

Amplifying Community Health Worker Voices to Examine the Implementation and Scaling of a Community Health Program: A Qualitative Study in the Philippines

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Abstract

Background: Scaling community-based health programs can contribute to efforts to achieve universal health coverage. Implementers of community-based health programs, such as community health workers (CHWs), hold valuable insights and experiences that can inform how these programs scale up and out.

Objectives: (1) To assess implementer experiences and perceptions of a community-based health program delivered by CHWs that underwent recent changes to broaden its programming and reach (ie, scaling up); and (2) to describe facilitators and barriers to the implementation of this community-based health program to inform subsequent scaling out.

Methods: In April 2023, an evaluation of an NGO-led CHW program was conducted with program implementers across 6 geographic regions in Negros Oriental, Philippines (n = 64 semi-structured interviews). Data were analyzed using a hybrid inductive-deductive analysis, informed by the Medical Research Council's framework for process evaluation of complex interventions. Ethics approval was provided by the University of Waterloo Research Ethics Board (Certificate #: 44828).

Results: CHWs perceived that the scaled up version of the program was more useful and impactful, given its expanded reach and provision of basic treatment; however, new program components also required significant time, effort, and strategy to implement which created new opportunity costs for CHWs. Implementation of the scaled up version of the program was facilitated via clear communication structures and supportive group training spaces. Pre-existing roles and social networks held by CHWs further facilitated the implementation of the scaled up version of the program. Overall, new individual-level and community-based strategies were leveraged by CHWs to implement the scaled up program, and participants described facilitators (eg, expanded reach) and barriers (eg, increased time and effort) that influenced program implementation.

Conclusion: This study contributes insights into how individuals involved in the scaling of a community-based health program may experience this process.

Keywords

community health workers, scaling, program implementation, process evaluation, Southeast Asia

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Introduction

Achieving universal health coverage (UHC) will require scaling promising community-based health programs in resource-constrained areas across low- and middle-income countries.¹⁻³ These community-based health programs are needed to address the multiple and intersecting barriers that individuals and households experiencing poverty face in accessing health services and receiving quality health care.

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In particular, community health worker (CHW) programs have been highlighted for their potential to facilitate and operationalize UHC at the community-level and within resource-constrained settings.⁴⁻⁶ Although there is diversity in CHW programs globally, many CHW programs equip and support lay community members to deliver basic health services, conduct screening for common health concerns, and provide health education within their communities. Thus, CHW programs are often viewed as a foundational component of community health systems by connecting local community members with health needs to appropriate health care and support.⁶⁻⁸ Further, efforts are underway by both governments and non-governmental organizations (NGOs) across multiple settings to scale up and out promising community health worker programs to address current health system gaps.⁹⁻¹¹

Increasingly, there is attention to the *process* of scaling up and out community-based health programs across resource-constrained settings.¹²⁻¹⁴ Although these concepts are closely connected, scaling up is about increasing the quantity or reach of an intervention or program, while scaling out involves expanding sites or opportunities for an intervention or program.^{15,16} Recent research highlights both the broad barriers and facilitators to the scaling up and out of community-based health programs, highlighting the importance of context and local capacity in guiding decision making and strategic planning when moving through the scaling process.^{17,18} However, most of this research focuses on scaling processes from a systems or program design level, and does not necessarily examine or integrate the knowledge, experiences, and perspectives of implementers involved in delivering community-based health programs.

Conceptual work also provides guidance on key elements and considerations needed in scaling out and up community-based health programs. For example, the International Development Research Centre's 'Scaling Science' outlines how the interplay of a moral justification and dynamic evaluation, together with coordination and optimal scale considerations provide principles to inform scaling processes of community-based initiatives across resource-constrained settings.¹⁶ More specifically, moral justification entails a critical reflection surrounding whether or not to scale a program or intervention; dynamic evaluation is attuned to the reality that intervention impact may shift or change as a program is scaled up or out; coordination calls for the participation of those involved in achieving scale to guide the scaling process; and optimal scale includes interrogating what success means in scaling a program. Of note, much of the previous research on the scaling up and out of community-based health programs focus at a conceptual, program design, or systems level, which may overlook the experiences of individuals tasked with implementing community-based health programs.^{19,20} In particular, examination of the experiences of 'on-the ground' implementers of community-based health programs undergoing scaling may provide critical insights into how scaling processes may unfold, as well as opportunities for innovation within program design as a program is scaled up and out.

Guided by a partnership between a Philippines-based NGO and researchers in Canada, this study evaluated implementer insights and experiences of an NGO-led CHW program in the Philippines. More specifically, this study assessed CHWs' experiences and perceptions of the 'scaling up' of a community-based health program, with lessons for the subsequent 'scaling out' of the program to other settings in the Philippines. Specific study objectives were: to assess implementer experiences and perceptions of a community-based health program delivered by CHWs that underwent recent changes to broaden its programming and reach (ie, scaling up); and to describe facilitators and barriers to the implementation of this community-based health program to inform subsequent scaling out. Overall, this study contributes insights into how individuals involved in implementing the scaling up of a community-based health program may experience this process, with implications for efforts to scale out the program.

Overview of Flourish Program Context and Changes

International Care Ministries (ICM) is a Philippines-based non-governmental organization that supports a network (approximately 1300 individuals) of CHWs to extend the reach of the health system into resource-constrained communities across the Visayas and Mindanao, Philippines. This community health program is called Flourish, and the program aims to improve maternal and child health outcomes, as well as facilitate health care access among households experiencing extreme poverty.^{21,22} The Flourish program operates within a decentralized health system that includes public, private, and NGO-based health providers and programs.⁵ Within this decentralized health system, ICM has identified gaps in the provision of maternal and child health care among populations experiencing extreme poverty.²³ The Flourish program aims to address these persistent care gaps for populations that historically have had difficulty accessing health care. Interactions between the Flourish program and the broader health system in the Philippines are reported elsewhere.²³

In the initial version of the program (called Flourish 1.0; started in 2020), CHWs were recruited through pre-existing savings groups facilitated by ICM. These savings groups were established to provide individuals experiencing extreme poverty with a supportive space to pool and invest resources with the goal of enhancing economic security. Social capital among savings group members is critical to maintaining group function and guiding collective decision making. Within these savings groups, individuals were nominated by a community leader or ICM staff member to be a CHW. Following this nomination and the successful completion of a literacy and numeracy assessment, these individuals were invited to participate in training and become a CHW within the Flourish program.

In Flourish 1.0, CHWs were tasked with providing screenings for maternal and child health concerns. When concerns were identified that warranted further medical attention, CHWs provided referrals to formal health care services. In

	Flourish 1.0	Flourish 2.0
Community Health Worker (CHW) Responsibilities	<p>Health Screening and Counselling</p> <p>Screening</p> <ul style="list-style-type: none"> • Tuberculosis screening/active case finding • Pregnancy danger sign screening • Infant & childhood (5-14 years old) danger sign screening • Malnutrition screening for children ages 6 months-14 years <p>Education & Counselling</p> <ul style="list-style-type: none"> • Family planning • Healthy pregnancy and breastfeeding • Emergency birthing plan development • Infant care and immunization promotion • Nutrition education 	<p>Direct Health Interventions</p> <p>Pregnant and Lactating Women:</p> <ul style="list-style-type: none"> • Nutripacks for malnourished women (based on measurements of height and weight) • Micronutrient supplementation • Provide transportation subsidy to formal health facility for specified conditions <p>Children ages 6 months to 5 years:</p> <ul style="list-style-type: none"> • Vitamin A supplementation • Oral rehydration salts and zinc for acute diarrhea • Paracetamol for fever • Deworming (12 months-5 years) every 6 months • RUTF for severe acute malnutrition and RUSF (i.e., 'Nutripacks') for moderate acute malnutrition (also for children ages 5-14) • Provide transportation subsidy to formal health facility for specified conditions (i.e., malnutrition, comorbidities) <p>Flourish 1.0 Tasks +</p>
Materials Used	Smartphone with mHealth app; provision of paper educational materials	Smartphone with improved mHealth app for screening and instruction RE: treatment
Anticipated Reach	Households within ICM savings groups (approximately 37 annually)	Households within broader community (approximately 120 annually, 10 per month)
Incentives	1000 Philippine Pesos (PHP) per month (approximately 17 USD)	Incentives provided as per reach to 'target' individuals (with a minimum incentive of 1000 PHP per month)
Support and Training	CHW trainers facilitate monthly regional meetings to provide professional development and training associated with CHW tasks, discuss any concerns, share challenges, and collectively problem solve how to address these challenges. CHW trainers also provide informal support via Facebook chat groups.	

Figure 1. Overview of Flourish 1.0 (initial program) and Flourish 2.0 (scaled-up program).

addition, CHWs provided education and counseling on a variety of health topics. Following internal evaluations of Flourish 1.0, Flourish 2.0 (scaled up program) was piloted in 1 province (Negros Oriental) in February 2023, with new program components added on top of the existing tasks associated with Flourish 1.0. These new program components included the provision of basic medical treatment (referred to as 'commodities' within the Flourish program) facilitated through an mHealth app (see Figure 1). The mHealth app provided step-by-step guidance to navigate screening and referral processes, as well as facilitated data collection for program monitoring and evaluation. Of note, this study was conducted approximately 2 months after the launch of the Flourish 2.0 pilot in Negros Oriental. As such, this was a dynamic period of transition for the program, as well as for CHWs intimately involved in program implementation.

In terms of the anticipated reach of Flourish 1.0, CHWs were responsible for screening households connected to their respective savings groups (on average, approximately 37 households annually per CHW). In Flourish 2.0 (scaled up program), the reach of the CHW program expanded substantially. CHWs (many of whom were involved in Flourish 1.0) were now tasked with supporting more households within their communities (approximately 10 months or 120 households annually per CHW) including households who did not have direct connections to the savings groups facilitated by ICM.

In Flourish 2.0, ICM also established new goals for the number of individuals with particular health concerns that CHWs were responsible for identifying and supporting at any one time (ie, 2 malnourished children under the age of 5 or between ages 5 and 12; 2 pregnant women). These

goals were established based on ICM's experience implementing community-based health screenings and active surveillance across resource-constrained communities in the Visayas and Mindanao, and the organization's understanding of the prevalence and incidence of various maternal and child health concerns based on the rigorous evaluation of these active surveillance efforts.

In Flourish 1.0, CHWs were provided with 1000 Philippine pesos (approximately \$17 USD) per month in recognition of their involvement in and contributions to the program. In Flourish 2.0, the incentive structure changed. CHWs were provided with at least 1000 Philippine pesos per month, with the opportunity to receive more according to the achievement of pre-set goals (ie, identification and support of 2 malnourished children and 2 pregnant women as described above). Goals were monitored through the mHealth app. At the time of the study, the amount provided for achieving these pre-set goals was under review with different nominal amounts undergoing testing and evaluation. Based on previous research in Negros Oriental, the incentive provided to CHWs in the Flourish program was slightly more than the monthly wages of government-funded *barangay* health workers (BHWs).⁵ Further, CHWs in the Flourish program as well as BHWs in the government-funded program are predominantly female.⁵

Across Flourish 1.0 and Flourish 2.0, ongoing training and professional development of CHWs was provided by CHW trainers. CHW trainers facilitated monthly regional meetings of CHWs to share any program updates and relevant training associated with CHW tasks, to discuss any concerns, to create space for CHWs to share about challenges, and to collectively problem solve how to address

these challenges. In addition to these monthly training and professional development meetings, CHW trainers also provided informal support to CHWs via Facebook group chats or one-to-one consultations with CHWs. CHWs also provide peer support to each other either through Facebook chat groups or through one-to-one meetings.

Methods

This study used a qualitative case study design,²⁴ which generated in-depth qualitative data relevant to a particular program. This in-depth data on a particular program can then be used to more deeply understand a broader event or phenomenon. In this study, ICM's Flourish program provides a meaningful case study to examine how CHWs may implement and experience the scaling up of a community health program.

Data Collection

An evaluation of the implementation of the scaled-up version of the Flourish program was conducted in April 2023. Semi-structured interviews were conducted with CHWs (program implementers) across 6 locations within Negros Oriental, Philippines by a research team of 6 individuals (3 Canadian researchers (n=2 females; n=1 male); 3 Filipino researchers (n=3 females)). Research team members brought complementary strengths to the research process including previous experience with qualitative data collection, as well as contextual and cultural understanding of the Flourish program and study locations.

ICM staff (ie, CHW coordinators) supported participant recruitment by contacting all CHWs affiliated with the Flourish program in each geographic setting and inviting them to participate in the study. Recruitment of participants across these 6 different settings (including urban centers and remote mountainous communities) provided insight into how CHWs implemented and experienced the Flourish program in different locations. No additional inclusion or exclusion criteria were applied for recruitment. From an ethical perspective, interviews were conducted with all interested CHWs in each geographic setting, past the point of data saturation, to ensure all CHWs were provided equal opportunity and voice within the research. Of the 78 individuals invited to participate, 64 CHWs (82.1%) participated in the study. Reasons for not participating in the study included a lack of interest or time limitations.

Prior to interviews, a participatory activity was conducted with CHWs to build rapport with participants and gain broad insight into participant experiences with the Flourish program.²² Following the activity, participants were invited to complete an interview. Interviews took place in a central community facility (eg, church, community center). Interviews were primarily conducted in Bisaya (local language) or Tagalog, according to each participant's preference, then translated into English. Interviews focused on how CHWs implemented and experienced the program changes (see Appendix 1 in the Supplemental Material for the semi-structured interview guide). The interview guide

was initially pilot tested with 7 participants (10.9% of all participants; participant data from pilot test included in results) and subsequently refined to ensure questions were clearly communicated. The length of interviews was between 19.3 to 87.5 minutes (average duration=44.4 minutes).

In line with approvals from our research ethics board, all participants provided verbal informed consent to participate. Verbal informed consent was audio recorded, noted in interview notes, and recorded in a verbal consent log for the study. Interviews were audio-recorded with permission, and the English translations were transcribed verbatim for analysis. Prior to analysis, all English transcripts were re-reviewed by a member of the research team who spoke Bisaya and Tagalog to address any errors or inconsistencies that were introduced during the translation process.

Data Analysis

Data from interviews were thematically analyzed using a hybrid inductive-deductive approach,²⁵ guided by the Medical Research Council's (MRC) framework for process evaluations of complex interventions. This framework underscores how a program's operational context influences the interplay between program implementation and mechanisms of impact, which together contribute to various program outcomes.²⁶ Research team members (LJB, WD) used *NVivo 14* qualitative analysis software for organization and retrieval of codes and coded excerpts. The MRC framework provided an initial structure for the code book (ie, operational context, program implementation, mechanisms of impact, and outcomes), which was then iteratively refined following inductive analysis of the data. This approach aimed to center participant voices and experiences amid the scaling up process, which represented a dynamic period for program implementation. Finally, the International Development Research Centre's work on 'Scaling Science'¹⁶ provided an interpretive lens for our findings, which is elaborated on in the Discussion section. This interpretive lens enabled team members to reflect on how participant experiences and study findings connected to broader considerations about scaling up and out complex interventions and broaden the contribution of our study beyond the specific program case study. Collaboration among team members throughout data analysis contributed to the validity of this process.²⁷ The validity of the analysis process was further strengthened by ongoing engagement with ICM staff members (partner NGO), which supported the research team's understanding of the Flourish program context as well as intervention changes in the scaled-up program. Ethics approval was provided by the University of Waterloo Research Ethics Board (Certificate #: 44828).

Results

Socio-Demographic Characteristics of Participants

In total, 64 CHWs affiliated with the Flourish program participated in this study. All CHWs were women residing across 6 different geographic settings in Negros Oriental.

Table 1. Sociodemographic characteristics of community health workers (CHWs) affiliated with the Flourish program in Negros Oriental (n = 64).

	Number (%)
Year started as a CHW	
2020	17 (26.6)
2021	30 (51.7)
2022	8 (13.8)
2023	3 (5.2)
No response	6 (10.3)
Education level	
Elementary school (did not graduate)	6 (10.3)
Elementary school graduate	5 (7.4)
High school (did not graduate)	11 (17.2)
High school graduate	23 (33.8)
College (did not graduate)	5 (7.4)
College graduate	8 (11.8)
Alternative learning system ^a	4 (6.3)
Vocational course	1 (1.4)
No response	1 (1.4)
Geographic area	
Guihulgan	15 (23.4)
La Libertad	12 (18.8)
Ayungon	12 (18.8)
Dumaguete	11 (17.2)
Manjuyod	10 (15.6)
Pamplona	4 (6.3)

^aAlternate learning system provides out-of-school youth and adults with the opportunity to access and complete basic education.

The average age of CHWs was 36 years old (± 8.6 years). Over half of participants (n=36; 56.3%) had completed their high school education or had some college education. Most participants (n=47; 73.4%) reported an affiliation with the Flourish program for over 1 year at the time this study was conducted (see Table 1).

How ‘Scaling Up’ Was Implemented by CHWs

Leveraging Individual-Level Strategies and Identities to Implement the Scaled Up Program.

With the old version, we did not struggle because we already knew the participants. Now, we need to approach [new people] (P15).

Community health workers (CHWs) shared several individual strategies they adopted to support the implementation of Flourish 2.0 (scaled up program). Some CHWs coordinated with community members to meet at a shared time and location (eg, a church) to provide screening and support to multiple households more efficiently (P16, P20). Others recruited family members to support with program tasks such as carrying supplies or syncing screening reports within the mHealth app (P19, P24, P26) or to provide child-care support so they would have additional time to complete tasks associated with the scaled-up program (P12, P20).

Often, implementation of the scaled-up program was facilitated through the positionality of implementers

(CHWs), including their embeddedness within their communities and their pre-existing social connections. CHWs drew upon these relational connections to more readily find specific individuals to support. As a CHW explained, ‘*I ask my neighbours to [tell] me if there’s someone who’s sick so that I can come and bring commodities for them*’ (P16). This leveraging of social networks was common among CHWs who shared information through these networks regarding the support they offer and encouraged households to contact them (P33, P36). Other CHWs described their knowledge of the community – ‘*so it’s easy to know who the pregnant women or malnourished children are*’ (P17) – which enabled them to more readily meet their new pre-set goals of identifying and supporting individuals with particular health concerns in the scaled up program (P40).

Leveraging Community Connections and Roles to Implement the Scaled Up Program. Other roles that CHWs held within their communities also shaped their capacity to identify individuals in need of support; gave them pre-existing skills relevant to new program tasks (eg, taking individuals’ height and weight measurements); and conferred credibility to the program among households new to ICM as an organization. For example, CHWs reported being known more broadly in their communities as *barangay* health workers (P6, P19, P22, P26, P46), religious leaders (P16, P35, P38), or municipal leaders within the *purok/barangay* (P17, P40), all of which supported implementation of new program components. With the program’s expanded reach, some households unfamiliar with ICM were initially hesitant to accept basic treatment from CHWs (P3, P31, P42, P44, P51, P60). As one CHW described:

It’s really hard in [the scaled-up program, Flourish] 2.0 that you have to explain everything about the program and especially that [households] have this thinking that [the program]’s a scam, that it’s not real, that is why they are hesitant to accept the commodities from the program (P21).

Despite this initial mistrust, pre-existing social relationships and other roles held by CHWs helped to build understanding and trust with households and facilitated the implementation of the scaled-up version of the program (P25, P33, P38).

Importantly, program changes necessitated closer engagement and collaboration with the public health sector to provide quality care. Many CHWs worked alongside *barangay* health workers and midwives in their communities to identify individuals in need of support (P9, P17, P21, P23, P25, P26, P31, P32, P36, P42, P53) and to coordinate who would provide basic treatment or referral to formal health care services (P18, P22, P39, P40, P47).

How ‘Scaling Up’ Was Experienced by CHWs and Community Members

Perceived Benefits and Facilitators of the Scaled Up Program.

Now we [as CHWs] just go around and look for people [to screen] because non-ICM [savings group] members are

allowed to be screened. . . it's better, because more people can benefit from the program, which is a good thing. But the hardest part is, it's now a lot of work (P27).

New program components were perceived by both CHWs and community members as enhancing the effectiveness and impact of CHWs in addressing maternal and child health needs. However, the introduction of new program components also created new opportunity costs among implementers, as some participants perceived the scaled-up program as more time consuming and complex than their previous CHW work.

Most CHWs identified the scaled-up program as more helpful due to the provision of basic treatments or 'commodities' (P2, P22, P27, P36, P39, P42, P45), especially for households who would otherwise need to travel a long distance and incur transportation costs to obtain basic medical treatment elsewhere (P6, P30, P32). As expressed by one CHW with respect to the usefulness of the new program: *'Before, with [the prior iteration of the program], [CHWs] used to not believe in the program because they'd have nothing to [offer]. But with [Flourish] 2.0, it's nice because then we have commodities to give'* (P3). Further, CHWs perceived that the pilot program was useful for actors in the public health sector (P48) and for community members (P43), as a CHW described:

Even if they have this screening, people in the community see it as pointless or useless. Because what's the point of doing a screening and then not having anything after. . . Now people in the community are glad because after the screening, they can get commodities (P47).

The presence of supportive group spaces for training and learning, facilitated by CHW trainers, were perceived to enhance CHW confidence with new program components (P2, P5, P10, P18, P22, P23, P24). Many CHWs described their use of a Facebook group chat for direct communication with their CHW trainer to ask questions and for mutual support among CHWs as they adjusted to the new program iteration (P3, P8, P11, P12, P13, P14, P17, P21). As noted by a CHW, *'When I have a problem, I ask other [CHWs]. We have a group chat. . . when the [CHW trainer] isn't able to reply to a question, others will reply with a solution. We help each other'* (P15). ICM's positive reputation and established presence within many of the communities CHWs lived and worked in was also perceived by some to be a facilitator of the pilot program's implementation – as a CHW described in response to the expanded reach of the pilot, *'I'm not having a hard time in dealing with [the changes] because the people in my community already knew about ICM'* (P53).

Perceived Challenges and Barriers of the Scaled Up Program. While perceived as more effective, most CHWs perceived of the scaled up program as being much more time consuming and requiring more effort overall, given the pilot's expanded reach (increased number of households supported; P1, P11, P13, P18, P29, P31, P39) and the

additional travel required to reach households, especially in remote, mountainous areas (P2, P3, P5, P6, P7, P9, P11, P12, P14, P19, P21, P32, P36, P39). These challenges due to the scaled-up program's expanded reach were also coupled with significant technical issues with the mHealth app, which almost all CHWs mentioned. Concerns were also expressed about the feasibility of achieving 'targets' and receiving incentives in the full program, if their communities did not have, for example, individuals who were pregnant or malnourished at a given time (P9, P21, P24, P26, P30, P33, P39). The added program components created new opportunity costs, particularly among CHWs who emphasized holding other paid or unpaid caregiving roles that required them to balance their time accordingly (P24, P26, P27). As one CHW described, in relation to the opportunity costs associated with the scaled up program:

I'm not really excited with [the] additional program [Flourish 2.0]. Not because I don't like it, but because of my time management. . . I actually love to be part of the [CHW program] because the incentives help me with my kids. But I can't really devote my entire life to doing projects with ICM because I'm a single mom, so I have to divide my time (P1).

Overall, many CHWs' perceptions of the program changes reflected a notable tension: While more was required of them, CHWs also appreciated the opportunity to make a broader impact in their communities, especially given extreme resource constraints (P13, P14, P17, P34). In the words of one CHW, *'At first, I was having a hard time because the scope [of the pilot program] is larger, but now I'm happy because I can help a lot of people in the community'* (P14). However, the scaled up program's requirements of increased effort and strategy also prompted some implementers to calibrate the benefits of program participation against the potential costs:

[Flourish] 2.0 is harder for us, especially if the app is not really working that [well]. . . it's hard for us. For one household, it took one hour to do this. It's hard for us. . . to say it frankly, it's not worth it for the pay that we're receiving (P1).

Taken together, significant changes to program tasks and reach were implemented by CHWs in the scaled-up program and facilitated by their community embeddedness and social connections, as well as enhanced collaboration with the public health sector. The program changes were perceived as more effective by both implementers (CHWs) and community members; however, these changes were accompanied by increased requirements of time, effort, and strategy by CHWs, which created new opportunity costs (see Appendix 2 in the Supplemental Material for additional exemplar quotations).

Discussion

This study examined the experiences and perceptions of CHWs affiliated with an NGO-led CHW program as they navigated the scaling up of a community-based

health program aimed at addressing maternal and child health concerns in resource-constrained areas of Negros Oriental, Philippines. The scaling up process of this community-based health program included the addition of new program components and the expansion of the program's reach to new community members. Amid these program changes, this study highlights how CHWs leveraged new individual-level and community-based strategies to implement the scaled up program. In addition, this study describes new opportunities and challenges that surfaced for implementers of a community-based health program during the scaling up process. Below, we discuss these new opportunities and challenges using the principles of moral justification, dynamic evaluation, coordination, and optimal scale, as outlined by the International Development Research Centre's work on 'Scaling Science'.¹⁶ Overall, we argue that the inclusion of implementer insights and experiences in the design and scale up of community-based health programs may provide valuable perspectives on the implementation and effectiveness of scaled up programs, with implications for the subsequent scale out of these programs.

Moral Justification

The principle of moral justification encompasses critical reflection of whether to scale a program or intervention, recognizing that not all programs need to be or should be scaled.¹⁶ In this study, there was a general perception held among CHWs that the scaled-up program (Flourish 2.0) was more effective in terms of reaching more people and meaningfully addressing maternal and child health concerns across resource-constrained communities. Further, CHWs highlighted how community members they reached through the scaled-up program also perceived the added program components to be more effective than the initial version of the program. This perceived effectiveness was often linked to the provision of basic treatment and medicine for common health concerns. The insights shared by CHWs are perhaps unsurprising, given gaps in health care coverage for maternal and child health concerns across resource-constrained settings in the Philippines.²⁸⁻³³ Further, research across other contexts has demonstrated the perceived benefits and effectiveness of home-based treatment of common maternal and child health concerns, particularly in resource-constrained areas.³⁴⁻³⁶ Overall, these findings point to the important role of implementer insights and experiences in building the moral justification for a community-based health program to be scaled up and out.

Dynamic Evaluation

The principle of dynamic evaluation considers how a program's impact may shift or change as it is scaled up or out, and reflects on how evaluation practices may need to account for and adapt to these changes.¹⁶ Various models and frameworks have been introduced to evaluate dynamic change and complexity within community-based health programs, underscoring how complexity can increase as

programs aim to make improvements in community-level health outcomes.³⁷⁻³⁹ In line with previous research,^{40,41} this study underscores how implementers of community-based health programs hold unique knowledge and expertise in how various program components interact and how these interactions may influence various aspects of program implementation, outcomes, and impact. For example, participants highlighted several new individual-level and community-based strategies they used to implement the scaled up program. These strategies differed from how the initial program was implemented and were not covered by formal training provided by ICM. However, identification of the implementation strategies by participants provides greater insight into how the scaled up program may be implemented in practice, with corresponding implications for program evaluation. Importantly, in developing evaluation processes that are attuned to how scaling may change a program's impact, implementers of community-based health programs may contribute valuable insights for dynamic evaluation design.

Coordination

The principle of coordination underscores how individuals involved in achieving scale should participate in guiding scaling processes. Further, there is an understanding that realizing impact at scale is often dependent on the inclusion of and collaboration among diverse actors and organizations.¹⁶ In this study, CHWs highlighted how the implementation of the scaled-up program meant they needed to forge new collaborations with local health care workers and facilities to identify community members who may benefit from the program. These collaborations further facilitated the scaled-up program's enhanced reach, especially to new community members who had not previously interacted with the Flourish program. These findings demonstrate how CHWs affiliated with an NGO-led CHW program may interact and partner with other health system actors in the implementation of a community-based health program.^{23,42,43} Connected to previous research, intersectoral collaboration among NGOs and other health system actors may create new opportunities in the delivery of community-based health programs.^{44,45} With that said, a higher degree of intersectoral collaboration necessitated through a community-based health program's scale up may also create new coordination challenges among health system actors, especially as a program looks to scale out. Thus, these findings also point to how implementer characteristics (eg, positionality, pre-existing relationships with other health system actors), may shape the degree and quality of intersectoral collaboration, with implications for both the scale up and scale out of community-based health programs.

Optimal Scale

The principle of optimal scale encourages critical reflection on what success may look like when scaling a program, and considers both opportunities and challenges that may

emerge amid scaling up and out.¹⁶ Findings from this study highlight important tensions that CHWs experienced during the scaling up of the community-based health program they implemented. On the one hand, CHWs valued the opportunity to reach new community members and provide basic medicines for common maternal and child health concerns through the scaled-up program. On the other hand, CHWs identified new opportunity costs and logistical challenges associated with program implementation that influenced their capacity and willingness to deliver the scaled-up program. Similar tensions between effective implementation of comprehensive community-based health programs and concerns surrounding implementer capacity to deliver the program as intended have been identified in the evaluation of other community-based health programs in resource-constrained settings.⁴⁶⁻⁴⁸ Critically, and as highlighted in this study, supportive training environments can be one mechanism that can enhance the confidence and capacity of implementers to deliver community-based health programs, especially in cases where new program components are added.^{49,50} Moving forward, this study contributes insights into the need for individuals involved in the design of community-based health programs to balance the addition of new program components and expanded reach with ongoing review of implementer capacity and willingness to participate in a scaled up program.

Broader Reflections on the Scaling Process

Implementers of community-based health programs can provide valuable insights into the process, outcomes, and impacts of scaling. Further, learning from implementer experiences of scaling a program could contribute to shifts in program design or broader decisions surrounding whether or not to scale a program. However, and aligning with our team's experience, meaningful attempts to incorporate implementer insights and experiences within scaling processes necessarily takes time as well as human and financial resources. This investment can present challenges for community-based health programs, especially amid pressure from funders to scale programs quickly and efficiently to demonstrate impact.^{16,51} Our team's reflections point to the need for critical reflection within community-based health programs on the trade-offs and tensions in the role of implementer insights and experiences in informing scaling processes. On the one hand, implementers hold valuable lived experiences with program implementation that may be critical for guiding thoughtful scaling of community-based health programs. On the other hand, high-quality engagement with implementers and flexible program design that is responsive to implementer insights can be challenging given resource constraints within many community-based health programs. This study also encourages reflection among funders of community-based health programs, particularly in low- and middle-income countries, to consider how funding mechanisms and processes could include resources and time for leaders of community-based health programs to deeply engage with program

implementers to ensure their insights are integrated into subsequent scaling processes.

Limitations

This study has several limitations. First, this study was conducted at a dynamic time in a community-based health program's history, as the transition from Flourish 1.0 to Flourish 2.0 had occurred only 2 months prior to participant recruitment and interviews. As a result, CHWs involved in this study were experiencing the scaling up process in real time. Although this facilitated our understanding of initial reactions to and experiences with the scaled-up program, participants may have had different views or experiences with the program as they became more familiar with new program components that were introduced in Flourish 2.0. Thus, there is an opportunity to set up processes that facilitate regular opportunities for implementers of community-based health programs to share their experiences and perceptions of scaling processes to assess how experiences and perceptions may change over time. In addition, facilitating regular opportunities to share these insights can provide important information on the sustainability of the scaling process and whether changes are needed prior to further scaling out. Second, beneficiaries of the scaled-up program were not formally recruited and interviewed for this study. Future research could examine how these community members experience the scaled-up program to facilitate a more fulsome understanding of how scaling processes unfolded at the community-level.

Conclusion


Scaling up and out promising community-based health programs can strengthen the delivery of UHC across resource-constrained communities. Implementers of community-based health programs hold valuable insights, knowledge, and experiences surrounding program implementation that can inform scaling processes. In examining the experiences and perceptions of implementing a scaled up community health program in the Philippines, this study identified new individual-level and community-based strategies that CHWs leveraged to implement the scaled up program. In addition, participants described various facilitators and barriers to implementing the scaled up program. Integrating these insights and experiences within scaling processes can strengthen program design and may contribute to effective program outcomes and impacts. However, integrating implementer insights and experiences within scaling processes needs to be navigated carefully, ensuring adequate time and resources are committed to implementer engagement, as well as thoughtful integration of implementer feedback into program design and scaling. There is an opportunity for funders and leaders of community-based health programs to critically reflect on the importance of meaningful engagement with program implementers and dedicate the necessary resources to facilitate the inclusion of their voices in efforts to scale programs.

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Ethical Considerations

Ethics approval was provided by the University of Waterloo Research Ethics Board (Certificate #: 44828).

Consent to Participate

All participants provided verbal informed consent to participate.

Consent for Publication

Not applicable.

Author Contributions

Warren Dodd: conceptualization, funding acquisition, investigation, methodology, project administration, writing – original draft. Laura Jane Brubacher: conceptualization, formal analysis, investigation, methodology, writing – original draft. Monica Bustos: conceptualization, investigation, methodology, project administration, writing – review and editing. Melinda Kelly Mijares: conceptualization, methodology, writing – review and editing. Krishna Lim-Mar: conceptualization, methodology, writing – review and editing. Lincoln Lau: conceptualization, funding acquisition, methodology, project administration, writing – review and editing.

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Data Availability Statement

All data relevant to the study are included in the article or uploaded as Supplemental Information.

Supplemental Material

Supplemental material for this article is available online.

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