

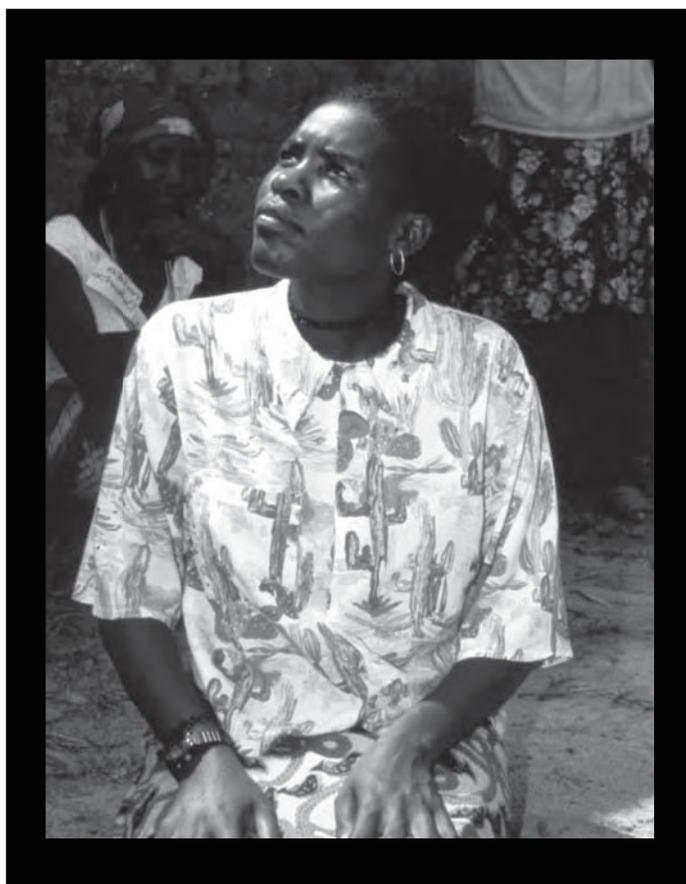
# Directions in Health

Guidance for working towards the time when ...

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*The communities  
we serve have  
taken charge of  
their own health  
in order to enjoy  
integral human  
development.*

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CRS HEALTH, 2008



**USAID**  
FROM THE AMERICAN PEOPLE

**CRS**  
CATHOLIC RELIEF SERVICES

Pending Final Edits

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## Guidance for working towards the time when ...

*The communities we serve have taken charge of their own health  
in order to enjoy integral human development.*

**CRS HEALTH, 2008**

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## **A. INTRODUCTION**

Maternal and child health has been a focus of Catholic Relief Services' (CRS') programming since its inception in 1943. CRS refocused this vision to improve the health of mothers and their children through empowered communities<sup>1</sup> in the 1995 Directions in Health paper. The paper states: "Empowerment of the community will be achieved by ... enabling the community to identify its health needs and assess and advocate for changes in its health environment."

The authors of the 1995 paper recognized the need for empowering communities. However, the specific guidance given in the paper focused on technical interventions aimed targeting household members (primarily the mother and other child care providers). As a result of that, CRS programs developed technical excellence in low cost, effective child survival and nutrition interventions. The 1995 paper also assumed that key health problems were the same across regions. However, epidemiological profiles have demonstrated wide variances from one region to another.

From May-July 2007, regional and HQ health technical advisors, program managers and others participated in an assessment of the current state of health programming. The findings showed that CRS has broadened its technical interventions to target community health issues (e.g. maternal and child health, mental health, HIV, TB, and malaria), seeking community involvement in addressing health issues that affect them. This expansion reflects the agency's responsiveness to external trends not foreseen in 1995 as well as its efforts to promote the spirit of solidarity needed for Integral Human Development (IHD).

The guidance in this 2008 Direction Paper will be on supporting the community to advocate for a caring environment that fosters healing, influences behaviors and sustains wellness between individuals and the private/public providers. CRS is committed to technical excellence and will take the steps necessary to ensure that its health programming adheres to globally-recognized protocols and supports evidence-based interventions. This paper will not provide guidance on specific health problems, as there are already sufficient technical protocols and guidance from the World Health Organization (WHO), other international bodies, and from the Ministries of Health.

Therefore, rather than prescribe a uniform approach to health conditions, this paper will encourage programs to engage communities in responding to their most pressing health needs. Each region/country will be responsible for identifying key health conditions to be addressed. This means that instead of a one-size-fits-all approach, there will be different foci depending on the project area. Such an approach is in line with our agency's principle of subsidiary<sup>2</sup>.

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<sup>1</sup> "Community" within the CRS-Health programming context is defined locally and may be a group of households, a village, a small town, or a community of practice such as mother-to-mother support groups, professional associations, clergy, or affinity groups such as association of the disabled. It is defined as a group who holds something in common and wishes to work together.

<sup>2</sup> Subsidiary: a higher level of government--or organization--should not perform any function or duty that can be handled more effectively at a lower level by people who are closer to the problem and have a better understanding of the issue.

Within CRS there are sufficient tools for each region to identify the prevalent health conditions that most impact the populations they serve, including the CRS' Strategic Planning Process for each CRS country office and regional strategy plans. Using information from the WHO, Ministry of Health, and major donors, among others, CRS regions and country programs should identify prevalent conditions and trends in health. (At a later date regional trends will be available on the HEALTH web page)

The guidance in this paper will focus on the following four strategic domains<sup>3</sup> necessary for CRS to achieve community-owned health programming:

- capacity strengthening
- advocacy
- synergy and sustainability
- learning environment

Having an agreed-upon set of strategic domains will enable us to be more deliberate in using our resource support communities to advocate, mobilize resources, and promote wellness and healthy behaviors. There are many examples of CRS interventions that engage communities to address certain diseases or health problems. Examples include home-based care programs targeting People living with HIV and Community-Integrated Management of Childhood Illnesses (CIMCI) programs targeting young children. However, we have not consistently institutionalized these four domains. This paper provides guidance for integrating these four domains into all health programming.

## A.1 Vision Statement

CRS strives to have high quality health programs, using proven low-cost, effective interventions. For health outcomes to be sustained, community leaders and members – along with the public and private sectors – must be involved in promoting optimal behaviors and attitudes that affect health. As such, CRS' vision of health is...

*The communities we serve have taken charge of their own health in order to enjoy integral human development.*

IHD is based upon the principle that people should be able to meet their basic needs, i.e., health, education, food, livelihood and shelter. Experiencing IHD does not necessarily mean to be in a "perfect state of health." Rather, the underlying premise is that individuals and their communities have the necessary resources to mitigate threats of preventable diseases or health conditions and have all necessary support to live a dignified and fully-developed life, regardless of personal health status.

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<sup>3</sup> Strategic domain: Used here to mean a field of study that is managed or processed for high quality program results.

As with any human right, the right to health should entail a dynamic partnership between individuals, their communities, and other stakeholders in the private and public sector. Individuals bring to the partnership social, biological and behavioral determinants that affect their individual health. Stakeholders in both the private and public sectors bring to the partnership a range of services, including policy-making, opinion-shaping, delivery of health services, and other resources that affect health or funds. Communities are thus ideally positioned to be advocates and caring providers and to provide a caring environment that fosters healing, influences behaviors and sustains wellness between individuals and the public/private sector.

A community that has taken charge of its own health would demonstrate the following characteristics:

- An awareness of its own ability to bring about sustainable health outcomes.
- A commitment to modeling behaviors and attitudes that promote healing, reduce vulnerabilities and maintain wellness.
- An inclusive manner of working with existing structures and leaders on health outcomes.
- A commitment to consensus-building among its members to achieve positive health outcomes.
- The use of advocacy tools and channels that lead to resource attainment from government and other sources for meeting its health needs.

Experience has shown that communities need the following if they are to take charge of their own health:

- The capacity to foster and maintain the solidarity of the community and its focus on the common good over the long term.
- The ability to define and manage plans for improved health outcomes: A community's commitment to change a health problem starts when it can claim health issues as its own, plan and implement actions in collaboration with appropriate stakeholders, monitor and evaluate results, and internalize lessons learned.
- The skills to build consensus with other members of the community: This means to engage individuals to a) claim the problem and b) act towards its mitigation. Actions can include individuals adopting new behaviors and/or supporting others to adopt new behaviors.
- Advocacy and resource acquisition: Even the wealthiest among us cannot claim health as a basic right without having a) effective policies and practices that promote health and well-being, and b) access to quality curative and preventive services, clean water and air, safe food and drug supplies, education, and public safety. The communities CRS serves need skilled advocates if their members are to be healthy.

## A.2 Programming Implications

CRS recognizes that principles of IHD community development and mobilization are critical for sustainable development. Beginning in the 1960s, CRS' traditional maternal and child health programming began shifting toward a multi-sectoral approach through community development and mobilization. The shift from traditional MCH programming to a multi-sectoral approach led to micro-finance, education, peace-building and agricultural activities with women and their households. These activities have the potential of addressing underlying causes of illness and malnutrition.

At the end of the 20th century, re-emerging diseases (e.g. TB and malaria), along with HIV, wars, natural disasters and inequities wreaked havoc on populations. Advances in maternal and child health outcomes in certain regions (such as Latin America) are threatened by violence, accidents, chronic diseases and disasters. Malnutrition contributes to 53% of under-five deaths<sup>4</sup> and exacerbates health problems throughout life. While advances in medicine help individuals, the underlying causes of illness and malnutrition remain largely unaddressed. Increasingly, there is recognition that to address these underlying causes, the communities need to take ownership of health and treat it as a basic human right. CRS as an agency needs to continue addressing prevalent illness and health conditions, while promoting an enabling environment for communities to define and address their health care needs.

**Community-centered approaches** will help communities to address the most prevalent causes of mortality and also the loss of economic and social assets that leads to diminished human capital within their geographic areas. Health is no longer the exclusive domain of the "health sector"; addressing underlying causes that impact and limit the potential of human capital means taking a multi-sectoral approach as well as providing specific health interventions when appropriate. Each region and country program would have to identify the "disease" priorities based on epidemiology profiles. In collaboration with the Ministry of Health, local partners, and communities, CRS will design interventions with the communities affected that address the underlying causes of these health conditions including but not limited to: poverty, domestic violence, the role of women as decision-makers; access and equity in services. To assure that our programs fully incorporate community-owned approaches, there are four strategic domains that must be present in all CRS' strategies and programs. These are:

- Capacity strengthening: Provision of technical and managerial support to our partners, communities and the larger environment
- Advocacy: Assurance that communities, partners and CRS are making certain that the enabling environments support and sustain positive health outcomes
- Synergy and Sustainability: Making certain that at every level there is appropriate stewardship, sharing and utilization of resources to obtain optimal health outcomes for communities
- Learning Environment: The means to learn from programs, including documenting results through high quality monitoring and evaluation systems

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<sup>4</sup> United States Agency for International Development Bureau for Global Health  
Office of Health, Disease, and Nutrition( USAID/GH/HIDN) Technical Reference Material - Nutrition

## B. CURRENT PROGRAMMING SUPPORT TO ACHIEVING THE VISION

As reported on the CRS internal Project Tracking System (PTS) in 2007, CRS implemented approximately 40 health projects globally with a combined value of approximately \$16 million USD. These projects do not include HIV or water and sanitation projects, as these are administratively considered separate sectors within CRS. Health interventions currently supported by CRS include: malnutrition, malaria, TB, pneumonia case management, maternal health, and diarrheal diseases. The makeup of this intervention-based portfolio reflects the agenda of external donors and technical organizations. Maternal and child health has been the historic target population since the agency's inception. In the recent past, the health sector in CRS has also directed interventions towards adults for prevention and treatment of infectious diseases such as malaria, TB, Avian Flu, and Kalazar.

### B.1 Current Capacity for Community-Owned Approaches for Sustained Health Outcomes

A review of project documents and anecdotal discussions has highlighted several types of tools and methodologies appropriate for the community-owned approaches currently used in various CRS health projects. The question that remains is whether or not these tools, methodologies, and strategies are currently applied effectively and appropriately for CRS to a) be a facilitator in community-owned development models and b) provide needs-based capacity strengthening to various partners.

Three surveys of CRS health programming<sup>5</sup> indicate that CRS needs to address two critical areas to carry out a community-owned approach. These are

- Looping information back to communities for their appropriate use: Respondents in these studies felt that CRS lacked methodologies and systems for looping information gathered from communities back to them.
- Modeling our approaches for partners: CRS perceives itself as being strong on accompanying partners yet weak at modeling approaches to partners for replication in the community.

CRS needs to ask questions to learn about how its systems, processes and structural issues can facilitate community-based approaches. These questions include:

- How can we assure program quality as community-based approaches are replicated in multiple projects and regions?
  - The Program Quality concern is for those cases where interventions and methodologies have been modified without regard to the underlying principles of community empowerment. The 2006 CRS study on PD/Hearth efforts highlighted some success stories but also found that not all projects followed the established PD/Hearth community-owned methodologies. Other interventions such as PHAST, PRA, and IMCI also face similar challenges when these have been replicated in multiple projects and regions.

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<sup>5</sup> 2004 Meta Evaluation, 2006 PD Hearth and 2007 mapping exercises.

- How can we manage the internal processes of replicating promising practices?
  - A concern is that some practices are appropriate for use in multiple settings but not in others. CRS-Honduras successfully documented a promising community-based practice that while taken to scale in Honduras by the Ministry of Health has yet to be institutionalized by other CRS programs. Yet, other agencies have had success in adopting this approach to other regions.
- How can we develop effective systems for managing knowledge of community approaches?
  - CRS tried in the last ten years to apply community-led approaches within its health programs. However, lack of systems for transferring knowledge and skills for implementing the guidance resulted in weak diffusion and application.
- How can we achieve multi-sectoral integration within an organizational structure that is “sectoral”?
  - For valid technical, management and administrative reasons, CRS is organized around sectors at every level. Communities, on the other hand, do not see their problems as stand-alone technical sectors but as a complexity of issues. A concern is that our stand alone sector-focused projects miss opportunities to utilize other sectors to achieve health outcomes.
- How can we achieve synergy between health, HIV and water sectors while acknowledging management reasons for separation?
  - There is consensus for the management reasons that led to separation of HIV and water sectors. Nevertheless concern is growing that this separation affects program quality and learning, resulting in duplication of efforts. At the PQSD level, the staff of each sector are often working on the same thematic areas like nutrition, TB, malaria, PMTCT and water- borne diseases or strategies such as behavioral change or health system strengthening. In contrast, staff at the regional level, are often tasked with supporting all three sectors – which may or may not be an appropriate use of resources. Advocacy agendas are affected, as the same goal is often promoted by three different sectors with different perspectives and messages for action.

## B.2 Links to the Future

The development of the this paper is timely as it is occurring within the context of agency-wide efforts to strengthen CRS’ capacity to manage knowledge, support and manage talent, rollout IHD, and enhance capacity to promote partnerships. Furthermore, PQSD and the PQ community within CRS are committed to continue strengthening technical excellence in all sectors. To this end the above questions are being addressed as part of the broader agency strategies. Several positive trends that will help foster the full attainment of this paper’s vision are outlined below. These trends include:

- Commitment to authentic community-owned programming in all sectors of CRS as IHD increasingly becomes the pillar of our programming and advocacy agendas.
- Capacity-strengthening skills: A critical assumption of our vision is that CRS and its implementing partners will be able to facilitate community approaches and provide needs-based capacity strengthening. The growing focus on partnership

building within CRS is helping to strengthen its partners' capabilities as well as its own.

- **Systems for monitoring impact:** As the agency launches the PTS system and the Indicator basket, we see opportunities in making certain that our systems are not only collecting on standard health indicators, such as percentage of children sleeping under bed nets, but also collecting on community-ownership indicators, such as the percentage of community-defined health initiatives achieved. Defining and collecting such indicators will help monitor progress towards the vision of community ownership of its own health.
- **Focus on learning across the agency:** The commitment of the agency to learning will allow CRS to take advantage of projects that combine both high quality health service delivery and community-owned approaches. In particular, the CRS-Philippines TB program is one of the many learning opportunities in how communities respond to a particular disease, in this case TB.

In short, there are many resources both internal and external that can support our efforts to facilitate community-owned approaches for improved health outcomes.

## **C. THE WAY FORWARD**

### **C.1. Strategic Domains of Programming for Community-Owned Approaches**

This direction paper guides our engagement with communities to take charge of their own health behaviors and resources. It prescribes what should be present in all health-related interventions to assure optimal community ownership and sustainability. The paper does not provide guidance on technical interventions to address specific diseases or health conditions. CRS' technical interventions follow globally-accepted protocols and meet or exceed the standards and policies set by the Ministry of Health in the host country. Furthermore, the projects we support are at the primary level of health services, where the partnership between community, individuals and other stakeholders is most dynamic. Outlined below are the four essential strategic domains that have been identified to address the questions of capacity-strengthening, advocacy and influential relationships; synergy and sustainability; and learning environment.

These four domains should be incorporated by CRS and our partners in working with communities on carrying out health projects.

#### **Strategic Domain 1 - Capacity-Strengthening**

1.1. Strategy: CRS health programs will strengthen the technical, organizational, and project management capacities of communities, health providers, partners and CRS staff where appropriate.

1.2. Rationale: Technical excellence, partnership, program quality are all terms that are frequently seen in CRS proposals, or documents. Yet strengthening the necessary capacity required is often relegated to activity levels of projects. Capacity strengthening must be

the cornerstone of all our health programming. This includes hiring and retaining technical staffs appropriate for the programs both at the partner and CRS levels as well as supporting the human resource needs of health providers and communities.

1.3. Description: CRS health programs will assess resources and needs and tailor plans to provide the identified capacities – technical, organizational, and project management – at different levels toward achieving the vision. CRS and partners will undertake periodic assessment with the communities to monitor progress of capacity- strengthening goals.

1.4. Principles:

- Capacity strengthening will respect technical and managerial standards.
- Capacity strengthening will respect culture and legal systems.
- Subsidiary is reflected in our business processes with partners and communities.

1.5. Challenges:

- Identifying appropriate human resources to carry out the capacity needs.
- Current monitoring and evaluation systems (within CRS-Health) have not defined clear capacity-strengthening indicators to sufficiently monitor progress.
- Assuring that all stakeholders are in agreement of the needs of capacity strengthening.

## **Strategic Domain 2 - Advocacy and Influential Relationships**

2.1. Strategy: CRS Health programs will support communities to participate in the larger enabling environment to advocate and build relationships that contribute to meeting their health needs.

2.2. Rationale: Community-owned health requires an enabling environment that provides not only access to basic health services but also policies, programs, and resources for good health. Often the communities “receive” services with little opportunity to express their needs and views at district, national and global arenas.

2.3. Description: Communities will identify advocacy agendas (policy- and resource-driven) and carry them out with the support of CRS and partners. A resource and needs assessment will be carried out to identify needs and develop appropriate plans. These will be systematically monitored and evaluated to adjust as needed. CRS will improve the capacity of communities to influence public policies. At the same time CRS country programs, regional offices and HQ will strengthen the capacity of partners to support the communities’ identified advocacy agendas. CRS will improve the capacity of its country, regional and HQ staff to effectively influence key stakeholders through existing advocacy networks at national and international levels, therefore further diffusing the communities’ agendas.

2.4. Principles:

- The process is community driven.
- Catholic Social Teaching Principles are respected.
- Advocacy approaches respect the dignity and rights of all.
- Advocacy is seen as an essential element of the CRS mission.

2.5. Challenges:

- CRS Health staff lacks skills and competency in advocacy.
- Need to disseminate existing agency-wide guidance on CRS’ participation in advocacy processes at country, regional and global levels.

- Willingness of partners, Church, and CRS staff to accept community-driven agendas that may differ from those they are currently supporting.

### **Strategic Domain 3 - Enabling Environment for Synergy and Sustainability**

3.1. Strategy: CRS health program will support an enabling environment among partners, communities, other CRS programming sectors, technical agencies, universities, and others to optimize financial, technical and human resources for improved and sustainable health outcomes.

3.2. Rationale: Health is a dynamic partnership among individuals, their communities, and other stakeholders. Often there is a perception that “other stakeholders” are limited to those in the health field. Yet, evidence shows where there are opportunities for collaboration among a broad range of stakeholders such as agriculture, micro-credit or education, health outcomes are more dynamic.

3.3. Description: From the initial planning phase throughout the project, CRS, partners, and communities will identify potential areas of synergy and sustainability. Opportunities for synergy and sustainability can be formally agreed to with signed Memorandums of Understanding (MOUs) or informal agreements with the participating institutions. CRS will adhere to its partnership strategies to govern these relationships and use existing resources and approaches rather than reinvent the wheel.

3.4. Principles:

- Use of partnership principles.
- Use of Catholic Social Teachings.

3.5. Challenges:

- Buy-in of the concept of collaboration among stakeholders, including other program sectors of CRS.
- Flexibility of ongoing grants and programs to incorporate new activities.
- Continuation of activities as one project ends and another begins.
- Roll-out and use of the IHD framework.
- Understanding of the concepts of synergy and sustainability.

### **Strategic Domain 4 - Learning Environment**

4.1. Strategy: CRS Health programs provide structured opportunities for CRS staff, partners, and communities for learning, testing, documenting and disseminating community-owned practices that contribute towards the vision.

4.2. Rationale: Learning, sharing and managing the knowledge is essential to dynamic programming. The day-to-day pace and demands of projects often are seen as barriers to structured learning opportunities. The health sector needs to be proactive in institutionalizing a shared learning agenda at each level of the agency, with partners and with communities, in order to advance innovations or promising practices.

4.3. Description: Learning opportunities are part of rigorous monitoring and evaluation components. Learning could be carried out through different mechanisms, formal and informal. Examples would be regular monitoring and evaluation of activities, community of practice, formal courses, and interactive self-directed work. Learning opportunities could be through exchange visits at the community, partner and CRS country program levels. It is

envisioned that each CRS country program, the regional structures, and HQ have a shared agenda with each unit identifying appropriate ways to create and monitor this learning environment. Some of the questions raised above about our current programming would be part of this agenda. At country, regional and global levels, CRS will identify mechanisms for sharing results of learning to larger external and internal audiences. Also these levels will champion and monitor the uptake of innovated or promising practices to wider audiences.

#### 4.4. Principles:

- Adherence to industry-accepted monitoring and evaluation and research practices.
- Utilization of agreed-upon definitions of “Best Practices, Promising Practices, and Lessons Learned.”
- Taking advantage of local knowledge and skills.
- Respect for adult learning principles.
- Adherence to standards of documentation and publication (internal and external).
- Stimulation of learning and sharing through appropriate incentives, including allocating enough time for learning to take place.
- Application of lessons for improved programs outcomes.

#### 4.5 Challenges:

- Identifying and overcoming barriers to different learning opportunities (workload?).
- Committing to allocate resources at all levels in CRS to participate and disseminate.
- Finding suitable mechanisms for meeting a variety of learning needs at several levels: community, partner, and internal to CRS.
- Modifying project plans for incorporating outputs of learning experiences.

## **C.2. Application of Strategic Domains**

These domains are interdependent. For example, there is no value in learning if it is not transferred to others. One therefore would have to have the capacity to train others in the relevant knowledge. Innovations that have demonstrated results should inform the advocacy agenda. Often innovations need resources and technical support outside the scope of a project and therefore synergy and collaboration are important tools.

Nor are the domains only for projects – the application of the domains is intended for use in strategic plans of countries or regions, the work plan of PQSD-Health, as well as in projects.

### **Appropriate times for applying the guidance include:**

Proposal design and development processes and tools: All throughout the proposal process (not just the period provided by the donor from release of Request for Application (RFA) to proposal submission) there are opportunities in tools such as Project Idea Notes, Concept Notes, and Proframes to assure the incorporation of the domains. Questions to address are:

- How does this proposal contribute to communities taking charge of their own health?
- What are the actions needed in the proposal to assure that communities can take charge of their own health?
- How does the proposal incorporate the four domains of learning, synergy, advocacy and capacity-strengthening?

- How will we measure progress towards each domain?

SPP and other strategic planning processes: Again, as these documents are developed the vision must be considered. Overarching all proposed health interventions should be the end: communities have taken charge of their own health. Questions to address are:

- Do the plans reflect the vision?
- Are the domains articulated in the strategic plan or other document?
- Are specific activities planned and resources allocated for each domain?

Work plans and learning agendas: These are key opportunities to advance the vision by targeting the domains. As work plans, personal performance plans, and learning agendas are formulated, all levels of the agency should incorporate these domains in health activities.

- Are job descriptions and performance plans of regional and PQSD technical advisors reflecting the domains?
- Is the sector's work plan reflecting the domains?
- Is the learning agenda on health throughout the agency coordinated and, where possible, is collaboration promoted?

Databases: The Project Indicator project and the PTS are examples of databases being used by CRS. The databases need to reflect two types of indicators for health:

- Health outcomes
- Community-owned-approaches indicators

The domains are "operational" and each application of them will vary. Therefore specific benchmarks and indicators under each are best left to the unit using them.

### C.3 Actions for Implementing the Directions in Health

There are three actions that need to be carried out within the agency if we are to achieve our vision of community ownership of their behaviors and attitudes in health: These are:

**ACTION 1:** Assure that this paper is widely used as a lens in developing, implementing and evaluating health activities and initiatives.

**Issue:** In a dynamic organization like CRS where there is a constant flow of personnel, papers such as this one are not as carefully transferred to incoming staff.

**Steps:** To make certain the Direction of Health paper is widely diffused and used in the agency we will:

- Make certain that all new hires in health from Program Managers (PM) to Senior Technical Advisors (STAs), and from Deputy Regional Directors to Business Development advisors, are provided orientation on this paper and understand its concepts. This will be the responsibility of PQSD and the Regional Technical Advisors in Health.
- Create a community of practice around the use of the paper in programming. Taking advantage of website technology develop a site where CRS staff and others can learn, post, and discuss advances to this approach.

- Develop a checklist to use in reviewing proposals, SPPs and other documents. This checklist will help to promote the domains and remind people of the need to address the domains in all activities.
- Implement a marketing strategy for the paper.

**ACTION 2:** Promote the adequate allocation of resources either during the project design process or through the country, regions and PQSD budgets to assure that domains are addressed.

**Issue:** It is easy to say “we will document innovations, build capacity, advocate, or strive for synergy” but often these activities are not clearly planned for with proper inputs.

**Steps:**

- Develop guidance on allocating a percentage of project or unit budgets for carrying out activities related to these domains.
- Document and share the results of improved resource allocations.

Ideally we would also like to see the agency accept the following recommendations to improve strategies, frameworks and lenses.

### **RECOMMENDATION 1: Unified visions and shared messages to meet the global CRS mission.**

- **Issue:** Over the recent years CRS has developed and rolled out various frameworks, strategies, direction papers and lenses. There needs to be cohesion and coordination among all of these documents. In addition, there needs to be clear communication to all levels of CRS on how best to use these documents and strategies for optimal programming.
- **Proposed Actions:**
  - A review process should specifically address if all documents adhere to the community-owned approach.
  - Based on the review, CRS should undertake measures to establish consistency in the principles of community-owned approaches.
  - It should also take steps to institutionalize a yearly agency-wide process of coordination of resources and actions attached to these documents as well as the review process.

### **RECOMMENDATION 2: Adjust systems and processes to reflect the four domains.**

- **Issues:** The four domains are not new concepts to programming. Throughout the agency, in Result Frameworks or Proframes and work plans, these domains are present. They are also in the Annual Planning Process, Project Tracking Systems reports, Monitoring & Evaluation systems, etc. However, there is no uniformity in how these domains are captured and tracked in the agency.

- **Proposed Actions:**
  - An exhaustive review of these processes should take place at the appropriate level. Where necessary, find ways of adjusting the systems and processes to utilize information coming from the domains.
  - Develop and track appropriate benchmarks (at each level) under each domain.
  - Incorporate lessons into the systems and processes.

## **D. CONCLUSION**

As partners, communities, and CRS work towards the day that communities take charge of their own health, these domains will strengthen and expand our community-ownership approaches. Our health portfolio will increasingly be reflective of empowered communities' self-defined health issues. The partnership of individuals, their communities, and other stakeholders now bear the burden of addressing health conditions and diseases such as: malnutrition, preventable childhood illnesses, HIV, malaria and TB. Global trends indicate that this partnership is rapidly facing a second set: chronic diseases such as cardio-vascular diseases, diabetes, and trauma.

Given the enormous threat to integral human development that the increasingly destructive double burden of disease represents to communities, it is imperative that our resources in health are used to support the empowerment of communities to promote and preserve health. It is only when one claims a health condition as one's own that one can take steps to improve or manage the condition. Even a resource-rich community cannot expect healthy outcomes unless it owns the problem and the solutions.

This paper should ultimately support the community to own their own behaviors and attitudes about their health and that of future generations, in a way that health outcomes are not only achieved but sustained.