



Community Health Network ~ Spring Meeting 2012

Meeting Theme: Demystifying and Using Data for Community Health Impact

Hot Topics and Key Messages

Maternal mental health. Measuring community capacity. Implementation Science. Operations Research. These were a few of the most talked about topics at CORE Group's 2012 Spring Meeting, in Wilmington, DE, April 30-May 4. A total of 223 participants represented 89 organizations and 17 countries (Bangladesh, Belize, Benin, Burundi, Haiti, Honduras, India, Ireland, Ghana, Kenya, Liberia, Madagascar, Malawi, Nepal, Republic of South Africa, Rwanda, USA). The schedule included six plenary sessions, 23 concurrent technical sessions, 17 Power Breakfast Roundtables, 16 Working Group gatherings, 12 lunchtime roundtables, two "laughter yoga" sessions, one reception amidst stunning artwork...and a host of ad hoc gatherings.

CORE Group Members, Associates and partners dove into the theme of *Demystifying and Using Data for Community Health Impact*, sharing a variety of methods and ideas on when, why and how we might measure community health and development efforts, and how to use the outcomes to improve programming.

Participants explored data and measurement challenges around several health topics, shared new or improved tools and materials, collaborated to advance a host of technical efforts through CORE Group's technical Working Groups, and "got the latest" from several experts.

Meeting presentations and dialogue highlighted persistent child survival gaps, such as low rates of exclusive breastfeeding, and also brought emerging issues into the spotlight, such as linkages between pediatric malaria, pneumonia, and tuberculosis, and the underserved status of very young adolescents. Participants examined the programming successes related to specific health topics, such as community case management, anemia and malaria in pregnancy, family planning, non-communicable diseases, and nutrition.

Organizations shared detailed program outcomes via three sessions focusing on the Child Survival and Health Grants Program, and one on Title II Food Security. Of great interest throughout the week was measurement of challenging issues, such as community capacity, sustainability, and equity. Also

examined was the relatively new data on the “hidden” topic of maternal mental health. Specific methodologies examined included quality improvement, verbal autopsies, CHW performance tools, child well-being assessments, and a process for using routine information feedback for improved program management. Keynote speakers introduced participants to the relatively new field of implementation science, and made the case for use of ethnographic methods to better plan and assess our community health programs.

A new round of the ever popular Power Breakfast Roundtables allowed participants to dialogue and learn about a range of methodologies, concepts, and programs, from positive deviance to knowledge sharing to public-private partnerships; and twelve lunch roundtables gave opportunities for people to informally network and brainstorm on specific areas of interest, and plan next steps.

Mhealth awards announced: During the opening plenary session, CORE Group and Dimagi unveiled the winners of a grant competition available to CORE Group Members and Associates. Each grant includes 10 new, locally purchased phones, a year of technical support from Dimagi, \$500 for expenses, and membership in a CORE Group-led learning collaborative. This effort is being funded by the *Norwegian Agency for Development Cooperation* through a grant from *the Innovation Working Group to support maternal, newborn, and child mobile health programs*. Congratulations to the winners: ADRA, Madagascar; Christian Reformed Church World Relief Committee, Bangladesh; Food for the Hungry, Mozambique; Future Generations, India; Future Generations, Peru; Pathfinder, Kenya; PCI, Guatemala; Relief International, Darfur; Save The Children, Bolivia; Save The Children, Nepal; University Research Co., Benin; World Vision, Uganda, Sierra Leone, and Ghana.

Technical Highlights

Academic collaboration included two plenary sessions led by professors from **Cornell University** and **University of Connecticut**. **David Pelletier** with Cornell University presented his ideas on the need for more and better “**implementation science**.” *The gist is that we meticulously document much research and highly academic knowledge, but very little is captured regarding the art/science of running projects and programs in real-life conditions. Seasoned professionals have no shortage of stories about well conceived efforts that didn’t succeed due to implementation problems. David shared an implementation science framework he is developing to help address this problem. He called for us all to work together to develop methodical and effective systems for better conceptualizing, capturing, and sharing this critical mass of undocumented knowledge. Perhaps his frustration is best summed up with a quote he shared from the literature: “We are faced with the paradox of non-evidence-based implementation of evidence-based programs.” He also reminded us that “you can train and hope, or train and coach”*

“We are trying to establish that culture of research in our communities of evidence-based practice. We seem to be struggling, but here you have been doing it. You have data and success stories and we are taking those with us. We thought we were in a little corner by ourselves, but we are here, excited to find out that we are not alone in this venture. Now we are connected. Thank you.”

--first-time CORE Group participant
Arlette Sheppard, Belize Ministry of Health

based on a recent analysis showing us that even with the best of training, only 10% of it is applied without coaching and mentoring.

Professor Steven Schensul with University of Connecticut got the crowd excited about **ethnography**. While most participants already use various quantitative and qualitative methods of monitoring and evaluation, many of them found the array of grounded, substantive qualitative methods and the framework presented to be very useful—given the complexity of the settings in which everyone works. The human element (as opposed to the clinical, biological perspective) accounted for by anthropological methods of research must be understood. Steven stressed the importance of using ethnography to find a “cultural hook” on which to hand an intervention. This underutilized source of data enables innovative and culturally-specific program design, implementation and evaluation.

Christopher Szecsey, trainer/consultant to governments and NGOs, trained a group of participants in another qualitative approach with many applications known as **Appreciative Inquiry**. Rather than beginning with the mechanistic and sometimes draining “problem solving” approach, AI focuses on what works and builds from there. Based on a deceptively simple starting premise, this field of practice offers many sophisticated tools, models and case studies. Christopher is currently working with the Kazakhstan government to reframe its national health efforts from Soviet-era punitive, top-down structures into positive and empowering model systems, with excellent results.

Maternal mental health was the topic of another riveting session. Several professors and mental health experts presented a compelling view of this neglected topic. Global data has linked poor health outcomes of both mothers and children to mothers’ mental health problems. While the scale of the global mental health concerns appears to be huge and may seem daunting, there is a great deal of low hanging fruit to start with. A few simple screening questions can be incorporated into pre and post partum visits, and simply identifying mothers suffering from depression is an important start. Support groups and other relatively “low tech” interventions can make a difference. Culturally appropriate interventions will differ from place to place—global sharing on this underdeveloped topic is critical.

I think anybody interested in community-based health should be involved in CORE Group because this is the place where the ideas are rapidly being developed and promoted, and, it’s just the place to learn about the latest and greatest things in the field.

CORE Group provides the opportunity and forum to learn what people are doing and how they are doing it. We know a lot about the “what to do” but not nearly enough about the “how” –the art of implementation at the community level. And that is what CORE Group Members are doing.

-David Pyle, Independent
(and new CORE Group Board Member!)

Conference Design Innovation

With reference to our hometown of Washington, DC and its penchant for “power breakfasts,” for the second time we organized a very popular session with 16 **Power Breakfast Roundtables** hosted by experts, advocates and/or researchers who welcomed 3 rotating groups of participants. Topics addressed included microfinance linkages to health; engaging fathers; community health workers; including people with disabilities; understanding positive deviance; planning for sustainability through systems thinking, and creative techniques to foster institutional memory.

Technical Working Group Priorities

- **Safe Motherhood & Reproductive Health:** Collaborate with MCHIP; family planning integration at the community level; reproductive health, human rights and equity; newborn practices and postpartum visits; helping babies breathe (HBB); revisiting traditional birth attendants; respectful care for delivering mothers.
- **Community Child Health:** CHWs; measuring community support; pediatric TB; community case management of sick children; child survival call to action.
- **Nutrition:** Dissemination and training for Nutrition Program Design Assistant, Essential Nutrition Actions and other tools, e.g. ProPAN; integrated control of anemia; NACS linkages to HIV.
- **Social and Behavior Change:** “Make Me a Change Agent” manual; formative research “behavior bank;” ethnography and qualitative methods; ongoing Quality efforts (QI, PDQ).
- **Monitoring and Evaluation:** mhealth for data collection; SMART orientation with Nutrition; ongoing equity work; KPC TOST and survey training; costing analysis guidance; revive qualitative methods work on ethnography; mortality measurement.
- **Malaria:** Community Case Management of Children and supplies beyond the public sector; malaria in pregnancy; check in on rapid diagnostic tests at the community level; anemia; collaboration with MCHIP; Roll Back Malaria involvement; link with pneumonia and TB.
- **HIV/AIDS:** Ongoing TB linkages, including pediatric TB; early childhood disability screening, assessment and intervention; Nutritional Assessment and Counseling (NACS) as the organizing framework.
- **TB:** Pediatric TB (via Ped TB task force); Primer for getting NGOs and CSOs involved, with WHO, MCHIP, USAID, Union, others; link with HIV; coordinate with WHO; representation at STOP-TB.

Other session highlights...

- **Verbal Autopsies.** Simple in concept and effective in practice, this tool involves going into a community to systematically engage in dialogue around a death that has occurred. Key questions help everyone understand what happened, and most importantly, what can be done to help prevent future deaths of this type, whether related to childbirth, infectious illnesses affecting children, or some other cause.
- **Working with Very Young Adolescents.** Ten to fifteen year-olds begin puberty and with that, a new phase in their lives—which unfortunately may be fraught with peril. This phase, called by some “the last best chance” to get them on a solid track before young adulthood, is unfortunately often neglected. Too old to be reached by child health programs and too young to be reached by reproductive health efforts, this group is too often invisible. The good news is they have some wonderful advocates (including those who ran the session) who have designed interventions and charming games that appeal to this group while simultaneously serving as monitoring and evaluation tools.
- **Community Health Workers.** Although this topic has been at the top of the agenda for the *Community Health Network* for more than a decade, it has now become a high profile issue in all of global health (and rightly so we think). Community Health Workers and Volunteers can play critical roles, in cost effective and sustainable ways—but only with proper systems in place. As with many

other implementation issues, the devil is in the details. Several sessions and activities unpacked those details over the course of the week.

- **Mhealth: Mobile technologies for Health.** A popular topic but chronically underdeveloped approach, mhealth has great potential, once all the complexities can be sorted out. These complexities include lack of NGO capacity in this new area, worries about cost and sustainability, questions about technology choices and new partners, e.g. cell phone providers and concerns about the feasibility in difficult settings. Nevertheless, innovators are breaking ground and helping building our collective capacity to tap into the potential of cell phones. The Knowledge for Health Project has been equipping community-based family planning providers with phones and systems to text for technical assistance. The Institute for Reproductive Health has rolled out an automated, text-based fertility awareness tool (using the Standard Days Method) in India, to highly positive response from the users. Groups like Dimagi and MedicMobile have emerged to provide the high tech partnerships that NGOs need to build capacity.

The Nitty-Gritty: Key Messages and Questions from technical plenary, concurrent and lunchtime sessions.

Research and Data

Assessing Child and Household Needs and Well-Being. Led by Shannon Senefeld, Catholic Relief Services

- There are several complementary and similar tools (Duke University, CRS, Pact, etc.) being used to assess the well-being and vulnerabilities of OVCs. Some tools are used by a frontline worker whereas other tools are used directly by the child. Each of these tools must be contextually oriented to elaborate specific vulnerabilities for each major indicator.
- Multiple methods need to be used to get a true picture of the situation of a vulnerable child; a frontline worker might notice something while a child may voice something different.
- While these tools are helpful to get a broad picture of the status of a population, each individual child requires a unique action plan since each child will have a varied set of vulnerabilities and resources.
- Use of the Assessment Guides requires a guide to help with tool adaptation so the tools are properly used; there is a need for age adaptation of the tools.

Verbal Autopsies. Led by Tom Davis, Food for the Hungry, and Henry Perry, JHU

- This interview-based qualitative and quantitative tool that helps staff obtain information about local causes of death and conditions which caused mortality. It empowers staff to focus their project resources and efforts. A verbal autopsy tool helps understand local causes of death, delays in care-seeking, homecare and follow-up, and a way to offer condolences.

- Periodic local verbal autopsies enable staff to improve the quality of programs to address current community health problems. The use of narratives offers a view of a problem that may not stand out in the “numbers.” It is a way to help take off the “health glasses.”
- Programs should not fall into the ecological fallacy: data on large populations do NOT reflect local conditions. Each population is unique.
- Users should be aware of possible ethical issues if they cannot address uncovered findings.

Systems Analysis for Intervention Design. Led by Stephen Schensul, U. Conn.

- Research and intervention programs need to address multi-level system factors such as demand and access, needs and resources at both the population and organizational levels to look for innovative systems solutions to problems.
- An adequate intervention theory must encompass an understanding of the total system, pairing organization and population resources with organization and population variables.
- A 2 x 2 systems analysis table can be used with multiple stakeholders in a participatory iterative way to example organization and population problems in an integrated way.
- Looking at how target population resources can meet organizational needs may lead to innovative solutions where the target population becomes partners with organizational efforts to address a health problem.

The CORE Group meetings are a very interesting melting pot of thoughts and ideas and perspectives...a great variety of people from different regions and perspectives, from policy makers to those in the field. It's a technically-focused forum that is interesting to me as a technical person, but also great to see perspectives from donors and learn what is influencing change.

–Anthony Duttine,
Handicap International

Using Ethnography to Generate Culturally-Based Interventions. Led by Stephen Schensul, U. Conn.

- Ethnography helps one understand the worldview of community members through face-to-face interaction with local communities. Mixed methods, both quantitative and qualitative, describe cultural patterns, local change, and intra-cultural variation.
- Culturally-based interventions require that we find a “hook” on which to hang the intervention – a set of commonly held beliefs across generations that are relevant to the intervention. Finding the “hook” requires various methods: key informant interviews, in-depth interviews, group interviews, social network mapping, community mapping, surveys, focus groups, cognitive mapping (free lists and pile sorts), all of which can explore, define and confirm an intervention.
- A common ethnographic pattern is: qualitative work followed by quantitative followed again by qualitative methods. Good qualitative research permits development of better quantitative surveys. Focus groups are a confirmatory method – not an exploratory one.

Data for Impact: A Critical Examination through the Lens of Implementation Science. Led by David Pelletier, Cornell U.

- Implementation Science is the study of methods to promote the integration of research findings and evidence into healthcare policy and practice to reduce the gap between knowledge generation and effective action. It is a new field with little consistency in the use of terms, contextually based and quite complex. In the US it currently takes 17 years to get a new policy implemented.
- Implementation Science takes us beyond “evidence-based interventions” to understand how the context of experiential and local knowledge influences a policy or implementation guidance. We need to find a way for contextual and tacit knowledge to feed into scientific / theoretical knowledge.
- An Implementation Science framework includes five domains, each with several categories: characteristics of the intervention, the outer setting, the inner setting, the characteristics of individuals and implementation processes. The framework can be used as a checklist to identify potential bottlenecks prior to implementation of a policy.
- We have a “paradox of non-evidence based implementation of evidence-based interventions.” We all know training is an ineffective method yet we keep on training—the “train and hope” approach. On-site coaching is what is critical to apply knowledge locally.

Child Survival and Health Grant Program: Special Studies. Led by Jennifer Yourkavitch, MCHIP

- PLAN Nepal conducted a chlorhexidine study for newborns through pregnant women’s groups (PWGs) supported by community health volunteers (CHVs). They measured compliance at the community level and found both coverage and compliance to be high. The Pregnant Womens Groups were found to be an effective delivery mechanism for chlorhexidine. CHX is now part of the essential drug list, incorporated into a Community Based Newborn Care package.
- CARE Nepal studies the feasibility, acceptability, and safety of community-based distribution of misoprostol through CHVs. Acceptability reached nearly 100%, was very feasible, and safe as most mothers knew correct timing. ANC coverage was a key factor in compliance.
- GOAL Ethiopia measured the acceptability of water treatment (Water Guard), and its cost effectiveness and sustainability. They used Care Groups to collect data and promote use. Use increased from 5 – 74%. Through social marketing they found that the price had to be adjusted to ensure that families were willing to buy and use the product.

Operations Research. Led by Florence Nyangara, MCHIP

- OR is a practical tool that any organization can use to answer programming questions. Every program system has a possible OR problem and solution waiting to be diagnosed/evaluated to inform on Scale-up, Cost – effectiveness, increased impact, quality improvement or acceptability to clients.
- OR studies must have strategic relevance to local programming needs (foremost). The ultimate goal and impact of OR studies is on the use of findings (not publishing) to inform practice, policy, etc. Problems and proposed solutions must come from the “doing” experience (not gaps in the literature, not ground-breaking ideas or technological).

- OR studies require partnerships to achieve its ultimate goal (Use of Results/process). OR requires collaboration between managers (sets program goals) and researchers (help model the study). OR requires organizational support and interest including engagement of key stakeholders especially government, and other local CBOs, etc.
- OR is critical for scale-up: making key program decisions, testing innovations, problem solving or comparing two or more approaches. OR is used to capture data on program activities in a systematic manner to use results to improve programs by changing a practice, guideline, or policy. Partnerships with academic institutions, local institutions, communities and other international partners have been key in CSHGP programs to both conduct and use the information learned.
- CSH Benin shared their story about getting started on their OR project. They had to change their OR question due to a change in the MoH policy regarding CHW incentives requiring negotiation with USAID, changes in the budget, and extra groups to minimize bias within the control and intervention areas.
- ChildFund Honduras shared their experience during an OR implementation of community-based health huts. Their challenges were protocol development, integrating OR into the overall project versus running a parallel implementation site, and finding in-country research experience to problem solve. Their formative research has already yielded results in understanding both costs of community-based health care as well as the savings achieved by families using community-based services. ChildFund stressed the need for clear benchmarks, roles and responsibilities when developing OR partnerships.
- HKI Nepal is finalizing their RCT OR on homestead food production with and without ENA and BCC. They have found an increase in production, consumption and income, but the results are still inconclusive on change in nutritional status. Some of their challenges included spillover, sampling size, age range to measure, lengthy preparation needed before they operationalized their activities, food seasonality and its effect on data. HKI is publishing findings throughout their study including their analysis of baseline data on household food insecurity, the formative research process, and an additional nested study.

Program Assessment, Monitoring and Improvement

Seven Steps to Use Routine Information for HIV/AIDS Programs—Led by Elizabeth Snyder, MEASURE Evaluation Project.

1. Identify questions of interest. 2. Prioritize key questions. 3. Identify data needs and sources. 4. Transform data into information > turning raw data into something useful. 5. Interpret information and draw conclusions > exploring causes and consequences. 6. Craft solutions and take action. 7. Continue to monitor key indicators – develop tools for monitoring.

- Analysis and interpretation are two different steps. Interpretation requires a group or team.
- Both data users and data producers must be involved.
- Question: How to build capacity > are the seven steps useful in changing behavior around data use.

- Future: Analyzing barriers to using data for decision making.
- Is time limitation or technical capacity a greater challenge? How to address those challenges?
- Diffusing seven steps to country offices to build capacity.

Moving from “Lack of resources” to “Resourcefulness.” How to improve the quality of programs. --Led by Lani Marquez, URC/CHS

- Quality improvement involves techniques and methods to achieve standards (Quality Assurance identifies those standards.) It identifies gaps and ways to fill gaps. There are 5 approaches to QI: new service, redesign of service, design of new process, redesign of existing process, improvement of whole system.
- QI theory from Deming’s System of Profound Knowledge: 1. Appreciation of a system (need to change a system to get different results). 2. Building knowledge (what people know, how do they know it, how people acquire knowledge). 3. Psychology (how people think and feel, how they change). 4. Understanding variation (everything varies, need to measure over time—e.g. run charts).
- Model of Improvement asks 3 questions: What do we want to accomplish? Be specific. How do we know change leads to improvement? Continuous measurement; what changes can we make? Creativity, change concepts.
- PDSA cycle: Plan, Do, Study, Act > Iterative, test on small scale, get information quickly, state theories/assumptions to design tests.
- There is natural variation in data. We must be careful not to attribute change due to intervention that is really only natural variation. This requires continuous measurement: not just baseline and endline.
- Need to view community as a system and focus on systems thinking (inputs, processes, outcomes).
- Unanswered question: Sustainability of community QI teams? How to motivate QI teams for long-term?

Program Assessment Guide. Led by David Pelletier, Cornell.

Key Messages

- The PAG is used to systematically integrate evidence with cultural knowledge and experience to plan a new program, assess an ongoing program that is lagging or expand a pilot program.
- While the PAG itself is a 3-day workshop, it takes 3-12 months to lay the groundwork (get Ministry commitment and right participants) followed by 1-3 years of program follow-up.
- There are five universal needs critical to the effective performance of each health worker that needs to be met with a system design.
 1. Awareness
 2. Knowledge, information, skills
 3. Motivation/commitment
 4. Resources (time, money, HR, bus fare, materials...)
 5. Support from others

- **New Learning:** Cornell wants to develop and field test training and coaching approaches to help NGOs and partners facilitate this process.
- **Question:** How could PAG be linked with other capacity assessment tools and quality improvement tools?
- **Future:** An opportunity exists to work with Cornell University to produce and test additional versions for more complex interventions, integrated programs and/or sub-national planning.

Program Design and Implementation Topics

Scale. Led by Laban Tsuma, MCHIP.

- Pathways to scale can take up to 20 years to develop but once the structure is developed and the ministry is ready, a new intervention can be added to the system and scaled up within two years.
- The CSHGP Expanded Impact Program, working with governments in Rwanda and Malawi, made major contributions to national health improvements through a systems approach.
- Flexibility was required in the EIP to link the CSHGP Project with the pace and evolution of the MOH in Rwanda and Malawi. Project delays were due to challenges in working with the MOH including government availability and readiness, process to create new indicators, changes in national guidance, and linkage with national surveys. In the case of Rwanda the MoH wanted to integrate nutrition into the MNCH package (which was not project funded) so the NGO was able over time to raise the required match to meet the MoH expectations.
- Partnerships were key to scale-up in Malawi and Rwanda resulting in added resources, more powerful advocacy, and greater influence showing that the sum of the partnerships was greater than the whole. For example, the EIP developed SC's capacity to enable SC to engage in the post-project bilateral and continue scale-up of newborn care in Malawi. SC was able to publish their findings in the HPP journal with authorship by government, hospital staff, SNL staff and project staff.
- Participation / convening of a national level working group with external partners was key to development of scale-up champions in the EIPs in Rwanda and Malawi.
- Use of the Rapid Catch tool was not ideal in an EIP given the need for large scale and national level linkages. Resources could have been better used differently.

Capacity, Country Ownership and Sustainability. Led by Eric Sarriot, CEDARS

- Capacity, ownership and sustainability are at the heart of community health programs. Power, relationships and shared accountability are central to capacity. We need to work within a systems view of capacity and sustainability, not just a functional view. Concerns about ownership can too easily stop at governments and institutions; we need to ensure that communities and beneficiaries find their rightful place in the health systems and country ownership dialogue.

- People can share information and experiences on sustainability at the CEDARS website and blog: [www. Cedarscenter.com](http://www.Cedarscenter.com) and at info@cedarscenter.com

Purple pinkies: Social Mobilization for Hard-to-Reach Populations. Led by Roma Solomon, CORE Group Polio Project

- With more than 1 B people, India has reached a one-year polio free status in 2012. However, with the size it is critical to maintain coverage to prevent reoccurrence.
- Incredible community resistance against polio immunization—people would throw rocks and water at vaccinators and mobilizers because they felt the vaccine would harm their children.
- The social mobilization net (UNICEF and CGPP Mobilizers) helped decrease this resistance by targeting resistant communities, making home visits, holding mother’s meetings, etc. Hard to reach populations!
- Newborns and migrants were sustaining transmission.
- 172 m children are immunized in every NIO but more than 15% are still missed., which is why govt wanted home visits.
- Fatwas issued by Muslim leader, but to overturn, original person has to overturn.
- Both Hindu and Muslim mothers felt they were being targets. They thought vaccine causes impotency.
- In most countries, you can’t just knock on people’s doors and give children a foreign drug, but the communities came around in India.
- To maintain polio-free status, the CGPP India must continue the coverage.
- Future: focus on hard to reach pops, google maps for social mobilization.

mHealth for Community Health: Nuts and Bolts. Led by Ann Hendrix-Jenkins, CORE Group

Key messages

- Don’t be intimidated by the technology aspect. Start with an idea and do formative research, as we do with any other possible intervention or activity. No need to roll out anything technological at this point.
- By working with a technology partner (e.g. MedicMobile, Dimagi, Techchange) you can then sort through technology questions and possibilities.
- Practical tip from MSH project in Malawi: We quickly realized we needed anti-virus software and a local person to provide ongoing IT support after the project ended. Lesson: plan for ongoing maintenance and support.
- Practical tip from Dimagi: Some projects buy a metal engraver to mark project equipment and prevent theft.

Learning that emerged

- NGOs without expertise in mhealth or in-house capacity can methodically envision, design and implement a good quality mhealth intervention.
- Start simple and build capacity. It’s a steep learning curve, but not necessarily steep for long.
- Don’t automate a broken system.

- **Budgeting:** The greatest costs are often associated with staffing and training over time, not the hardware. Because of the costs of getting started/building capacity/training, don't plan for short-term cost savings (however, in the long run, they often emerge).
- **Future:** Even successful efforts run into problems and barriers along the way. Let's have a fail fair to help us avoid repeating mistakes and reinventing the wheel.

Community Health Workers

Tigers in CHWs' Tanks. Led by Fe Garcia, WV.

- An Integrated Care Group model may be more sustainable than the traditional Care Group model but you need to consider all players and costs involved per total coverage.
- CHWs as registration agents could play a key role in collecting vital statistics and registration that could better inform national data needed in the reporting of accurate MDG4 and 5 achievements.
- IRC's tool to assess the quality of individual CHW performance in communities is a simple, user-friendly tool to use in community health programs. The respiratory counting beads used by IRC and SC is a better, more user-friendly tool for semi-literate CHWs requiring only 5 minutes to learn as compared to respiratory timers.
- Given the results of the AIM OR in Zambia it is too early to reach a conclusion about its effectiveness in assessing a CHW program.
- More research needs to look into balancing a comprehensive CHW program vis-à-vis the cost to sustain it.

Materials to Empower CHWs. Led by Sarah Shannon, Hesperian

- There are six principles of curriculum development: 1) know your audience (start with peoples' experience); 2) choose what to include (aim at the most essential); 3) keep language clear (concrete, relevant information that acknowledges context); 4) use active learning (to get discovery); 5) follow design principles (consistent, easy to follow, clean layout, lots of pictures and icons and lots of white space); 6) it's not over when it's over – give people a path for future learning on the topic.
- Hesperian has a new digital commons so you do not need to reinvent the wheel that includes a health wiki, bilingual language hubs, image library, health materials workshop and exchange, mobile apps (such as one on Safe Pregnancy and Birth). The Health Materials Workshop and Exchange allows for customizing Hesperian Guide content and for sharing your customized materials as well. Go to www.hesperian.org
- Hesperian is looking for partnerships, especially in field testing new applications, sharing / integrating new images into the image library, and setting up language hubs.

Adolescents

One Size Doesn't Fit All: Integrating FP into Youth Programs. Led by Victoria Graham, USAID

- Providing youth with FP services and information is sensitive issue—to be framed in broader youth services context.
- Services must be youth friendly.
- Audience was surprised to learn that youth peer educators were also distributing contraceptive methods.
- Gaps: indicators, engaging vulnerable youth, e.g. those with disabilities

Promoting Evidence-Based Health Programs for Very Young Adolescents. Led by Mychelle Farmer, CRS

- VYAs experience significant growth, including pubertal development, learning and adapting to her socio-cultural environment.
- Most adolescent and youth programs are not adapted for VYA.
- Evaluation methods for gathering data from VYA should include a variety of methods, including art (photovoice, drawings), storytelling, games.
- Advocacy for policy change & provider training will improve the quality of care & quality of evaluations
- New learning: New methods to evaluate attitudes and percepts (of gender roles for example) show great promise. The methods and terms need to be refined based upon the cultural context. Some methods are more effective in a specific country or culture.
- How can the adolescent/youth interest group effectively advocate for policy change?
- Challenges of youth participation in program development and implementation.
- Multi-sectoral interventions and evaluation are needed that have the potential to influence BOTH policy change and community norms.

Nutrition

Integrating Nutrition and Family Planning. Led by Holly Blanchard, MCHIP

- Strong evidence supports health and nutrition benefits to infants under five resulting from couples spacing birth to pregnancy intervals to 24+ months.
- Key linkage: LAM including nutrition aspect of breastfeeding and transition to complementary feeding.
- Several logical key opportunities exist for integrating nutrition and FP services and messages.
- Engage actors from both nutrition and RH at the national, regional, district and community levels, including community and facility-based interventions.
- Gap: Getting health workers and community health workers to provide FP proactively at the time of the contact, vs. waiting until the woman has need.
- Future: CORE members are invited to join the MIYCN-FP Technical Working Group which currently has 33 participating organizations.
- Visit the new toolkit on the K4Health website—many resources and tools.

The Success of SHOUHARDO. Led by Faheem Khan, CARE

Key Messages

- SHOUHARDO is a \$126 million Title 2 project in Bangladesh, meaning: Strengthening Household Ability to Respond to Development Opportunities. The project has resulted in an annual stunting reduction of 4.5% per year for 2 million poor people, compared to a national reduction of 1% per year.
- Using a statistical method called “Propensity Score Matching,” researchers found the women’s empowerment led to greater reduction in stunting than any other interventions, especially when combined with MNCH interventions.
- By working with 13 different Ministries in Bangladesh, from national to village level, many of the project gains have been sustained.
- Targeting is key rather than blanket coverage.
- **New Learning:** Once empowered, villages organically developed life saving interventions such as berms that protected cropland from flooding. These berms were then replicated across the country because their success was discussed throughout the ministry systems.
- **Question:** Would this type of integrated approach be possible if there were no Title II programs?
- **Future:** We need to learn more about gender and women’s empowerment as it relates to nutrition outcome.

ProPAN: Promotion of Child Feeding. Led by Joy Del Rosso, Save the Children

- Updated version of tool to allow/guide both qualitative and quantitative formative research to identify YBCN problems, inform implementation plans and develop M&E plans. Major element is formative research/design.
- A software program ProPAN 2.0 will be released in the fall that allows computerized input and analysis of data collected on a large “menu” of methods.
- Tools can be used as package or cafeteria style.
- One of the 12 ideal practices included is interactive feeding.
- WHO/FANTA are developing another software OPTI FOODS to calculate least cost diet for achieving nutritional goals. ProPAN will be compatible with OPTI FOODS.
- Data must be input in computer—ideally a mobile app for androids will be developed.
- Practical exercises for mastering the tool are also useful and may be included.

Future

- Nutrition Working Group will alert CORE Group community when tool is released in updated form and will add link to the NWG webpage.
- Perhaps future training in how to use package?

Maternal/Child Health

Maternal Mental Health. Led by Shannon Senefeld, Catholic Relief Services

- Mental health is not just absence of mental illness but complete state of well-being, including functionality and productivity. It includes both physical and emotional symptoms and should be viewed on a continuum of needs and issues, varying over time and populations. There are distress issues not meeting clinical definitions that include fears, concerns, social pressure, etc, AND clinical disorders.
- There are a variety of risk factors for maternal depression including poverty/economic stress, low social support, domestic violence, also maternal nutrition (anemia). Consequences include impaired parenting, breastfeeding problems, perception of child as being difficult, behavior problems, child depression, poor motor development, undernutrition, and diarrhea. Study in Bangladesh showed negative effect of maternal depression on infant development.
- Also possible link between maternal depression and youth delinquency.
- Fathers are important.
- Interventions show that early diagnosis and treatment can be effective: social support, group therapy, existing health mechanisms (home visits by CHWs), and enhancing maternal-infant interaction. Task shifting is often required but can be a very good thing for maintaining fidelity to an approach.
- New learning: Meta-analysis showed that there would be 23=29% fewer undernourished children without maternal depression.
- Question: Is post partum too late? Should be addressed pre-partum.
- Catch-22: Prevention approaches can work but then eliminate opportunity to show evidence of symptom reduction.
- Resources: Marce Society (marcesociety.com) and Postpartum Support Int'l

Many Actors, One Goal: Tackling Anemia in Mothers and Children – A Mali Case Study. Led by Kathleen Hill, URC/CHS

- Anemia rates in pregnant women and children 6-59 months extremely high in Mali and worse since 2006. USAID HCI Project goal of reducing anemia prevalence, including operations research on impact of the Mali MOH anemia intervention package in one district versus control district.
- Main direct and indirect causes of anemia indentified.
 - Direct Causes: Micronutrient Deficiency:** primarily **iron deficiency**; also vitamin A & zinc (decreased *production* red blood cells) / **Malaria:** hemolytic anemia (*destruction* red blood cells) / **Other parasitic infections:** mainly schistosomiasis & hookworm (*excessive loss* red blood cells)
 - Indirect Causes:** Food insecurity, malnutrition, poverty /Lack of childbirth spacing /Poor sanitation & access to potable water / Weak access to health services / Early childhood feeding practices (e.g., delayed breastfeeding)
- MOH anemia intervention package to address micronutrient deficiency, malaria and parasite infections:
 - **Community- and home-based** antenatal, post-partum and early childhood services (via CHW, TBA & other)
 - Quarterly regional **“Week of Intensive Nutrition Actions”** (SIAN)

- **Antenatal & post-partum consultations** at ambulatory health centers (CSCOM) & district hospitals (CSRef)
- **Well-child and sick-child consultations** in ambulatory health centers & district hospitals

New Learning

1. Baseline assessment in Mali project:
 - 70-75% young children (0-4 yrs) & women slept under LITN previous night
 - Malaria chemoprophylaxis (IPTp) coverage pregnant women: 60%
 - Care seeking w/in 24 hr. onset fever in child: 23%
 - Anti-malarial treatment w/ ACT (standard): 7.8%
 - Immediate BF 1st hour: 46%
 - Exclusive BF until 6 months: 38%
 - Complementary feeding 6-11 mos. (fruits/vegetables/meat):11-12%
2. 85% of women said they take iron supplements and yet anemia rates are still very high.
3. Operations research within a project design will allow actual implementation practices be compared to best practices and to possibly identify missed opportunities or barriers.

Questions

1. Despite an MOH anemia intervention package in Mali, anemia rates are still very high. Why?
2. Where ANC visits are happening, nutrition counseling rates are low, as is implementation of integrated package.
3. Anemia specific policies are still lacking, especially around integrated approaches.
4. Missed opportunities: diagnosis not only for anemia specifically, but also possible contributed causes.

Malaria in Pregnancy: Strengthening Health Systems to Improve Outcomes for MIP. Led by Aimee Dickerson, Jhpiego

Key Messages

- Malaria poses a major health risk to pregnant women and their unborn babies in endemic areas:
 - 1) For women – increased anemia and greater threats of post-partum hemorrhage, pre-eclampsia, and mortality and 2) For the child – fetal growth retardation, miscarriage, still birth, low birth weight, perinatal/infant mortality.
- Nine core components of MIP programming: health policy/guidelines; integration/coordination; human resource capacity; procurement/commodities; community involvement; quality assurance; governance; adequate financing; and monitoring and evaluation.
- Collaboration is essential between national malaria control programs, which provide technical oversight for MIP, and safe motherhood/reproductive health divisions, which implement MIP through antenatal care, to ensure effective integration of programs and coordinated implementation.
- Link health facilities with communities to raise awareness and early ANC attendance and use of IPTp and ITNs.

- Strong M&E system critical: Program outputs and health outcomes met? Communities involved? If not, how to correct?

New Learning

- A husband/male partner is highly influential and one of the very first people to notice a woman is pregnant. Strategy include him to encourage her to attend ANC early for optimal malaria prevention.
- Can be done in post-conflict, fragile state like South Sudan by integrating with existing high-impact services (i.e. antenatal care) through strengthened health systems. Sudan Health Transformation Project Second Phase malaria interventions: 1) strengthening ANC services; 2) training providers in case management and delivery of ANC; 3) integrating malaria prevention activities into ANC visits; 4) outreach through village health committee members and health education to create demand for the services and 5) ensuring constant supply of essential medicines and commodities.
- Two impact indicators: 1) percentage of low-birth weight singleton live births (<2500 g), by parity and 2) percentage of screened pregnant women with severe anemia (hemoglobin 7 g/d) in third trimester
- WHO recommends 1) Insecticide treated nets (ITNs) to prevent infection; 2) Intermittent preventive treatment (IPTp) to prevent asymptomatic infections among pregnant women living in areas of moderate or high transmission of *P. falciparum*; and 3) Effective case management for malaria illness and anemia. As part of comprehensive focused antenatal care (FANC). Much investment in malaria has been vertical when many of the solutions need to be integrated and available at the community level.
- Stockouts of sulfadoxine-pyrimethamine (SP), used for prevention of MIP, are pervasive and misuse of SP for treatment is a problem. The supply chain management of SP and long lasting insecticide-treated nets (LLINs) must be prioritized to provide a regular supply at antenatal care vs. intensified campaigns only.
- Post-conflict fragile states challenges: service quality, dormant community outreach, data quality issues, and stakeholder synchronicity.

Future: Highlight best practices and lessons learned in MIP for program learning – what some countries are doing successfully and how are they doing it.

The biggest value of CORE Group meetings is the connection back to implementation. There's not the old touchy-feely, pie in the sky, cloud theory stuff that makes me say "Bring it back to reality!" CORE Group meetings are really focused on how we can put this into action. It's one of many things that I value about these meetings.

--Christy Gavitt, American Red Cross

Non Communicable Diseases

New Frontiers in NCDs. Led by Charlotte Block, Project HOPE

- Chronic NCDs are conditions over extended period of time, not transmitted person-to-person.
- WHO top 4: cardiovascular disease, diabetes mellitus, cancer, and chronic respiratory diseases.

- Causal links: Social determinants—tobacco, alcohol, inactivity, nutrition.
- Growing burden in LIC and MIC, which have a higher NCD death rate and are losing people to NCDs at younger ages (<60 = premature death). Risk factors increasing.
- Integration with existing platforms is good beginning. PSI examples: Screening for gestational diabetes via RH program. Cervical cancer screening during IUD insertion. Other possible synergies: tobacco or diabetes + TB, tobacco + RH, cervical cancer + RH, HIV.
- Project HOPE using variety of indicators to measure NCDs depending on type of pgm: clinical labs—diabetes, self-reporting—healthy habits, tests—knowledge/awareness, anthropometrics.
- Gaps: How to fund, defining global targets, no global agreed upon solutions.
- Future: engage with NCD alliance.

Concurrent Session: New Frontiers in NCDs: Integration, Indicators and Evaluation

Key points of the presentations:

1. Integrated services are the ideal for NCDs.
2. 80% of deaths due to NCDs occur in LMIC countries. Partly due to delayed diagnosis and treatment.
3. WHO has designated some targets for priority NCDs, hoping for a whole of society response.
4. M&E critical.
5. RH integration points: diabetes and pregnancy, female cancer screening/education.
6. Measuring indicators will enhance understanding of precursors in LMIC.

Questions

1. Given the challenges of treating NCDs in US-based facilities, how will treatment of NCDs be addressed in LMIC?
2. What lessons learned from HIV care and treatment programs apply?
3. Screening for NCDs is critical, in order to determine the magnitude of the problem.
4. Protocols can be developed for cost-effective approaches for early intervention of NCDs. Universal health care and expanded access to medication will be part of the solution.
5. How should health systems transition to address both acute and chronic diseases?
6. No Global Fund for NCDs...so existing platforms will be used. WHO will be primarily responsible for NCDs, but the World Health Assembly (WHA) will also address them. The UN member states must endorse the plan to address NCDs.
7. NCD Alliance is an important repository of information, and advocate for prevention and early intervention of NCDs. Also linked to civil society, to promote information sharing. WHO designated ten targets originally, but they were recently reduced to five targets. WHA is focusing on the indicators.
8. Some MICs (Mexico, Thailand) are providing some funding through the MoH for integrated NCD management. Countries that accept health as a human right are willing to provide funding for services through national health budget. Also is a Pink Ribbon Red Ribbon campaign.

NCD Roundtable Discussion: Future directions of NCD Interest Group...

- Sharing/developing programmatic tools at the community level and training tools at the primary care level in the areas of prevention, diagnosis, treatment and management.
- Develop a manual or guide for community-based management of NCDs (in cooperation with Hesperian – Where there is No Doctor)
- Map what other NCD related entities are doing in order to prevent overlap and add value.
- Have one focus on youth, specifically adolescents and young adults, to develop NCD indicators that are age appropriate.
- Provide case studies, stories from the field, to serve as the “human connection” to larger policy-related entities.
- Engage in activities consistent with the priorities of CORE Group, specifically community-based care and health care management in basic care settings.

Other points of discussion:

- Injuries are of interest, but not consensus on including injuries in the next phase of activities. This is a broad category, and the group felt attention to injuries might dilute efforts in other areas.
- USAID is using the acronym NCD-I, but there has been little information to indicate how injuries will be addressed.
- There is an interest in improving self-care skills, to improve patient management when access to care is limited.
- Support was voiced for a collaborative, integrated approach across agencies, so that organizations share information about successful approaches to NCDs.
- Concern was raised about the future of related NCD interest groups, such as the Global Health Council’s NCD Roundtable. There will be future updates about this issue.

Next Steps for this Interest Group: Interest in NCDs is great and growing from a variety of stakeholders and areas

- We need to map what other groups (NCD Child, NCD Alliance, and future form of the GHC roundtable) are doing to both avoid duplicating efforts and identify where we can add value.
- Focus on NCDs as they pertain to community-based health - which aligns with the CORE Group focus.
- While there are a multitude of conditions that fall under the NCD heading, it is best to not divert too far from the four major conditions (CVD, DM, Cancer, Resp)
- There are two primary considerations for our group's objs/activities:
 - Internal: knowledge sharing, tool development, working with Hesperian to create a chapter or separate publication along the lines of Where there is No Doctor
 - External: Connecting with policy stakeholders as a source for data, case studies, success stories - both of community health providers and beneficiaries.