Mobilising Communities for Action on Health and Social Change

Community Mobilization Strategy

Support for Service Delivery Integration, Ministry of Health, Malawi

USAID FROM THE AMERICAN PEOPLE

SSDI SUPPORT FOR SERVICE DELIVERY INTEGRATION

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FOREWORD

In its quest to improve the health status of its people, the Government of Malawi is calling for the strengthening of community engagement in health issues to make sure that communities at a grassroots level have a say about health related issues that concern them. Community Mobilization (CM) is the preferred process that will help build the capacity of communities, individuals, groups, and organizations to better plan, implement, and evaluate activities on a participatory and sustained basis to improve their health.

Community mobilization is a proven development strategy that has helped communities around the world bring people together to identify and address pressing health-care issues. It strengthens and enhances the ability of the community to work together for any goal that is important to its members. The end result of a successful community mobilization effort is not only a problem solved, but also the increased capacity to successfully address other community needs and desires.

This Community Mobilization Strategy intends to provide direction on how to make communities participate fully and own the process of improving their health by using the community action cycle (CAC). The strategy also provides a community mobilization roadmap and spells out roles and responsibilities of different players (stakeholders). In order to make the approach sustainable, the strategy recommends using the already established decentralized community structures to implement the process.

It is hoped that the guidance provided in this document will motivate many people to seek more information on community mobilization and implement the community action cycle.

Dr. Charles Mwansambo
Secretary for Health

LIST OF ABBREVIATIONS

ADC	Area Development Committee
AEC	Area Executive Committee
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Treatment
BCC	Behaviour Change Communication
CAC	Community Action Cycle
CAG	Community Action Group
CBDA	Community Based Distribution Agent
CBIMS	Community Based Information Management System
CBO	Community Based Organization
CHC	Community Health Committee
CHV	Community Health Volunteer
CHW	Community Health Worker
CM	Community Mobilization
CMT	Community Mobilization Team
DC	District Commissioner
DEC	District Executive Committee
DHMT	District Health Management Team
DHO	District Health Office(r)
DHS	Demographic Health Survey
EHP	Essential Health Package
FP	Family Planning
GVH	Group Village Head (man/woman)
HBCV	Home Based Care Volunteer
HC	Health Centre
HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
ITN:	Insecticide Treated Net
IPTp	Intermittent Preventive Treatment in pregnancy
JHU-CCP	Johns Hopkins University Center for Communication Programs
LLIN	Long Lasting Insecticide-treated Net
MCHIP	Maternal and Child Health Integrated Program
MNCH	Maternal, Neonatal and Child Health
MoAFS	Ministry of Agriculture and Food Security
MoE	Ministry of Education
MoGCCD	Ministry of Gender, Children and Community Development
MoH	Ministry of Health
MLGRD	Ministry of Local Government and Rural Development
NCD	Non-communicable Disease
NGO	Non-governmental Organization
NTD	Neglected Tropical Disease

PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PoW	Program of Work
RH	Reproductive Health
SBCC	Social and Behaviour Change Communication
SEP	Social engineering process
SoW	Scope of Work
SSDI	Support for Service Delivery Integration
SWAp	Sector Wide Approach
TA	Traditional Authority
TB	Tuberculosis
TOT	Training of Trainers
USAID	United States Agency for International Development
USG	United States Government
VDC	Village Development Committee
VHC	Village Health Committee
WALA	Wellness and Agriculture for Life Advancement
WASH	Water, Sanitation and Hygiene
WG	Women's Group
WHO	World Health Organization
YG	Youth Group
YONECO	Youth Net and Counselling

1. INTRODUCTION

1.1 Support for Service Delivery Integration (SSDI) - Communication

SSDI-Communication is a 5-year (2011–2016) Social and Behaviour Change Communication (SBCC) project, funded by USAID. The Center for Communication Programs at Johns Hopkins University's Bloomberg School of Public Health (JHU-CCP) implements the project in Malawi in partnership with Save the Children and several local organizations.

SSDI-Communication supports the Ministry of Health to focus on the following six priority Essential Health Package (EHP) areas:

- reproductive health
- maternal, newborn and child health
- nutrition
- HIV/AIDS and tuberculosis
- water and sanitation
- family planning.

SSDI-Communication developed this Community Mobilization Strategy under the leadership of the Ministry of Health's Health Education Unit, using a participatory approach.

1.2 Mobilizing communities for improved health

Community Mobilization (CM) is a specific approach for engaging communities to become their own agents of change in order to make improvements in the health and well-being of their families and communities. The CM strategy therefore provides guidance on how to mobilize communities for improved health by setting up processes at various levels of the health system and engaging the participation of stakeholders outside the health sector.

1.3 Users of the Community Mobilization Strategy

The Community Mobilization Strategy is designed to be used by the following ministries:

- Ministry of Health (MoH)
- Ministry of Gender, Children and Community Development (MoGCCD)
- Ministry of Local Government and Rural Development (MLGRD)
- Ministry of Agriculture and Food Security (MoAFS)
- Ministry of Education (MoE).

Also, other stakeholders at each level of the health system, such as non-government extension workers and Area Development Committee (ADC) members, will benefit from the strategy.

The CM Strategy will serve as a daily guide for the Community Mobilization Teams (CMT) that will be formed and based at the Traditional Authority (TA) level in selected TAs. A **CM Toolkit** accompanies the strategy.

1.4 Background: Malawi's health system

About 80 percent of Malawi's population of over 13 million lives in rural areas where only basic health-care services are provided. Most of the national disease burden has preventable causes, and contributing factors include low socio-economic status, low literacy, limited decision-making power among women, inadequate access to and utilization of essential health services, and cultural beliefs that lead to harmful practices.

The health-care delivery system in Malawi is organized into three levels:

- **Referral hospitals**, known as the Central Hospitals, located in the 4 main urban areas.

- **District hospitals** (one in each district) provide most essential health-care services, including operations and caesarean sections; complicated cases are referred to central hospitals.
- **Health centres** serve a catchment area of about 50 villages and populations of about 20,000 people. They are staffed by nurses/midwives and medical assistants. Health centres provide basic preventative and curative services. Complicated cases at the health centre level are referred to district hospitals.

Malawi has an acute shortage of health workers at all levels, making it difficult to provide care to the population, especially in the rural areas. A cadre of community health workers called **Health Surveillance Assistants (HSAs)** has been established and has assumed greater responsibilities over time. Each HSA is responsible for 1–4 villages with an average population of 1,000 people, though the current national average population covered by HSAs is close to 1,300. The HSAs deliver primary health care to all age groups, including mothers, newborns, and children; they also promote good preventative practices, such as improving water and sanitation facilities.

1.5 Governance structure of the health system in the districts

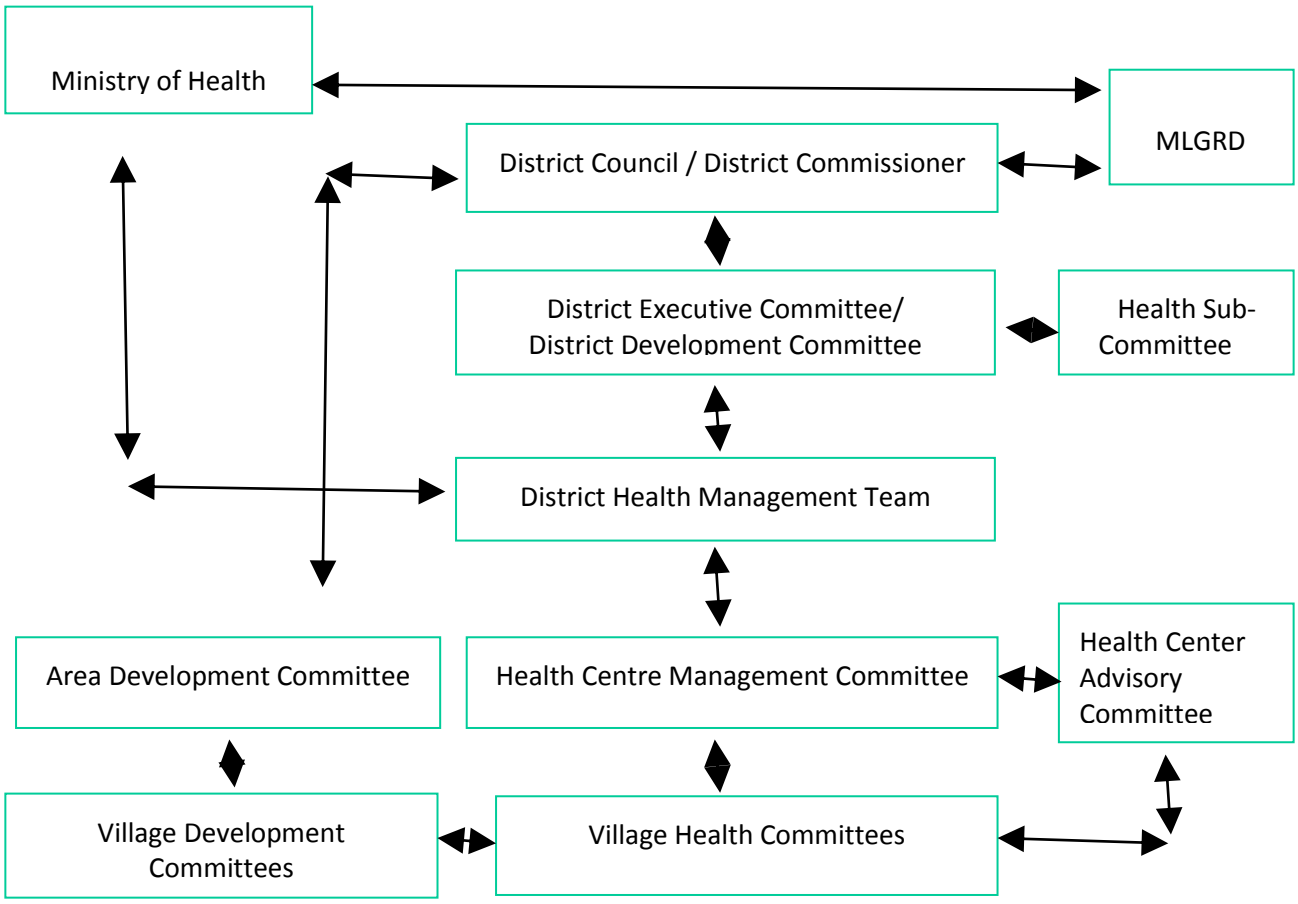


Figure 1: Governance structure of the health system in the districts

There is one Area Development Committee (ADC) in each TA (Traditional Authority). The TA presides over this key committee, reporting back to the DC (District Commissioner). The TAs are subdivided into Group Village Headmen (GVH) who have jurisdiction over a number of

Village Development Committees (VDC). Local development plans are developed at the VDC level, consolidated at the ADC level, and then taken for approval as part of the District Development Plan.

1.6 Malawi's Health Sector Strategic Plan

The overall goal of the Health Sector Strategic Plan 2011–2016 (HSSP II) is to improve the quality of life of all the people of Malawi, thereby contributing to the social and economic development of the country. In 2004 Malawi introduced the **Essential Health Package (EHP)** t o ensure universal coverage and cost-effective interventions to combat the main causes of disease. The DHS 2010[1] registers a number of achievements that have been made since 2004, such as:

- a reduction in the infant mortality rate from 76/1000 to 66/1000
- a reduction in the under-five mortality rate from 133/1000 to 112 /1000
- a reduced maternal mortality ratio from 984/100,000 to 675/100,000
- an increase in women delivering at health centres from 57.2 percent to 73 percent
- an increase in the proportion of children with acute respiratory infections taken to health facilities for treatment from 19.6 percent to 70.3 percent.
- an increase in full immunization coverage among children aged 12–23 months from 55 percent to 81 percent. Also, a reduction in pneumonia case fatalities has been registered, from 18.7 percent in 2000 to 5.7 percent in 2008.

Despite all these achievements in public health, the numbers of women dying due to maternal complications and of children dying before their fifth birthday are still very high. Till recently, there has been an emphasis on facility level care, with very little done at the community level. In view of the fact that most of the causes of morbidity and mortality in Malawi are preventable, the new HSSP (2011–2016) recommends the **strengthening of community involvement** as one of its key pillars. Thus the Government of Malawi wants to ensure that communities at a grassroots level can have a say and participate in issues that affect their health.

1.7 The SSDI consortium

The Support for Service Delivery Integration (SSDI) project (1 October 2011–30 September 2016) has been awarded US $100 million by USAID Malawi to support the Government of Malawi in achieving its vision of improving the health status of all Malawians. In partnership with the Ministry of Health, SSDI supports **effective integration and delivery of quality services under the EHP**, thus strengthening the national health system in line with the HSSP II.

[1] Malawi Demographic Health Survey 2010.

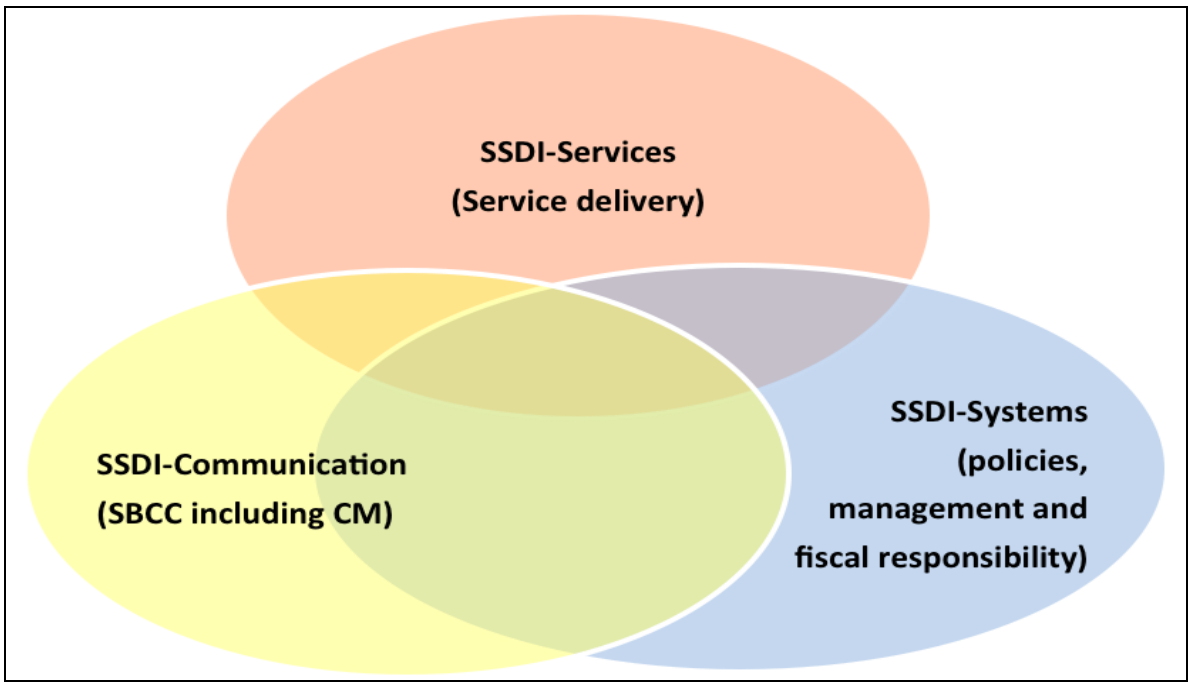


Figure 2: The SSDI Consortium

The SSDI project consists of three separate, but interrelated Co-operative Agreements in health:

- **SSDI-Services** supports the government to achieve improved service delivery
- **SSDI-Systems** supports the government to improve policies, management, and leadership
- **SSDI-Communication** supports social and behaviour change communication (SBCC) in health.

SSDI is guided by the principles of country ownership and leadership, integration for greater efficiency, and building on existing systems and past achievements. Its central theme is ***'Together we build healthy families'***.

SSDI focuses on a comprehensive program of support in 15 districts (Nsanje, Phalombe, Chikhwawa, Machinga, Mangochi, Mulanje, Balaka, Zomba, Salima, Nkhotakota, Dowa, Kasungu, Lilongwe, Chitipa and Karonga) spread across the country's five health zones.

The international NGOs Save the Children International, CAREMalawi, and Plan Malawi are partners in the SSDI Services Consortium. They themselves cannot be sub-contracted, but they will sub-contract other NGOs to implement community mobilization in their SSDI focus districts.

2.0 THE COMMUNITY MOBILIZATION STRATEGY

2.1 The process of developing the strategy

1. SSDI-Communication held meetings in March and April 2012 with government partners (the Ministry of Health – Director of SWAp, Director of Preventive Health Services, and the Acting Director-Health Education Unit; representatives from MLGRD and MoGCCD) to get their views on community mobilization for the Essential Health Package.

2. Consultations were held with the two USAID-funded projects **WALA** (Wellness and Agriculture for Life Advancement) and **BRIDGE II**. The following NGOs were also consulted: **CARE Malawi** and **Plan Malawi** (SSDI-Services' partners); **Concern Universal**, **Malawi Red Cross**, **YouthNet and Counselling (YONECO),** and ***Mai Khanda*** and ***Mai Mwana***. All of these organizations are implementing community mobilization activities, and SSDI-Communication has learned from its experiences. The main areas of inquiry were: project focus, distinctive processes and platforms, and strengths and challenges of each community mobilization approach.

3. A working group was set up, composed of SSDI-Communication, SSDI-Services and the MoH Health Education Unit (HEU). This working group conducted field visits to three projects that have different community mobilization approaches (WALA, BRIDGE II, and Plan Malawi) to gain more insights for use as a basis for recommending best practices to be adopted. The Working Group analysed findings and then drafted the **SSDI Community Mobilization Roadmap** (see Chapter 5). This **Community Mobilization Strategy** was also drafted, and a meeting was held to invite input from stakeholders.

2.2 What is Community Mobilization?

Community Mobilization (CM) is defined[2] as *a process of building the capacity of communities to plan, carry out, and evaluate activities in a participatory and sustained way in order to improve their health*. CM aims to facilitate positive and sustainable changes in social norms and attitudes and also in individual, household, and community practices. CM is a proven approach to development that has helped people around the world identify and address pressing health-care concerns. For instance, numerous studies have been published that demonstrate the power of community mobilization to decrease newborn and maternal mortality[3]. The approach not only helps people improve their health status and living conditions, but by its very nature it

[2] Howard-Grabman L and Snetro G (2003), How to mobilize communities for health and social change – a health communication partnership field guide. Baltimore: Health Communication Partnership.

[3] Baqui et al. (2008), Effect of community-based newborn-care intervention package implemented through two service-delivery strategies in Sylhet district, Bangladesh: a cluster-randomized controlled trial. *Lancet* (371): 1936–44.
Kumar et al. (2008), Effect of community-based behavior change management on neonatal mortality in Shivgarh, Uttar Pradesh, India: a cluster-randomized controlled trial. *Lancet* (372): 1151–62.

strengthens and enhances the ability of the community to work together for any goal that is important to its members. The end results of a successful community mobilization effort, in other words, are not only a 'problem solved' but also the **increased capacity to solve other problems.**

This SSDI project defines 'community' as the population living under a Group Village Headman (GVH). In the Malawian context, this population will share a common language, ethnicity, and culture. This CM initiative therefore targets its activities at the GVH level.

Principles of Community Mobilization

- Social change is more sustainable if the individuals and communities most affected **own the process** and content of behaviour-centred approaches;
- Communication for social change should be an **empowering, horizontal** (versus top-down) approach;
- CM should **give voice** to the previously unheard members of the community and be centred on **local content** and ownership;
- **Parents, families, and communities** should be the agents of change;
- Emphasis should shift from persuasion and the transmission of information from outside technical experts to **support for dialogue, debate, and negotiation** on issues that resonate with members of the community;
- Emphasis on outcomes should shift from only focusing on individual behaviour to a greater **emphasis on social norms, policies, culture, and the supporting environment**.

2.3 Community Mobilization approaches already in use in Malawi

Malawi has experienced various community mobilization approaches to health issues. However, these approaches have been implemented on a very small scale, thereby benefiting only a small proportion of the country's population.

- **Community Action Cycle (CAC)** has been used for maternal and newborn health interventions in 16 districts (Phalombe, Machinga, Nkhotakota, Rumphi, Chitipa, Dowa, Thyolo, Chiradzulu, Balaka, Ntcheu, Dedza, Salima, Nchinji, Karonga, Mzimba and Nkhatabay). The Malawi BRIDGE II project is implementing CAC to promote social and normative changes for HIV prevention in all 11 districts in the Southern region. Many success stories have emerged from CAC.
- **Community Score Card** is being used by Plan Malawi and CARE Malawi as a tool to assess the provision of health care in five districts (Kasungu, Salima, Dowa, Chitipa and Karonga).
- **Care Group Model** and **Lead Mothers** are used by the WALA Project in Zomba to reach communities with health information on MCH and nutrition issues, and their work has led to improved behaviours.

Although external evaluations of these participatory community-based approaches are lacking, District Health Management Teams (DHMT) report increased uptake of primary health services in areas where communities have been engaged.

Table 1: Existing approaches in community mobilization

Approach	Aim of the approach	Key strengths and challenges
Community Action Cycle	Strengthen skills within communities to help them participate in defining and	Builds capacity of the participating community for identifying their own problems and coming up with solutions;

	resolving health problems, including addressing root causes, such as restrictive social norms and harmful practices.	facilitates behaviour change and addressing social norms and practices. However, it requires intensive capacity-building and facilitation support; the length of the process inhibits public appreciation.
Community Score Card	Improve quality of health services from the users' perspectives in order to encourage increased use.	Improves service delivery and accountability of service providers but does not bring about behaviour change.
Care Group Model	Build a sustainable community-level structure for the intended program.	Builds capacity of the participating community members but does not promote exploration of causes of health problems.

2.4 Objectives of Community Mobilization

The Ministry of Health in collaboration with SSDI will mobilize and support communities in their efforts to achieve the following broad objectives:

- **Create demand for comprehensive health services** by helping communities to recognize their health needs and demand appropriate and quality health services.
- **Increase community access to health services** by empowering communities to mobilize community resources and enhance participation in and ownership of health services.
- **Enhance equitable coverage of services** by helping the most vulnerable[4] and marginalized people in all geographical areas to access the services provided.
- **Address the underlying causes of health issues** (gender-related power inequities, stigma, harmful cultural beliefs, discrimination, etc.) by facilitating a deeper dialogue and understanding between community members and health providers.
- **Increase community ownership and sustainability** by developing systems to ensure ongoing community involvement and ownership of the health services delivered. The commitment to improving health and quality of life will be sustained beyond the life of the project.

2.5 EHP priorities to be addressed by CM

Through consultations with MoH the following priority health actions have been identified:

- **Maternal Health**: early antenatal care, birth preparedness, and skilled attendance at birth;
- **Child Health**: hand washing, use of ORS for diarrhoeal disease, immunization, treatment of malaria and diarrhoea, and early treatment of childhood pneumonia;
- **Nutrition**: essential nutrition actions such as exclusive breastfeeding, continued breastfeeding to 2 years, timely and appropriate complementary feeding, Vitamin A supplementation, continued feeding during illnesses; early detection and management of malnutrition at the community level;
- **Family Planning**: uptake and sustained use of methods of FP, including condoms for dual protection; healthy timing and spacing of pregnancies;
- **Malaria**: increased uptake of LLIN distribution, including IPTp for pregnant women, and early treatment for malaria;

[4] Vulnerable groups include pregnant women, households with children under two, those living farthest from health centers, and the poorest (i.e. fifth quintile according to DHS criteria).

- **HIV and AIDS**: reducing the number of partners, use of condoms for dual protection, HTC, PMTCT, family planning, timely access to ART, prevention with positives, promotion of and access to male circumcision;
- **Water and sanitation**: increased hand washing and use of safe water;
- **TB**: early diagnosis, treatment of TB and adherence.

CM should therefore focus on promoting these key behaviours.

2.6 Structures to be used for Community Mobilization

The following groups are involved in CM; some already exist, and others will be formed for this initiative.

- **District Health Promotion Sub-committee of the DEC**
  This is a multi-sectoral group of DEC members, selected in agreement with the DEC to form the engine of community mobilization at the district level. The DHO is the secretary of this group. See section 5.3 for its roles.

- **Community Mobilization Team**
  The Community Mobilization Team (CMT) is a group of existing governmental and non-governmental extension workers in each Traditional Authority (TA) area, drawn together from a multi-sectoral team. Other extension workers may already be working at the community level for NGOs, and they, too, may be included in the CMT. The CMT is tasked with facilitating the rollout of CM in the area. Full details of the roles and responsibilities of the CMT can be found in Section 5.4.

- **Community Action Group**
  A Community Action Group (CAG) is a group of community members that leads the rollout of community mobilization activities on behalf of the community, at the GVH level. The CAG members may enter the group through self-selection (this is encouraged); or they can be nominated by the community or by Community Health Volunteers (CHVs) for their specific skills or qualities.

- **Community-based Organization**
  A Community Based Organization (CBO) is a development structure formed by a group of people permanently residing within a particular community. With the community's backing, the CBO works to address common problems affecting that community. CBOs differ from NGOs because they are initiated and managed by community members and do not employ full-time staff. A CBO has a formal structure with a co-ordinating committee, a constitution, and clearly formulated plans. CBOs need to be registered with the relevant district offices (such as the District Social Welfare Office) and should have a Trustees Declaration and a certificate of registration under the Trustees Incorporation Act. A CBO should have a council or committee with a minimum of 20 members, and it is expected to identify partners for financial, technical, and material support.

- **Care Group**
  A Care Group is a group of 10–15 volunteer **Lead Mothers**. Lead Mothers are chosen by the mothers within the group of households they will serve or by the leadership in the village. Each Lead Mother is responsible for 10–15 households and conducts home visits to households with pregnant or lactating mothers, new born babies, or children under the age of five. Lead Mothers impart information they have learned from the Area Supervisor

(employed by the NGO sub-grantee; see Section 4.5). The aim is to facilitate any needed behaviour change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behaviour change communication. They also provide the structure for a community health information system that reports on new pregnancies, births, or deaths detected during home visits.

- **Volunteers**

Among the various ways found to increase the equitable coverage of health services at the community level, the use of volunteers is very valuable. Community Health Volunteers are already lending support in the areas of Information, Education, and Communication (IEC); Community Based Distribution Agents (CBDAs) work in family planning; Home Based Care Volunteers help care for the chronically ill or weak; and Growth Monitoring Volunteers assist at under-five clinics. Volunteerism is an important feature of CM.

3.0 THE COMMUNITY ACTION CYCLE – A STEP-BY-STEP PROCESS FOR IMPROVING COMMUNITY HEALTH

3.1 Outline of the CAC

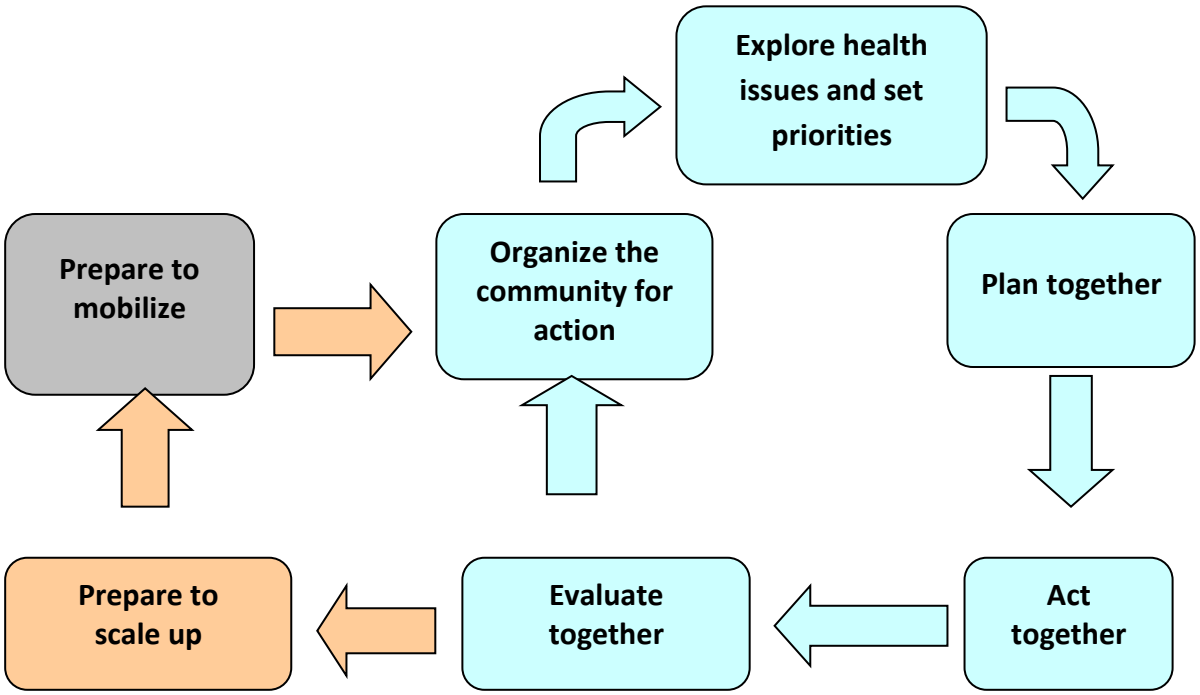
SSDI supports the MoH in applying the Community Action Cycle (CAC) approach to encourage communities to mobilize themselves on health issues. The process will seek to address the critical issues that affect access to and utilization of health services by different population segments, which include the socially marginalized.

As the diagram below shows, community leaders, CBOs, community health workers, and other community members at large will collectively carry out these tasks:

- identify health priorities
- design interventions consistent with the HSSP and local development plans
- implement the interventions
- monitor and evaluate the results.

Adjustments can be made to the process as circumstances dictate.

Figure 3: The Community Action Cycle



It is very important for all stakeholders and the community health implementers to consider the CAC rollout as a **Social Engineering Process** (SEP). SEP is a procedure whereby interventions or actions are carried out within a group, a community, or a large section of society in order to trigger a social change.

Each GVH catchment area will be considered as a unit of implementation of the CAC. For each major step and phase that the community develops for CM at the GVH level, the CMT (at the TA

level) will design a training mechanism and facilitation guidelines. This will ensure a standardized rollout of the process and facilitate learning in each community.

A comprehensive **Community Mobilization Toolkit** will assist all those working in mobilizing communities for health. It contains the following items: CM Training Manual, CM Participants Manual, Organize the Community for Action Toolkit, Explore Health Issues Toolkit, Plan Together Toolkit, CAG Training Manual Toolkit.

3.2 Steps in the Community Action Cycle

There are six stages to introducing the CAC process:

1. ***Prepare*** to mobilize
2. ***Organize*** the communities for action
3. ***Explore*** the health issues and set priorities
4. ***Plan*** together
5. ***Act*** together
6. ***Evaluate*** community activities together.

1. **Prepare to mobilize**

Step 1: Conduct orientation meetings

Before starting the rollout of the CAC at the community level, preparations need to be made at the district and TA levels. Stakeholders need orientation regarding the CM initiative, as follows:

District level

- The National SSDI Communication (CM) Team will orient the MoH and SSDI Communication Zonal Teams together at a zonal meeting organized by either the MoH or SSDI Services.
- After the zonal orientation meeting, the SSDI Communication Zonal Community Mobilization Team will orient the District Health Management Team and the District **SSDI-Communication Project Team. The District SSDI Team** comprises the NGO sub-grantee, the District Team Leader, and the District Community Co-ordinator – all employed by SSDI-Services.
- The DHO, together with the Zonal CM Co-ordinator, the District Community Co-ordinator, and the NGO sub-grantee, will orient the District Executive Committee (DEC).
- At the DEC meeting, the following decisions will be taken:
  - A **District Health Promotion Sub-Committee** will be formed (DHPSc). This is a multisectoral group of DEC members, selected in agreement with the DEC to lead community mobilization at the district level. The DHO is the secretary of this group. See section 5.3.
  - The DEC should agree upon the TAs to be chosen to start the initiative in the district, using criteria set by the DEC with guidance from SSDI-Communication (e.g. history of poor EHP indicators generated from health facility data; staffing levels at the health centre; organized and committed community).
  - The DEC should agree that participants to be trained as **CM trainers** will be multi-sectoral and will be selected from the MoH, MLGRD and MoGCCD. These Ministries should be mandated by the DEC to select the participants from their respective ministries. A member from the NGO sub-grantee is an automatic member for the TOT course.

TA level

The District Health Management Team (DHMT), SSDI-Communication Project Team, and NGO sub-grantee will orient **each selected TA and the ADC members** on the CM initiative – its goals, objectives, and strategies. The TAs are gatekeepers for community work and therefore need to be engaged from the beginning. The MLGRD will assist in organizing the meeting and will introduce the project. The MoH will explain the CM objectives and the selection criteria for the TA. The NGO sub-grantee will describe the project and how it will be staffed. The NGO will also initiate discussion on the respective roles of the TA office and the community in this CM project; at this same TA level orientation meeting, membership of the **Community Mobilization Team** will be discussed.

Step 2: Set up the Community Mobilization Team and draw up the Community Mobilization Plan

The Community Mobilization Team (CMT) is selected from the team of extension workers (government employees) from different ministries working in the TA area. SSDI recommends extension workers to come from the Ministry of Health (Assistant Environmental Health Officer or Senior HSA); the Ministry of Education; the Ministry of Gender, Children and Community Services; and the Ministry of Local Government. For sustainability purposes, three members from the community may be added in the CMT, and these can include males or females who can read and write, who are patient, and who are able to teach others what they have learned. Retired teachers from the same community may also be considered. The CMT will be identified and recruited by the ADC and trained by the district CM trainers on the rollout of the CAC. The CMT will attend training on the CAC, focusing on identifying health priorities and designing interventions.

During the training, the CMT will develop draft CM Plans. Afterwards, the CMTs will go back to their respective TAs and collect additional information in order to refine and finalize the draft Community Mobilization Plan.

2. **Organize the communities for action**

A village discussion meeting

Given that Malawi has already decentralized community structures and groups in place at different levels, the model will be adapted as follows:

Step 1: Orient communities at health centre and GVH levels

This stage is an opportunity for the CMT to inform the community about the initiative and answer these fundamental questions:

- What is the nature of the partnership that the MoH/SSDI wants to build with the community?
- What are the goals, objectives, and strategies of the community mobilization program?
- What will be the community's roles and responsibilities in this partnership?

When all is clear, the CMT will negotiate with the community to buy into the program. Several informal and formal meetings, facilitated by the CMT, will be held to that effect. At the end of the orientation process, the CMTs will make sure that at least a verbal commitment from the community is obtained during a meeting or any other form of activity. The community will also understand about representation to the CAG and will be in a better position to recommend or accept the self-selected or nominated member from their catchment area to the CAG. (This process is explained in detail in the CM Toolkit.)

Step 2: Form Community Action Groups (CAGs) and orient them on CM

The output of this step will be the confirmation or the formation of a group that will serve as the engine (the leaders) of the CM process. Malawi already has decentralized community structures and groups in place at different levels, as shown in the diagram above (Section 1.5), and so on a case-by-case basis, the CMT will facilitate a dialogue with community members so that they can agree on a structure to build on. In some places, Community Action Groups (CAG)

are already in place, or there may be an active Community Based Organization (CBO) ready to take on the role.

In areas where there is no community group to build on, a new group (the CAG) will be formed from the VDC. This group's composition will consist of approximately 40 percent VDC members and 60 percent community members from vulnerable groups. Selection of the vulnerable groups will be based on guidelines established with the agreement of the community.

After gaining the consent of communities in the villages to work together towards the achievement of their health goals, the CMTs will help the CAGs or the existing community groups at the GVH level to organize themselves in order to take on the remaining phases of the CAC. Once the CAG is fully oriented, the CMTs will rapidly assess the capacity of the group in order to develop a plan for strengthening that capacity. This step is also an opportunity for the CMTs to continue building trust and good relationships with community members.

3. Explore the health issues and set priorities

Exploring the issues

The CMTs will facilitate the exploration session within each CAG/CBO. Given that health is a vast domain, and also in the interest of consistency with participatory approaches, SSDI will avoid dictating the health issues to be explored. Instead, CMT members will first present to the CAGs the EHP priorities being addressed by the SSDI project as a whole (e.g. maternal, neonatal, and child health; HIV and AIDS; malaria; nutrition; water and sanitation). Then, under each of these categories, top priority issues will be chosen **through discussion and exploration**.

The CAG members will again ask the wider community (through village meetings or house-to-house visits) to explore the 6 prioritized EHP areas through questions such as the following: Why are these particular problems common in the community? What are the problems' root causes? What beliefs and practices surrounding each health topic? etc.) Then CAG members, together with some additional village representatives and CMT members, will facilitate meetings to further explore these specific health issues. The facilitators and community

members will learn as much as possible about the current feelings, attitudes, knowledge, practices, and beliefs around these health issues. Participatory tools will be used, such as **mini dramas**; **problem trees**; **picture cards**; **score cards**; and **priority ranking matrices**. Participants will list all the relevant health issues, set priorities, and identify the underlying causes of these priorities.

At the end of the 'Explore' phase each community will have selected 3 to 4 top priorities in various health domains to work on. Next the meetings will explore the local capacity to address these needs. The priorities will be addressed during the next stage, the planning phase.

The exploration and prioritization of health issues will also be guided by SSDI-Communication's Behaviour Change Communication Strategy, by mass media messages, and by advice contained in the CM Toolkit.

4. Plan together

The main objective of this phase is to develop a Community Health Plan that really belongs to the community. Here again, the process is highly participatory, with the CMTs acting as facilitators.

Who will be in the planning team? The CMTs will work with the CAGs and additional village representatives from each GVH to determine who will be involved in the planning process, and roles and responsibilities will be assigned. This choice will be guided by a checklist, to be developed by the CMTs and the community representatives together.

How will the Community Health Plan be developed? In designing a community health plan, the planning team will consider the objectives of the planning session and the identified problems. They will formulate strategies that take into account the available resources, opportunities, and challenges. The plan will be developed to solve the identified problems. Depending on the nature of the problems, the plan will include **health prevention, health promotion, and care and support interventions.** The length of the planning cycle will be agreed upon jointly. The MoH/SSDI strategies will serve as a point of reference, but flexibility will be allowed so that each group can be innovative and identify additional strategies to tackle specific issues. The planning team will also agree on the M&E indicators at this phase. Every possible effort will be made to share the developed plans with the broader community.

5. Act together

The CAG will be at the forefront in putting the Community Health Plan into effect. It is necessary at this stage to take time to redefine or clarify the roles and responsibilities of all stakeholders: the CAGs, the community leaders, the Community Health Volunteers (CHVs), the CMTs, etc. During the implementation phase the following activities will take place:

- The CAG will be trained in how to carry out the Community Health Plan
- Community Health Volunteers will be selected by the CAGs and trained in specific CM areas
- Lead Mothers will be identified to form Care Groups.
- Activities will be monitored and reports will be written monthly or quarterly describing changes and progress. Tools and methods for participatory M&E will be explained in the CM Toolkit.

- A monitoring and supervision checklist will be developed.
- CAGs will be trained in problem solving, conflict prevention, and management.
- Certain health services will be promoted and linkages made to them, as appropriate.

This phase will also involve community capacity assessment and strengthening. Tools for capacity gap assessment and capacity building will be in the CM Toolkit.

A community monitoring system called the Community Based Information Management System (CBIMS) will be used and strengthened.

6. Evaluate community health activities together

This stage is about taking stock of what the CAGs and all the other community level actors have achieved at the end of the planning cycle. It is an opportunity for the community groups and leaders to identify what has worked well and what needs to be improved, learning from experience in order to improve the quality of future community actions. The monitoring and evaluation (M&E) will follow the system set up earlier.

The results of participatory evaluations will be shared with the broader community, giving the opportunity for celebration and recognition of individual contributions and collective achievements (e.g. the establishment of a village emergency transport system). Other communities will be invited to learn from the group conducting the evaluation activity. Likewise, villagers will be encouraged to share their successes and lessons learned with other communities to 'spread' CM for improving health into surrounding areas.

The CAG will then go on to explore the next set of problems that they wish to tackle in their area.

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4.0 HOW WILL SSDI IMPLEMENT THE STRATEGY?

4.1 SSDI's participatory approach

SSDI will adopt a participatory approach in implementing the CM strategy. At each level (national, zonal, district) of the health system, SSDI will work with the MoH and selected NGO partners in rolling out the program. Leadership of the program lies with the Health Education Unit of the Ministry of Health. At the district level the DHO leads the project, and at the Health Centre level the Assistant Environmental Health Officer take

SSDI-Services will award sub-grants to **national NGOs** to implement the community mobilization activities in a district. The NGO sub-grantees will also work in collaboration with the MoH at each level and with other government sectors. At the district level, SSDI-Services will co-ordinate with the DHMT, NGO sub-grantees, and other stakeholders for effective implementation of the CM program.

Appendix 1 shows the key milestones to be achieved over the five years of the program, along with the expected outputs and indicators. Appendix 2 shows the budgetary implications of the

three main areas of the project – staffing, training, and supervision, dividing the costs between the NGO sub-grantees, SSDI-Communication, and SSDI-Services.

4.2 Sustainability

SSDI will work with MoH and its partners on the following principles to ensure sustainability and efficiency of the CM efforts:

- **Building on existing groups:** SSDI will collaborate with stakeholders at each level to identify existing structures that the project can build on to achieve its objectives. For instance, SSDI will build on the structures (CAGs, CBOs, CMTs) that received support from Maternal and Child Health Integrated Program (MCHIP) and the BRIDGE II project; this will involve expanding their mandates and roles to cover all areas of the EHP.
- **Promoting multi-sectoral teamwork**: Although the project focus is on health outcomes, SSDI will team up with staff from other line ministries (education, local government, community services, social welfare, etc.) whose extension workers possess the kind of facilitation skills that are needed for this type of community development work.
- **Institutionalization** is paramount for sustainability. Therefore SSDI will ensure that the planning, monitoring, supervision, and budgeting mechanisms at the community level are integrated to the district level planning, budgeting, and monitoring mechanisms. This would allow the staff at a district health centre to see what is happening at the community level as complementary to what they are doing. For example, the health centre will have a copy of the Community Health Plans of each GVH in their catchment area.
- **Transparency in defining and implementing incentive strategies** is another key condition to success and therefore to sustainability. Staff and community volunteers need to be motivated for such a community-based program to succeed. SSDI will work transparently with MoH, partners and community stakeholders on feasible motivation and incentive strategies.

4.3 SSDI staff at national, zonal, and district levels

National Level: SSDI-Communication and SSDI-Services

SSDI-Communication will:

- Co-ordinate with MoH and other line ministries
- Design the CM Toolkit
- Define the scope of work for contracts for NGO sub-grantees, which SSDI-Services will manage
- Carry out mass media and community media activities at national, district, and community levels.

SSDI-Services will:

- Identify and contract Malawian NGOs
- Monitor technical quality
- Build on the CM platform for community-based delivery of EHP services, including development of training package for CHVs and Care Groups.

Zonal Level: SSDI-Communication and SSDI-Services

SSDI-Communication **Zonal Community Mobilization Co-ordinators** will:

- Build the capacity of SSDI-Services zonal and district teams for community mobilization

- Train staff of NGO sub-grantees
- Provide ongoing quality monitoring for CM/BCC activities
- Conduct periodic CM assessments and reviews.

SSDI-Services Zonal staff will:

- Support district teams to ensure technical quality and monitoring
- Work together with SSDI-Communication zonal level staff
- Submit reports to the SSDI-Services Community Mobilization Technical Advisor.

District Level: SSDI-Services

SSDI-Services **District Community Co-ordinators,** with support from the **SSDI District Team Leader** and **District M&E Officers,** will:

- Monitor, Supervise, and support all CM/BCC activities implemented by the NGO
- Establish links between CM activities within the district and also with other districts
- Compile reports and data from the Sub-grantee on CM for reporting
- Submits reports to Zonal and National SSDI Community Offices.

4.4 Working through NGOs – expected coverage

By the beginning of the second year, SSDI-Services will have awarded **fifteen** sub-grants to Malawian NGOs to undertake community mobilization in each of the 15 SSDI focus districts**.** Each of these NGOs is expected to begin implementation in at least one TA in each district by January 2013. The maximum duration of the sub-grants will be 36 months. It is expected that the sub-grants will be phased out by December 31, 2015. Each NGO sub-grantee is expected to implement CM activities in at least half the number of TAs within each district by the end of the sub-grant period. Additional coverage of implementation beyond this minimum level is highly encouraged**.** Experience suggests that due to the time-intensive nature of the CM process, 10–15 % of the population is likely to be directly reached in areas where the CAC is fully implemented. Given that the IPC messages will be extended via CHVs and other community-level groups and individuals, SSDI estimates that in the communities where CM is implemented, 50 % of households with pregnant women and/or children aged two years or younger will be reached with IPC messages. The reach of SSDI messages will be further enhanced via other outreach activities, such as open days, road shows, videos on wheels, faith leaders, and other local-level initiatives, as well as by radio.

Table 2: Required minimum level of geographic coverage for Community Mobilization sub-grants

District	Total No. of TAs in District	Minimum No. of TAs to be covered	SSDI-Services Implementing Partner
Nsanje*	9	7	Save the Children
Chikhwawa	10	7	Save the Children
Machinga*	14	7	Save the Children
Mangochi*	9	7	Save the Children

Phalombe	6	6	Save the Children
Mulanje	11	7	Save the Children
Zomba	10	7	Save the Children
Balaka	7	5	Save the Children
Lilongwe	16	8	JHPIEGO
Nkhotakota	6	6	CARE
Kasungu*	15	8	CARE
Salima*	10	7	CARE
Dowa	7	7	CARE
Karonga*	5	5	Plan
Chitipa	5	5	Plan

Note: SSDI-Communication will also support six sub-grants for malaria SBCC in six districts, marked with asterisks above, for year two only. The CM activities in these districts will ensure close co-ordination and synergy with the recipients of malaria SBCC awards in these six districts. Thereafter, SSDI-Communication will support community media activities in all 15 districts through zonal/ multi-district sub-grants

4.5 The role of NGO sub-grantees

The NGO sub-grantees are the primary implementers of community mobilization activities below the district level and will have the following structure:

- **Partnership Co-ordinator** (one for each NGO sub-grantee) will be based at the district level and provide overall management of the sub-grant and lead the staff.
- **Area Supervisors** will:
  - Supervise CM activities within one Traditional Authority;
  - Facilitate the formation and training of Community Mobilization Teams at the ADC (TA) level;
  - Supervise Community Facilitators. There will be one Area Supervisor to cover 1–3 TAs.
- **Community Facilitators** will:
  - Reside in the community and work with the CMT to implement the CAC and form the CAG;

- Support communities to identify CHVs who will provide community-based EHP services[5] and information;
- Support community groups (e.g. Care Groups, Village Discussion Groups, Youth Groups) and volunteers to deliver SBCC messages to households through interpersonal and group communication.

There will be one Community Facilitator to cover 4–6 GVHs.

The NGO sub-grantees will lead the community mobilization with support from the CM Trainers and (in the long term) from the District Health Promotion Sub-Committee. The NGOs will work with existing community-based structures and individuals to strengthen ownership. This approach will involve engagement with local structures such as the ADCs, the VDCs, Village Health Committees (VHCs), CHVs, CBOs, and other interest groups.

The NGO sub-grantees are expected to:

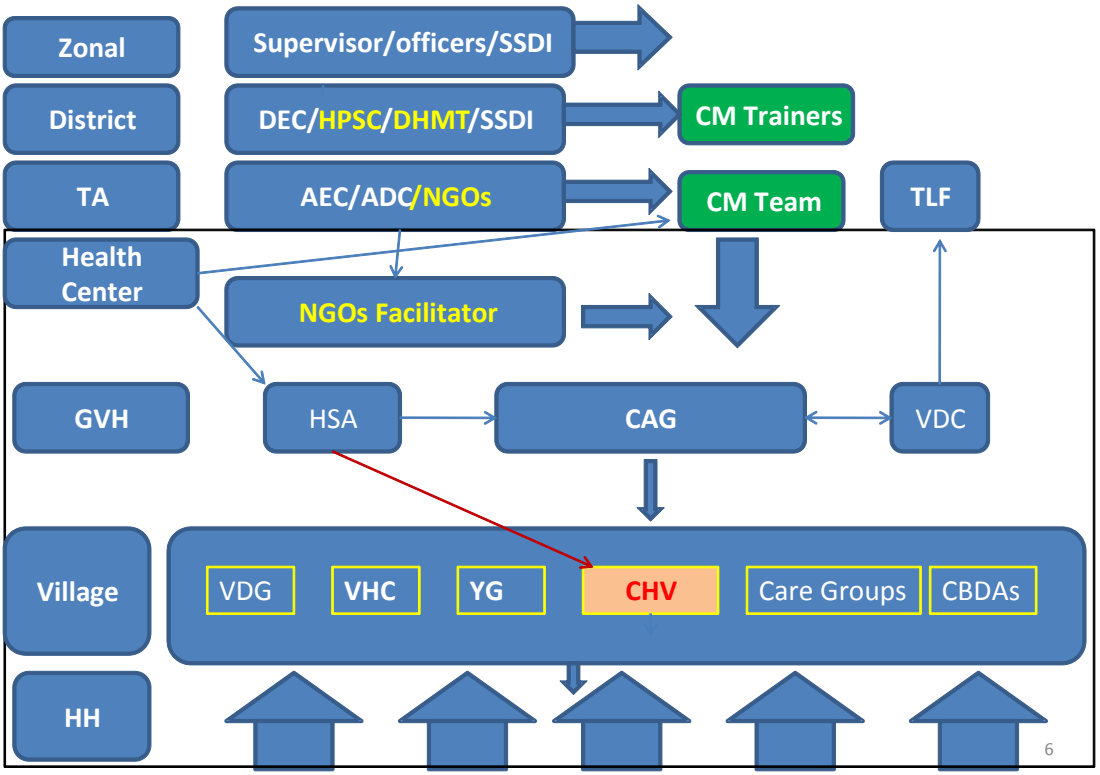
1. *Build the capacity to form, train, and coach the CMTs* (Levels: DHMT, other related district committees, existing community structures in targeted TAs).
2. *Build the capacity of existing decentralized community structures* to implement the CAC (Levels: TA level, including the CMT; Group Village Headman, including VDCs and CAGs; Health Centres; CBOs).
3. *Support the CAGs to identify new or confirm existing CHVs* who will support the delivery of basic EHP health commodities and information to their communities. The NGO sub-grantees shall sensitize community members about the benefits of improving access to the EHP and of volunteerism for their households and communities. By bringing existing CHVs under the umbrella of the CAGs, community ownership and support for volunteerism will be ensured.
4. *Build the capacity of and provide ongoing support to CHVs, other frontline workers, and members of existing community groups* (e.g. care groups, youth groups) to deliver Interpersonal Communication (IPC) messages at the household level using the CM Toolkit. Ensure the delivery of IPC messages at the household level using the Family Health Booklet.
5. *Support traditional leaders and other influential members of the community* to set social norms and policies that support optimal household practices for health.
6. *Create/strengthen community linkages with facility-based services* (family planning /reproductive health/HIV /child health), including referral.
7. *Develop and reinforce a system for the flow of information from the grassroots to national levels* and across implementing partners for decision making.
8. *Support the health workers (HSAs) and volunteers for improved reach of community-based services*, especially in underserved areas, e.g. requesting a CBDA.
9. *Develop and use community-level tools for monitoring quality and accountability for services provided in the community by public and private sector providers,* e.g. community Score Cards.
10. *Encourage community groups to participate in community media events* organized by other SSDI partners, e.g. radio listeners clubs, community champions, and role models for different behaviour-change activities. Support partners in organizing the activities.

[5] The package of services to be delivered by Community Volunteers will be defined by SSDI-Services. The focus will be on the provision of health services (e.g. distribution of services) and promotion of basic health practices. SSDI-Communication will lead on the information package.

5.0 THE COMMUNITY MOBILIZATION ROADMAP – ROLES AND RESPONSIBILITIES

5.1 Outline of the CM Roadmap. The CM initiative will be a collaborative effort of various actors, from the national level all the way down to the village. This section presents in detail their roles and responsibilities. The Ministry of Health, in collaboration with SSDI, is convinced that empowering the already existing structures to have district-based Community Mobilization Trainers, a CMT, at the TA level and a CAG at the community level will enhance ownership of the program at each level and maximize chances for sustainability. Existing groups such as Care Groups, Youth and Women's Groups, Peer Educators and Home Based Care Volunteers will be used as platforms for the activities. The diagram below shows how SSDI/MoH intends to engage the various stakeholders.

Figure 4: SSDI Community Mobilization Roadmap



DC	Area Development Committee	**HH**	Household
AEC	Area Executive Committee	**HPSC**	Health Promotion Sub-Committee
CAG	Community Action Group	**HSA**	Health Surveillance Assistant
CBDA	Community-based Distribution Agent	**TA**	Traditional Authority
CMT	Community Mobilization Team	**TLF**	Traditional Leaders' Forum

CHV	Community Health Volunteer	**VDC**	Village Development Committee
DEC	District Executive Committee	**VDG**	Village Discussion Groups
DHMT	District Health Management Team	**VHC**	Village Health Committee
GVH	Group Village Headman	**YG**	Youth Group

5.2 A national team of Master Trainers in CM

SSDI-Communication and SSDI-Services technical staff at the national level and the SSDI-Communication Zonal CM Co-ordinators will work with the Health Education Unit (HEU) of the MoH to form a national team of community mobilization Master Trainers (9 members). This expert team will provide technical guidance for the CM and SBCC activities rollout at district and community levels. The team will:

- Adapt material and tools for CM and SBCC trainings;
- Plan, budget, and co-ordinate CM activities at the program level;
- Plan for, train, mentor, and coach the District CM Trainers;
- Report to various partners;
- Disseminate best practices;
- Advocate with different line ministries to win sustained buy-in and support.

5.3 Teams of District Community Mobilization Trainers and the District Health Promotion Sub-committee of the DEC

District Community Mobilization Trainers (DCMT)

At the district level, SSDI will encourage the formation of a multi-sectoral team of District Community Mobilization Trainers (DCMT). This team will comprise:

- a member from the Ministry of Health (the Environmental Health Officer, Health Education Officer, or Community Health Nurse)
- the SSDI District Community Co-ordinator
- one member from the NGO sub-grantee
- one member from the Ministry of Gender, Children and Community Services.

Participants who are DCMT team automatically become additional members of the District Health Promotion Sub-committee (DHPSc). (See section 3.2.)

District Health Promotion Sub-committee of the DEC

The role of the DHPSc is to:

- Endorse the project in the district and ensure the integration of SSDI-Communication and SSDI-Services activities into district-level detailed implementation Plans (DIPs)
- Orient various groups at the district level about the project
- Lead the CM at the district level (Co-ordinate and carry out CMT training; supervise and coach CMTs)
- Hold monthly consensus and committee meetings
- Disseminate best practices on CM within the district
- Promote partnerships among extension workers from different ministries
- Guide the DEC as to where to implement the project at the TA level
- Introduce the project to TAs and ensure the TA understands CM and his/her own role
- Monitor and compile reports at the district level
- Build the skills within communities to mobilize resources as required.

5.4 Community Mobilization Teams (CMT) at the TA level

In each TA, SSDI/MoH will draw on the existing government and non-government extension workers to form a multi-sectoral CMT. Thus it will comprise extension workers from MoAFS, MoGCCD, and MoE, as well as HSAs, and to a considerable extent the health centre staff. The CMT will be led by the AEHO or Senior HSA. In addition, the NGO sub-grantee will hire a CM Supervisor and CM Facilitators to join the CMT. The ADC will also nominate some of its members to be part of the CMT. The minimum size of the CMT is 8 people and maximum is 10. Two CMTs should be established where the TA catchment area is very big and has two ADCs established.

The main responsibility of the CMT will be to facilitate the rollout of the CAC at each GVH level. **The Assistant Environmental Health Officer (AEHO) or the Senior HSA (if the AEHO does not exist), in collaboration with the NGO sub-grantee, will lead the CMT activities in the HC catchment area.**

CMT training

The CMT is the engine of CM at the TA level, and its role is to:

- Plan, co-ordinate, and monitor CM at the GVH level
- Train, coach, and give supportive supervision to the CAGs and volunteers on the CAC
- Provide strategic direction and technical support to CAGs
- Support CAGs in the selection of volunteers
- Mobilize the community to identify and implement sustainable mechanisms to motivate volunteers
- Report monthly on the progress of the CM process to the ADC and NGO Partnership Co-ordinator
- Together with CAGs, support volunteers (who may be CHVs, CBDAs, Home Based Care Volunteers-HBCVs, Lead Mothers, or Peer Educators)
- Encourage community members to take part and ensure that marginalized voices are heard
- Work with VDCs to encourage volunteerism in various village committees
- Be a role model for community mobilization in the area

- Ensure that quarterly review meetings on CM are held at the TA level.

5.5 Role of all TA and ADC members

The CMT will encourage the TA's office to:

- Sensitize ADC members about the project, ensure collaboration between the community structures and health centres, religious groups, and all community workers.
- Establish a Traditional Leaders' Forum (TLF) – otherwise known as a Chief's Forum – that will support weak and reluctant VDCs and CAGs. By-laws may be instituted where necessary. This forum will also discuss detrimental cultural beliefs and practices in the community and agree on ways to stop them at the TA level.
- Keep a record of the participating VDCs in the project area and monitor their progress. Provide support to VDCs that have problems and refer to them to the Chief's Forum where improvements are noted.
- Call for quarterly review meetings on CM at the TA level.
- Submit reports to the District Commissioner (DC) on the progress of the CM initiative.

5.6 Role and responsibilities of HSAs and Health Centre staff members

The AEHO or the Senior HSA leads the CMT activities at the TA level in collaboration with the NGO Partnership Supervisor. He/she will work closely with the NGO sub-grantee. He/she will:

- Consolidate the Community Health Plans from all GVHs into one **Health Centre Action Plan.**
- Supervise the CHVs and hold regular review meetings with them.
- Access health supplies from the health centre and regularly replenish the stock with the CHVs.
- Oversee, co-ordinate and monitor CM activities in the HC catchment area.
- In collaboration with the CM Facilitators and CM Supervisor, consolidate data received from the catchment area; use it for decision making and submit summarized data to the DHO and the project team.
- Work closely with communities in their catchment area.
- Seize the opportunity to share observed benefits of CM at meetings in the HC catchment area.

5.7 Roles and Responsibilities of the Community Action Groups (CAG)

SSDI/MoH will work with the CAGs at the level of GVH. Each village will send a representative to the CAG. GVHs will be oriented on the selection process during the VDC orientation meetings that will be held by CMTs and the HC team.

Some communities may opt to use already existing groups in the area (e.g. CBO, Village Health Committees) to plan and carry out the community response to the health issues. In several districts, CAGs have been formed with support from the MCHIP and BRIDGE II. It is anticipated that CMTs could build capacity in these existing groups.

In communities where there is no structure of the like, CMTs will support community efforts to form one. The community leaders and entire community need to understand the process of forming a CAG, and their buy-in is essential.

The CAG will:

- Explore health-related problems in the community and develop action plans.

- Gather information on disease prevention, health promotion, and care activities.
- Act as a catalyst for community responses to health-related issues and facilitate awareness-raising activities.
- Identify CHVs, Lead Mothers, etc. and agree on the support and motivation arrangements for them.
- Develop internal by-laws.
- Help to link community initiatives with health facilities and other social services.
- Encourage the community to build on traditional coping strategies and avoid becoming over-dependent on external resources.
- Meet on a regular basis to monitor and document progress and make necessary adjustments.
- Participate in training and capacity building activities.

Within each village under a GVH, SSDI will consider **two or three community-level structures and volunteers** as platforms through which very specific health interventions will be implemented – e.g., CHVs, Care Group Mothers, CBDAs, Home Based Care Volunteers, Women's Groups, Youth Groups, Peer Educators.

SSDI-Services and its MoH counterpart will define a minimum package of services that could be provided by each community platform. The anticipated responsibilities of each platform are discussed in the following two sections.

5.8 Roles and Responsibilities of Community Health Volunteers

SSDI envisions a cadre of Community Health Volunteers (CHV) who will be responsible for the distribution of basic health products (e.g. iron-folic acid, Vitamin A, de-worming tablets, condoms, bed-nets) and for the provision of health information to families. The CHV are active, interested members of the community who act as promoters and monitors of health and nutrition practices in a neighbourhood of about 50 families. Under the guidance and support of the HSAs, these volunteers are expected to:

- Ensure that households with pregnant or lactating mothers and children under two years are enrolled with the HAS; keep in touch with these households.
- Visit households with pregnant women to ensure they are enrolled with the HAS and are receiving ANC at the health facility.
- Encourage pregnant women to deliver at a health facility to ensure clean and safe delivery practices.
- Conduct prioritized home visits to households with a new born during the first week of life, with a special focus on pre-term or low-birth weight babies.
- Track and counsel households with children below two years in their neighbourhood for immunization.
- Distribute basic health products – iron folic acid for pregnant women, vitamin A, and de-worming tablets for children and pregnant women. Distribute LLINs, condoms, oral contraceptives, etc. (to be sourced from the HAS) and promote the use of the products.
- Promote early care-seeking for illnesses, particularly for fever, respiratory infections, and diarrhoea.
- Lead the discussions on health at village discussion groups.

Table 3: Criteria for selection of community members to become Community Health Volunteers

Essential	Desirable
- Accepted by the community - Having leadership qualities - Socially active and interested in volunteering time - Available to volunteer - Residing in the village/*limana* that would be assigned to them - Sensitive to vulnerabilities of the target population - Committed to the welfare of the neighbourhood - Able to communicate well with other community members	- A good mix of male and female volunteers in every village, including couples - A mix of young and elderly persons - Ability to read and write

SSDI-Services, in collaboration with the MoH, will develop a training and capacity-building package for the CHVs. Typically, the capacity-building plan will involve 2–4 days of initial training, followed by periodic refreshers and on going supervision, mentoring, and progress reviews.

On a pilot basis, SSDI/MoH will also explore the feasibility of providing additional life-saving services at the community level through the CHVs. This may include the provision of integrated Community Case Management (iCCM) of uncomplicated malaria, pneumonia, and diarrhoea in very hard-to-reach communities.

5.9 Roles for Care group Lead Mothers

These key volunteers will be supported by the NGO sub-grantee Area supervisor and by SSDI-Services. They will work in harmony with the CHVs and HC staff in the following roles:

- Serve as role models for healthy living within the community
- Lead in the promotion of EHP interventions in the neighbourhood
- Conduct home visits to households assigned by the NGO supervisor and teach good health practices
- Follow up on how EHP services are being accessed at the community level; refer people to the Health Centre
- Promote exclusive breast-feeding followed by complementary feeding; assist mothers and family members in overcoming simple barriers to these practices
- Monitor and report on the progress of EHP interventions at the community, family, and individual levels to the HSA/AEHO and the project staff through the CM Facilitator
- Participate in community mobilization activities
- Represent their respective communities at various forums concerning health services
- With support from the HSA, educate couples on the need and options for family planning
- Promote HIV testing and provide information on where to seek services
- Support screening children for acute malnutrition by HSAs or other health workers
- Conduct periodic review meetings on the progress of these activities.

APPENDICES

Appendix 1

Community mobilization results

a. Milestones in the process

Year 1 (July 2012-September 2012)	Year 2 (October 2012-September 2013)	Year 3 (October 2013-September 2014)	Year 4 and 5 (October 2014-December 2015)
Start up: Community Mobilization Strategy developed *(SSDI-Communication)*	Community Mobilization Strategy adopted and being used in all the Community Mobilization activities	Community Mobilization strategy reviewed and evaluated (Mid Term Evaluation)	CAGs and other community groups able to implement community media activities on EHP
Community Mobilization tool kit developed and field tested *(SSDI-Communication)*	CM Strategy and Tool kits ready for scale up	Community Mobilization Toolkit adopted by all the 15 districts of the project.	CM Toolkit re-evaluated, new tools adopted. All CM teams able to use the tools.
Scope of Work of NGO sub-granting finalized *(SSDI-Communication)*	National Community Mobilization team providing support to all Community Mobilization Teams in pilot districts	National Community Mobilization team providing support to all Community Mobilization Teams at all levels.	National Community Mobilization Team review meeting conducted. Able to support the National CM initiatives
	NGO Sub-grants awarded in 15 districts *(SSDI-Services)*	All CMTs trained	District level networks of CAGs formed
National Community Mobilization training team in place *(SSDI-Communication)*	National Community Mobilization training team supporting start up of project activities at district level	All CAGs fully functional	All CAGs demonstrating decentralized planning, supervision, and monitoring mechanisms that integrate the community-based health interventions
District CM trainers trained in six districts *(SSDI-Communication)*	District CM trainers trained in nine districts *(SSDI-Communication)*	All Community Volunteers receive the complete training package *(SSDI-Services)*	Monitoring system functional, re–evaluated, and reviewed. New approach explored

Six DEC committees oriented on CM *(SSDI-Communication)*	Nine DEC committees oriented on CM *(SSDI-Communication)*	All Care Groups receive complete training package *(SSDI-Services)*	Community Volunteers receive non-monetary incentives and support from communities
Six TA- level entry meetings conducted in six districts	TA-level entry meetings conducted in 15 districts (*NGO sub-grantees*)	All CAG demonstrate decentralized planning, supervision, and monitoring mechanisms that integrate the community-based health interventions	Final evaluation of CM interventions *(SSDI-Communication)*
Six Community Mobilization Teams formed and trained in six districts	Fifteen Community Mobilization Teams formed, trained, and functional in all districts *(NGO sub-grantees)*	Monitoring system of community-based service delivery in place (from grass roots to district levels)	All NGO sub-grants phased out
	Community Action Groups formed and functional in all GVHs in selected TAs of 15 districts (*NGO sub-grantees)*	All Community Volunteers supervised by HSAs using supervision tools (*SSDI-Services)*	All Community Volunteers supervised by HSAs using supervision tools (SSDI-Services)
	Work plans developed by all CAGs in one TA per district *(NGO sub-grantees)*	CAG groups hold regular review meetings, cross learning visits to share knowledge on EHP services	Cross learning trips conducted, CAGs registering success stories
	Community Volunteers identified in all GVHs in selected TAs of all 15 districts *(NGO sub-grantees)*	Communities mobilize their own resources or look for outside assistance (where they cannot afford) to solve identified problems	Communities mobilize their own resources or look for outside assistance (where they cannot afford) to solve identified problems
	Training package for Community Volunteers and Care Groups developed ***(****SSDI-Services****)***	Mid-term review of all NGO sub-grantees conducted *(SSDI-Services and SSDI-Communication)*	Care group members trained and functioning
	Training of Community Volunteers *(SSDI-Services and NGO Sub-grantees)*	Six-monthly review of CM at district and zonal levels (*SSDI-Communication*)	Six-monthly review of CM at district and zonal levels (*SSDI-*

			Communication)
	All CAGs with by laws to foster social norms and supportive environment for health	Supportive supervision by Zonal CM Co-ordinators and SSDI-Services district staff	Supportive supervision by Zonal CM Co-ordinators and SSDI-Services district staff
	Existence of decentralized planning, supervision, and monitoring mechanisms that integrate the community-based health interventions	Existence of decentralized planning, supervision, and monitoring mechanisms that integrate the community-based health interventions	Existence of decentralized planning, supervision, and monitoring mechanisms that integrate the community-based health interventions
	Supportive supervision by Zonal CM Co-ordinators and SSDI-Services district staff	Supportive supervision by Zonal CM Co-ordinators and SSDI-Services district staff	Supportive supervision by Zonal CM Co-ordinators and SSDI-Services district staff
	Six-monthly review of CM at district and zonal levels *(SSDI-Communication)*	Six-monthly review of CM at district and zonal levels *(SSDI-Communication)*	

b. Expected outputs and indicators

Expected Output	Indicator
Enhanced capacity of the DHMTs and other related committees to form, train, and coach Community Mobilization Teams based at each selected TA level.	# of DHMTs trained and performing according to standard
Enhanced capacity of existing structures in each targeted TA as Community Mobilization Team (CMT) in order to facilitate and maintain the Community Mobilization process	# of CMTs formed, trained, and performing according to standard # of community facilitators using SBCC packages in community-level service delivery to promote use of services and behaviour change
Strengthened capacities of existing community structures at the Health Centre, GVH, and village levels (CAGs, ADC, CBOs VHC etc.) in each targeted community to prioritize, plan, implement, and monitor collective actions in response to their health needs and problems:	# of CAGs formed, trained, and performing according to standard # of ADCs oriented and performing according to standard # of VHCs oriented and performing according to standard # of community action groups that have developed community action plans as a result of SSDI community mobilization (CM) efforts # of CBOs engaged, trained, and performing according to standard
Strengthened capacities of existing community structures and leaders to identify and implement interventions that will create an enabling social environment for good health practices	# of community leaders oriented and trained on community mobilization process
Identified Community Volunteers from each GVH who will support the delivery of basic health commodities and information to their communities	# of CHVs identified from each GVH and supporting the delivery of basic health commodities and information to their communities
Strengthened linkages and referral between community members and FP/RH/HIV services providers	# of people referred for EHP conditions (FP, RH, HIV, Malaria, Diarrhoea, TB, Nutrition problems)
Strengthened social-support networks/systems for pregnant women, sick children and adults	# of Care Groups formed and trained # of communities with adequate transportation arrangements for emergencies in delivery
Developed and reinforced a system for the flow of information between the grassroots and the national levels and across implementing partners for decision making	# of reports produced (quarterly) # of quarterly/semi-annual review meetings conducted # of cross learning visits conducted
Decentralized planning in place	# of activities identified during planning referred to ADC for further action
Supportive supervision being conducted	# of CAGs that received a supportive supervision visit from CMT each month

Built existing planning and monitoring systems and tools for bottom-up planning and community-based monitoring	# of planning and monitoring systems and tools for bottom-up planning and community-based monitoring
Trained individuals in Malaria treatment and prevention with USG funds	Number of individuals trained in malaria treatment and/or prevention with USG funds

c. SSDI Community indicators

The DHMT, District CM Trainers, and the Health Promotion Sub-Committee will closely monitor community mobilization interventions at each level (CMT, CAG, and community levels). The primary responsibility for gathering the following data lies with SSDI-Services.

Demographic indicators

- Number of households in the communities
- Number of under-five children (disaggregated by sex)
- Number of households with under-five children (disaggregated by sex)
- Number of households with pregnant women
- Number of people in the catchment area, disaggregated by sex and age

Community Action Cycle indicators

- Number of Community Action Groups formed
- Number of Community Action Groups trained, disaggregated by topic
- Number of communities with adequate transportation arrangements for emergencies in delivery
- Number of CAGs with prioritized health problems
- Number of CAGs that have developed action plans for the year
- Number of CAGs that have implemented 80 percent of the planned activities
- Number of CAGs that have evaluated their planned activities
- Number of community volunteers supporting EHP interventions (state by EHP area)

EHP Specific indicators

Please note that the following indicators will be influenced by the combined and synergistic effects of all communication interventions, including CM, outreach activities, radio, and SMS.

Malaria

- Proportion of under-five children sleeping under an LLIN the previous night (disaggregated by sex)
- Proportion of pregnant women sleeping under an LLIN the previous night
- Proportion of children under five who reported fever, and sought care within the previous 24 hours
- Proportion of pregnant who women had ANC visit in their first trimester
- Proportion of households with LLINs
- Proportion of individuals reached with messages, disaggregated by sex and by health topic (malaria, MNCH, FP/RH, Nutrition, HIV and AIDS, WASH)

Maternal New-born and Child Health

- Proportion of pregnant women who initiated ANC visit during the first trimester
- Proportion of pregnant women completing at least 4 ANC visits
- Proportion of births attended by a skilled birth attendant
- Proportion of villages with emergency transport (or money set aside for this purpose); alternately, proportion of villages with plans to improve transport in the village as a result of SSDI CM program
- Proportion of children under 5 years with prompt access to appropriate Community Case Management (CCM) of pneumonia, malaria, and diarrhoea
- Proportion of children 0–5 years with fast breathing who were treated with antibiotics by trained facility or community health workers
- Proportion of febrile children under five accessing prompt and effective treatment
- Proportion of infants 0 to 5 months of age who are fed exclusively with breast milk

Family Planning and Reproductive Health

- Number of FP products provided through CBDAs disaggregated by product (pill, condom, Depo-Provera)
- Number of people accessing FP services from CBDA services, disaggregated by sex
- Number of people who approve the use of modern FP methods

Nutrition

- Proportion of under-5 children who are underweight, WAZ<2 (disaggregated by sex)
- Number of children under five reached by USG-supported nutrition programs (disaggregated by program type – i.e. SBCC messages, community gardens, home gardens, growth monitoring, micronutrient fortification/supplementation, anaemia reduction package, promotion and management of acute malnutrition)
- Proportion of children aged 6–59 months who received Vitamin A from USG-supported programs
- Proportion of children 6–23 months with appropriate infant and young child feeding practices (continued breastfeeding, age-appropriate dietary diversity, age-appropriate frequency of feeding)
- Proportion of children who receive Vitamin A supplementation every 6 months

HIV and AIDS

- Number of clients counselled and tested for HIV (including couples counselling)
- Number of eligible adults and children provided with a minimum of one care service disaggregated by sex, age, and type of service (support or preventive)
- Number of HIV-positive women with under-five children

WASH

- Proportion of households with access to safe drinking water source
- Proportion of households with hand washing facilities
- Proportion of households using chlorinated water to make drinking-water safer
- Proportion of households with latrines
- Proportion of households with waste-disposal pits

Appendix 2

Budget requirements

Activity	NGO	SSDI-Services	SSDI-Communication
Staffing	● 1 District Co-ordinator ● 1 Community Mobilization Supervisor (1 per 2 TAs) ● 1 Community Mobilization Facilitator per 4–6 GVH ● Mobility for the Officers Co-ordinator, supervisors, facilitators, and CMT members	District SSDI-Services Team	Zonal CM Co-ordinator Zonal BCC Co-ordinator
Training	● CMTs (8–12 per CMT) 6 days (in 2 sessions; 3 days per session) ● CAG training in phases – 1 day per phase at the beginning of each phase to introduce the phase except explore phase should take 2 days.). Please do not conduct 6 days training at once for CAG members; it is a waste of resources ● CAG members training on (3 days covering M&E, Leadership, conflict management, team work, communication including Interpersonal communication) ● Provide refresher courses of all CM implementers	● Support CM sub-committee at district level ● Training of CHVs on identified service delivery activities ● Strengthen collaboration of Care groups and CAGs at community level	● Training of CM Trainers ● Training of SSDI-Services district level staff ● Training of NGO staff on CM Strategy and Toolkit ● Provide full CM training to District Health Promotion Committee at District level (as engine of CM at the district) ● Provide refresher courses for Trainers; DHPSc, NGO Sub-grantee staff ● Train staff from training institutions to incorporate the CCA

Supervision	Supervision of CM activities with district partners ● Quarterly progress reviews at VDC level ● Quarterly progress reviews at ADC level ● Quarterly progress reviews at District	● Develop monitoring and reporting forms for GVH ● Supervision for NGOs ● Attend CMT meetings	● CM Data quality monitoring ● Quarterly joint supervision ●
Meetings	● Explore meetings with community members at GVH level ● Planning meeting with community members; one at each GVH level ● One meeting to prepare for evaluation ● One meeting to disseminate achievements each year	● Bi-annual co-ordination meetings ● Quarterly review meetings	● Bi annual review meetings ● Annual NGO Reviews