PROJECT MODEL

COMM
Community Health Committees

COMM (Community Health Committees) is one of three core models making up World Vision's (WV's) 7-11 health strategy. COMM is the core model at the community level and is normally carried out alongside Community Health Worker/Timed and Targeted Counselling (CHW/ttC) and Citizen Voice and Action (CVA) models.

COMM involves the capacity building and empowerment of health committees to coordinate activities leading to (1) increased community capacity, (2) improved health policy and service environment and (3) strengthened CHW programmes, which, taken together, lead to strengthened community health systems and positive health outcomes.

COMM is normally implemented in partnership with the Ministry of Health (MoH). A front-end programme functionality assessment is carried out to ensure that the contextual factors necessary for programme success are in place. The capacity of COMMs is then strengthened by WV and/or MoH staff using a suitable MoH curriculum or the WV-produced package of materials. Staff then support the COMMs in their activities and monitor the results.

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List of Abbreviations

ADAPT	Analyse, Design and Planning Tool
ADP	area development programme
AP	Area Programme
CWB	child well-being
CVA	Citizen Voice and Action
COMM	community health committee
CHW	community health worker
DPA	Development Programme Approach
FBO	faith-based organisation
HCC	health centre committees
HFC	health facility committees
IQA	implementation quality assurance
NO	national office
NGO	non-governmental organisation
MUAC	mid-upper arm circumference
MoH	Ministry of Health
OCB	organisational capacity building
RC	registered children
SDG	Sustainable Development Goals
TSO	Technical Services Organisation
ttC	Timed and Targeted Counselling
ToF	training of facilitators
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

1. Model Snapshot

Contribution to global sector approaches and child well-being (CWB) aspirations

'COMM', the WV-internal term for Community Health Committees, is a generic title given to a **health-focused community group** empowered to coordinate and manage activities leading to increased community capacity, strengthened community health systems and improved overall community health. In most cases, COMM programming is carried out through an existing community health group; usually a Ministry of Health (MoH)-led and supported 'village health committee'.

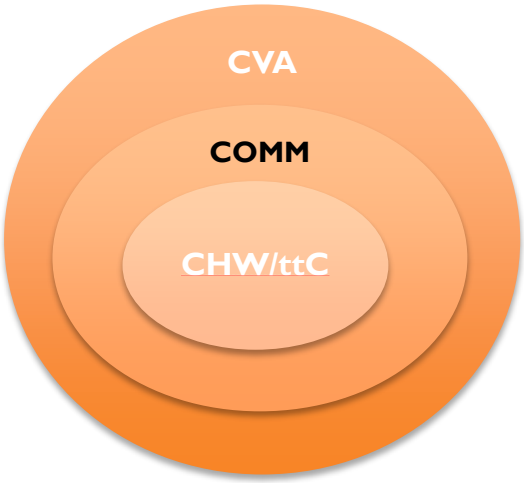
Illustrative objectives of a COMM may include:

- provide a support system for community health workers (CHWs) and other community health volunteers
- assess and track the community health situation, mobilise the community for improved health
- respond to barriers to health-related behaviour change at the community level
- assist with communication to and from the health system and the local administration
- advocate for issues leading to improved health systems.

COMM is one of **three core models** making up WV's **7-11 health strategy.** This strategy for maternal and child health is based on a model of social and behaviour change that calls for intervening at the three levels of **individual**, **community** and **environment** in order to provide pregnant women and caregivers of children under 2 with '360 degrees of support' for the practice of healthy behaviours.

COMM is the **core intervention at the community level** and should normally be implemented alongside CHW programming, the core model at individual level,[1] and Citizen Voice and Action (CVA), the core model at environment level. COMM *can* be implemented independently if other programming is not taking place in the area, as its community systems strengthening objectives are valuable in their own right. Ideally, however, individual- and environmental-level programming would be phased in over time.

Figure 1. WV 7-11 health strategy core models



[1] WV offers the Timed and Targeted Counseling (ttC) curriculum to MoHs for implementation through CHW or other health volunteers. Not all MoHs will take up ttC if an existing CHW curriculum is in use. As such, the core model at the individual level is reaching individuals through CHWs/volunteers using ttC or a similar MoH curriculum

2. Model Description

2.1 Strategic relevance of this model

2.1.1. Contributes to CWB objectives and Sustainable Development Goals (SDG) targets

Table 1: COMM contributions to child well-being outcomes

Child well-being outcome	Contribution
Direct contributions	
Children are protected from disease and infection	• Increases community capacity to recognise and address key health issues, with first priority on the 7-11 health interventions and practices, while with unlimited scope for adding other life-cycle stages or issues of concern as per context • Emphasises the identification of root causes or determinants of health issues, and taking action to respond to these • Strengthens links between the community and health services, thereby improving the continuum of care
Children are well nourished	• (Issues of nutrition are embedded in the 7-11 framework; thus, as in the first bullet in the row above) • Increases community capacity to recognise and address malnutrition, with particular emphasis on its root causes or determinants • Enables linking of community stakeholders for a multi-sectoral response to malnutrition, with the recognition that improvements in nutrition require interventions beyond the health sector • Strengthens links between the community and health services, thereby improving the continuum of care for prevention and treatment of malnutrition
Indirect contributions	
Primary school children can read	• There is substantial evidence showing that improvements in children's nutrition, especially in the first 1,000 days (the focus of the 7-11 strategy) leading to improved cognitive development and improved educational outcomes. As COMMs directly contribute to nutritional outcomes, this will indirectly have an impact on educational attainment as well. • There is potential for COMMs to contribute directly to literacy/education outcomes insofar as they will always be exploring the root causes or determinants of health issues and taking action on these. Often, improvements in certain root causes such as gender equality or community and social norms, for example, will have outcomes beyond the health sector, contributing to improvements in areas such as education and child protection as well.
Girls and boys are protected from violence	• While the primary mandate of COMMs is to seek improvements in community health status, there is unlimited scope for COMMs to take on any topic or issue deemed important in their contexts. If issues of child protection, e.g. early marriage, are salient, COMMs can be active in addressing these issues. • Many of the health-related practices that COMMs will be supporting contribute to child protection as well – for example, increasing access to immunisations or ensuring adequate health care for pregnant adolescents – married or not. • As COMMs take action to address root causes of health issues, progress in these areas may have outcomes beyond the health sector; contributing to improvements in areas such as education and child protection as well.

2.1.2. Sector alignment

Primary Sector: Health
Contributing Sectors: Child Protection; Water, Sanitation and Hygiene (WASH); Livelihoods

Table 2: COMM contributions to SDG targets

Sustainable Development Target	Contribution
SDG 2: Zero Hunger	
SDG 2.2: By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	• As per Table 1. Addressing malnutrition is a core function of COMMs within the 7-11 framework
SDG 3: Good Health and Well-being	
SDG 3.1: By 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births	• As per Table 1. Addressing health issues, including those that contribute to maternal mortality, is a core function of COMMs within the 7-11 framework
SDG 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to as low as 25 per 1,000 live births	• As per Table 1. Addressing health issues, including those that contribute to neonatal, infant and child mortality, is a core function of COMMs within the 7-11 framework
SDG 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases, and other communicable diseases	• As per Table 1. Addressing health issues, including those related to AIDS, TB and malaria per the 7-11 framework, is a core function of COMMs
SDG 4: Quality Education	
SDG 4.5: By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the most vulnerable, including persons with disabilities, indigenous people and children in vulnerable situations	• COMMs will always analyse the root causes of health issues and take action to address these. Frequently, these will be related to gender or other forms of inequality. As the COMM achieves successes in these areas, these successes will impact not only health, but areas such as education as well • As COMMs achieve improvements in nutrition outcomes, there is evidence for corresponding improvements in educational achievements
SDG 5: Gender Equality	
SDG 5.1: End all forms of discrimination against women and girls everywhere	• As COMMs analyse root causes of health issues and focus on gender inequality, they will contribute to ending discrimination against women and girls
SDG 5.3: Eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation	• Within WV's campaign to end violence against children, child early and forced marriage will be presented as an issue for consideration to COMMs for their analysis and action
SDG 5.5: Ensure women's full and effective participation and equal levels for leadership at all levels of decision-making in political, economic and public life	• The COMMs themselves are participatory decision-making bodies, and the COMM model is clear on the need for equal participation of women as COMM members
SDG 10: Reduced Inequalities	
SDG 10.2: By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status	• The COMM model explicitly calls for representation of marginalised groups in its membership • In addition, COMMs are specifically trained to identify and reach the most vulnerable and

	marginalised, both for root cause analysis and for action
SDG 16: Peace, Justice and Strong Institutions	
SDG 16.7: Ensure responsive, inclusive, participatory and representative decision-making at all levels	• COMMs are responsive, inclusive, participatory and representative decision-making bodies at community level
SDG 16.9: By 2030, provide legal identity for all, including birth registration	• Birth registration is included within the 7-11 framework for health that COMMs are mandated to address

2.2 Expected benefits (impact) of the model

2.2.1 Root problem causes and core benefits

The COMM model supports and enables the CHW model and ensures effectiveness by addressing barriers to positive health practices that CHWs are unable to address in the homes. The model is further strengthened by successes in the advocacy arena. Main issues targeted through the COMM include:

- weak or uncoordinated community systems to support health
- need for community mobilisation in establishment of community systems to support health
- lack of community oversight and involvement with CHW programme planning
- lack of community engagement in CHW programming
- poor community-based monitoring of health behaviours and health outcomes
- barriers to the practice of health behaviours that cannot be solved at household level, to include harmful social, cultural and gender norms
- gaps in organisational capacity of health groups.

Ultimately, as barriers to the practice of the recommended 7-11 behaviours are addressed and increased numbers of pregnant women and caregivers of young children adopt the recommended health behaviours, the health and nutrition status of these key target groups is improved, leading to overall reductions in morbidity and mortality.

2.2.2 Target beneficiaries with emphasis on most vulnerable children

COMM members and CHWs are benefited directly through social capital and cohesion, positive impacts of improved health service, community engagement and involvement, empowerment, and support (Popay et al., 2007). Pregnant women and children are benefited indirectly through dialogue counselling with CHWs, which supports them as they navigate and overcome common health barriers to adopting the 7-11 health practices. Communities as a whole are benefited to the extent that COMM is successful in addressing common health barriers. COMMs are trained to intentionally identify and include the most vulnerable in all of their needs analyses and activities, ensuring that the most vulnerable families and children receive the attention and support they need.

2.2.3 Contribution to transforming beliefs, norms, values and relationships

Per the logframe/theory of change shown in Section 4, the COMM model will contribute to (1) improved and enabling community context for positive health outcomes, (2) improved health policy and service environment, and (3) strengthened CHW programmes, which, when taken together, will lead to strengthened community health systems and positive maternal and child health outcomes.

Under the objective 1 (improved and enabling community context for positive health outcomes), the COMMs will carry out root-cause analyses of the health issues in their communities. These root causes may relate to harmful social, cultural and gender norms that the COMMs will then seek to address through engaging with faith communities and other 'community gatekeepers', and perhaps requesting WV assistance in bringing in supplementary models known to be effective at norm shifting, such as Channels of Hope or Community Conversations. These actions can result in transformed norms, values and relationships. Under the second objective, the COMM will identify prioritised health issues to add to the CVA advocacy agenda and engage health service providers around these issues, thereby bringing about a transformed relationship between the service providers and the communities in their catchment areas. Under the third objective, the COMM will support CHWs, helping to build strong links and relationships between the CHWs and the health facilities on the one hand, and the CHWs and the communities they serve on the other. Taken as a whole, the model promotes the

overall strengthening of the community health *system*, with strengthened relationships implicit therein. Fundamentally, COMM recognises the ability of humans everywhere, created in the image of God, to be agents of change in their own situations, rather than passive victims or merely recipients and able, with assistance as needed – including assistance from God – to transform their circumstances for the better.

2.3. Key features of the model

2.3.1 Methodology

In general, the methodology involves working closely with the MoH to strengthen the capacity of community health committees to perform various functions including: connecting health stakeholders, supporting CHWs and/or other community health volunteers, assessing community health issues and mobilising appropriate action, tracking and reporting community health status, advocating for improved health services as needed, and addressing social, cultural and gender norms to improve health outcomes.

The global literature reveals that while community health committees form part of MoH strategies in many countries, these groups are commonly not well-supported and receive insufficient training for carrying out their roles. WV is stepping into this gap with the COMM model. The model includes a mandatory 'Country Readiness' process of engagement with MoH, to include an overall programme functionality assessment to ensure that key systems, policy and support elements are in place. The model additionally ensures seamless integration into WV's Development Programme Approach (DPA), with the COMM appropriately identified and engaged during Step 5 of the critical path. The full package of training materials available for building the technical and organisational capacity of the committees ensures that the current, common training gap evident around the world is filled. Finally, the monitoring system enables tracking of COMM achievements and will thereby contribute to what is currently a thin evidence base.

2.3.2 Implementation steps

Note: The documents and tools referenced in the steps to follow are summarised in Section 7: Field Guides, and a link to the COMM Project Model landing page is found there

The overall process and specific steps of implementing the COMM model are as follows:
Country Readiness: Ideally, COMM programming will be implemented within the MoH system, through MoH-linked community health committees (or other similar title). Numerous decisions around the parameters of this programming must be taken together with the MoH, and therefore partnership and agreements with MoH must be established before implementation can begin. The three main programme parameter decision points are: (1) identification of the appropriate group to play the role of COMM, (2) curriculum selection and/or adaptation for technical training of COMMs selected, and (3) staffing structures determined for training, monitoring and follow-up support of the COMMs. Following these decisions, a national-level COMM programme functionality assessment process is then carried out together with the MoH using a specified tool which describes 14 components required for successful programming. (See Section 7: Field Guides: COMM Programme Functionality Assessment Tool.) The result of the functionality assessment is the development of an action plan to address the areas assessed as weak. Certified COMM trainers from WV and/or the MoH will then run a training of facilitators (ToF) to prepare identified individuals to work with COMMs.

Getting Started with COMMs: COMM programming is initiated at the Area Programme (AP) level in response to the community priorities for child well-being. Where community priorities indicate weak local health structures as a root cause of health issues, COMM can be an appropriate response. The community group to engage with as the COMM is identified during Step 5 of the critical path, and will usually be the formal MoH-backed health committee. Decisions to engage with these groups in WV programme settings emerge as a result of the community consultation and critical path process. As work with COMMs commences, facilitators will ensure that the COMM's membership is broadly representative of all community stakeholders, to include appropriate gender balance and representation of the most vulnerable and marginalised. An appreciative assessment and gap analysis of the group is then carried out to understand their existing roles and responsibilities and trainings received to date, and to determine additional capacity building needs. (This is different from the *programme* functionality assessment indicated previously, which is carried out together with MoH and relates to the programming setup for all COMMs. The appreciative assessment described here pertains to individual COMMs and is carried out separately with each group.) All COMMs receive a 7-11 health information training shortly after programme start up, and then receive health-specific training and organisational capacity building (OCB) support on an as-needed basis per the gap analysis results. COMMs directly supervising CHWs are

trained or receive an orientation in the CHW activities (e.g. ttC) conducted by certified facilitators. The COMM will additionally be brought into CVA activities where this programming is being implemented.

Ongoing Support to COMMs: As COMMs begin to carry out their work, facilitators from WV and/or MoH will provide mentoring support and will track the COMMs' progress with select indicators incorporated into an overall monitoring system.

Programme start up: 'Country Readiness'

1. Review the *COMM Project Model: Description and Guidance for Design*
2. Engage in MoH dialogue to determine programming parameters.
    a. Identifying the COMM: Use *Scenarios for COMM Identification* if needed (if no existing MoH-backed groups)
    b. Decisions regarding curriculum: Use *Curriculum Comparison Tool* if needed
    c. Decisions regarding personnel for engaging with COMMS (e.g. MoH, WV and/or partners)
3. Carry out COMM Programme Functionality Assessment together with MoH, WV staff, COMM representatives. One or more workshops are needed. Use the *Community Health Committee Assessment and Improvement Matrix (CHC-AIM)*.
4. Develop an action plan for any programming elements assessed as weak and begin work on responding to these areas.
5. Request certified COMM trainers to carry out an in-country ToF with WV, MoH and/or partner staff. Facilitators should be those individuals who will directly work with COMMs. Allow five days for classroom and four days for field practicum.
6. Facilitators should receive supervisory support as they begin to work with COMMs

Engaging with COMMs

1. Facilitators use *Overview for the Facilitator* to guide initial meetings with COMMs.
2. Facilitators and COMMs carry out *Appreciative Discovery* and develop a capacity building plan for responding to gaps.
3. Facilitators introduce COMMs to the 7-11 health information using the *Facilitator's Guide to 7-11 Health Content.*
4. Facilitators carry out other agreed capacity building sessions with COMMs, using the *Facilitator's Manual* or other agreed (MoH or partner) curricula.
5. COMMs engage in community activities and are mentored and supported by facilitators, who also assist COMMs to develop links with other partners.
6. Facilitators collect monitoring data using Tools A and C. Data is input and aggregated and results reported back to facilitators, COMMs and community.

2.3.3. Implementation details

The COMM model should be implemented as a whole package. The 'Country Readiness' phase must not be omitted, for example.

The only part of implementation that is modularised is the capacity building of the COMMs. Facilitators will train COMMs per the appreciative assessment carried out at the beginning of engagement with each group. They will select from among the six technical sessions in the WV COMM package of materials (or from among sessions taken from a similar MoH curriculum as agreed during the 'Country Readiness' phase with MoH), and from the modules and supporting materials available in WV's *Organisational Capacity Building* package as needed per the gaps identified during the assessment.

2.4. Level of evidence for the model

2.4.1 Evidence analysis framework, evidence of effectiveness

- Community health committees can improve the quality and coverage of health services: Utilisation of general outpatient services is approximately 20 per cent higher in communities with community health committees compared to communities without committees. Health facilities in communities with local committees did better than in communities without committees on a number of measures, including better user satisfaction and access for the poorest. Facilities with a health centre committee have significantly higher likelihood of

health service use (2.3% $p<0.05$) and significantly greater use of antenatal care, and are better funded and had stronger links between communities and health workers compared with those without.

- Community health committees can lead to improved community health outcomes: There is evidence that programmes working collaboratively or those that achieve shared leadership with the community can improve critical health behaviours, increase knowledge, improve practices, affect social norms, lower disease incidence, and reduce poor health outcomes and mortality, even in low resource settings where social conditions and practices could otherwise result in poor child health. Evidence suggests that community engagement has a positive impact on certain social determinants of health. The evidence also indicates that building community capacity serves as a means to an end – improved health behaviours and reported collective action for health.

2.4.2 Evidence gaps

While the literature is fairly conclusive that mobilising community action and/or increasing community participation leads to improved health outcomes, very few of the studies refer to community participation *in the form of Community Health Committees* specifically. More studies are needed that focus exclusively on the impact of the committees themselves (i.e. the COMMs).

2.4.3 Sustainability of outcomes

The literature is full of examples of community health committees not receiving sufficient capacity building to carry out their roles and with exhortations that the time and effort needed to build the capacity of these groups not be underestimated. The sustainability of the model will depend, in part, on the time commitment that is given to training and supporting COMMs. Each committee will need an average of at least 10 days of front-end capacity building (not necessarily all at once) as well as ongoing support and mentoring. This must not be short-changed. Sustainability will hinge partly on the quality of implementation in this regard and per the implementation quality assurance (IQA) standards (see Section 7: Field Guides).

An additional factor affecting sustainability will be the motivation of COMM members to remain on the committees as volunteers over an extended period. The COMM training of trainers programme reviews numerous motivation considerations that trainers – and especially facilitators – will need to be cognisant of, and ongoing programming experimentation, innovation and lessons learned will be needed.

Assuming that COMM implementation follows the IQA standards designed for the model such that the COMMs do receive sufficient capacity building and support, the question will then become that of the sustained, ongoing work of COMMs over time; ultimately independently of WV's support. To this end, the following are important:

- **Linkages and partnerships**: It is unnecessary to expect or desire COMMs to be fully autonomous, independent bodies, unlinked to other organisations in order to be considered sustainable. On the contrary, a permanent 'institutional home' for the COMMs when their involvement with WV comes to an end is a key success factor for sustainability. In most cases, the expectation is that the COMMs' primary linkage and source of support will be the MoH at the local level (local clinic administrators or supervisors, or perhaps district MoH authorities). In addition, however, the COMM will ideally be strongly linked in to a full network of health stakeholders, to include local councils, other non-governmental organisations (NGOs) and other civil engagement groups. The COMM model includes materials for capacity building and/or support of COMMs as they form these important linkages and partnerships for sustainability.

- **Local ownership and social accountability**: Although it is key that the COMMs are linked with others and have permanent institutional support from the MoH or another recognised body as in the previous point, they should at the same time *own* their own vision, mission, objectives and priorities. This ownership cannot be manufactured, but it can be facilitated – partly through sufficient capacity building to enable the COMM members' confidence in their own abilities and partly through discussions on their motivations to serve. These discussions will ideally reveal increasing maturity over time whereby COMM members not only express motivation in terms of benefits to self, such as increased knowledge or increased face time with health service providers, but also in terms of their awareness and appreciation of their own agency – of the fact that they have a *right* to participate in health activities that affect their lives, the fact that their actions can lead to civil change and transformation, and that these are their *own* goals, objectives and ultimate desires. As expressions of motivation take this form, greater levels of local ownership are thereby evidenced, and the probability of sustainability is increased.

- **Transformed relationships:** This is linked to the previous point concerning local ownership. As COMMs gain greater self-confidence and appreciation of their own ability to be agents of change, their self-perceived relationship to authorities changes – from one of passivity to one of actors able to demand rights. At the same time, as COMMs are involved in assessing and addressing root causes of issues in their communities, it is most likely that existing power dynamics leading to inequality and marginalisation will be increasingly questioned and, over time, transformed. These types of transformations in relationships – both with community members and with authorities – places the COMMs on ever-firmer ground to be a self-confident, active and effective group, able to work for change in a sustainable fashion.

2.4.4 Evidence rating

The following table provides a detailed analysis of the evidence review carried out by the project model review panel in 2017. Ratings and colour coding range from 0 per cent (red) to 100 per cent (deep green), indicating poor to high quality respectively.

0%	20%	40%	60%	80%	100%
Very Poor	Poor	Fair	Average	Good	Excellent

The supporting material provided promising results measured through reliable methodologies and covering most causal assumptions in the project model design. However, result effectiveness and sustainability were not well-captured. These areas should be covered in future implementation of the project.

		Evidence Rating		
	Evidence Material	**A**	**B**	**C**
Evidence Criteria	Relevance	67%	100%	66%
	Effectiveness	67%	66%	50%
	Internal Validity	68%	68%	61%
	External Validity	71%	92%	67%
	Average Score	68%	81%	61%

A: WV Ireland Access – Infant and Maternal Health (AIM Health) Evaluation Report
B: Systematic review on health facility committees
C: Community capacity as means to improved health practices and an end in itself

For more information on the evidence review criteria and process, please contact the Evaluation and Impact Reporting team.

2.5. External validity

2.5.1 Countries and contexts where the model was tested

COMM implementation has taken place in the four national offices (NOs) participating in the *Child Health and Nutrition Impact Study (CHNIS)*, namely: Guatemala, Kenya, Zambia and Cambodia. and in five NOs through the Irish Aid *AIM-Health* grant programme; namely: Sierra Leone, Mauritania, Uganda, Tanzania and Kenya. In addition, COMM 'Country Readiness' processes are underway in Swaziland, Lesotho, Malawi and Ghana.

All settings are rural.

2.5.2 Contextual factors

Literature suggests that many contextual factors influence the effectiveness of health committees. These include: the mandate and authority that the groups are given in national policy and/or strategy; accountability arrangements; training and support; wide community mobilisation in the establishment of the committees; ongoing commitment of health authorities; registration; and capabilities and resources of the committee members (McCoy et al., 2012). Additionally, McCoy found that the methods used to select members and the

extent to which they represent local issues are crucial in determining perceived legitimacy in the eyes of the population served.

In light of this, WV, together with the US-based CORE Group, has developed the *Community Health Committee Assessment and Improvement Matrix* tool (see Section 7: Field Guides) to specifically look at these and other contextual factors, as part of the overall programme functionality assessment described earlier. A descriptive matrix is provided to enable scoring of 14 contextual elements; all considered essential for programme success, as in Table 3. It is important that these components be put into place nationally through the leadership of the MoH prior to wide-scale programme implementation, as the success of the COMM model will be undermined if the overall context is not enabling in this way.

Table 3. COMM 14 contextual elements

1. **Strategic Description and Clarity of Community Health Committee (CHC) Programming**: Whether CHCs are included in MoH community health strategy and their strategic intent is clearly described
2. **CHC Formation**: How the CHCs are formed: what entity catalysed and supports the programme, the existence of policies and procedures, and the degree of community awareness
3. **CHC Member Recruitment and Selection:** How members are selected and recruited to the CHCs
4. **CHC Roles, Organisation and Structure**: Clarity and effectiveness of CHC organisation and structure with regard to roles, expectations, decision-making and procedure
5. **CHC Member Training and Capacity Building**: Training and capacity building provided to CHC members to equip them with knowledge and skills to fulfill their roles
6. **Budget for CHC Programming**: Funding available for CHC activities, and processes for fiscal management
7. **Supervision of CHC Members**: The extent to which CHC members receive supportive supervision, and the incentive system for the supervisors
8. **Incentives for CHC Members**: A balanced incentive package for CHC members that is standardised, well known, and results in member motivation
9. **Wider Community Support and Involvement**: The extent to which the wider community is aware of, recognises the value of and participates in the activities of the CHCs
10. **CHC Support of the Referral System:** Processes for patient referrals and counter-referrals, and the extent to which the CHCs play a role in supporting the processes
11. **Communication and Information Management:** How data flows to and from the health system and how the CHCs make use of the data
12. **Linkages to the Broader Health System:** How CHCs are linked to the broader health system at higher administrative levels
13. **Country Ownership**: The extent to which the MoH has policies in place that legitimise CHCs within the health system, and the types of MoH support to the groups
14. **CHC Programme Performance Evaluation**: General CHC programme evaluation against targets, objectives and indicators carried out on a regular basis

3. Model Implementation Considerations

3.1. Adaptation scope during design and implementation

The COMM **Implementation Quality Assurance (IQA) Standards** include two parts and seven essential elements.

Table 4. COMM IQA standards

Part One: Pre-implementation (Country Readiness)
COMM Identification: In cases where MoH-backed committees do not exist, the decision/scenario process outlined in *COMM Project Model Guidance Document* is followed to select from among existing community groups to perform the functions of the COMM. If carried out within the *Development Programme Approach (DPA)* process, this process of COMM identification happens during Step 5 of the 'critical path'.
Curriculum Selection: In cases when MoH and/or other partner materials exist for building the capacity of the COMMs, a comparative curricula review process is carried out to ensure that the materials ultimately selected (MoH, partner, WV or hybrid) meet the minimum standards.
COMM Functionality Assessment: A COMM functionality assessment using the *Community Health Committee Assessment and Improvement Matrix* tool is carried out prior to programme implementation with the involvement of MoH. Action plans are developed for all areas scoring below 2, and results shared with all stakeholders.
Training of Facilitators ToFs are carried out by certified COMM trainers, and to a standard that ensures facilitators are qualified to work with COMMs.
Part Two: Implementation
COMM Membership: COMM membership is representative of the communities in its coverage area and inclusive of specified and marginalised groups.
COMM Capacity Building Only certified facilitators work with COMM, developing and carrying out capacity building plans based on the results of an appreciative assessment, and adhering to stipulated time frames for quality training.
Programme Monitoring and Evaluation: A system is in place to monitor programme activities and COMM outputs, and aggregated data reports are provided to MoH partners, COMM facilitators and COMMs.

What are the core features of the model that should always be central to implementation?

1. 'Country Readiness' process: MoH dialogue and agreement, curricula comparison between COMM curriculum and existing MoH and/or partner resources, appropriate COMM identification, and COMM programme functionality assessment.
2. ToF led by at least two certified COMM trainers and adheres to the stipulated participant selection criteria and course duration. The quality of the training cascade is central to successful COMM implementation and all ToF stipulations should be adhered to.
3. COMM appreciative assessment.
4. 7-11 technical health information training for COMMS.
5. COMM capacity building, per the needs identified in the appreciative assessment.
6. Monitoring of COMM programming using specified tools, data input, aggregation and feedback.

What are the negotiable features that can be adapted for context and negotiated with partners?

Integration with other programming

The strategic framework is 'expandable' or 'reducible'. If there is no CHW or CVA programming taking place alongside the COMM programming, then Outcome Objectives 2 and 3 will be removed. This is not recommended, however. If there is other health-related programming taking place such as Community Change, Positive Deviance (PD)-Hearth or Community Management of Acute Malnutrition (CMAM), for example, and the COMM is effectively linking with and supporting this programming, then additional outputs can be added to the strategic framework to incorporate these links. These would be added as Outputs 6, 7, etc., under Outcome 1. Where child protection programming exists, the COMM also connects to the child protection working group to ensure local child protection issues can also be addressed in the work of the COMM and the local CHWs/volunteers.

COMM identification

In many cases, the identification of the appropriate group to perform the functions of the COMM will be uniform within a given country. If there are MoH-linked community health committees in the country, these groups will

be the COMM in every programme area. NO-level health staff can make these determinations and then communicate the result to field staff. In some cases, however, there may be variability across the programming areas in the country in terms of the most appropriate group to be the COMM. For example, some areas may have applied the DPA and formed health working groups while other areas have not, and it is conceivable to find different scenarios in these situations. The NO-level health staff will attempt to make the necessary identifications per the guidelines provided in the COMM materials.

If a programme area is just beginning with the processes of the DPA, then the identification of the appropriate COMM should not be made by the NO-level staff but, rather, should emerge as part of the process. Specifically, field staff together with the community will identify the most appropriate health working group (i.e. the COMM) during Step 5 of the 'critical path'. The NO-level health staff should provide guidance to the field facilitator at that stage of the process. For example, if there are MoH-linked community health committees in the country, that group should always be selected as the health working group/COMM, and it will be important that the field facilitator understand this minimum standard as he/she proceeds through the critical path.

COMM roles

While there are some generally agreed roles that a COMM can play, the things that COMMs will do may not be identical in every country. COMMs' roles may differ because of (a) MoH policies, guidelines and expectations, (b) whether or not there are CHWs and/or health volunteers in the community, and (c) the availability of the members and time commitments they can make. Possible roles in the COMM approach are as follows, and relevant resources exist for capacity-building in each role:

- coordinating mechanism for health stakeholders in the community
- supporting community health workers or other health volunteers
- information management: tracking and reporting community health status
- participatory learning and action
- advocacy
- supervising CHWs.

Capacity building for COMMs

Of the available COMM modules/sessions, facilitators may or may not carry out all sessions with a COMM, depending on the unique needs of each group. The appropriate trainings of the COMM will be based on the results of the (mandatory) appreciative assessment. There are six possible sessions (see Section 7: Field Guides, for a listing of the sessions in the Facilitator's Manual).

3.1.1. Fragile contexts

At the time of writing, initial discussions with the following fragile context NOs have taken place: Afghanistan, Chad, Democratic Republic of Congo, Jerusalem/West Bank/Gaza, Pakistan, Somalia, South Sudan, Sudan, Zimbabwe. All consider the COMM model relevant to their health strategies and are planning to implement it, pending a training of trainers event to take place specifically for this cohort of countries.

Of note is the fact that the majority of these countries *do not* already have MoH-backed health committees. This is distinctly different from the contexts where COMM is currently being implemented, wherein most programmes are working with existing MoH-supported groups as opposed to mobilising new committees.

A key distinction of the fragile contexts will therefore be the need to work with MoHs to advocate for the inclusion of health committees in health strategies and policy. Assuming success, this will be followed by the presentation to the MoH of the WV-produced package of materials for capacity building of COMMs, and decision-making as to its relevance for the context, uptake for national use, and need for adaptation. WV and MoH staff availability for capacity building and support of COMMs will also need to be determined.

The extent to which the COMMs can effectively carry out their various roles and responsibilities in contexts of instability or fragility will need to be assessed and the materials adapted per decisions reached in this regard. This will form part of the curriculum adaptation process, which must be carried out as part of 'Country Readiness' in all contexts in any case. As COMM activities get underway, a benefit will be their ability to report on health situations in communities in instances where WV staff may have limited movement and access.

Further assessment and contextual adaptation for fragile contexts will form part of the discussions leading up to, during and after the proposed COMM training of trainers for fragile contexts.

3.1.2. Transitioning economies

Implementing the COMM project model in transitioning economies is not currently under consideration.

3.2 Partnering scope

WV Partnerships

WV partnership with MoH is mandatory, but roles could vary. Questions to be asked concerning MoH linkage include: Is the COMM officially or unofficially linked to MoH? Who supervises and who trains COMM (WV or MoH, or shared)? The literature shows that a clear MoH mandate for and support of these groups is extremely important for their perceived legitimacy and for the motivation of the members.

In the rare cases where COMMs are not an official part of MoH structure and policies, the partnering scenarios will be different. First, WV should nevertheless engage in dialogue with the MoH around eventually incorporating community health committees into official, national-level community health strategy and continue to advocate and support movement in this direction, as this is the scenario that will best ensure the COMMs' long-term sustainability.

In the meantime, though, WV will need to run projections in terms of how many COMMs WV staff will realistically be able to support (number of COMMs per area development programme [ADP], number of ADPs, any grant-funded programmes including COMM) and then assess the landscape for potential partners to assist in scale up (e.g. international and local NGOs and community-based organisations [CBOs]).

In addition to partnerships for implementation, WV may consider other types of innovative partnerships to support the COMM model – for example, private sector collaborations where COMMs may go for fund-raising to support their community-level activities or for mHealth solutions. Innovations to the COMM model such as these will be increasingly taken up by the Senior Advisor for Quality and Innovation for Health in the Global Centre.

COMM Partnerships

In terms of who the COMM will partner with, it is important to remember that the COMM will ultimately become the main link or principle nodal point with regards to health issues in the community, connecting community members, CHWs/volunteers, health facilities, mother's groups or women's support groups, CBOs and local NGOs, and WV, all of whom may be considered as partners. The most updated version of the *Overview for the Facilitator* section of the COMM package of materials describes a process that the WV facilitator can assist the COMMs to undertake in mapping all stakeholders in the area (see Section 7: Field Guides). This initial stakeholder mapping is an essential step enabling COMMs to identify who they may link and partner with, and in enabling the COMM to know where it may seek support.

It is also important that COMMs establish links with partners in other sectors (e.g. WASH, agriculture community actors) to better address the broad-based determinants of health.

3.2.1 Case studies of successful partnering for this model

The literature shows that the effectiveness of health committees is clearly tied to the level of support they receive from health staff at the facilities they are linked to, and the extent to which health officials recognise the legitimacy and authority of these committees (McCoy et. al. 2012) (Baez, 2006). This underscores the importance of the partnership with MoH, as MoH support and buy-in – and legitimation through policy – is needed to gain the cooperation of health facility staff.

'Realistically, committees cannot arise, be sustained and actively participate in health services without invitation and support from those that they deal with directly within the health care system' (Molyneux et. al. 2012).

'Where there is no community mandate and no policy framework, health committees are dependent on facility managers, who then become the gatekeeper' (Mdaka et. al, 2014).

In addition, WV should ensure that the COMMs are linked to higher administrative level (e.g. district) managing or governing bodies over time: 'Health programs aimed at improving health outcomes through better community participation should focus as much attention on district governance structures and their relationships with district and community management structures, as on community participation' (Baez, 2006).

3.2.2 Value proposition of partnering

- Community groups: COMM membership should be inclusive of representatives from other health-related community groups and, potentially, multi-sectoral community groups, for the inclusion of multi-sector considerations in improving health outcomes.
- Faith communities: One of the important roles of the COMM is to address harmful social, cultural or gender norms that may adversely affect community health. The churches and faith communities should be engaged in these efforts, as they are often primary influencers and shapers of existing norms. A partnership with a church or faith-based organisation (FBO) may help to ensure their cooperation in norms-transformation initiatives.
- Private sector: May be able to assist with COMM fund-raising efforts or innovative forms of programming.

3.3 Local and national advocacy (as relevant)

In some cases, the COMM will be the group that CVA programming is carried out through. In other cases – if a separate CVA group has been formed or if the advocacy agenda is broader than health – the COMM should actively participate in CVA activities by providing health information and data, identifying key community health issues, including the issues of the most vulnerable and marginalised, and working with the CVA group to ensure that the prioritised issues are included in the advocacy agenda.

When CVA project model work is ongoing (see separate project model), the CVA programming should be aggregating evidence from various CVA groups for use in national-level advocacy engagements. If the COMM is the CVA group, then those responsible for CVA programming should ensure that the relevant indicators from the COMMs are included in their aggregations.

WV is still gaining experience in this area, as COMM and CVA programming are being implemented concurrently in only a small number of NOs to date.

One of the main functions of the COMM is to understand and monitor the general health situation of the area it covers and use the findings to plan follow-up action as needed. The COMM should carry out at least one front-end participatory root-cause analysis to understand the health status of the community. This is usually done in Step 6 of the critical path. The root-cause analysis focuses on health statistics/data, facility services, and underlying health issues and barriers among the community population, to include the vulnerable and marginalised. The COMM action plan, developed based on the findings of the root-cause analysis, will often include activities to raise community awareness around the important health issues.

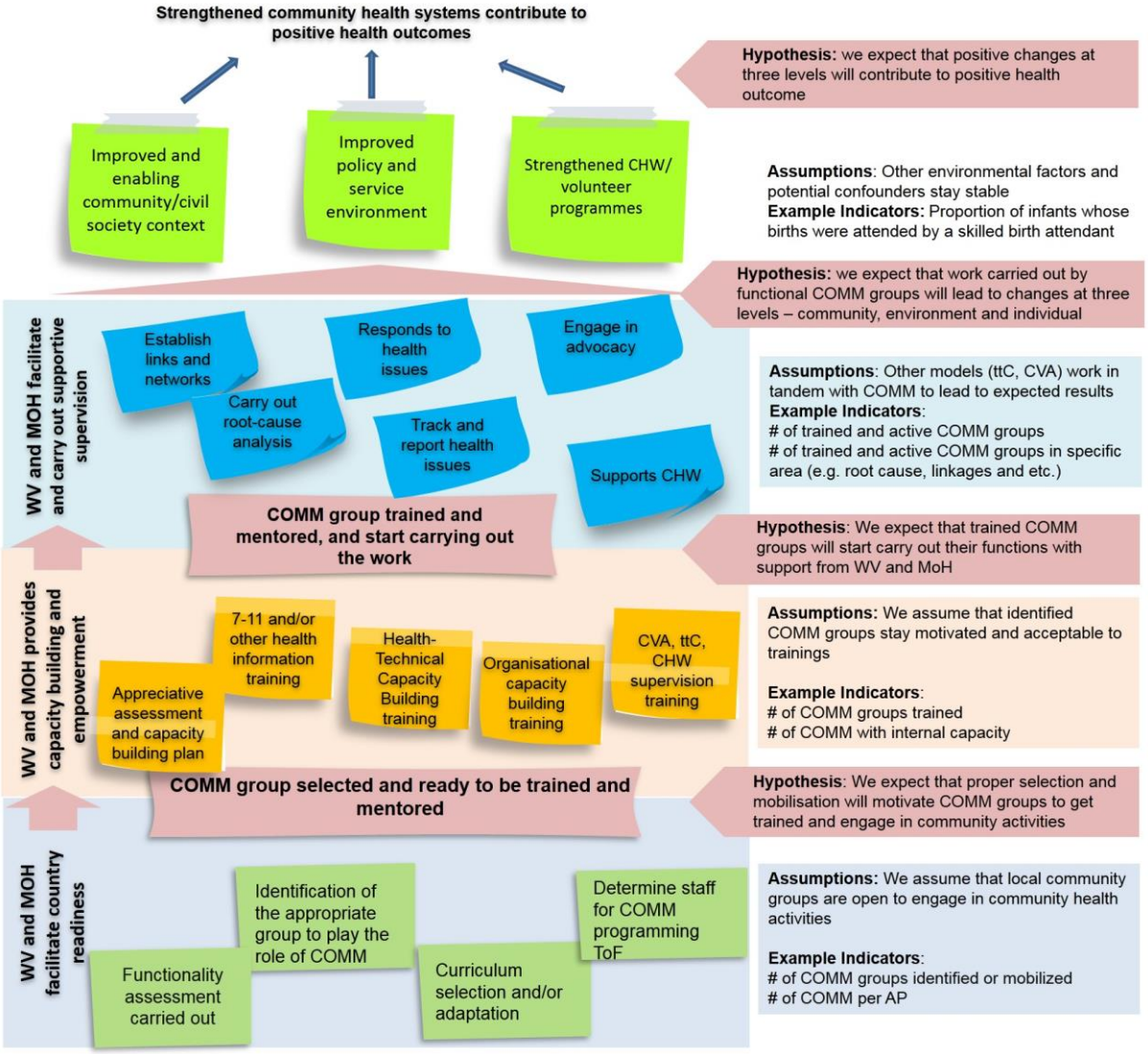
The COMM programme functionality assessment carried out during the 'Country Readiness' phase of implementation, previously described, includes the important contextual factors of government *policy and strategy* for the legitimacy and authority of community health committees. When preserved and protected in policy, these groups are far more effective in their health-related work and associated health (CWB and SDG) outcomes.

4. Programme Logic

4.1 Pathways of Change and Logic Diagram

The COMM Theory of Change (ToC) is based on fundamental logic of community systems strengthening through proper mobilization, empowerment and supportive supervision of community key players and groups. The ToC starts from the identification of COMM groups in close partnership with MoH. The key success factor of this stage is identification and mobilization of proper groups that will have ownership over community health issues. Once groups are identified they will go through extensive capacity building training and be ready for community work. The hypothesis and assumptions are that active COMM groups will utilize their knowledge and lead various community activities contributing to improved health outcomes. The success of this stage depends on the level of engagement with other project models and partnership with WV and MOH.

Figure 3.Pathways of Change



4.2 Use of standard indicator and alignment to CWB objectives

Table 5. Framework of indicators for COMM project model

Level	Objectives	Indicators	Indicator status	Means of Verification	Assumptions
Goal	Strengthened community health systems contribute to improved health outcomes and well-being	• Coverage of essential vaccines among children • Prevalence of stunting in children under 5 • Prevalence of underweight in children under 5 • Prevalence of diarrhoea in children under 5			

Outcome 1	Improved and enabling community context for positive health outcomes	Proportion of parents or caregivers with appropriate hand-washing behaviour	Core and in Horizon (C1B.0128)	Caregiver survey	Programme beneficiaries have interest in self-awareness raising and behaviour change.
		Proportion of adolescents with unmet family planning needs	Core and in Horizon (C1C.0166)		
		Proportion of infants whose births were attended by a skilled birth attendant	Core and in Horizon (C1C.0152)		
		Proportion of mothers who report that they had four or more antenatal visits while they were pregnant with their youngest child	Core and in Horizon (C1C.0156)		
		Proportion of women who were offered and accepted counselling and testing for HIV during most recent pregnancy, and received their test results	Core and in Horizon (C1B.0085)		
		Proportion of children under 2 with presumed pneumonia who were taken to appropriate health care provider	Core and in Horizon (C1B.0072)		
		Proportion of households where all children under 5 years slept under a long-lasting insecticide-treated net (LLIN) the previous night	Core and in Horizon (C1B.0079)		
Output 1.1	Linkages and coordination among community health stakeholders strengthened (linkages)	# and % of COMM groups with established linkages with local health facility and providers	Core and in Horizon (C1C.20986)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged Community health stakeholders are supportive of project
		# and % of COMMs who send representative to health facility committee meetings	Core and in Horizon (C1C.20987)		
		# and % of quarterly debriefing meetings organised by COMM with	Core and in Horizon (C1C.20988)		

		community participation			
		# and % of linkages created and fostered among COMM and supporting NGOs and/or other partners	Core and in Horizon (C1C.20989)		
Output 1.2	Root cause analysis of health issues assessed (once-off) and community health status tracked (ongoing) (analysis)	# and % of COMMs that have carried out a one-time root cause analysis/participatory situation analysis	Core and in Horizon (C1C.20990)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged
		# and % of COMM that report regular use of CHW/volunteers community health data	Core and in Horizon (C1C.20991)		
		# and % of COMMs (in community with disease outbreak) reporting disease outbreaks to health authorities (within 48 hours?)	Core and in Horizon (C1C.20992)		
		# and % of COMMs (in community with adverse health events) investigating adverse health events	Core and in Horizon (C1C.20993)		
		# and % of COMMs whose root cause analysis includes at least one focus group discussion (FGD) with those identified as most vulnerable in the community	new – MVC focus		
Output 1.3	Community activities are implemented to address identified health issues (action)	# and % of COMMs with action plan responding to root health issues	Core and in Horizon (C1C.20994)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged Community health stakeholders are supportive of project
		# and % of COMM active/engaged in improving access to health facilities	Core and in Horizon (C1C.20995)		
		# and % of COMM active/engaged in improving access to water	Core and in Horizon (C1C.20996)		
		# and % of COMM active/engaged in improving access to LLINs	Core and in Horizon (C1C.20997)		

		# and % of COMM active/engaged in reducing barriers to HIV testing	Core and in Horizon (C1C.20998)		
		# and % of COMM active/engaged in activities focused on adolescent girls	Core and in Horizon (C1C.20999)		
		# and % of COMMs whose action plan involves working with the faith community for social/cultural norm change	new – faith focus		
		# and % of COMMs requesting and participating in Channels of Hope programming	new – faith focus		
		# and % of COMMs whose action plan specifically addresses issues of the most vulnerable	new – MVC focus		
Output 1.4	Community health status and activities regularly reported to all stakeholders (reporting)	# and % of COMMs carry out quarterly debriefing meetings	Core and in Horizon (C1C.21000)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged
		# and % of COMMs produce community health board and update quarterly	Core and in Horizon (C1C.21001)		
Output 1.5	COMM demonstrates strong internal capacity	# and % of COMMs with internal capacity that meets minimum standard recommendations	Core and in Horizon (C1C.21002)	COMM Action Plan (Tool C)	
Outcome 2	Improved policy and service environment for positive health outcomes	Proportion of users who are satisfied with the health services they have received	Core and in Horizon (C1C.22911)	Caregiver survey	Local authorities and governmental officials are supportive to project implementation
		Proportion of health centre users who report increased responsiveness of health service providers to communities	Optional in Horizon (C1C.22914)		
Output 2.1	Linkages and coordination with health facilities and providers are strengthened	# and % of COMMs with effective linkages with health facilities and providers	Core and in Horizon (C1C.20986)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged CVA programme works in pair with COMM

Output 2.2	CVA local-level advocacy initiatives are supported and implemented	# and % of COMMs active in local-level advocacy initiatives	Core and in Horizon (C1C.21003)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged CVA programme works in pair with COMM
		# and % of functional CVA groups focused on health and/or nutrition and/or WASH	CVA indicator in Horizon (C1B.0370)		
		# of local-level advocacy initiatives led/contributed to by COMM	Core – new		
		# of evidence-based policy or service improvement recommendations on health emerging from community action plans which are presented to local government/decision makers	Optional – CVA indicator in Horizon		
Outcome 3	Strengthened CHW/volunteer programmes for household-level behaviour change communication (BCC)	# and % of health facilities served by a fully functioning ttC Home Visitor programme	Core and in Horizon (C1C.21341)	Health Facility Evaluation	CHW programme works in pair with COMM
		Coverage of nutrition and infectious disease counseling outside of the health facility	Core in Horizon (C1B.21340)	Caregiver survey	
		Proportion of caregivers of children under 5 years satisfied with health services received during recent child illness episode	Optional in Horizon (C1C.21342)	Caregiver survey	
Output 3.1	Support, oversight and promotion provided to CHW programmes	# and % of COMMs supporting CHW/volunteer activities in locally-agreed ways	Core and in Horizon (C1C.21004)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged CHW/volunteer-related community
		# and % of COMMs meet quarterly with CHWs for support, discussion and feedback	Optional		
		# of CHW/volunteer-related community sensitisation activities by COMM	Optional		

Output 3.2	CHWs receive supportive supervision from COMMs	# and % of COMMs supervising CHWs to agreed standard	Core and in Horizon (C1C.21005)	COMM Action Plan (Tool C)	Trained COMM groups stay motivated and engaged
		# of CHWs being supervised by COMMs	Core and in Horizon (C1C.21006)		

4.3 Information flow and use

See Section 7: Field Guides for a summary of these tools and the link to access them

1. **Monitoring Tool A** will track the programme activities, usually carried out by the WV and/or MoH field facilitator. The programme will use quarterly results to address low levels of activity if required.
2. **Monitoring Tool C** is owned and managed by the COMM, and tracks COMM outputs (e.g. the output indicators presented in Table 5 above), and collected by the field facilitator using Monitoring Tool C Summary Form.
3. **The COMM Monitoring Spreadsheet** enables the aggregation of outcome indicator results from each COMM (e.g. number and per cent of COMMs completing root cause analysis, number and percent of COMM responding to issues related to adolescents, to HIV, etc.). These results are shared with programme managers quarterly (upward flow). It remains to be seen if any Tool C data can be used for national-level advocacy initiatives.
4. **Aggregated Tool C results** are also shared with field staff (downward flow). This data may indicate areas where COMMs could benefit from additional assistance. Field facilitators will use the data for decision-making in that regard. Field facilitators can also choose to share aggregated Tool C results with COMMs (downward flow), as this enables them to compare their outputs with those of other (neighbouring) COMMs. This may lead to learning visits or other forms of collaboration.
5. COMMs will share their work and the data from Tool C with the wider community (downward flow) during quarterly debriefing meetings, ensuring that information regarding their outputs (their work) flows back to the communities that they serve. Summaries of this data may be shared at annual community review and planning meetings.
6. Finally, over time, the data may be shared externally. Output data should be of interest to external stakeholders in terms of the types of activities that COMMs are engaged in.
7. Monitoring Tools B and D are quality assurance/mentoring tools and thus serve different purposes. Tool B is used by the facilitator's supervisor when observing a COMM training carried out by the facilitator, for feedback and quality assurance. Tool D is used by the facilitator when observing COMMs in action during mentoring or support visits, for feedback and quality improvement.

5. Management Considerations

5.1. Guidelines for staffing

To successfully implement this project, the following staff is required:

- National Office Health Manager, Technical Programme Manager
- 1 health-focused facilitator per ADP/Area Programme, if WV is responsible for capacity building, mentoring (as opposed to MoH); works with three to ten COMMs
- If MoH is carrying out those roles, the generalist Development Facilitator should nonetheless be trained in COMM to be able to support.

Project implementers (both WV staff and partners) need to have the following competencies:[2]

NO Health Managers

- CSS 201:[3] Provide strategic guidance and lead management of programming for community systems strengthening for health

Field Facilitators

- CSS 002: Facilitate and strengthen community health committees
- CAP 003: Facilitate and support training
- SEP 001: Build and maintain relationships with community stakeholders
- SEP 002: Facilitate community groups and meetings
- ADV 001: Facilitate local-level advocacy
- DME 021: Facilitate monitoring processes with partners and the community

Technical support and supervision that will be required:

- Facilitators need to go through ToF carried out by a certified COMM trainer, to include a mentored practicum component
- NO Health Manager should supervise facilitators as they implement
- NO Health Manager usually needs technical assistance from Global Centre and/or a certified COMM trainer during the 'Country Readiness' process.

5.2. Budget

Costing variables across categories for COMM:

- COMM Programme Functionality Assessment workshop with MoH (Appx: 20–25 people x 2–3 days: venue, meals, accommodation if needed, 1 day field visit to COMMs – fuel, packed lunch)
- Resource development: Translation, adaptation of materials, printing of materials (Facilitator's Manual; all sections)
- Training cascade: Trainer's costs (international travel and accommodation), Facilitator's costs (local travel and accommodation), COMM members' costs (local travel, accommodation as needed, allowances as per country policy), training venue and refreshment and catering, local travel (fuel) for field practicum
- Monitoring and evaluation: Materials reproduction (e.g. monitoring tools, evaluation survey), transport
- Staff salaries: WV health staff involved in COMM programming
- Other: Other potential meetings/workshops with MOH (Introduction to COMM, curricula comparison, contextualisation, etc.)

Economies of scale that should be considered as as follows:

- One ToF per country (train 15–20 facilitators at once)
- While COMM may be piloted in one or two ADPs, the most efficient economies of scale will come when scaling up COMM programming across most or all ADPs/area programmes
- Number of COMMs per ADP/Area Programme will vary based on administrative levels at which the groups are found, but in most cases, will be three to ten per ADP.

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[2] Competencies referenced here are taken from the full *Integrated Competency Development (ICD)* set of competencies, and may be accessed at: https://www.wvecampus.com/course/view.php?id=629.

[3] All competencies are given codes. See the ICD site (link in footnote 2) for a complete listing of competencies and their corresponding codes.

6. Linkages and Integration

6.1. Child focus

Child participation

Because the 7-11 life cycle stage focuses on pregnant women and children under 2, child participation in this age category is not considered. However, the COMM is responsible for identifying the health issues affecting this cohort of children age 0–2 and ensuring that the most vulnerable are included in analysis and activities.

Additionally, the COMM supports CHW and ttC programming and the ttC model contains mechanisms for intentionally targeting and monitoring most vulnerable families and children.

COMMs may expand their focus over time to include other age cohorts outside the 1,000 day-period. As this happens, they should begin to include children in their work, both by involving children in health messaging at home and in schools, for example, and through participatory monitoring of health changes from the perspective of the children. To the extent that COMMs prioritise work with adolescents, the adolescents themselves must be the participants, as opposed to parents or guardians on their behalf. If COMMs address issues of child/early/forced marriage, they must work directly with the youngsters affected, in design and implementation of possible solutions.

Further, there will be additional scope for child participation when COMM is linked to other programming models, such as CVA or Channels of Hope. The CVA project model includes community-level monitoring of services (health, education, etc.), and recommends that children participate in these monitoring processes.

Child protection

The COMMs will liaise regularly with CHWs who are visiting the homes of community members. CHWs will usually refer suspected child protection issues directly to the appropriate authorities, as issues of confidentiality advise against informing the full membership of the COMM. In some instances, however, it may be most appropriate for CHWs to inform the COMM chairperson or other identified COMM leader, to channel the referral accordingly.

If there is a child protection committee in the community, the COMM will actively liaise with this group.

Child Sponsorship (as relevant)

Child Sponsorship should be integrated into the COMM model in the following ways:

- COMMS should be part of the community-based CWB monitoring committee that overseas and responds to CWB issues, including sponsorship monitoring
- Registered children (RC) and their households should be included in the samples when COMMs are carrying out root cause analyses of health issues in their communities. Further, since COMMs are instructed to access any secondary data as may exist when carrying out the root cause analysis, they should be guided to make use of STEPwise/Horizon health data as an important source.
- Reported health issues can be referred to the COMM through RC case management.
- COMMs can support the training of sponsorship monitors in health issues.

6.2. Development Programme Approach (DPA)

The DPA begins with an assessment which will underscore and confirm the need for health programming. When health is considered a priority to the community, ADP staff together with community members will follow the steps of the critical path to determine the specifics of the programming. As part of this process, ADP staff will explain the 7-11 health strategy and the three core models that make it up, and will seek to agree with the community on the importance of implementing these three models; one of which is COMM.

Step 5 of the critical path involves forming working groups to respond to the key issues identified in the assessment and in the in-depth inquiry that takes place in Steps 1–4. When health is identified as a critical issue requiring response, some type of health working group is then identified or formed in Step 5, usually from among an existing group such as a MoH-led community health committee, for example. This health working group is the COMM.

The COMM, therefore, emerges in Step 5 of the critical path. As ADP staff work though the critical path and, together with the community, identify the health working group, this group should therefore be considered the

COMM, and the programming described in the COMM package of materials can then be carried out with this group.

In line with the DPA philosophy, the COMM model sees change as originating primarily from within the community. WV has models, data and other information to share, but the agents of change are the community members themselves, as they are children of God, endowed with human capacities to learn, grow and transform.

6.3. Faith

Christian faith is invoked through the involvement of churches and faith communities in the COMM model, especially as part of Output 1.3: *Community activities implemented to address identified health issues*. The COMM has an important role to play in addressing harmful social, cultural and gender norms that adversely affect health outcomes, and will usually need to engage the church/faith community in its transformational efforts. This will be tracked through the indicator *'# and % of COMMs whose action plans involve working with the faith community for social/cultural norm change'*, and *'# and % of COMMs requesting and participating in Channels of Hope programming'*.

While COMMs may choose to independently reach out to faith communities as they assess the root causes of health issues and recognise the important role that these influencers can play in transforming harmful norms contributing to the health issues, the COMMs and the faith leaders may not always know *how* to go about effecting such transformations. In most cases, it will be most beneficial for WV to assist by bringing in one or more additional models with this aim, such as Channels of Hope, Community Change, or The Grandmother Approach, for example. WV is still gaining experience in carrying out COMM programming together with social transformational models.

Christian faith will also work within the COMM model through the participation of representatives of the faith community as members of the COMM, which is a specific recommendation/Implementation Quality Assurance standard given for COMM programming.

Examples of harmful social, cultural and gender norms that may adversely affect health outcomes include:

- female genital mutilation
- selective abortion of female foetuses
- HIV-related stigma, adversely affecting care-seeking behaviours
- norms related to intra-family food distribution favouring men that may compromise the nutritional status of pregnant women
- stigma related to adolescent pregnancy, resulting in late revealing of pregnancy and late attendance at ante-natal care
- myths regarding infant and young child feeding, e.g. food taboos
- early cessation of breastfeeding due to prevailing beliefs (e.g. when pregnant with another child)
- beliefs related to reduced feeding during childhood illness.

The COMM will carry out a root-cause analysis of health issues to identify these types of barriers and will develop action plans in response. Activities to address harmful norms and beliefs will often involve other stakeholders (e.g. the faith community and other community 'gatekeepers'). One recommendation in these examples will be that the COMM request that WV bring in Channels of Hope programming, which has been shown to be effective in norms transformation. WV is still gaining experience in programming the two models together.

Additionally, the recommendation is that COMM membership includes one or more representatives of the faith community and/or local FBOs.

6.4. Integration and enabling project models

As previously described, the objectives of the COMM model are best achieved when COMM is implemented alongside CHW/ttC and CVA. In this way, all levels of potential barriers to positive health practices – individual-level barriers, social/cultural norms at community level, and services and policies at the environmental level – can be addressed in tandem.

The need to incorporate models that address social and cultural norms has been discussed. When norms are identified as barriers to positive health practices, models such as Channels of Hope for MNCH, HIV, Child

Protection and/or Gender; Community Change; and/or The Grandmother Approach, for example, should be considered.

Where possible, linkages between the COMM and child protection committees should be established. These linkages support early identification of at-risk situations, reporting and referral of child protection incidences. A coordinated response strengthens the safety net for children experiencing abuse, exploitation, neglect and other forms of violence.

7. Field Guides

Resource name	Description
Project Model Landing Page: (all documents found here) https://www.wvcentral.org/community/health/Pages/COMM.aspx#InplviewHash2abf95c7-4298-498d-a1fe-60dbddad33a0=FolderCTID%3D0x012001	
COMM Design Guidance	
COMM Project Model: Description and Guidance for Design	This document provides a description of the COMM project model. As a descriptive (as opposed to operational) document, its purposes are to provide background information and justification for the model, and guidance for NO - level staff responsible for health technical support to ADPs, and/or for grant proposal-writing. It is aimed at the level of description and design parameters, and at 'Country Readiness' processes needed to prepare an NO to engage in this programming. It is *not* a 'how-to' manual for ADP staff. Includes Quality Assurance Implementation Standards.
COMM 'Country Readiness' Tools	
Scenarios for COMM Identification	In cases where there is more than one type of community health group in programme areas. This document provides guidance on COMM identification and selection in 11 different scenarios.
Curriculum Comparison Tool	In cases where the MoH and/or other partners have materials for the capacity building of community health committees. This tool provides a structure for comparing the alternative curriculum(a) with the WV COMM package.
COMM Programme Functionality Assessment Tool: Community Health Committee Assessment and Improvement Matrix	A matrix with 14 elements considered necessary for effective COMM programming, with a scoring range of 0–3 to enable programming assessment and action planning around areas assessed as weak.
COMM Core Curriculum Package	
Trainer's Guide for Training Facilitators in COMM Assessment and Technical Capacity Building	Provides all necessary guidance for trainers to effectively carry out a ToF in four phases (pre-classroom, classroom, practicum, and follow-up support). Includes a full toolkit in appendix to enable trainers to comply with Individual Learning & Development (IL&D) implementation protocols and measurement requirements.
Facilitator's Manual for COMM Assessment and Technical Capacity Building	The Facilitator's Manual for working with COMMs is made up of various sessions, which facilitators and COMMs will select as relevant based on the appreciative assessment. The full Facilitator's Manual is comprised of the following: • Overview for the Facilitator • Introduction to 7-11 Health Content and 360 Degrees of Support for Behaviour Change • Appreciative Discovery ('Light Assessment') • Session 1: Linkages and Networking • Session 2: Supporting CHWs • Session 3a: Root Cause Analysis (light version) • Session 3b: Root Cause Analysis (robust version) • Session 4: Responding to Health Issues and Barriers, and Mobilising for Action

	• Session 5: Tracking Community Health Status • Session 6: Reporting Community Health Status
Facilitator's Guide to 7-11 Health Content	A companion document to the COMM package of materials. Written in a Q&A format, this guide enables facilitators to train COMMs in the basic 7-11 health information and answer the questions they are likely to pose. May be used for many purposes (i.e. not only with COMMs), with staff or others requiring improved health literacy.
References for Organisational Capacity Building	Additional resources to assist COMMs in building capacity in internal functions such as leadership, procedures, financial management, etc.
COMM Monitoring Tools	
COMM Monitoring Tools	Four standard tools for COMM programme monitoring: • Tool A: Monitoring facilitator activities • Tool B: Quality assurance of facilitator activities • Tool C: Monitoring COMM outputs • Tool D: Quality assurance of COMM outputs (e.g. a tool for mentoring COMMs)
COMM Indicator Tracking Spreadsheet	A spreadsheet for data input from Tools A and C enabling data aggregation and analysis of achievements against indicators
Implementation Quality Assurance (IQA) Tool	A document outlining the essential elements for COMM implementation, and a spreadsheet/calculator for entering results of IQA exercises
COMM Related Competencies	
Competency CSS 201: Provide strategic guidance and lead management of programming for community systems strengthening for health (Included in ICD competency bank)	This competency is required of NO Health Managers responsible for overall health strategy and programming support. The competency describes that which is needed for strategic decision-making regarding CSS programming, and for effectively overseeing its implementation
Competency CSS 002: Facilitate and strengthen community health committees (Included in ICD competency bank)	This competency is required of field facilitators working directly with COMMs. The competency describes the ability to work effectively with community health committees as part of health community systems strengthening, in alignment with local MoH guidelines.

NOs considering COMM programming should contact the Global Centre COMM project model champion, Michele Gaudrault, at michele_gaudrault@wvi.org.

APPENDICES

Appendix A: Level of Evidence for Community Health Committee Programming

Project Model	Evidence Rating	Justification
Community Health Committee (COMM) The foundational approach at the community level within WV's 7-11 Health strategy is the community health committee (COMM). A COMM is a group structure created with the intent of facilitating, coordinating and encouraging overall community health. COMMs empower communities to bring about change by strengthening health systems and building community capacity, which leads to improved maternal and child health outcomes, overall community health, and a stronger civil society. Objectives of a COMM may include: • Provide a support system for Community Health Workers (CHWs) and other community health volunteers • Assess and track the community health situation, mobilise the community for improved health • Respond to barriers to health-related behaviour change at the community level • Assist with communication to and from the health system and the local administration • Advocate around issues leading to improved health systems		1. Community health committees can improve the quality and coverage of health services. Utilisation of general outpatient services is approximately 20 per cent higher in communities with community health committees compared with communities without committees. Health facilities in communities with local committees did better than in communities without committees on a number of measures, including better user satisfaction and access for the poorest. Facilities with health centre committees have significantly higher likelihood of health service use (2.3% $p<0.05$) and significantly greater use of antenatal care. They are better funded and have stronger links between communities and health workers compared with those without. 2. Community health committees can lead to improved community health outcomes. There is evidence that programmes working collaboratively or those that achieve shared leadership with the community can improve critical health behaviours, increase knowledge, improve practices, affect social norms, lower disease incidence, and reduce poor health outcomes and mortality, even in low resource settings where social conditions and practices could otherwise result in poor child health. Evidence suggests that community engagement has a positive impact on certain social determinants of health. The evidence also indicates that building community capacity serves as a means to an end – improved health behaviours and reported collective action for health.

APPENDICES

Appendix B

Study Reference	Study Dates/link	Study Description	Study Results	Type of Evidence	Scale of Evidence	Level of Evidence
Bjorkman, M., Svensson, J., 'Power to the people: evidence from a randomized field experiment on community-based monitoring in Uganda', *Quarterly Journal of Economics* (2009) 124(2): 7635–69.	2009 http://qje.oxfordjournals.org/content/124/2/735.short	Randomised case-control study of an intervention to strengthen the community monitoring of rural primary health-care facilities; 55,000 households, before and after surveys of households and health facilities (Uganda).	Immunisation and Vitamin A coverage significantly improved in intervention communities. Utilisation of general outpatient services about 20% higher in intervention facilities for deliveries, antenatal care and family planning. Differences in under-5 mortality suggested a substantial treatment effect.	Mixed method impact evaluation	Multiple contexts in 1 country	Level 2
Farnsworth, S., Bose, K., Fajobi, O., Souza, P., Peniston, A., Davidson, L., Griffiths, M., Hodgins, S., 'Community Engagement to Enhance Child Survival and Early Development in Low- and Middle-Income Countries: An Evidence Review,' *Journal of Health Communication: International Perspectives*, (2014) 19:sup1, 67–88.	http://dx.doi.org/10.1080/10810730.2014.941519	The authors conducted a systematic review of the effectiveness of community mobilisation and participation that led to behavioural change and one or more of the following: child health, survival and development. The level and nature of community engagement was categorised using two internationally recognised models and only studies where the methods of community participation could be categorised as *collaborative* or *shared leadership* were eligible for analysis.	There is evidence that programmes working collaboratively or those that achieve shared leadership with the community can improve critical health behaviours, increase knowledge, improve practices, affect social norms, lower disease incidence, and reduce poor health outcomes and mortality, even in low-resource settings where social conditions and practices could otherwise result in poor child health.	Systematic review / meta-analysis	Multiple countries in 1 or 2 regions	Level 3
Iwami, M., Petchey, R., 'A CLAS Act? Community-based organizations, health service decentralization and primary care development', *Peru. Journal of Public Health* (2002) 24: 246–51.	https://www.ncbi.nlm.nih.gov/pubmed/12546199	Retrospective study of the impact of Local Committees for Health Administration (CLAS) in identifying unmet health needs, generating resources to meet those needs and developing payment system to protect the poor. No control group, but some comparisons made with non-CLAS run facilities (Peru).	CLAS facilities did better than non-CLAS facilities on a number of measures including better user satisfaction and access for the poorest, partly through better outreach and more effective exemption of user fees for poor individuals and families.	Cross sectional / evaluation without baseline	1 context in 1 country	Level 1

Study Reference	Study Dates/link	Study Description	Study Results	Type of Evidence	Scale of Evidence	Level of Evidence
Loewenson, R., Rusike, I., Zulu, M., 'Assessing the impact of Health Centre Committees on health system performance and health resource allocation', *EQUINET Discussion Paper* (2004) 18. Harare, Zimbabwe.	http://www.equinetafrica.org/sites/default/files/uploads/documents/DIS18%20res.pdf	Ecological case-control study in three rural districts comparing four wards/facilities with health centre committees (HCC) with four wards/facilities without. Also studied factors affecting HCC performance (Zimbabwe).	Facilities/wards with HCCs had significantly higher likelihood of health service use for last illness (2.3% $p<0.05$) and significantly greater use of antenatal care, fewer cases of diarrhea, more staff, better funded, has better community health indicators, and has stronger links between communities and health workers compared with those without.	Case-control	Multiple contexts in 1 country	Level 2
McCoy, D.C., Hall, J.A., Ridge, M., 'A systematic review of the literature for evidence on health facility committees in low-and middle-income countries', *Health Policy Plan* (2012) 27(6): 449–66.	http://heapol.oxfordjournals.org/content/early/2011/12/08/heapol.czr077.full.pdf+html	Systematic literature review of: (a) the evidence of effectiveness of health facility committees (HFC) in community health and (b) the factors that influence the performance and effectiveness of HFCs. Out of 341 potentially relevant publications, only four (Peru, Zimbabwe, Kenya, Uganda) provided reasonable evidence of the effectiveness of HFCs.	All four studies described a positive impact, suggesting the possibility of publication bias. Only one of the studies involved a randomised controlled study design, but two other studies involved reasonable study designs that provide convincing evidence of benefit.	Systematic review	Multiple countries in 1 or 2 regions	Level 3
Olayo, R., Wafula, C., Aseyo, E., Loum, C., Kaseje, D., 'A quasi-experimental assessment of the effectiveness of the Community Health Strategy on health outcomes in Kenya', *BMC Health Services Research* (2014) 14(Suppl 1):S3.	2011 - 2012 http://doi.org.offcampus.lib.washington.edu/10.1186/1472-6963-14-S1-S3	Quasi-experimental study of effectiveness of the community health strategy on health outcomes. Pre- and post-intervention surveys in intervention and control sites. The intervention was implementation of all components of the Kenyan Community Health Strategy, which includes community health committees (Kenya).	A number of health indicators, health facility delivery, antenatal care, water treatment, latrine use and insecticide treated nets, presence of clinic card, and measles vaccination improved in the intervention sites compared to non-intervention sites. The difference was statistically significant ($p<0.0001$).	Quasi-experimental	Multiple contexts in 1 country	Level 2

Study Reference	Study Dates/link	Study Description	Study Results	Type of Evidence	Scale of Evidence	Level of Evidence
Popay, J., Attree, P., Hornby, D., et al, eds. *Community engagement in initiatives addressing the wider social determinants of health: A rapid review of evidence on impact, experience and process.* Lancaster UK: Lancaster University, Liverpool University, Central Lancashire University; (2007).	https://www.nice.org.uk/guidance/ph9/documents/social-determinants-evidence-review-final2	This report examined the evidence for the effectiveness of initiatives seeking to engage communities in action to address the wider social determinants of population health and health inequalities.	The evidence shows that for some groups there are a range of clear and identifiable benefits of direct community engagement, but across the studies the range of methods and approaches used vary. Evidence suggests that community engagement has positive impact on following social determinants of health: housing, crime, service delivery, community engagement and empowerment.	Qualitative review	Multiple countries in 1 or 2 regions	Level 3
Ricca, J., Kureshy, N., LeBan, K., Prosnitz, D., Ryan, L., 'Community-based intervention packages facilitated by NGOs demonstrate plausible evidence for child mortality impact', *Health Policy and Planning* (2013) 1–13.	http://heapol.oxfordjournals.org/content/29/2/204.full.pdf+html	The study reviewed 12 projects in the Child Survival and Health Grants Program database (NGO projects implementing community-based intervention packages) completed within the prior 12 months that had sufficient information for analysis of the coverage changes for evidence-based interventions for reducing under-5 mortality. As none of these projects had independent direct under-5 mortality rate (U5MR) estimates, project coverage data were modelled in the Lives Saved Tool (LiST) created by Johns Hopkins University to estimate mortality effects.	NGO projects implementing community-based intervention packages appear to be effective in reducing child mortality in diverse settings. There is plausible evidence that they raised coverage for a variety of high-impact interventions and improved U5MR by more than twice the concurrent secular trend. All projects used community-based strategies that achieved frequent interpersonal contact for health behaviour change.	Systematic review / meta-analysis	Multiple countries in more than 2 regions	Level 4
Rifkin, S., 'Examining the links between community	10.1093/heapol/czu076	The purpose of this work was to review research seeking to link community	Community participation is increasingly recognised as key to	Systematic review /	Multiple countries	Level 3

participation and health outcomes: a review of the literature', *Health Policy and Planning* (2014) 29 (Supplement 2):ii98-ii106.		participation with improved health status outcomes programmes. It updated a review undertaken by the author in 2009. The search includes published articles in the English language and examines the evidence of in the context of health-care delivery, including services and promotion where health professionals have defined the community's role.	improving and maintaining interventions that improve health outcomes. To date, community participation has most often been seen as an intervention to improve health outcomes rather than a process to implement and support health programmes to sustain these outcomes.	meta-analysis	in 1 or 2 regions	

Study Reference	**Study Dates/link**	**Study Description**	**Study Results**	**Type of Evidence**	**Scale of Evidence**	**Level of Evidence**
Sohani, S., 'Health care access of the very poor in Kenya', Workshop paper 11. Meeting the health-related needs of the very poor, DFID Workshop (14–15 February, 2005), Kenya: Aga Khan Health Service.	2000-2004 http://www.eldis.org/fulltext/verypoor/11_agakhan.pdf	Before-and-after intervention study of a model of community participation in health involving ten dispensary health committees (DHCs) in two rural districts. No control dispensaries. Parallel study of the process of the intervention (Kenya).	Health-care utilisation and revenue generation increased in all clinics, weekend outreach for distant villages initiated, medicines more readily available. Improved financial systems. Although study lacked control clinics, study was able to describe a number of plausible causal pathways linking the intervention to the improvements described.	Mixed method pre- and post-test / evaluation with baseline	Multiple contexts in 1 country	Level 2
Underwood, C., Boulay, M., Sentro-Plewman, G., et al. 'Community capacity as a means to improved health practices and an end in itself: evidence from a multi-stage study', *Int Q Community Health Educ* (2012) 33(2): 105–27.		Endline evaluation of a programme for strengthening community-based systems and networks. A two-stage cluster sample using three strata: high intensity intervention, low intensity intervention and control communities (Zambia).	Intervention communities (no difference between high and low intensity) had significantly higher levels of community capacity than the non-intervention communities. Enhanced community capacity was associated with having taken community action for health, with indirect effects on health behaviours including contraceptive use, receipt of HIV test results and bed net use among young children. The results indicate that building community capacity served as a means to an end	Mixed method pre- and post-test / evaluation with baseline	1 context in 1 country	Level 2

			– improved health behaviours and reported collective action for health – and an end-in-itself, both of which are essential to overall well-being.			

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