Community Platforms for Public Health Interventions

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INTRODUCTION

Community health platforms are the partnerships formed to assess and ensure public health. They provide the context in which outside interventions should be implemented and sustained, and they offer a way to develop and maintain community-centered solutions. Although local boards of health and health departments are the official bodies with the mandate to sustain strong community health platforms, they do not always achieve their full potential (Bellagio District Public Health Workshop Participants 2016). In the absence of an effective government presence, nongovernmental organizations (NGOs) can build community health platforms.

Well-functioning community health platforms can serve as vehicles for health information and advocacy and can convene local resources to support successful public health interventions. Well-designed and well-implemented community health platforms can function as the engine in the public health cycle of convening communities to monitor, review, and act (figure 14.1). These are functional tasks that are best conducted in a partnership among public health professionals, politicians, and community members. Effective partnerships among these parties ensure that health data are collected to answer questions posed by the community, that local health data are shared with the community to guide actions, and that actions marshal all of a community's human and capital resources as well as public revenue.

Then the cycle repeats. A community that has the ability to engage successfully in the cycle shown in figure 14.1 has a platform that can support all types of community health initiatives.

The provision of legal authority for community health platforms can be traced to England's first health law, the Public Health Act of 1848, which gave cities the option to create local health boards (Rosen 1958; Szreter 1988). In the mid-nineteenth century, functional health departments were established throughout Canada, Europe, and the United States before the development of effective medical care and drove the dramatic decline in mortality in the twentieth century (McKeown, Record, and Turner 1975). However, western governments had largely omitted the creation of functioning local health departments when they formed colonies in the Americas, Africa, and Asia; countries that gained independence in the mid-1900s faced an urgent need to catch up. By the late 20th century, the growing recognition that public health and primary care were lagging became the topic of international concern. In 1978, an International Conference on Primary Health Care in Alma-Ata, USSR, attended by nearly all member nations of the World Health Organization and the United Nations Children's Fund, demonstrated the degree of concern about access to primary health care (Lawn and others 2008). It resulted in the Declaration of Alma-Ata.

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Figure 14.1 Public Health Cycle: Monitor, Review, and Act

Act

Monitor population health

Community + Multisector stakeholders

Review data, prioritize actions

Chapter Overview

The Declaration of Alma-Ata asserted that health is a fundamental human right and that community consultation and participation in health care are essential elements of successful programs (Lawn and others 2008; Rohde and others 2008). Following the declaration, global health indicators improved despite inadequate adherence to the principles laid out in the declaration. The recent transition from the Millennium Development Goals to the Sustainable Development Goals of the United Nations has renewed attention to strategies that build on local capacity to strengthen community health platforms (Open Working Group of the General Assembly 2014).

This chapter presents a brief review of how the public health cycle supports the sustained success of any of the interventions discussed in the *Disease Control Priorities* volumes. It offers a typology of the stages of development of community health platforms, as well as a framework for assessing their success. We illustrate four stages of development of community health platforms with four case studies that range from a most developed case in Indonesia to a primitive case of near-paralysis of the state's efforts in public health. The chapter closes with a discussion of investment opportunities for policy makers who are interested in strengthening community health platforms.

Background and Historical Context

The lack of a clear roadmap to implement community involvement, combined with changes in the global economy, slowed the progress of low- and middle-income countries in achieving the primary health care goals set by Alma-Ata (Lawn and others 2008; Rohde and others 2008). The Cold War fostered a culture of development planning that emphasized interventions that were rapidly deployed and easily measured. Health commodities, such as vaccines, oral rehydration solutions, micronutrients, contraceptives, and antibiotics, became the focus of health care systems (Lawn and others 2008; Perry 2013). The emphasis of global health donors on results and short project cycles made the focus on commodities rather than systems more expedient.

The urgency of saving lives in the moment and the truth that the commodities really did save lives perpetuated a stronger emphasis on delivery of medical services and health care goods and a lighter emphasis on communities' development of Alma-Ata—style platforms. The term *vertical* was used to define projects focused on getting a selected health commodity or service to households in the most expedient way, typically using a stand-alone organization of staff, vehicles, and capital. The term *horizontal* was used to define initiatives to build more comprehensive institutions of primary care services and for population-level public health. A short-term focus on vertical programs delivering good health at low cost crowded out attention to building long-term horizontal platforms. The *World Development Report 1993: Investing in Health* (World Bank 1993) offered an excellent listing of population-level public health interventions that could be implemented, but it neglected any discussion of how to make them happen, other than by raising money. This report was novel in that it demonstrated for the first time that international health investments could be justified on the basis of having measureable outcomes and effects.

Volume 1 of the first edition of *Disease Control Priorities in Developing Countries* (*DCP1*) also offered a comprehensive list of public health policies, with recommendations for developing and financing state capacity in data collection and data analysis (Mosley, Bobadilla, and Jamison 1993). The authors shared aspirations for better policy environments that would be conducive to structural approaches to public health. Volume 2 of the second edition of *Disease Control Priorities in Developing Countries (DCP2)* explicitly recognized the need for community-driven global health efforts to strengthen health systems and infrastructure and suggested the need to strengthen platforms that would allow communities to hold health systems accountable for improved quality and access to services (Mills, Rasheed, and Tollman 2006). *DCP2* also emphasized that a lack of intersectoral action through cross-sector partnerships and the failure of health systems to address community-level barriers to accessing the health system were key constraints for health system strengthening (Mills, Rasheed, and Tollman 2006).

However, *DCP1, DCP2,* and the *World Development Report 1993* did not offer specific recommendations about how to create conducive policy environments that could enable and sustain public health interventions, cross-sectoral partnerships, and community engagement with local health departments (Macinko, Starfield, and Erinosho 2009; Mosley, Bobadilla, and Jamison 1993; Rohde and others 2008).

The lack of a roadmap for creating community health platforms and cross-sectoral action made room for vertical programming to dominate the policy landscape (Lawn and others 2008; Macinko, Starfield, and Erinosho 2009; Rohde and others 2008). These vertical programs saved lives, but they left populations vulnerable by failing to create resilient systems in situ that would marshal local political will and local resources to address the root causes of poor population health.

Actions that improve public health are often met with resistance about who will pay for them, because results are often less tangible and urgent than medical interventions. Further, public health actions often threaten the livelihoods of industries and occupations whose harmful aspects are regulated. Resistance is to be expected. Examples of public health actions range from the need to pay for sewers and waterworks to the need to enact and enforce restrictions on tobacco, food labeling, and road safety. Solving these problems is fundamental to public health. Solutions are often political, and vertical approaches are only partial responses.

The inability to sustain a local consensus and to mobilize community buy-in regarding the health risks leads to difficulty in imposing the measures needed to control health threats. Poorly performing public health departments are part of the reason that HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) and the Ebola virus arose and overwhelmed many health systems.

Essential Public Health Functions

To improve public health functioning, between 1989 and 1994, groups at the Centers for Disease Control and Prevention and the U.S. Public Health Service developed a list of 10 essential public health functions to benchmark the quality of practice in public health agencies (Dyal 1995). The consensus was that country health ministries and regional offices needed to define national-level lists of functions and items deemed essential and that the lists should be country specific (Bettcher, Sapirie, and Goon 1998). Countries and regions have adapted their own priority lists of essential public health functions on the basis of local stakeholder input

(Bishai and others 2016). For example, the Pan American Health Organization's (PAHO) list of Essential Public Health Functions (EPHFs) is as follows (PAHO 2001):

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.
11. Engage in disaster preparedness to reduce the impact of emergencies and disasters on health.

PAHO's 11 items fall into the same basic cycle of monitor, review, and act shown in figure 14.1. EPHFs 1 and 2 are for monitoring; EPHFs 3–5 are for reviewing, typically through participatory multistakeholder community engagement; and EPHFs 6–11 are for acting. The best community health platforms successfully make their populations healthy by understanding what constitutes health threats and by sharing this information with community members from multiple sectors. Community health platforms mobilize parts of a coherent solution using the strengths and resources present in the community.

Health Care and Health Facilities

The care of the sick and the delivery of health commodities are integral parts of public health practice and are parts of the work plan of community health platforms. Community health workers can play multiple roles in generating health data (PAHO 2001, EPHFs 1–2), informing and mobilizing communities (PAHO 2001, EPHFs 3–5), and helping to provide primary care services (PAHO 2001, EPHFs 7–9). Many of the interventions discussed in Volume 4 of the third edition of *Disease Control Priorities* (*DCP3*) rely on facilities and community health workers (Patel and others 2015). When community health platforms fulfill their

mandate to provide essential public health functions like those mentioned earlier, interventions based in facilities and involving community health workers become integrated and sustained by local support and action.

MEASURING SUCCESS IN COMMUNITY HEALTH PLATFORMS

The literature shows that community health platforms that enable participation and engagement lead to improved health outcomes (Edmunds and Albritton 2015; George and others 2015; Kenny and others 2013; McCoy, Hall, and Ridge 2012; O'Mara-Eves and others 2015; Rifkin 1996, 2014). Measuring health outcomes associated with community participation can be difficult, but community participation in public health generally leads to improvements in health knowledge, service quality, and health-related outcomes (Kenny and others 2013; Russell and others 2008).

The degree to which a community health platform is high functioning lies along a continuum. At one end is development that extends from mere delivery of services. At the other end is facilitation of an active community through an engagement platform whereby communities are informed and enabled to take shared responsibility for addressing their changing health risks and concerns (Beracochea 2015; Cyril and others 2015; Dooris and Heritage 2013; Draper, Hewitt, and Rifkin 2010; George and others 2015; McCoy, Hall, and Ridge 2012; Raeburn and others 2006; Rosato and others 2008; Russell and others 2008).

The breadth of the literature on community health platforms demonstrates the range of ways that the concept can be applied. Types of platforms described in published and gray literature generally fall into the following categories:

- Health committees
- Community health worker interventions
- Community-based participatory research and health scorecards
- NGOs or academic community partnerships for specific community interventions (Beracochea 2015; Draper, Hewitt, and Rifkin 2010; George and others 2015; Kenny and others 2013; Marmot and others 2008; Meier, Pardue, and London 2012; Rifkin 1996; Tiwari, Lommerse, and Smith 2014; UK Aid and DFID/HDRC 2011).

The literature also covers concepts of community engagement, participation, and mobilization as they relate to multiple types of community platforms (Cyril and others 2015; Draper, Hewitt, and Rifkin 2010; Frumence and others 2014; Meier, Pardue, and London 2012; Rifkin 1996, 2014; Rosato and others 2008; Russell and others 2008; UK Aid and DFID/HDRC 2011).

The likelihood that community engagement will result in improved health outcomes depends on many factors. Cyril and others (2015) identified the following components of success: engaging in real power sharing, building collaborative partnerships, providing bidirectional learning, incorporating the voice and agency of beneficiary communities in research protocol, and using multicultural health care workers for intervention delivery. Draper, Hewitt, and Rifkin (2010) suggested a continuum of process measures for use in evaluating community participation in a health system context (table 14.1).

Table 14.1 Example of Process Indicators for Participation

Indicators of participation	Continuum of community participation		
	Values for mobilization	**Values for collaboration**	**Values for empowering**
Leadership: Professionals introducing interventions, or by community of intended beneficiaries	Health professionals assume leadership. Local leadership does not necessarily try to widen the decision-making base in the community.	Collaborative decision making occurs between health professionals and community leaders. Local leadership tries to present the interests of different groups.	Program is led by community members who are selected through a representative process. Health professionals give leadership training, if necessary.
Planning and management: The way partnerships between leadership and the community are forged	Health professionals tell the community how it may participate. They decide the program's focus, goals, and activities and provide the necessary resources.	Health professionals initiate collaboration. Communities are invited to participate within a predetermined remit. Activities reflect community priorities and involve local people and existing community organizations.	Partnerships between communities and health professionals are created and institutionalized. Professionals facilitate, and the community defines priorities and manages the program. Local people learn skills they need for management and evaluation.

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Table 14.1 Example of Process Indicators for Participation (continued)

Indicators of participation	Continuum of community participation		
	Values for mobilization	**Values for collaboration**	**Values for empowering**
Women's involvement	The inclusion of women is not specifically sought outside their traditional roles.	Women actively participate in some aspects of the program, but they have minor decision-making roles.	The active participation of women in positions of decision making and responsibility is a program objective.
External support for program development: In terms of finance and program design	Funding comes from outside the community and is controlled by health professionals. Program components are designed by health professionals.	The majority of funding comes from outside the community, but local people are asked to contribute time, money, and materials. Health professionals allocate resources, although they may consult community members. The program is designed by health professionals in discussion with community representatives. Each role in the program, including those for women and minority groups, is negotiated.	Community members work to find ways of mobilizing resources, including through external funding and their own resources (for example, microfinancing). The program is designed by community members with technical advice from health professionals on request. The design is flexible and incorporates wide community participation, including that of women and minority groups.
Monitoring and evaluation: The way intended beneficiaries are involved in these activities	Health professionals design monitoring and evaluation protocols, choose outcomes, and analyze data in ways to suit their information needs. The approach is mainly one of hypothesis testing and statistical analyses of health-related outcomes. Communities might not be made aware of the findings.	Health professionals design mixed method monitoring and evaluation protocols and perform analyses, but community members are involved in data collection. A broad definition of "success" is used. Responses to monitoring findings are jointly decided, and community feedback is both sought and given.	Communities do a participatory evaluation that produces locally meaningful findings. A variety of data collection methods is used, and the community chooses the indicators for success. Health professionals assist at the request of the community. Communities are actively involved in participatory monitoring and decide how to respond to monitoring findings. Communities contribute to wider external evaluations.
Score given	1–2	3–4	5

Source: Draper, Hewitt, and Rifkin 2010.
Note: Scores range from a low of 1 (lowest level of community participation) to 5 (highest level of community participation).

Figure 14.2 From Passive to Active Community Participation

Increasing empowerment		
Information-sharing consultation	Collaboration	Full responsibility

Source: Rosato and others 2008.

Figure 14.2 summarizes a process of increasing empowerment in the development of community participation.

INTERVENTIONS, POLICIES, AND EFFECTIVENESS

Community Health Platform Case Studies

We describe the continuum of developmental stages that low- and middle-income countries move through in their health systems as they improve in their ability to empower communities to take on health challenges. Using themes that emerged from the literature, we identified broad domains of function in the development of community health platforms:

- **Level of community engagement:** To what extent was the community empowered to engage with the health care system?
- **Health-system context and role of the government:** Was the health system decentralized? Did local health departments have power to innovate and to work with communities? Was the government a support or a hindrance to community health platforms?
- **Breadth of intersectoral partnerships:** Was the community able to work with NGOs, community-based

organizations, local governments, and other sectors in addition to the health sector? Did this ability predict the comprehensiveness of improvements? Was the community able to influence action across sectors?

- **Sustainability:** Was the community health platform's ability to be both scalable and sustainable a key factor in its success and longevity? This category includes the financing strategies and the ability to create lasting change while reducing inefficiencies across the system. Is the community health platform legally recognized?
- **Leadership and platform structure that promotes integration across all partners:** Who initiated the community's involvement with the health system? Did the platform create opportunities for shared vision, shared leadership and decision making, and shared financing across sectors?

Identifying Case Studies Demonstrating Community Health Platform Development

Among the countries with recent rapid reductions in mortality under age 5 years, Indonesia and Peru offer informative examples of community health platforms that have been sustainable and high achieving (Altobelli 2008; Blas, Sommerfeld, and Kurup 2011; Kowitt and others 2015; Rasanathan and others 2012; Siswanto 2009; Tanvatanakul and others 2007; Tiwari, Lommerse, and Smith 2014; Westphal and others 2011). Table 14.2 shows a staged typology of community health platforms as countries move from low-functioning platforms with little accountability (level 1) to high-functioning platforms that promote intersectoral action (level 4).

Factors That Support Successful Community Health Platforms

Supportive factors that emerged from the case study review and that contribute to sustainability include government participation, advocacy, cross-sectoral partnerships, and community-owned vetting mechanisms.

Successful community health platforms were developed to fit in the political and cultural context of the local area they served, but they were strengthened by advocacy from NGOs or universities, which also

Table 14.2 Continuum of Functioning, from High to Low, across Functional Domains of Community Health Platforms

Features	Level 1-> Poor functioning, not accountable	Level 2-> Contractor and donor driven, uncoordinated across sectors	Level 3-> Sectorwide partnerships, working to address burden of disease, but unsuccessful in improving health outcomes	Level 4 Frontier of intersectoral collaboration where all sectors and community are involved in creating health aspects in all policies, intersectoral action, existence of a global budget, and successful health outcomes
Community engagement	No platform exists for community engagement or priority setting.	Limited community engagement is through select organizations or contractors working with community for specific purposes.	Community is engaged and able to voice needs to government and other sectors.	Community works closely with government sectors, NGOs, and other community organizations to ensure needs are met.
Role of government	Government is centralized. Health system is fragmented and lacks resources to support intersectoral action for health. No accountability exists.	Contractors and donors guide government decisions. Government does not work to integrate sectors or address community needs.	Government participates in cross-sectoral partnerships.	Government is decentralized, focuses on partnerships with community and other sectors, has high accountability and transparency, has sufficient funding to support the public health and medical system, has legislation that enables public health and community integration, and uses global budgeting.
Partnerships across community	No substantial partnerships exist across sectors.	Partnerships exist between sectors, but they are limited to a few partners working together at a time, not sectorwide.	Multiple partnerships exist across sectors; integrating entity brings together government sectors, community, NGOs, and others.	Action across sectors is fully realized.

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Table 14.2 Continuum of Functioning, from High to Low, across Functional Domains of Community Health Platforms (continued)

Features	Level 1-> Poor functioning, not accountable	Level 2-> Contractor and donor driven, uncoordinated across sectors	Level 3-> Sectorwide partnerships, working to address burden of disease, but unsuccessful in improving health outcomes	Level 4 Frontier of intersectoral collaboration where all sectors and community are involved in creating health aspects in all policies, intersectoral action, existence of a global budget, and successful health outcomes
Sustainability	Spending is wasteful, and duplication of efforts occurs; platform is not sustainable without continuous donor funding.	Sustainability is low, and platform is reliant on outside assistance to maintain health system.	Sustainability is moderate: intersectoral action improves efficiency and reduces duplication of efforts. However, continued reliance on outside funding remains necessary	Partnerships across sectors are used to fill gaps in funding across government. Improved social determinants result in improved health and less medical spending, with minimal reliance on outside funding sources.
Health outcomes	Health MDGs are not met.	Few MDGs are met.	Improvements are achieved in reaching MDGs, but substantial improvements are still needed.	Majority of MDGs are met, and social determinants are being addressed.
Type of integrator	There is no integrator.	Contractor or NGO integrates with one or two other sectors at a time.	Government or community board integrates with multiple sectors.	Government brings together all sectors in partnership to improve health.

Source: Authors.
Note: MDGs = Millennium Development Goals; NGOs = nongovernmental organizations.

provided technical support for emerging platforms. Support from the government was essential for longer-term sustainability, but strong internal and external advocates from nongovernment sectors helped communities engage with governments and health systems, which led to more formal structures.

Successful community health platforms relied on coordination across sectors to meet health goals, which resulted in reduced duplication of efforts and more efficient use of government funding. Successful platforms also provided a mechanism to vet new projects or accept funding from external donors or NGOs based on the priorities of communities. The ability of platforms to set their own health agenda further reduced duplication of efforts and empowered communities to establish control over their own health priorities.

Case Study: Gerbangmas Movement as a Community Health Platform, Lumajang District, Indonesia, Level 4

Among lower-middle-income countries, Indonesia has achieved the highest reduction in the rate of mortality under age 5 years in recent decades (Rohde and others 2008; Siswanto 2009). One component in this success was a network of community health posts (*posyandus*)

that involved communities in primary health care. In the 1980s and 1990s, these posts offered limited services, and quality and performance varied (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009). After Indonesia decentralized in 2001, district governments were empowered to run district-level health systems.

The experience of Lumajang district in East Java is notable as an example of a health-in-all-policies approach driven by public health and community participation, as well as for its ability to adapt and sustain itself despite political and environmental changes over time. The district health office originally created enriched health posts with three key functions: community education, community empowerment, and community services. The enriched health post hosted activities such as clinical maternal and child health, family planning, nutrition, immunization, diarrhea control, under-five growth stimulation, and early childhood education. Other sectors outside of health care, such as education, became involved (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009).

Starting in 2005, with encouragement from the governor, the district health office led subsequent efforts to create the Gerbangmas movement, a platform for communities, the public health sector, and other government sectors to work collaboratively

to achieve 21 indicators of concern (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009). The more specific objectives were to achieve 14 indicators for human development, 1 indicator for the economy, and 6 indicators for the household environment that together represented the priorities of the government and the community, as well as the religious, education, industry and trade, health, family planning, agriculture, and public works sectors (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009). The sectors worked together with support from the district governor, leadership from a local NGO to address family welfare issues, and a funding stream that allowed all sectors to contribute to progress on the chosen indicators.

This movement for community development resulted in improvements in all indicators (Marmot and others 2008). The multisectoral Gerbangmas movement was sustainable and successful, even in the context of a changing economic and government landscape. Although the Gerbangmas movement has experienced numerous changes over time, its central tenants of building a community health platform to lead cross-sector partnerships has remained relevant in Indonesia for the past 15 years. Lessons learned from this case study illustrate important roles for local government, cross-sector partnerships, and leadership.

Heath Systems and Role of Local Government

The development of the Gerbangmas movement stemmed from decentralization of the Indonesian health system, allowing peripheral innovation. The local government offered support and leadership for the initiative, as well as a mechanism for funding. Once the movement was planned and funded, the district health office created a single vehicle through which the communities, the health system, and other sectors could collaborate around common goals without competing for volunteers or resources. The district health office did not dominate the partnership; it included itself as a stakeholder, with leadership provided by a neutral entity.

Partnerships across Sectors

The partnership structure provided clear roles for each sector to develop programs to help achieve the shared indicators. The district PKK (a family welfare semi-governmental NGO consisting of spouses of government officials and community members) helped coordinate and support the partnership across organizations. The funding structure created a common pool of funds from which communities were able to draw for investment in interventions in multiple sectors. Some sectors also contributed funds to achieve action plans. Essentially, the partnership structure of this movement allowed sectors to compete for community dollars in their respective programs, while preventing duplication of efforts and competition across sectors (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009).

The district governor mandated that all community empowerment programs use the Gerbangmas movement as an entry point, thereby reducing competition and keeping outside interests (such as those from NGOs) from affecting the success of the partnerships across sectors (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009). With the community at the center of the partnership structure, a hierarchy that placed all sectors on equal footing, and a common set of indicators to work toward, the Gerbangmas movement helped sectors work together effectively.
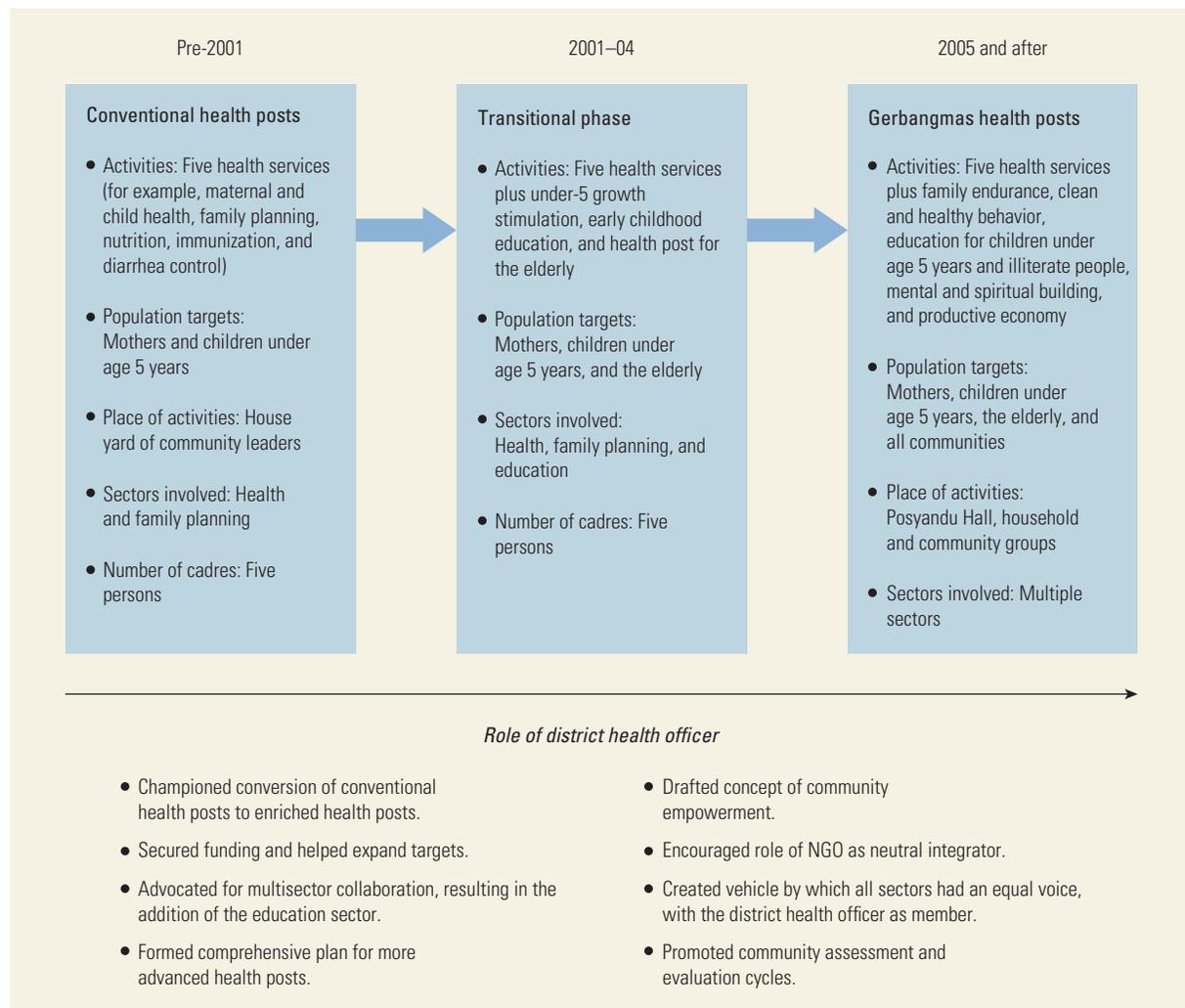
Leadership and Integration

The district health office was the initial champion for the Gerbangmas movement, which eventually assumed the role of the integrated health platform. During the initial scale-up from health posts to enriched health posts, the district health office garnered support from local government and encouraged involvement of other sectors (such as education) while demonstrating the importance of involving other sectors in achieving common health goals. As the health posts evolved into enriched posts, or Gerbangmas health posts (figure 14.3), the district health office took a step back to participate as a member of a team engaging other sectors; an NGO took on a more significant role as an integrator and coordinator of the movement. Part of the significance of an NGO's heading an integrated platform is that such an organization can be sector neutral, allowing each sector equal weight in achieving agreed-upon goals. Notably, the community itself held power over the management of the programs and the priorities of the Gerbangmas movement.

Role of Communities

Community volunteers conducted needs surveys in their respective villages, and maps of community needs were developed on the basis of the data gathered. The community problems in each village were discussed in open forums where members created action plans. Final proposals were drawn up that became the community action plans. Community members had input on the allocation of funds. Financing came from government funding allocation and from financial contributions from the community. Community volunteers also participated in the monitoring and evaluation of activities that had been carried out each year.

District Gerbangmas teams trained subdistrict teams. A training-of-trainers approach helped educate

Figure 14.3 Evolution of Conventional Health Posts to Gerbangmas Health Posts in Lumajang District

Pre-2001	2001–04	2005 and after
Conventional health posts	**Transitional phase**	**Gerbangmas health posts**
• Activities: Five health services (for example, maternal and child health, family planning, nutrition, immunization, and diarrhea control)	• Activities: Five health services plus under-5 growth stimulation, early childhood education, and health post for the elderly	• Activities: Five health services plus family endurance, clean and healthy behavior, education for children under age 5 years and illiterate people, mental and spiritual building, and productive economy
• Population targets: Mothers and children under age 5 years	• Population targets: Mothers, children under age 5 years, and the elderly	• Population targets: Mothers, children under age 5 years, the elderly, and all communities
• Place of activities: House yard of community leaders	• Sectors involved: Health, family planning, and education	• Place of activities: Posyandu Hall, household and community groups
• Sectors involved: Health and family planning	• Number of cadres: Five persons	• Sectors involved: Multiple sectors
• Number of cadres: Five persons		

Role of district health officer

• Championed conversion of conventional health posts to enriched health posts.	• Drafted concept of community empowerment.
• Secured funding and helped expand targets.	• Encouraged role of NGO as neutral integrator.
• Advocated for multisector collaboration, resulting in the addition of the education sector.	• Created vehicle by which all sectors had an equal voice, with the district health officer as member.
• Formed comprehensive plan for more advanced health posts.	• Promoted community assessment and evaluation cycles.

Source: Adapted from Siswanto 2009.
Note: NGO = nongovernmental organization.

many community volunteers and village staff members on the way to assess community health, facilitate community dialogue about the findings to lead to community involvement in proposing and implementing action plans, and evaluate the results of those plans (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009).

Sustainability

Sustainability was supported by an overall structure that included resources, funding, and training from partnering organizations and did not rely on grant funds or external donor dollars (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009). In addition, the partnership structure did not depend on the success of any single organization or leader. The largest hurdle to sustainability was the turnover of government officials. Sustainability relied on the new district governor's approval of the Gerbangmas movement in the subsequent five-year plan. In response, the district government created an official book on the Gerbangmas movement, including write-ups of the success of the movement in the governor's accountability report. The report covered a summary of the governor's achievements during his term and included the movement as policy in the district regulation, which was ratified by the district legislative body (Blas, Sommerfeld, and Kurup 2011; Siswanto 2009).

Case Study: Local Health Administration Committees, Peru, Level 3

The Peruvian government has legalized, regulated, and institutionalized community participation as a means of ensuring its role in primary health care (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). Local health administration communities (comunidades locales de administración en salud, or CLAS) are private, nonprofit civil associations that have agreements with the government to receive and administer public funding for the purpose of implementing primary health care services responsive to community needs.

Evolution of Local Health Administration Committees

The path to development of the CLAS movement was a complicated one. The CLAS movement emerged in 1994, following the collapse of the health sector in Peru. Terrorism and hyperinflation were major national challenges, and decentralization was beginning (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). Rural areas had a strong mistrust of the government; initial efforts to expand primary health care in these areas resulted in further mistrust, because community members often felt mistreated by physicians (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). When Jaime Freundt became the minister of health in the mid-1990s, he sought reform through a process that involved convening technical experts and community members. As a result, a new form of CLAS was proposed (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002).

Role of Communities

In the new CLAS, community members were part of a civil association under the authority of the Peruvian Civil Code. Community members had a formal relationship with the government by electing community representatives to a general assembly that worked with the regional health directorates (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002).

The elected assembly provided a way to demand accountability from health personnel (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). The CLAS became a platform through which community representatives and volunteers could perform public health roles of community assessment, identifying health priorities across local areas, guiding interventions, and choosing where resources should be allocated. The CLAS structure also allowed communities to control the quality of care and distribution of services. Unlike a community advisory board in which participation is often based on board members' advising those with the power to make decisions and allocate funding, each CLAS had the power and resources to act as the local health department for its respective community.

The CLAS's financing came from direct government transfers from general revenue, reimbursements from the government health insurance program for the poor, and in-kind stocks of medicines and supplies from the regional health directorates. Control over allocation of these funds resided in the hands of the CLAS (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). The CLAS assemblies conducted community assessments for health needs and helped identify unmet health needs to determine how best to tailor primary health care services to local contexts (Iwami and Petchey 2002).

Sustainability

The CLAS movement began as a pilot with 250 health facilities incorporated into the program. Early evaluations showed improved equity, quality, and coverage of health services in CLAS facilities, compared to non-CLAS facilities (Beracochea 2015). Advocates helped demonstrate the positive effects of the model, and in 2007, the Peruvian Congress approved a statute for citizen participation in primary health care at local levels. The passage of this law ensured the sustainability of the CLAS movement and confirmed Peru's commitment to empowering communities to have some control over their own health care (Altobelli 2008).

CLAS Achievements

The CLAS movement increased the availability of physicians in rural areas; improved access to care for the poor; improved usage rates, especially for children; improved quality in health facilities; and improved connections among people in Peruvian communities (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). These achievements were the result of the communities' ability to allocate budgets to attract higher numbers of physicians to areas where they were needed and to provide full or partial fee exemptions based on financial need. In addition, the number of women members of the CLAS general assembly grew substantially (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002).

Heath Systems and Role of Government

One interesting lesson learned from the CLAS movement is that public mistrust of the government can be counteracted through structures for communities to take ownership and oversight of public programs (Altobelli 2008; Beracochea 2015; Blas, Sommerfeld, and Kurup 2011; Iwami and Petchey 2002). The CLAS movement was a key driver in creating transparency, participation, and social control over the health system that built community trust and improved relations between communities and the government (Altobelli 2008). The Ministry of Health, with internal and external champions, was instrumental in helping the CLAS expansion to continue and become law (Altobelli 2008).

Partnerships across Sectors

In addition to primary health care needs, CLAS began to focus on the development needs of communities through community work plans that used discretionary funds and partnerships with local municipalities to allocate dollars to community-identified development projects (Beracochea 2015). CLAS appears to be well on its way to transitioning from level 3 to level 4 in the typology of table 14.2; CLAS is already a community platform for addressing health needs and is broadening its intersectoral reach to partner with additional sectors. The CLAS movement has been spreading through the SEED-SCALE model of sustainability (Taylor and Taylor 2002). Successful models in each region served as training centers and hubs for lateral diffusion of innovations.

Case Study: Community Scorecards in Nine Districts, Uganda, Level 2

Examples of contractor- and donor-driven platforms (level 2 in table 14.2) are fairly common in practice, and extensive literature documents this approach. We present a district scorecard program conducted in Uganda in 2004 to promote community oversight of health services at the primary care level.

The goal of the intervention was to strengthen provider accountability through a process that used community organizations as facilitators of village-level meetings to inform communities about the status of health service delivery in their area relative to the standards held in surrounding areas (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010). Facilitators encouraged community members to identify areas for improvement in health service provision and to develop action plans that could lead to improvements (Abdul Latif Jameel

Poverty Action Lab 2015; Björkman and Svensson 2009, 2010). The intervention sought to create a community-led process of monitoring to ensure that health care workers were performing their assigned tasks (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010). The results of the study indicated that, compared to control communities, community-based monitoring improved the quality and quantity of primary care delivered, reduced the number of deaths among children under age 5 years, improved outpatient service use, and improved quality measures such as wait time in primary care (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010).

Analysis of Uganda District Scorecards

The example of the district scorecard study in Uganda represented a limited intervention that was driven by outside agencies for the purposes of involving the community in health service improvement. Despite positive outcomes, ongoing success was reliant on ongoing collection of scores from scorecards by third-party entities (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010).

Health Systems and Role of Government

In Uganda's decentralized system, local health unit management committees monitored the day-to-day health service activities of the public dispensaries. The government was not the driver of the interventions and did not have a large role in the improvements to community health, other than through its role in running the committees (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010).

Partnerships across Sectors

Partnerships across sectors were limited in this example. NGOs and community organizations participated in community meetings, but there were few other partnerships across sectors or across government agencies (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010).

Leadership and Integration

The community health platform was originally developed by researchers at the University of Stockholm and the World Bank, and the researchers generated the report cards that served as the basis for the program. Local NGOs facilitated program meetings and served as community leaders for the intervention. There was no means for integration across sectors (Björkman and Svensson 2009, 2010).

Role of Communities

The role of communities was to attend meetings where health care provider performance and quality were examined, discuss health care delivery problems that could be improved, and develop action plans for needed changes (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010). Although the communities' ability to hold health care providers accountable was limited, they were able to participate in the improvement process and were given a voice for addressing their concerns.

Sustainability

Because the scorecards—determined to be a crucial piece of this intervention—were not developed by communities or the government, this intervention was scalable and sustainable only as long as researchers continued to provide data, or until a cheaper and more direct way of creating the scorecards was established (Abdul Latif Jameel Poverty Action Lab 2015; Björkman and Svensson 2009, 2010). Without further government and community buy-in to allocate resources to these activities, the district scorecard intervention faced many challenges in scalability and sustainability.

Case Study: Weak Government Platforms for Community Empowerment, Haiti, Level 1

Challenges to Development of Community Health Platforms

Haiti faces many challenges in developing local government engagement of community health platforms. It provides a case study where important lessons can be learned about the role of NGOs and donor agencies in helping promote or hinder development of community health platforms.

Haiti has long suffered from natural disasters, disease outbreaks, poverty and social divisions, political instability, and other social and political inequalities that have led to instability (Fatton 2006; James 2010). Numerous NGOs arrived with varying agendas; before the 2010 earthquake, an estimated 8,000–9,000 were working in the country (Batley and McLoughlin 2010; Zanotti 2010). Nearly all of the interventions in the education, health, and development sectors were led by NGOs, which provided 70 percent of health care services and 85 percent of education support (Vaux and Visman 2005; Zanotti 2010). The flow of funds through NGOs rather than the government weakened the elected government, created instability, and further undermined the accountability and sustainability of the state (Zanotti 2010). After the earthquake, the negligible state capacity

that did exist was destroyed, and the vulnerability of the state and subsequent reliance on NGOs, faith-based organizations, and formal providers for care was further exposed (Hill and others 2014).

Given the diversity of NGOs working throughout Haiti, health care delivery was largely inconsistent in quality, quantity, and coordination across the country (Hill and others 2014). The role of the Ministry of Public Health and Population was marginal, and external resources were often allocated according to the priorities of NGOs or donors (Hill and others 2014; Zanotti 2010). Ultimately, many of these NGOs did not have local origins, did not understand local context, and did not focus on creating sustainable, responsive platforms where communities could be empowered to address their own health needs (Zanotti 2010).

Analysis of Haiti's Challenges with Development of Successful Community Health Platforms

Unreliable health services and access to those services promoted health inequities and created a reliance on external entities that created difficulties for communities to voice their own needs (Hill and others 2014). Lack of service integration and coordination led to further fragmentation and duplication of efforts, and Haitians often relied on traditional medicine that was widely available (Hill and others 2014).

Despite the challenges, Haiti's structure also provides the opportunity for NGOs to develop community health platforms that are responsive and engage local communities. Several NGOs engaged the needs of communities and helped build community capacity in the areas of development, health, and education. Successful NGOs had several factors in common:

- They had local origins in Haiti.
- They had a diverse international network of donors and were not accountable to a single funder or government agency.
- They focused on addressing local needs and the needs of the poorest individuals.
- They shared a vision that tied economy, politics, and human rights (Zanotti 2010).

Health Systems and Role of Government

The weakness of the state and the reliance on NGOs created an environment in which external entities often influenced resource allocation and priority setting. The lack of a focus on Haitian governance and the subsequent lack of health system structure and community input created difficulties for the community to engage meaningfully in the public health process and hampered the creation of sustainable and responsive health care systems.

The ability of communities to hold the government accountable for health service access and quality was nearly absent.

Partnership across Sectors

Coordination among health and other sectors has been slow owing to lack of government leadership. However, successful NGOs acknowledged the importance of other sectors in improving health outcomes and worked on issues of sanitation, economic development, and education, in addition to health (Zanotti 2010). NGOs served as providers of services, as well as social advocates pursuing reforms to address poverty and social injustice (Zanotti 2010).

Leadership and Integration

One of the key difficulties that Haiti faces in creating community health platforms is that the country's leaders are highly influenced by external funding sources. The ability of an NGO to make decisions on the basis of community needs would be much greater if it did not depend on external agencies with specific agendas. Addressing community needs requires flexibility in setting agendas that not all NGOs possess.

Role of Communities

Successful NGOs were those that were able to engage communities, to set priorities for community input, and to include communities in identifying problems and developing and delivering solutions. These included, for example, community health workers and health care providers (Zanotti 2010).

Sustainability

One of Haiti's most significant challenges is creating sustainable solutions in the presence of NGOs that provide the majority of the health-related services in the country. NGOs that can create a platform through which communities can carry out basic public health functions and partner with other sectors to address the social determinants of health represent a way forward. NGOs that can empower communities and provide them with the necessary skills are setting the stage for the sustainability and effectiveness of a future health system.

STRENGTHENING COMMUNITY HEALTH PLATFORMS

Benefits of Strengthening Community Health Platforms

The reviewed literature and the focal case studies highlight the benefits of and provide a framework for strengthening community health platforms. The benefits arise whether the priority is (a) implementing or scaling up delivery of commodities, services, and programs or (b) building the capacity of communities to identify and address long-standing and emerging public health problems.

The benefits of stronger platforms arise because the more health platforms develop along the continuum in table 14.2, the better they can carry out the essential public health functions and the cycle of monitoring, reviewing, and acting to achieve solutions. Strength means the capability of health data collection through local surveillance and outbreak investigation. Strength means that public health personnel can find ways to share the data with their communities and to engage communities in developing local solutions that mobilize external resources as well as untapped resources in communities. Strength also means that local public health personnel can facilitate implementation of existing programs and develop modifications in response to emerging issues.

Because only some communities have community health platforms that can effectively carry out essential public health functions, outsiders often develop action plans that can succeed in the absence of these platforms. The unintended consequence of neglecting core strength in community health platforms is the continued building of partial substitutes for what community health platforms ought to be doing. The partial substitutes crowd out the necessary business of building indigenous strength.

Factors That Strengthen Community Health Platforms

Our review found the following identifiable factors that strengthen community health platforms:

- Access to data about health problems and health threats
- The means and will to share data and control with community members
- Achievement of a balance between delivering clinical services and preventing disease in whole populations
- Advocacy to maintain community engagement against pressure to consolidate control.

In some cases, these factors were present fortuitously. However, evidence suggests that the success factors can be present as the result of intention and effort. A commitment to engage community stakeholders cannot be maintained for long simply because of circumstances. However, a widespread political movement toward openness and grassroots engagement can make maintaining a community orientation easier.

Priorities for Investment in Strengthening Community Health Platforms

Effective strategies must come from taking stock of the current position of a community on the development continuum shown in table 14.2. Tools to measure a community's performance of essential public health functions have been used extensively in the Americas (Corso and others 2000; PAHO 2001; Upshaw 2000). Measurement of current strength in public health care services through a performance and quality improvement tool that targets the essential public health functions can help identify areas of emphasis within a district if the measures are provided to the public health staff to help create a performance improvement plan (Bishai and others 2016).

A strategy to develop community health platforms requires a modest investment in a central unit devoted to the quality of public health practice. Quality units are a growing feature in public health departments (Gunzenhauser and others 2010). The best practice for a quality unit is to use measurement of practice as a conversation starter rather than a disciplinary bludgeon. A public health practice quality unit for a central or regional health ministry requires a small investment. The budget should allow a team of district supervisors to make quarterly supervisory visits to specified districts and remain in regular electronic communication. Checklists and protocols for supervisory visits have been developed and are available from several sources. (The library of these resources can be found at http://www.ianphi.org/documents /pdfs/evaluationtool and https://sites.google.com/site /ephfjhu/.)

CONCLUSIONS

Communities vary in their level of sophistication in conducting a cycle of monitoring, reviewing, and acting on the basis of local data and local multisector community-engaged partnerships. Helping communities do this well is a concept that goes back to the foundations of the field of public health. Because good health can exist at low cost with vertical programs that rescue people regardless of their community's functional level, making the case for investing in community resilience can be challenging. The situation does not need to be an "either-or" option; the way forward ought to be a "both-and" option. Rescuing and building resilience are complementary. Especially where budgets are finite, strong community health platforms can marshal new resources to the service of public health.

Valuing Community Health Platforms

Given the common misinterpretation that cost-effectiveness (as dollars per disability-adjusted life year averted) is the key to understanding an intervention's value, one might be lulled into thinking that any investment that cannot show its disability-adjusted life years averted is wasteful—perhaps even unethical, given that people are dying of preventable causes every day.

Without initiatives to help community health platforms flourish around the world, the health gains promised by interventions will cost more and deliver less. Communities will miss opportunities to activate partners and resources that can shift health determinants in schools and workplaces and the commerce, transport, and culture sectors. Political will to make changes in public health law enforcement and regulation and to hold governments accountable is a precious resource that community health platforms can nurture and maintain. With the availability of local data, local forums for sharing data, and local multisectoral stakeholder engagement, the solutions will work better and deliver more. This human infrastructure has been neglected for far too long.

A Way Forward for Health Systems

With the Sustainable Development Goals and calls for health system resilience, we are entering a new era in which this neglect of community engagement and capacity is ending (Bellagio District Public Health Workshop Participants 2016). Community health platforms require a respectful trust that people being presented with data about their health problems and evidence about what works to solve the problems will choose wisely. Community health platforms require a recognition that health is too big for the health care sector alone; we need a decision-making forum that includes the education sector, commercial interests, transportation, law enforcement, and media. These partnerships are essential if we are to address upstream social determinants.

Our model of community health platforms is explicitly drawn at the local level. The national and global policy makers have important roles in setting up expectations and tools to support local communities. Fundamentally, human bodies are small objects; most

of the time, what makes a body sick (or worse) is a microbe from across the street or a cigarette from the local store or a speeding car with a drunk driver behind the wheel. Protecting a body requires a protector that is close to that body. The emerging burden of noncommunicable diseases caused by health behavior choices, lifestyles, mental health trauma, and injuries underscores the need for local approaches. High-income country data show that noncommunicable disease burdens differ intensely at the scale of a census tract. Modern cities are seeing life-expectancy differentials of 20 years across neighborhoods.

The other advantage of local communities is their sheer number. For a failed state, efforts to work at the national level can remain frustrating for decades. At the local level, one can find failed communities, but one can also find successful communities. One can even find successful communities inside failed states and accomplish at subnational levels what cannot be done when a central government is not prioritizing health.

The model of community health platforms asks local government health officials to play a prominent role as conveners and integrators. Government presence does not suggest that government workers perform all of the roles in the public health cycle. The decisions about who does what emerge from the community, on the basis of its own stock of possible actors and doers. Community health platforms can mobilize resources through volunteers and voluntary activities independent of the budgets of governments and donors.

A Chinese proverb says that the best time to plant a tree was 20 years ago, and the second-best time is today. High-functioning community health platforms are the trees that we wish our ancestors had planted in every community many years ago. Future generations cannot afford to have us spend the next 20 years attending to local epidemics and global pandemics that could have been snuffed out and quickly controlled if all local communities had been performing all of the essential public health functions and engaging their communities in building a culture of health.

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NOTE

World Bank Income Classifications as of July 2014 are as follows, based on estimates of gross national income (GNI) per capita for 2013:

- Low-income countries (LICs) = US$1,045 or less
- Middle-income countries (MICs) are subdivided:
  (a) lower-middle-income = US$1,046 to US$4,125
  (b) upper-middle-income (UMICs) = US$4,126 to US$12,745
- High-income countries (HICs) = US$12,746 or more.

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