Brief: Improving health service delivery transitions in public health emergencies: Development and Use of a Community Health Service Delivery (CHSD) Tool

December 19, 2019

Background

Recent attention by the global community on the 'nexus' between humanitarian and development work has been instrumental in the creation of CORE Group's Humanitarian-Development Task Force (HDTF), with support from the U.S. Agency for International Development (USAID), Office of U.S. Foreign Disaster Assistance (OFDA). This case study is part of OFDA-funded collaborative with CORE Group entitled "*Addressing Gaps in the Evidence for Health and Nutrition in the Humanitarian-Development Nexus*." The purpose of this initiative is to increase global capacity for coordinating, integrating and transitioning community health and nutrition services in response to protracted crises and transition from crises to recovery and included the development of two tools (i.e. matrix exit tool and community health service delivery framework tool), accompanied by two prospective case studies and briefs, and one retrospective case study on health systems strengthening within the nexus. A literature review included published and grey literature on primary health care approaches in the humanitarian development nexus and identified existing tools and approaches used in health systems strengthening, transitioning primary health care facilities, and the adaptation of development approaches that impact the community level for emergency settings (i.e. Care Groups and integrated community case management (iCCM). The literature review confirmed some evidence-based work, on use of iCCM and Care Groups in emergencies had been conducted, yet there is little guidance on use or adaptation of developmental community-based health approaches for humanitarian emergency contexts. CORE Group partnered with Medair to specifically address the operational evidence gaps around health and nutrition in the humanitarian-development nexus and strengthen research to develop effective tools.

Purpose

The aim of the community health service delivery (CHSD) framework tool is to guide planning, selection and adaptation of community-based approaches traditionally used in development settings for humanitarian emergency use. Following development and roll out of the CHSD tool, the usefulness of the adapted CHSD tool for complex, chronic emergencies was assessed and used to further refine the tool. The framework is useful for any implementing partner such as a Ministry of Health/government, non-government organization (NGO) or other humanitarian organizations who want to use community health service delivery approaches in their emergency responses.

The framework can be used to:

- Provide considerations for use or adaptation of community-based interventions for emergencies
- Provide tools for action planning, based on global guidance/best practice and recent evidence to strengthen community-based programming for emergencies

Methods

The CHSD tool was developed following several steps:

- Development of a summary of the evidence-based interventions and considerations for adapting or using approaches for emergency contexts, based on a CORE Group led literature review of key community-based approaches adapted from development and previously used in emergency settings.
- Development of a CHSD tool based on literature review
- Conduction of rapid key informant interviews (n=4) with country staff from Middle East, Asia and Africa Medair country programs[1], and with international NGO staff (n=2) following use and/or review of the tool (October-December 2019)
- Collection of feedback during Medair workshop discussions on the CHSD tool in Nairobi, Kenya from 10 country programs (November 2019).

How to use the tool – step by step practical guidance (refer to Annex 1)

- **Step 1:** Read through the table to gain an understanding of the different types of community-based approaches, the evidence and how they have been used or adapted in emergency contexts.

- **Step 2:** If you do not have previous knowledge about one or more of the approaches, which is of interest to your country context, review the resources with links within the table and examine the list of references in Annex 1, 2 and 3.

- **Step 3:** Following your review of the table and/or the resources and references provided on the approaches, use the checklist to guide you and your team on key information you need to review for selection of approach or approaches for your country context/situation.

- **Step 4:** The checklist will help ask key questions on selection of these approaches, whether these approaches could be used in your country or program site, and the feasibility of rolling out the interventions.

- **Step 5:** Once you have narrowed down information in the checklist and selected an approach/approaches, it is important to discuss with key implementing partners and the government as to planning the implementation of the chosen approach(es).

Acknowledgements

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[1] Countries are not named, due to security and protection of country staff

Annex 1 – CHSD Tool

A framework for adaptation of community health service delivery (CHSD) approaches tool

Background: The CHSD framework tool assists in the planning, assessment, and adaptation of community-based approaches and interventions traditionally used in the health development sector for use in humanitarian emergencies. The framework includes two components 1) a table which can be used to gain an understanding of key community-based approaches and interventions from the development sector for use and adaptation in emergencies and 2) a checklist which provides program considerations when selecting and adapting a specific community-based approach(es) for use in your country. These approaches/interventions align with current evidence and innovations around implementation of humanitarian interventions (see Annex 1), with key references (see Annex 2).

Audience: The framework is useful for any implementing partner such as a Ministry of Health/government, non-government organization (NGO) or other humanitarian organizations who want to use community health service delivery approaches in their emergency responses.

Objectives:
This tool compiles key evidence-based community-based approaches. The aim is to:

- Provide guidance on how these approaches, used in development settings, which are critical for improved health and nutrition outcomes, can be used during emergencies.
- Provide key points to consider for applying these approaches for emergency contexts and can be helpful in creating country action plans.

How to use this tool:

1. Use the table to gain an understanding of the different types of community-based approaches, the evidence and how they have been used or adapted in emergency contexts. If you are not familiar with the approaches, there are resources with links to find out more (Annex 1, 2) and a list of references in Annex 3.
2. Use the checklist to ask yourself questions to guide which approach or approaches to select for use at the community level in your emergency context. Use the links provided in the tool to learn more about adaptations of these approaches to emergencies and how these adaptations can be implemented.

Community health service delivery intervention/ approach	Description of the community-based approach	Key elements & consideration for use and/or adaptation for emergency programming
Care Groups Care Group training manual https://coregroup.org/resource-library/care-groups-a-training-manual-for-program-design-and-implementation/ **Recommendation for using CGs in Emergency Settings** https://fsnnetwork.org/sites/default/files/TOPS_CG_Recommendations.pdf	Care Groups are defined as a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. Each volunteer is responsible for regularly visiting 10-15 neighbors, sharing what she has learned and facilitating behavior change at the household level	**When you would consider using Care Groups (CGs):** - When behaviors change for certain health and nutrition practices need improvement at the community level - If CGs previously set up or implemented in your country, (while not required, can be helpful in ensuring sustainability) - If the project duration is at least a year -unless CGs already in place - After the acute emergency phase has "stabilized" (< 6 months) and population movements have stabilized. - CGs are not recommended with temporarily displaced populations or mobile groups with no predictable pattern of migration. - If staff implementing CGs are able to focus on behavior change communication (BCC) without additional responsibilities for responding to immediate needs - If higher level personnel are able to be trained in Care Group methodology and the ability to follow up implementation -especially if there is high staff turnover. **How have CGs been adapted or used in emergency settings?** - Smaller groups (2-10 care group volunteers) - Meetings greater than 2 hours in duration - Added psychosocial support for trauma due to emergency - Extended target groups to entire community (not only children and women) - Flexible training times implemented in intervals to work around security concerns (i.e. secure locations were chosen, such as a health post, if neighborhood/open community space was unsafe). **Results of adaptation** - Documented effectiveness for behavior change, offer large coverage, rapid dissemination of messages, peer support through social cohesion, trusted channel of communication, screen + referral, community integration. **Additional considerations:** - Use community leaders/program staff to select interim care group volunteers (based on CG criteria) if too chaotic during the initial acute phase for the community to choose them. Once situation has stabilized, evaluate and encourage beneficiaries to conduct future elections. - Ensure time for commitment from community leaders - Consider culture & beliefs, literacy levels, language, & knowledge of CGs, when engaging program staff/volunteers - Avoid CGV incentives or selection for livelihood schemes that undermine CG cohesion, even in emergencies. Instead, funds can be used for projects/activities that benefit the whole community or

		for providing non-monetary tools for the job, such as signs, ID badges, refreshments, certificates, boots, umbrellas, coats, hats, bags, notebooks, etc. If incentives are given, be transparent while setting up the project that it will be withdrawn when the emergency stabilizes.
Community-Based Management of Acute Malnutrition (CMAM) surge approach, Concern https://www.concern.net/insights/cmam-surge-approach CMAM training manual/handouts https://www.fantaproject.org/focus-areas/nutrition-emergencies-mam/cmam-training	***CMAM surge*** Based on the CMAM model consisting of community outreach, outpatient care for children with severe acute malnutrition (SAM) without medical complications, inpatient care for children with SAM with medical complications, and programs for the management of moderate acute malnutrition (MAM), CMAM surge outlines a process and set of practical tools to help health facility and health district teams determine when seasonal CMAM caseload surges are likely to occur and to better prepare for and manage services during those periods of high demand.	**When you would consider using CMAM surge:** • When CMAM services are already integrated into the health system and part of national protocol/policy • When there are recurring, often seasonal, spikes in acute malnutrition (i.e. SAM) • When the health system functions at a moderate standard in non-emergency times • It should not be considered for new implementation at the peak of an acute nutritional emergency, or beginning integrated CMAM programming, yet may be considered as part of future preparedness. **Contingency planning for emergencies** it's important to strengthen the CMAM workforce, case management, procurement of essential CMAM supplies, and integrate with infant and young child feeding (IYCF) at the national and sub-national levels, when possible. **Results of adaptation:** • In Kenya, CMAM surge has been shown to contribute to health system strengthening and management of higher caseloads both in foreseen and unforseen emergencies • In Mali, CMAM Surge resulted in empowered health facility staff decision making, faciliated understanding and integraton of SAM within health, and improved community and health authority relations **Additional information and considerations on CMAM surge:** • The community component requires active participation of community health workers or community volunteers which are needed in planning and implementation phases for community-led intiatives. During surges, community workers would be expected to increase screening of children and active follow-up of defaulters, absentees and nonresponders. • It is not recommended to start CMAM Surge for a quick exit strategy
Mother-MUAC Innovations in community management of malnutrition **https://www.ennonline.net/attachments/3021/Innovations-in-CMAM-FINAL_Updated-October-2018.pdf**	Protocol to simplify screening for acute malnutrition at community level through the involvement of mothers in addition or instead of community health workers/community volunteers	**When you would consider using Mother-MUAC:** - When you are trying to improve CMAM program coverage and improve early diagnosis of acute malnutrition, and you have tools developed to plan and deliver training sessions for mothers and caretakers on how to use MUAC tapes and check for oedema, and have the capacity to monitor the quality of implementation. • Where there are feasible options to train mothers (dedicated mass training campaigns, at the health facility and/or individually in households), alongside CHWs

Alima, Mother MUAC Teaching Mothers to Screen for Malnutrition https://acutemalnutrition.org/en/resource-library/3AVAcDdQfuE8OScS2mK8MA		**How has it been adapted or used in emergency settings?** - When access and/or insecurity hindered caregivers to bring malnourished children to outpatient nutrition sites on a weekly basis, up to a month of Ready-to-use therapeutic food was given with caregiver's training on how to use MUAC and recognize danger signs. - Trainings have been done at facility and community level in nutritional emergencies *At community level:* • Dedicated mass training campaigns were used with group trainings in villages and individually in households • CHWs were used as trainers of mothers in their community. • Training was linked to mass community-based activities such as vaccination campaigns, coverage surveys, food distributions or to existing mothers' groups such as Care Groups if there is good coverage. • *At health facility level:* In the waiting areas or after triage if not needing further treatment • During cooking demonstrations or other health promotion activities at the facility • On discharge from SAM or MAM treatment In addition, follow-up post-training of mother's measurements and technique was linked to outpatient appointments, EPI, ANC/PNC and other services. **Results of adaptation:** • Potential to increase coverage • More cost efficient than use of CHWs • Mothers are in the best position to detect the earliest signs of malnutrition and enables them to participate in promoting the health of their children • Trained Mothers can classify their children by MUAC as well as trained CHWs • Mothers can follow-up their children during treatment and bring to the OTP if MUAC diminishes • Training may include other family members such as fathers, grandparents, teenagers, soon-to-be mothers, etc., though to date data on effectiveness is on mothers • Regular screening within the community has improved early diagnosis while decreasing risk of medical complication or death
Integrated community case management (iCCM) + strengthen integration with nutrition	ICCM is a strategy to provide lifesaving curative interventions for common childhood illnesses where there is minimal access to	**When you would consider using iCCM:** • When there are health facility coverage gaps for treatment of common childhood illnesses or first line care of a single disease (e.g. outbreak) • When iCCM exists as a national policy already or treatment of common illnesses is permitted by CHWs

Community case management Essentials—A Guide for Program Managers http://resources.jhpiego.org/system/files/resources/ccmbook-internet3.pdf **iCCM with Uncomplicated Severe Acute Malnutrition Treatment** Innovations in community management of malnutrition https://www.ennonline.net/attachments/3021/Innovations-in-CMAM-FINAL_Updated-October-2018.pdf	facility-based services. Guidelines have primarily focused on identification, treatment, and referral of children who are ill with diarrhea, pneumonia, and/or malaria initially in developmental settings. While iCCM guidelines also incorporate nutritional components, including the identification and screening of acute malnutrition (by measuring a child's mid-upper arm circumference and the presence of bilateral pitting edema), immediate referral of severe acute malnutrition (SAM) cases, and guidance on the continued feeding of any sick child treated at home, though this is not often implemented consistently in countries. Recently some countries have trialed guidelines for including uncomplicated SAM management in addition to the management of the standard diarrhea, pneumonia and/or malaria.	**How has it been adapted or used in emergency settings?** • iCCM has been adapted to include simplified protocols, SAM treatment, IYCF strengthening and adapted for single disease treatment in outbreaks. *iCCM in emergencies, overall* • Adapted to specific emergency context, available staffing, and literacy levels • Adapted to single disease treatment to expand coverage in outbreak situations when health facilities were overwhelmed or to improve poor geographical coverage • Adapted communication with regards to drug supply and reporting due to insecurity • Delivered large buffer of stocks to CHWs in areas of intermittent access and insecurity to avoid stockouts • Conducted reporting and monitoring adapted/reduced to achievable levels. • Used with mobile internally displaced persons and nomadic populations *iCCM + SAM:* • Added uncomplicated SAM management which linked iCCM CHW worker to a 2nd CHW responsible for acute malnutrition has been successful • Developed guidelines for illiterate CHWs in some countries included the integration of SAM management into iCCM *iCCM and strengthening nutrition: Considerations for strengthening IYCF counseling* • It is important to disseminate the national iCCM/nutrition policies and guidelines to strengthen IYCF counselling, management of acute malnutrition, as well as strengthen the capacity of community health workers • Strengthen health provider capacity (including community health workers) through training on IYCF, and IMCI/iCCM and treatment of acute malnutrition, as has been done in development settings • Equip health workers with SBCC materials to strengthen nutrition practices, including key culturally relevant messages and illustrated counselling cards on IYCF practices, including feeding during and after illness. • Strengthen the preventative components of nutrition with iCCM, using the adapted counselling cards to assure facility- and community-based health workers are well equipped and trained to assure early initiation of breastfeeding; counsel on early introduction of foods prior to 6 months of age and how it disrupts exclusive breastfeeding practices; counsel on appropriate complementary feeding practices with an emphasis on quantity, diversity, and frequency of foods to provide for children 6– 23 months of age; and counsel caregivers on feeding children during and after illness.

		Results of adaptation:
		
		• Evidence shows that CHWs, including internally displaced CHWs, can continue to provide treatment for childhood illnesses (iCCM) during an acute emergency, and service provision recovered faster to pre-crisis levels than the formal health sector
		• Community based interventions for treatment of common childhood illnesses can achieve greater coverage than facility-based in emergencies
		• CHWs in emergencies can provide a platform for the delivery of urgent interventions throughout conflict and insecurity
		• iCCM + SAM results:
		  ○ Well supervised and trained CHWs demonstrated able to manage uncomplicated SAM
		  ○ Coverage, cure rates and defaulter rates better in some studies with iCCM workers vs. health facilities
		  ○ No need for referral thus potential to increase coverage of treatment of acute malnutrition.
		  ○ Potentially more cost efficient than treatment at health facility level.
		  ○ Potential decrease in burden of care at health facility level.
		  ○ Potential decrease in defaulter and death rates.
		  ○ Reinforces link between nutrition and disease.
		  ○ Allowed rapid roll out of CMAM after training (10 days), using CHWs
		
		Additional considerations:
		• Allow sufficient time for initial procurement of iCCM commodities to avoid stock outs and for integrating iCCM commodities into the national supply chain from the beginning of implementation to support program sustainability where possible. The supply chain can be strengthened by basing quantities on consumption data and increasing buffer stock, especially in the rainy season or periods of insecurity. Consider advocating for political will at the central level to promote sustained procurement and distribution.

Infant and young child feeding in emergencies (IYCF-E) IYCF-E Toolkit https://resourcecentre.savethechildren.net/library/infant-and-young-child-feeding-emergencies-iycf-e-toolkit-rapid-start-emergency-nutrition	Infant and young child feeding in emergencies (IYCF-E) focuses on the protection and support of safe and appropriate feeding for infants and young children (0-23 months) in emergencies to safeguard their survival, health, growth and development. IYCF-E focuses on supporting optimal IYCF, which is	**When you would consider using IYCF-E:** - IYCF-E should be a part of all nutritional emergency responses and integrated with CMAM. Assessment, policy guidance and coordination as well as multisectoral support to infant and young child feeding in emergencies are integral parts of Sphere's minimum standards for nutrition in emergency responses and global guidance on IYCF from WHO. **How has IYCF can be adapted for emergencies (IYCF-E)?** - IYCF-E includes all the recommended behaviors of IYCF including a strong emphasis on guidelines for donation of Breastmilk Substitutes (BMS) in emergencies. Free samples of BMS and bottles distributed in both development and emergency contexts interfere with breastfeeding. Provision of a supportive environment for mothers/care givers who went through severe disruption of their family life, communities, etc., is essential. For example, often mothers feel they cannot produce enough breast

IYCF-E operational guidance: https://resourcecentre.savethechildren.net/node/12719/pdf/2.1._iycf-e_operational_guidance_v3_ife_core_group_2017.pdf	defined as exclusive breastfeeding for the first 6 months, continued breastfeeding for 2 years, and introduction of quality, energy and nutrient dense complementary foods at 6 months of age) as this provides the greatest protection for infants and young children, it also aims to provide appropriate support for infants who are not-breastfed. Every emergency response should include an **assessment**, an IYCF-E **policy, coordination** and implementation of **basic** and **technical interventions**.	milk due to stress or not eating as much food as they were pre-emergency. Supporting mothers to ensure breastfeeding production is maintained (feeding on demand) and support for resolving any initial breastfeeding problems, as well as not providing breastmilk substitutes is critical. - All sectors of interventions are involved: Pregnant and lactating women (PLW) should be prioritized in queues, distributions and provision of shelter, water, food and security. - Sphere recommends the following multisectoral entry points for identifying and supporting IYCF-E: ante-natal and post-natal care, immunization points, growth monitoring, early childhood development, HIV treatment services, acute malnutrition treatment, community health, mental health and psychosocial support, WASH services, places of employment and agricultural extension work. **Additional considerations for supporting IYCF during emergencies:** In supporting **IYCF-E at the community level**, in complement to facility level efforts (as feasible): ▪ Examine resources and availability of **existing community structures** to **mobilize support for IYCF/IYCF-E** (i.e. lay/peer counsellors, lead/mentor mothers, multi-purpose community health workers, community development and extension workers, traditional health practitioners, local nutrition advocates (i.e. grandmothers, teachers, village health committees), mother-to-mother/IYCF support groups ▪ Ensure **support for early initiation of exclusive breastfeeding** for all newborns in an emergency (link to baby friendly hospital or baby friend community initiative, any community support), including **support for exclusive breastfeeding, and continued breastfeeding** for 2 years o For infants who are not breastfed, look at breastmilk options should first e.g. wet nursing. Some infants may need to be fed using a breastmilk substitute. Before undertaking an artificial feeding program, it is critical to do an assessment to determine the need and clear criteria for targets. Ideally this should be agreed by the Nutrition Cluster / IYCF-E working group. It is important not to undermine breastfeeding and minimise the risks of artificial feeding. Adhere to strict guidelines in the Operational Guidance on IYCF-E (which embodies the International Code endorsed by World Health Assembly resolution 63.23, 2010). IYCF-E Operational Guidance Version 2.1 o Support should include initial assessment of caregiver/baby pair, a full home assessment, training for caregivers on how to minimize the risks of artificial feeding e.g. cup feeding, provision of necessary breastmilk substitutes (BMS) and resources, follow-up visits to ensure protocols are being followed and to check on the health of the infant, etc. ▪ Availability and provision of safe, appropriate (energy and nutrient dense), local **complementary foods** for children 6 months -2yrs. ▪ Examine **legislative status of the International Code for Breastmilk Substitutes** and any existing national IYCF and/or IYCF-E policies or action plans. o Determine proportion of children less than 6 months with acute malnutrition as a reflection of sub-optimal IYCF practices ▪ **Establish secure and supportive places** for mothers/caregivers of children 0-<2yrs to breastfeed and receive additional feeding support through frontline health workers. Create safe places in camps and other collective settings for women to support breastfeeding, such as baby friendly spaces to support exclusively breastfeeding.

		▪ **Provide for nutritional needs of pregnant and lactating women,** which can include micronutrient supplements as necessary, (daily supplements to pregnant and breastfeeding women, whether the women receive fortified rations or not). Continue iron and folic acid supplements when already provided Note: **CMAM should be integrated with IYCF/IYCF-E programming as prevention of malnutrition and full coverage of IYCF/IYCF-E programming is the aim.*
Expanded CHW role **CHW AIM Toolkit** **https://www.who.int/workforcealliance/knowledge/toolkit/54/en/** **Updated matrix CHW AIM tool:** **https://www.chwcentral.org/community-health-worker-assessment-and-improvement-matrix-chw-aim-updated-program-functionality** **WHO guideline on health policy and system support to optimize CHW programs** **https://www.who.int/hrh/resources/health-policy-system-support-hw-programmes/en/**	Community Health Worker is a health worker who performs a set of essential health services and who receives standardized training outside the formal nursing or medical curricula and has a defined role within the community and the larger health system. (CHW AIM definition)	Many of these approaches relate to the role of CHWs. Please see CHW AIM Toolkit for more information on maximizing the role of CHWs and community level cadres. **Additional considerations:** • Train CHWs on WHO Psychological First Aid in order to better prepare them for the types of psychological difficulties they will encounter with clients, including care, referral, and humane, supportive and practical help following serious crisis events. Ensure links with appropriate government and non-government gender-based violence supports units in the country. • Train CHWs on elements of psychosocial self-care and self-management, similar to the Red Cross training "Caring for Volunteers" used for community volunteers. • In considering task shifting, compare curriculum with national policies and with the WHO Optimise MNCH and H4+SRMNCH task shifting guidance

Checklist	
	Considerations for adapting community-based approaches/intervention for emergencies

General considerations	• What type and stage of emergency (acute, protracted/chronic)?
	• How long are you likely to be able to intervene (funding cycle, suspected emergency timeframe, security situation, access)?
	• Who is your target population—IDPs, refugees, host, nomads? Are there different tribes, clans or sub-clans in your area of intervention?
	• Are there any community networks that exist already?
	• Are there national policies or guidelines for community health service delivery?
	• Any national or local guidelines for community level incentives or payment?
	• How are other actors supporting or reimbursing community level workers?
	• What is the relationship and communication between the community and health facility staff?
	• Is there a village health committee system and is it active?
	• What is the relationship between Ministry of Health and community leaders?
	• Are you likely to be able to mobilize community volunteers with the assistance of community leaders? If not, is it acceptable to do it another way? What needs to be put in place to keep them involved and informed?
	• What are some linkages to informal health care providers such as traditional healers, traditional birth attendants, and religious/faith leaders that would help the community-based approach?
	• What existing community outreach, services and programs in other sectors could you link to? (e.g., with food security, livelihood programs, vaccination campaigns)?
	• What staff capacity do you have for engaging community-based providers/workers/volunteers? Consider the following:
	  ○ Role in job description, changes in role based on needs during emergencies, and formalizing that role
	  ○ Topics and interventions covered by community level providers
	  ○ Areas covered (distance, rural vs. urban)
	  ○ Incentives (paid vs unpaid)
	  ○ Motivation
	  ○ Gender and age groups
	  ○ Links to functional health facilities
	  ○ Links to mother support groups and/or mothers' participatory discussion groups

Care Groups	• Is the population mobile or frequently displaced? Is the mobility seasonal, following a predictable pattern? • What are the most lifesaving behaviors that need to be targeted and in which target groups? • Who, in the family, is the key person to implement the new behaviors and who decides if the family can be part of the project? • What is an acceptable walking/travel distance for a person who is paid? Who isn't paid? • Any existing national or global BCC materials that can be adapted?

	• Are there any gender-based or other restrictions on movement or household visitation due to security or cultural factors? • What is the literacy level of the communities? Of the existing community workers? • Are there any informal meetings already taking place spontaneously between women or other groups of people? If not, was there something like this happening before the emergency?
CMAM Surge	• Is the treatment of SAM at the health facility level a part of the national health policy? • Are there recurring spikes of acute malnutrition such as seasonal? • In the non-emergency phase (nutritional) was the health system functioning reasonably well? • Is this the peak nutritional emergency period? • Is the main health service delivery actor--usually the Ministry of Health—willing to explore improving nutritional preparedness? • Are there CHWs or a volunteer community network and what is their coverage? • How is the health facility/staff perceived by the community? • Is active MUAC screening and referral occurring at the community level? • Are community workers paid or provided with incentives? • Who supervises the community workers—health facility staff? Village health committees? • Who makes decisions on when to spend money for the health facilities? • What is your likely timeframe for intervention?
Mother-MUAC	• Are there any planned mass population activities that training could be linked to, such as: mass vaccination or screening campaigns, targeted blanket supplementary feeding, coverage surveys or seasonal malaria prophylaxis? • Are there already mothers' groups in the community with good coverage such as Care Groups? • What are other services for mothers and children that MUAC usage and results could be followed up on such as: health facility waiting areas, ANC, PNC, EPI, outpatient health visits, SAM/MAM program discharges, etc.? • Are there any community messaging channels that can be used to remind people of MUAC screening their children like radio advertisements, SMS or social media?
iCCM	• Is there a national policy or guidelines on iCCM? • Are there any national restrictions on community workers prescribing antibiotics? • Are there areas that lack continual access to treatment of common illnesses at the health facility level? • What are the suspected barriers for health facility usage in these areas—demand, geographic, perceived low quality, ethnic tensions (clan/tribal)? • Are there better approaches to address these gaps in service delivery besides iCCM? • Are there already existing community structures—such as CHWs and/or community health committees? • Is there an already existing cadre that could implement iCCM? • Where are the hardest to reach locations with poor access to health facilities?

iCCM + Uncomplicated SAM	• Is there likely to be community and MOH support and acceptance of iCCM? • Is uncomplicated SAM a common cause of morbidity and mortality in the targeted area? • Are there areas that lack continual access to treatment of uncomplicated SAM at health facilities or nutrition outreach or mobile sites? • If iCCM is already operational what is the current workload of most CHWs? • What is the anticipated workload if uncomplicated SAM management is included in the area? • Is the anticipated workforce likely to be literate or will some be illiterate?
IYCF-E	• What are the existing community resources that could be mobilized to support IYCF-E? • Are there existing national IYCF policies or C-MAMI guidelines or SBCC materials for IYCF? • Is there knowledge of the legislative status of the International Code for Breastmilk Substitutes? • Are key actors informed about IYCF-E (PLW priority in queues, report any BMS seen etc.)? • Are there baby friendly safe spaces to support exclusive breastfeeding? • What were the IYCF practices prior to the emergency? • What is the perception of wet nursing in the community? • Who are the key persons in the family and in the community who have decision-making power regarding infants and mothers? • Who decides who eats what and how in the family? • What multi-sectoral entry points can support an integrated IYCF-E approach? ○ Antenatal and postnatal care; ○ Immunization points; ○ Growth monitoring; ○ Early childhood development; ○ HIV treatment services (include prevention of mother-to-child transmission); ○ Acute malnutrition treatment; ○ • Community health, mental health and psychosocial support

Annex 2 – Literature Review Findings on Community Interventions

A literature review led by CORE Group on community interventions adapted from development to emergency contexts is summarized below:

- Evidence indicates that for community health service delivery - CHWs, Care Groups, integrated Community Case Management (iCCM), Infant and Young Child Feeding (IYCF) and Community-based Management of Acute Malnutrition (CMAM) actions including mother to mother support groups and social accountability efforts with scorecards can work in both humanitarian and development contexts.
- Particular drivers of success for these models lie in the community's ability to safely participate and willingness to be mobilized. During the Ebola crisis, CHWs remained active and continued to provide health services.
- CHWs have provided health services in communities and the tool - CHW AIM - can provide guidance on how to build capacity of CHWs.
- Care Groups have proven effective in achieving positive health and nutrition outcomes in both humanitarian and development contexts. Specifically, in the humanitarian context, Care Groups have demonstrated effectiveness for behavior change and rapid dissemination of information, peer support, and created a system for monitoring, screening and referrals, when the model is adapted.
- iCCM is gaining momentum as an effective, integrated community-based strategy to reduce morbidity and mortality. The use of CHWs is a key driver of the success of the model with potential for high impact in humanitarian responses. Leveraging the participation and mobilization of CHWs is central to iCCM, who are often trusted by the community.
- Initiatives such as IYCF including IYCF-E, have been identified as a major preventative factor for malnutrition and instrumental in integration across different sectors including food security, WASH, education, and protection. For CMAM, the support of government through integration of CMAM into the health system is key.
- Factors for success in communities within the development- humanitarian nexus are initiatives that leverage participation and mobilization, as well as demonstrate integration and country ownership.

Annex 3 – Key References

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