Background

Community level actors can play a critical role in reaching the 90-90-90 goals for people living with HIV by applying quality improvement methods to increase access and uptake of services, create strong linkages with care, spread health promotion messages, and reduce barriers and stigma related to testing and seeking treatment. Smaller groups of community actors can assist with patient self-management, treatment support, addressing barriers to care such as food insecurity, and tracing of patients lost to follow-up. Much of a patient’s care takes place at the household and community level, so strong linkages and communication between community members and health care workers can improve health outcomes over what a facility alone can accomplish. Programs have traditionally focused their efforts on working through community health workers (CHWs) without working directly with community-based structures (groups) made up of individuals from the communities being served. Worldwide, CHWs are overwhelmed with the numbers of households they are trying to serve. It is physically impossible for each CHW to reach as many as 200 or more households they are expected to cover, even when provided with effective motivational incentives. CHWs cannot be expected to work alone and instead must work within the networks and structures that exist in the community and develop linkages with established groups in order to increase their reach. These networks and structures work in conjunction to create a Community Health System, though this system’s level of functionality varies widely between settings.

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project is working with local groups and partners to apply quality improvement methods within the Community Health System, in order to strengthen the impact of CHWs and other service providers at the community level, while at the same time increasing sustainability of programmatic impacts. This work builds on the work of the USAID Health Care Improvement Project.

Community Health System Strengthening Model

Communities in low-resource settings possess their own informal indigenous community support and social welfare systems where community members make decisions and...
work together to improve the health of community members and the general welfare of the community. This system may consist of existing community groups, such as a village government, schools, religious groups, agricultural groups, ‘savings and credit’ groups, etc.

In the Community Health System Strengthening model, the improvement intervention is managed by representatives from each community group, representatives from the facilities, and delegates from the local government, who all come together to serve as the community improvement team for the purposes of identifying local health gaps and developing and testing strategies to overcome those gaps.

The community improvement team applies improvement principles to strengthen the performance of the community health system by identifying and strengthening the processes by which participating groups and structures function and interact with each other to provide integrated, seamless care. When all elements of the community health system are harmonized and functioning well and coordinated with the efforts of CHWs, health services become more accessible to community members, and accurate information exchange between health facilities and households occurs more rapidly and effectively. Families and community members are empowered in this process to share their needs and concerns with the community groups, to be shared at higher levels (including CHWs and health facilities), thereby increasing the responsiveness of services provided for the community. The burden of work is spread between all of the members of the community, as they all participate in helping to identify cases, encourage care seeking and in some cases, follow-up on those who have received care. Furthermore, by engaging and strengthening the Community Health System, programmatic efforts and impacts are made more sustainable, as they are owned by community members and supported through traditionally established community structures.

Engaging Community Groups in a Community Health System to Improve Care

In order to create a functioning community health system, there are several general steps that take place. These are adapted for local contexts and settings.

1. Orient leaders and train coaches: Leaders at the national, district, local and community level are oriented to the Community Health System Strengthening model.
and to improvement. Coaches are chosen to support community-level activities from facility and district staff who have some kind of supervisory or oversight responsibility for CHW or community health activities. They are trained on how to support community groups in forming a functional community health system and in improving the care they provide.

2. **Map active and functional groups in the community:**
The coaches together with community leaders map exiting community groups, both formal and informal, which are functioning and meeting on a regular basis. This might include school, leadership, religious, savings and loans, agriculture or women’s groups among others. These groups are invited to participate by sending a representative to a community-wide meeting once per month, discussing specific health topics in their group meetings, and participating in activities such as data collection, case identification, health promotion, referral to facilities, and follow-up.

3. **Form a team at the community level:** Once community groups have agreed to participate, a team or committee at the community-level is set up including all of the community group representatives (typically 1-2 members), representatives of local government, CHWs and health facility staff. In many communities, a committee tasked with health issues already exists and can be used as the base for improving care, adding new members to represent all groups. The community team is tasked with several aims for improving care, such as reducing loss to follow up for HIV patients or increasing antenatal care coverage.

4. **Develop a data collection and feedback system:**
Knowing how a system is performing is critical to improving it. Without data, teams will not know if they are making improvements or not. Measures will be developed based on the improvement aim. Coaches work with the community team and health care workers to determine how to collect and aggregate data. For example, in identifying pregnant women, each community group would be responsible for keeping a list of who was identified as pregnant. This would be shared at the monthly meeting with the health care workers, who report back to the community team on the percent of identified women who received ANC care or not. This information allows teams to know how they are performing and where they need to test changes.

5. **Set up ongoing communication between community groups, community team and facility:** The community team members serve as a constant liaison between the facility health care workers and CHWs and community groups. Health care workers can pass on key health messages through the community health team members for the community groups to share with their members. Community groups pass information up the system to health care workers including barriers to care, specific case identification or follow-up results through their community team representatives. In turn, the health workers will give provide information back down through the team to groups on how the health system is working. This may include aggregated information on performance (such as the overall percent retention in HIV care as a very confidential issue) or on specific cases in need of follow-up support (such as pregnant women who did not attend ANC).

6. **Test changes to strengthen and improve the system:** The first step is to develop a process for information exchange and two-way communication and then the community team can design processes, where none exist, to support the health of community members. Through the data collected in the community and in the facility, the community teams can identify gaps in care for which community groups can play a role in improving care. The community team will then need to take action to improve using a plan-do-study-act cycle. The team will develop solutions or “changes” that may work to help improve the community process. An example of a change would be to visit the mother-in-laws of pregnant women who did not attend antenatal care to see if they can...
influence the care seeking decision. The team will plan a test of one change at a time and then carry out or do the test on a small scale first to determine if it is effective before rolling it out across the community. They then study the results of the change. They act based on what they have found: if the results are positive they will keep this change and implement it for the whole community; if the results are mixed, they may adapt the change and test it again; and if the results show this change doesn’t work, they will drop it and test something else.

7. **Share learning with other teams:** If possible, every few months community team representatives from different communities should be brought together to discuss how each community used its information to track the progress of improvement, share best practices learned during implementation, and develop action plans to address emerging issues and spread effective changes.

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### USAID ASSIST Applications of the Community Health Systems Strengthening Model

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<th>COUNTRY</th>
<th>APPLICATION</th>
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<tr>
<td>Botswana</td>
<td>HIV testing, care and retention</td>
<td>Goal to improve linkages and referrals to care, and increase retention</td>
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<tr>
<td>Burundi</td>
<td>Prevention of mother-to-child transmission</td>
<td>Increased the number of pregnant women accessing antenatal care before 14 weeks of pregnancy; increased the percent of women tested for HIV; increased the number of exposed infants tested for HIV at 18 months</td>
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<tr>
<td>Mali</td>
<td>Maternal and newborn health</td>
<td>Increased the number of pregnant women identified and enrolled in antenatal care in the first three months; increased uptake of elements of birth preparedness; Increased number of women receiving home visits during pregnancy</td>
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<tr>
<td>Mozambique</td>
<td>Partnership for HIV-Free Survival (prevention of mother-to-child transmission)</td>
<td>Increased number of pregnant women identified and the percent enrolled in antenatal care; shifted timing first ANC visit from late second and third trimester to early second trimester</td>
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<tr>
<td>Tanzania</td>
<td>HIV care and retention</td>
<td>Increased the number of people tested for HIV; improved follow-up and referral of PLHIV between the community and the health facility; decreased loss to follow-up of PLHIV</td>
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<tr>
<td>Uganda</td>
<td>HIV Continuum of Response</td>
<td>Increased percent of HIV patients on ART linked to community services; Increased percent of HIV patients on ART followed up for appointment reminders in the community; increased percent of HIV patients on ART in the targeted villages keeping HIV appointments; increased percent of HIV patients on ART keeping HIV appointments at health facilities overall</td>
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Photo credit: Ram Shresta

Community savings and loan group holds their regular meeting and discusses health issues in Muheza, Tanzania.