

MCSP Community Health Contributions Series: Haiti

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Background

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) operated globally and within 32 countries with the ultimate goal of preventing maternal and child deaths. To support community health structures in these countries, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers (CHWs), and supporting community infrastructure in partnership with country governments and civil society organizations. This brief is one of an eight-part series developed by MCSP to review and understand the processes of community engagement in MCSP-supported countries and identify how the community health approaches implemented by the project have contributed to changes in health service uptake and behavioral outcomes.



A CHW visits a family with a newborn. SSQH trained community health agents to provide community-based interventions for RMNCH. Photo Credit: Karen Kasmauski/ MCSP

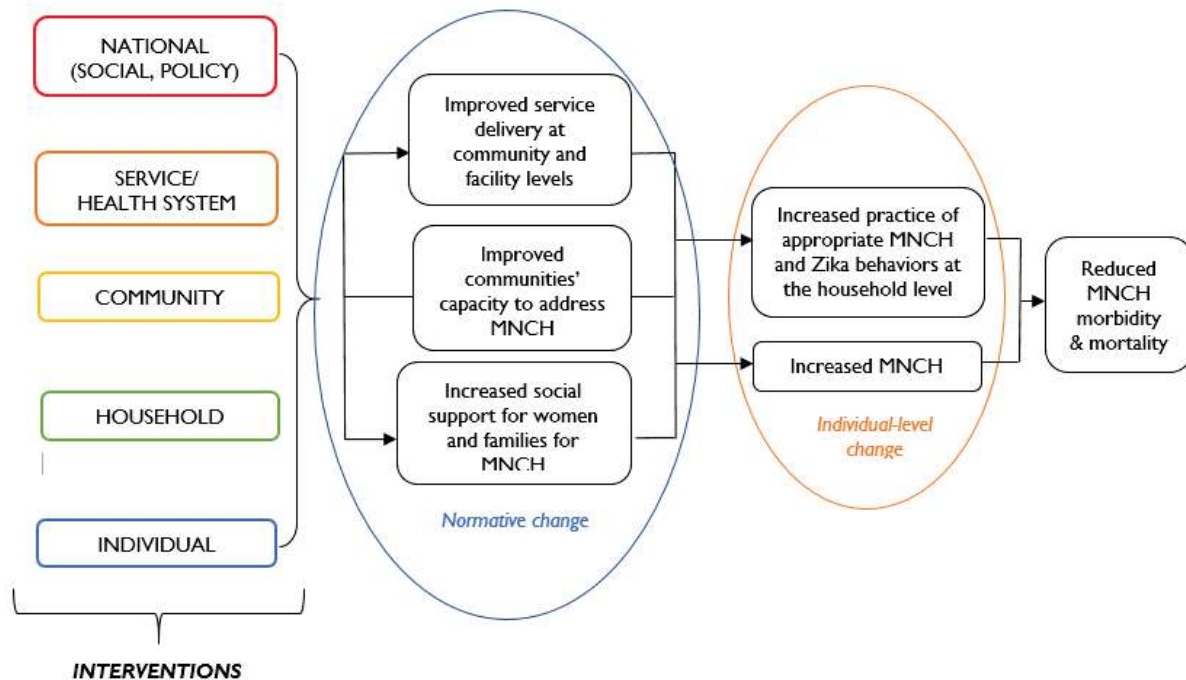
MCSP in Haiti, known locally as *Services de Santé de Qualité pour Haïti* (SSQH), supported the Haitian Government on its journey to self-reliance. The project helped strengthen the capacity of nongovernmental organizations and national and departmental health systems across the continuum of reproductive, maternal, newborn, and child health (RMNCH) care and nutrition from 2014 to 2018. MCSP collaborated closely with the Haitian Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population* or MSPP) in all 10 departments of the country, in 64 civil townships (known in Haiti as *communes*), and in 164 health facilities. SSQH worked closely with various MSPP entities—from the central to the peripheral levels—in health systems strengthening and quality improvement. Additionally, the project assisted communities in identifying their own priorities and monitoring local service delivery to improve access and quality, and to advocate for government funding to maintain and expand those services.

Community Health Focused on RMNCH and Nutrition

The goal of SSQH's community health component was to contribute to the reduction of maternal, newborn, and child morbidity and mortality. The project implemented an assortment of activities at various levels of the

ecosystem to strengthen community collective action and increase demand generation and uptake of services. **Figure 1** outlines the conceptual framework used by SSQH. Specifically, the project worked with the MSPP to ensure the delivery of the Ministry’s essential health package (*Paquet Essentiel de Services*) through a cadre of community health agents (called *Agents de Santé Communautaire Polyvalents* or ASCPs) with the goal of improving the availability and sustainability of quality of health care, and institutionalizing key management practices at the community level.

Figure 1. SSQH community health framework



MCSP’s global community health strategy was based on three pillars—community service delivery, community capacity strengthening, and community social and behavior change. **Table 1** outlines the activities the project undertook in Haiti to enhance community engagement. Approaches ranged from establishing mutual solidarity funds (microloans) to training ASCPs and their supervisors to provide community-based interventions focused on RMNCH. Additionally, SSQH used the community action cycle (CAC) model¹ of community engagement to establish community mobilization teams (CMTs) at commune and department levels to improve participation in health-promoting activities at the community level and to encourage health-seeking behaviors at the individual and household levels. SSQH community mobilization officers (CMOs) trained and guided these teams through implementation of their community action plans.

The CMOs also played a key role in supporting ASCPs and their supervisors to better organize and execute quality community-level education and home visits, thereby expanding demand for health services in the community. At times, the project’s CMOs accompanied ASCPs on home visits to ensure that the agents were correctly recording information, as well as appropriately covering the necessary topics (e.g., Zika virus prevention, family planning if needed, ante/postnatal visit follow-up). These visits reinforced health-seeking behavior among community members. Additionally, the SSQH CMOs attended community health posts (known as rally posts) to ensure that ASCPs were following MSPP standards for cold chain storage, immunizations, nutrition screening, and RMNCH consultations. These rally posts also provided opportunities to educate the community on various health issues, such as the Zika virus. This supportive supervision

¹ The CAC model reinforces the capacity of communities to resolve their own health-related challenges, particularly around uptake of quality health services and healthy behaviors at the household and community levels. The CAC process is comprised of seven phases (i.e., prepare to mobilize, organize communities for action, explore and set priorities, plan together, act together, evaluate together, and prepare to scale up).

provided by the CMOs was important to address identified quality issues. CMOs also attended ASCP meetings to assist with reviewing data collection in registers and data sharing with supervisors and provide guidance on improving the process. Because of this support, data collected by ASCPs were more complete and accurate. An adapted Reaching Every District/Reaching Every Community (RED/REC) approach² was utilized to more effectively identify and target health service resources to underserved communities and marginalized populations.

Table 1: Three pillars of SSQH’s community health approaches in Haiti

Service Delivery	Capacity Strengthening	Social and Behavior Change
<ul style="list-style-type: none"> • Equipped SSQH CMOs to attend and offer support during basic health service days at rally posts. • Provided salary support for ASCPs. • Adapted and applied the RED/REC approach. • Developed model referral networks to enable community-to-facility referrals and counter-referrals. • Nutritionally assessed children under 2 years of age at the community level and made referrals. 	<ul style="list-style-type: none"> • Trained community leaders on how to use the CAC to drive community collective action in addressing RMNCH and Zika issues through locally generated activities. • Established commune-level mobilization teams. • Provided microloans to community members to enable individuals to take out small loans and invest in income-generating activities that strengthen their capacity to afford health care costs. • Trained ASCPs and community health center personnel to deliver the MSPP’s essential health package of quality health services through home visits, referrals, and community-level education. • Provided training to community health center personnel on how to supervise the work of the ASCPs. • Established a system (method, tools, and mechanisms) of information and health data management at the community level to inform decision-making by the community. • Trained ASCPs on integrated community case management and improved related tools and job aids. • Adapted guidelines that outline attainable steps for communities to work toward Baby Friendly Community Initiative³ certification. • Provided supportive supervision to ASCPs on home visits. 	<ul style="list-style-type: none"> • Organized community-level education events, health screenings, and demonstration sessions to reinforce health care providers’ knowledge about maternal and child health and increase community awareness of maternal health services. • Developed social and behavior change communication materials (flipcharts, fliers, posters, banners, and radio spots) on a range of RMNCH topics. The materials were distributed to community members and used as job aids by ASCPs and health facility providers.

² Implemented since 2002, the RED approach emerged from the World Health Organization and partners in their attempt to devise an innovative strategy to improve stagnating immunization coverage and effectiveness in Africa. The approach is comprised of five main strategies: (1) Planning and management of resources; (2) Engaging with communities; (3) Monitoring and using data for action; (4) Supportive supervision; and (5) Reaching all eligible populations.

³ The Baby-Friendly Community Initiative is an extension of the tenth step of the Ten Steps of Successful Breastfeeding and the Baby-Friendly Hospital Initiative and provides continued breastfeeding support to communities upon facility discharge after birth. The Baby-Friendly Community Initiative creates a comprehensive support system at the community level through the establishment of mother-to-mother and community support groups to improve breastfeeding.

Achievements

A critical component of the project's community mobilization strategy was facilitating the CAC to increase the ability of communities to collectively address RMNCH and Zika prevention issues. In total, the project established and trained 571 facility staff and community leaders, 10 departmental teams, 35 commune-level teams, and 59 health committees on how to work through the CAC process. In terms of normative changes, there was increased social and community support for women and families for seeking RMNCH services, including Zika. Networks of structured, trained teams improved participation in health-promoting activities at the community level. Overall, the project's capacity-strengthening efforts at the local level and the ASCPs' abilities to forge strong relationships with community members contributed to an increase in health service uptake.

SSQH's effectiveness in driving community-level demand for and access to RMNCH services at the community is evident in data collected by the project. For example:

- SSQH increased community engagement efforts to encourage pregnant women to go to antenatal care visits. **The project exceeded its target goal (30%) of pregnant women attending at least three antenatal visits by approximately 10%.**
- To increase the number of institutional deliveries and to meet population needs, SSQH motivated ASCPs and traditional birth attendants to serve as *accompagnateurs*, or companions, to encourage women to seek facility births. **The rate of institutional delivery at SSQH sites increased from 10% to 20% in one year.**
- The project promoted postnatal care at community events, and ASCPs offered postnatal consultations during home visits. These visits reinforced health-seeking behavior among community members. **The percentage of newborns receiving a postnatal health check within 2 days of birth was 16% at the end of the project, exceeding the target of 8%.**
- Good nutrition in infancy and childhood is essential for normal growth and development. SSQH promoted the evaluation of nutritional status in this vulnerable age group so that any problems observed could be addressed. **The project nutritionally assessed 98,080 more children under 2 years of age at the community level than originally planned, an increase of 40% beyond the target goal.**

Conclusion

SSQH in collaboration with the MSPP addressed a number of identified challenges. As a result, the quality, access, demand, and utilization for MSPP's essential health package improved. Future maternal and child survival projects should continue to collaborate with the MSPP to develop an effective, transparent, and accountable health system and to better mobilize domestic resources that allow them to finance community health structures. Moreover, future projects should continue to provide technical and coordination support to the MSPP to finalize its community health strategy and guidelines and integrate both documents into the national health strategy. They should also provide technical and coordination support to ensure that the health system can integrate and institutionalize community health approaches. Furthermore, community capacity-strengthening should be scaled up to cover a wider health facility catchment area with a focus on data utilization to inform community collective action including the work delivered by the ASCPs. Lastly, the partnership between ASCPs, health committees, and formal health workers should be strengthened so that they can analyze data together that will inform their collective action for better coordination and synergy.

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