for solutions created by communities, owned by them, and sustained by them".[2]

Ministries of Health (MoH) and governments have acknowledged and acted on these principles, developing community health strategies that include varieties of local participation, to include processes of community mobilization, the work of Community Health Workers (CHWs), and the functions of community health groups.

The COMM model focuses efforts on two types of representative health groups: The Community Health Committee (CHC) and the Health Facility Management Committee (HFMC). While CHCs and/or HFMCs are backed by Ministries of Health around the world, the reality on the ground shows that these groups are often weak and poorly supported. COMM programming aims to work with MoH to improve this situation, and to strengthen the capacity of these groups to identify and respond to important health issues in their area - including those of the most vulnerable and marginalized - thereby contributing to overall community-health systems strengthening, community capacity and equity, and improved overall health outcomes.

1 Marston C et al. Community participation for transformative action on women's, children's and adolescents' health. Bulletin of the World Health Organization 2016;94:376-382.
2 WHO. The world health report 2008. Primary health care – now more than ever. Geneva: WHO; 2008.

WHAT IS THE COMM PROJECT MODEL

COMM involves the capacity building and empowerment of local health committees to coordinate activities leading to (1) increased community capacity, (2) improved health policy and service environment and (3) support of CHW programmes, which, taken together, lead to strengthened community health systems and positive health outcomes.

The COMM model may be carried out through CHCs, HFMCs or other appropriately identified community health groups. CHCs around the world are typically embedded in the community and carry out their work there, are comprised of membership almost exclusively from within the community, and may or may not have a strong formal link with the health facility and the MoH at large. Their roles and responsibilities generally relate to identifying and addressing health issues within the community, and supporting CHWs and/or other volunteer health cadres. They may also be involved in actions of a social accountability nature raising issues regarding health service performance.

HFMCs are by definition attached to local health facilities and formally linked with MoH, usually include both community representatives and facility staff as members, and typically hold meetings and carry out their work at the facility, often with less presence in the community as compared to CHCs. Roles and responsibilities may relate more to facility management concerns, and the channeling of community health concerns to facility staff, than to work in the community as such. COMM programming may work with either type of group.

COMM is normally implemented in partnership with the MoH. A front-end programme functionality assessment is carried out to ensure that the contextual factors necessary for programme success are in place. The capacity of COMMs is then strengthened by WV and/or MoH staff using a suitable MoH curriculum or the WV-produced package of materials. Staff then support the COMMs in their community activities and monitor the results.

ALIGNMENT TO OUR PROMISE AND THE SDGs

The model builds the capacity of the COMM to identify and respond to key health and nutrition concerns and as such contributes directly to the CWB aspiration 'Girls and Boys enjoy good health', specifically, CWB #5: increase in children who are well-nourished, and CWB #6: increase in children protected from infection and diseases.

By the same token, the model contributes to the SDG goals related to nutrition (SDG 2) and health (SDG 3), in particular to the following:

- SDG 2.2: By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons
- SDG 3.1: By 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- SDG 3.2: By 2030, end preventable deaths of newborns and children under 5 years, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to as low as 25 per 1,000 live births
- SDG 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases, and other communicable diseases

Nevertheless, although the core focus of the COMM model is on health and nutrition, there is unlimited scope for adding other life cycle stages and issues of concern to the COMMs' trainings and to the issues they choose to focus on, particularly as they undertake root cause assessments and identify those determinants of health that lie outside of the health sector, and choose to take action on them. New content has been added to the COMM set of materials to enable the COMMs to respond to this broader scope of issues. Seen in this light, the COMM model can potentially contribute to all eight of the CWBOs, to many of the multi-sectoral and cross-cutting SDGs, and to all five areas of the Nurturing Care Framework.

CORE COMPONENTS OF THE COMM PROJECT MODEL

Country Readiness: Ideally, COMM programming will be implemented within the MoH system, through MoH-linked CHCs or HFMCs (all known internally as 'COMM', although the original name of the group on the ground is always retained). Numerous decisions around the parameters of this programming must be taken together with the MoH, and therefore partnership and agreements with MoH must be established before implementation can begin. A national-level programme functionality assessment process is carried out together with the MoH using a specified tool which describes 14 components required for successful programming, and development of an action plan to address the areas assessed as weak. Certified COMM trainers from WV and/or the MoH will then run a training of facilitators (ToF) to prepare identified individuals to work with COMMs.

Getting started with and training COMMs: As work with COMMs themselves commences, facilitators will ensure that the COMM's membership is broadly representative of all community stakeholders, to include appropriate gender balance and representation of the most vulnerable and marginalised. An appreciative assessment and gap analysis of the group is then carried out to understand their existing roles and responsibilities and trainings received to date, and to determine additional capacity building needs. Trainings are then carried out accordingly.

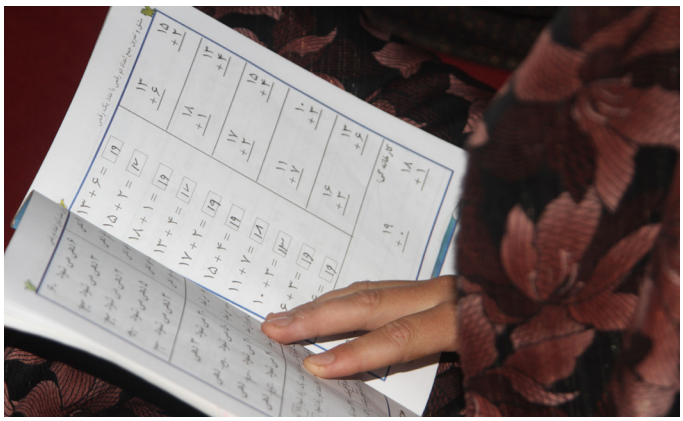
All COMMs receive a health information training shortly after programme start up, as well as a mandatory session on safeguarding and child protection, and then receive health-specific training and organisational capacity building (OCB) support on an as-needed basis per the gap analysis results. This may be supplemented with trainings in additional content areas to include WASH, adolescent health, child marriage and more, to enable the broadening of the COMM's scope of action outside of the health sector to include a more comprehensive range of issues. The COMM will additionally be brought into local level advocacy where this programming is being implemented.

Ongoing Support to COMMs: As COMMs begin to carry out their work, facilitators from WV and/or MoH will provide mentoring support and will track the COMMs' progress with select indicators incorporated into an overall monitoring system.

WHAT IS NEW IN THE HNSA UPDATE OF THE MODEL?

A new mandatory training session for all COMMs on Safeguarding and Child Protection, to be carried out before general COMM trainings get underway, to help ensure that the COMM is a "child-safe group" and knows how to effectively respond to and refer suspected or disclosed cases of abuse within the community.

- Four new technical training modules that will prepare COMMs to respond to issues beyond the original health and nutrition-related areas, as reflected in the new HNSA, as follows:
  - » Technical Module 1: Community Water, Sanitation and Hygiene
  - » Technical Module 2: Adolescent Health
  - » Technical Module 3: Child Marriage and Other Forms of Violence
  - » Technical Module 4: Health and Development of Children 2-9 Years
- New guidance on integrating COMM and CVA programming, when COMM and CVA-for-health programming are being implemented at the same administrative level



GOALS, OUTCOMES AND EXPECTED IMPACT

Goal: Strengthened community health systems lead to positive health outcomes

Outcome 1: Improved and enabling community/civil society context
Outcome 2: Improved health services
Outcome 3: Strengthened CHW/volunteer programmes

Secondary outcomes:

- Linkages and coordination among community health stakeholders strengthened
- Root causes of health issues assessed and community health status tracked by community itself
- Community implements activities to address root health issues
- Community health status and activities regularly reported to all stakeholders
- Support, oversight and promotion provided to CHW programmes
- Local level advocacy initiatives supported and implemented
- COMMs demonstrate strong internal capacity

Value proposition: Action on health and nutrition – and potentially a broader array of issues – is taken by community members themselves, while also holding

THE EVIDENCE BASE

Underwood, C., Boulay, M., Sentro-Plewman, G., et al. 'Community capacity as a means to improved health practices and an end in itself: evidence from a multi-stage study', Int Q Community Health Educ (2012) 33(2): 105–27.

- ***Summary:*** Intervention communities had significantly higher levels of community capacity than the non-intervention communities. Enhanced community capacity was associated with having taken community action for health, with indirect effects on health behaviours including contraceptive use, receipt of HIV test results and bed net use among young children.

Farnsworth, S., Bose, K., Fajobi, O., Souza, P., Peniston, A., Davidson, L., Griffiths, M., Hodgins, S., 'Community Engagement to Enhance Child Survival and Early Development in Low- and Middle-Income Countries: An Evidence Review,' Journal of Health Communication: International Perspectives, (2014) 19:sup1, 67–88.

- ***Summary:*** There is evidence that programmes working collaboratively or those that achieve shared leadership with the community can improve critical health behaviours, increase knowledge, improve practices, affect social norms, lower disease incidence, and reduce poor health outcomes and mortality, even in low-resource settings where social conditions and practices could otherwise result in poor child health.

Loewenson, R., Rusike, I., Zulu, M., 'Assessing the impact of Health Centre Committees on health system performance and health resource allocation', EQUINET Discussion Paper (2004) 18. Harare, Zimbabwe.

- Facilities/wards with Health Center Committees had significantly higher likelihood of health service use for last illness (2.3% $p<0.05$) and significantly greater use of antenatal care, fewer cases of diarrhea, more staff, better funded, has better community health indicators, and has stronger links between communities and health workers compared with those without.

Recommendation for scale-up from PM summary 2017: It is recommended to scale up the project model while ensuring future studies employ rigorous evaluation methodologies to validate the long term impact of the approach.

IMPLEMENTATION AND SCALE

14 known field offices are implementing the COMM model and are working with at least 2,000 COMMs.

- Burundi
- Cambodia
- China
- Eswatini
- Ghana
- Kenya
- Lesotho
- Malawi
- Mauritania
- Myanmar
- Sierra Leone
- Tanzania
- Uganda
- Zambia

RESULTS, KEY ACHIEVEMENTS, SUCCESSES

Illustrative examples of what COMMs have achieved in various countries:

- Guatemala: Successful in lobbying for construction of health facility in their area
- Cambodia: Raised money for purchase of emergency transport vehicle, for electricity at a health facility, and for a health facility waiting room
- Zambia: Built a washing center at a health facility for mothers to wash up after giving birth
- Sierra Leone: Worked with boat owners on an island to reduce transport costs for pregnant women
- Uganda: Land acquisition and maternity construction, health center renovations and water supply

RESULTS, KEY ACHIEVEMENTS, SUCCESSES

Innovations seen to date with community health committees include:

1. The possibility of linking COMMs with IGAs as part of incentive system (Sierra Leone)
2. Forming COMMs at more than one administrative level, with links and reporting arrangements between them – an apex level structure (Sierra Leone)
3. COMMs with bank accounts (Sierra Leone)

LINKS TO KEY DOCUMENTS

https://www.wvcentral.org/community/health/Pages/COMM.aspx?project-Model=Community%20health%20Committees

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