GOAL

COMMUNITY-LED ACTION (CLA)

FOR COVID-19

A RESOURCE GUIDE FOR COUNTRY OFFICES

Community-Led Action (CLA) For COVID-19

A Resource Guide for Country Offices

"This is not just a public health crisis, it is a crisis that will touch every sector… so every sector and every individual must be involved in the fights."

Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, 11th March 2020

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Established in 1977 GOAL is an international humanitarian and development agency, committed to working with communities to achieve sustainable and innovative early response in crises, and lasting solutions to poverty and vulnerability. GOAL has worked in over 60 countries and responded to almost every major humanitarian disaster and are currently operational in 13 countries globally. GOAL's purpose is to save lives and empower communities to develop resilience and greater control over their lives and livelihoods. GOAL aims to increase the resilient wellbeing of the world's poorest people and focuses on those who are excluded or marginalised, particularly those who are vulnerable due to socio-economic status, gender or age. Intervention focus areas include: food and livelihood security; health and nutrition; water and sanitation; and humanitarian assistance, resilience and social behaviour change.

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Statement on Acknowledgement
The present document aims to provide public access to the Community-Led Action for COVID-19 Resource Guide for other organisations who wish to implement the CLA approach as part of their COVID-19 pandemic response. We ask that GOAL be explicitly and visibly credited in any use of the material or the approach.

This is a working document. Any comments or correction to this version may be sent to: gmcrossan@goal.ie

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Community-Led Action (CLA) for COVID-19 was developed to assist GOAL to implement an evidenced-based approach to community engagement during the COVID-19 epidemic. GOAL's CLA for COVID-19 approach builds on the lessons and evidence gathered from six years of implementing CLA during Ebola Virus Disease (EVD) and Cholera outbreaks. We want to acknowledge all the colleagues in Sierra Leone and Uganda who have provided valuable insight into the adaption of the CLA approach for COVID-19, especially Mustapha Kallon and Shirley Brown (GOAL Sierra Leone) and Vincent Mujune and Sam Okidi (GOAL Uganda). Katharine Owen led the Social Mobilisation Action Consortium (SMAC) during the Sierra Leone EVD outbreak and her experience from rolling out the first programme of CLA (called Community-Led Ebola Action (CLEA)) is reflected throughout the document. Restless Development led the original development of the CLEA approach in 2014 as members of the SMAC consortium. Finally, thanks to colleagues in GOAL's global Programme Technical Team (PTT) and Monitoring, Evaluation, Learning and Accountability (MEAL) team who were instrumental in providing guidance and the M&E system.

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Acronyms

CLA	Community-Led Action approach
CO	GOAL's Country Offices
WHO	World Health Organisation
RCCE	Risk Communication & Community Engagement
CLTS	Community-Led Total Sanitation
SBC	Social Behaviour Change
PTT	GOAL Programme Technical Team
CMs:	CLA Community Mobilisers
MoU	Memorandum of Understanding
MEAL	Monitoring, Evaluation, Accountability and Learning
IPC	Infection Prevention Control

1. About this Resource Guide

1.1. Who is this Resource Guide for?

This Resource Guide was developed to support GOAL Country Office management to operationalise GOAL's Community-Led Action (CLA) approach. CLA is GOAL's community engagement approach that recognises that communities have the power to stop the spread of COVID-19 through their collective decisions and actions. This resource guide focuses on the operationalising of CLA within community level but please note that CLA can also be applied where there are groups of people who have a common purposes such as market 'communities'. (See annex 1). The guide can also be used by other organisations as part of COVID-19 responses.

1.2. How should this Resource Guide be used?

The resource is intended as a guide for senior management and implementing teams within GOAL's Country Offices (COs). Elements of the guide may be adapted according to country situation, in-country laws, disease prevalence, risk levels, perceptions, local capacities, and the evolving nature of the COVID-19 pandemic. GOAL will continuously review, adapt and update this guide based on feedback and rapidly changing needs. This guide should be read in conjunction with the CLA for COVID-19 Field Manual for Community Mobilisers.

2. COVID-19

COVID-19 is an infectious disease caused by a newly discovered coronavirus first detected in Wuhan, China on 31st December 2019. On March 11th the World Health Organisation (WHO) declared that the outbreak could be described as a pandemic[1] due to its rapid spread across the globe.

In all GOAL operating countries the COVID-19 pandemic threatens not just the health of communities but will also have huge social and economic impact now and into the future. In a context where most people work in the informal sector, and many live in highly congested urban areas with limited access to water and soap, preventive measures for COVID -19 such as social distancing and hand washing will be challenging. The signs and symptoms of COVID-19 are similar to common respiratory diseases; few people are hospitalised therefore even with strong awareness campaigns people may not react to the outbreak and transmission will go on unchecked and underreported. As more severe prevention measures are put in place people may be confused and become fearful and concerned for their livelihoods. Fear, mistrust and financial hardship will lead to stigma, rumours, misinformation and denial.

3. Rick Communication & Community Engagement (RCCE)

[1] WHO defines a pandemic as the worldwide spread of a completely new disease, with sustained and efficient transmission across multiple countries/regions. CDC defines a pandemic as a disease that spreads across regions.

Within this rapidly evolving context it is important that RCCE is at the heart of the response. GOAL considers risk communication as the provision of consistent and coherent messages through trusted and appropriate channels to those faced with the threat of COVID-19. Community Engagement refers to partnership between COVID-19 response teams and the communities in affected areas to enable people to have ownership in controlling the spread of the outbreak within their own communities. See Annex 2 for more information on RC.

3.1. Community-Led Action

Community-Led Action builds on a strong foundation of awareness raising (often promoted by RCCE National Taskforces) and recognises that communities have the power to stop the spread of COVID-19 through their collective decisions and actions. CLA Community Mobilisers (CMs) working in pairs and within their own communities enables small neighbourhood units to do their own appraisal and analysis of the COVID-19 pandemic, its effects and likely future impact if no local action is taken. This helps people understand the urgency and the action they can take to prevent the spread of COVID-19, and to 'trigger' a collective desire to develop a Neighbourhood Unit Action Plan. Within this action plan, community members decide how they will: ensure good hygiene practices, re-design community hubs to facilitate physical distancing, stay at home without going hungry, monitor entry into the community, seek medical attention for those who are sick, and shield older people and those with underlying medical problems.

The CLA process is based on similar participatory approaches such as Community-Led Total Sanitation[2] (CLTS) and Community Conversations[3] used within HIV response programmes. It is aligned with GOAL's global approach to Social Behaviour Change (SBC) which focuses on supporting communities to develop critical aptitude so they can act independently to make changes. Once people are motivated and have the ability they can be triggered to take different actions quickly if there is perceived threat or danger to their families or themselves.[4]

GOAL first implemented CLA[5] during the EVD outbreak in Sierra Leone and within six months had triggered 9,284 communities to change key practices and behaviours. This resulted in over 95% of EVD cases being referred within 24hrs to a treatment centre and 97% of burials being conducted with safe, dignified medical burial standard operating procedures (SOP). The CLA approach was also applied to improve community-level EVD preparedness in Uganda in 2019, and within a few weeks of communities being triggered 93% of households (HHs) had taken action to protect their families and themselves.[6]

[2] https://www.communityledtotalsanitation.org/page/clts-approach
[3]https://www.undp.org/content/dam/aplaws/publication/en/publications/hiv-aids/upscaling-community-conversations-in-ethiopia- community-conversation---launch-pk/47.pdf
[4] https://www.behaviormodel.org/
[5] Known as Community-Led Ebola Action (CLEA)
[6] GOAL Uganda EVD programme 2019 internal document

Communities will respond to CLA triggering in different ways. Some will be inspired to take immediate action, while others may be resistant, reluctant or indifferent. The amount of time and experience or exposure to disease outbreaks that the community has had can also greatly impact a community's willingness, openness and urgency to develop preparedness and response action plans.

When CLA for COVID-19 works well, it should:

- Be based on c**ollective** household and/or community **decision-making** and a**ction** by all
- Be driven by a sense of **collective achievement** and **motivations** that are internal to households and/or communities, not by **coercive pressure** or **external payments**
- Generate diverse **local actions** and **innovations** that support protection of household and communities, especially the most vulnerable and those at high risk.
- Lead to emergence of **new Champions** and/or **new commitment** of existing leaders
- Build on traditional social practices of household and/or community cooperation and **create new local examples** that can be shared with other communities
- Focus on and **celebrate** community-wide outcomes
- Gain **momentum and scale up** to other communities, divisions and districts as communities and authorities gain confidence
- Rely on clear **accurate two-way information** flow that builds trust and positive feedback-loops between communities and health authorities

Figure 1 CLA 5-Steps

3.2. Preparing to Implement CLA

GOAL's global Programme Technical Team (PTT) can support COs in planning and adapting CLA in line with national guidelines and the in-country situation. GOAL COs will need to work under the national, government-led COVID-19 response to implement all RCCE activities including CLA, in full coordination and partnership with the RCCE response infrastructure. There will likely be windows of opportunity in most countries for direct engagement with and within communities, interspersed with periods of restricted movement and limited access to communities. GOAL will need to act rapidly to implement CLA, seizing the opportunity to mobilise CMs who will go on to trigger communities. The roll out of CLA can work to build community cohesion which in turn can create a strong foundation for other responses as the outbreak continues.

3.3. Identifying Operational Areas

CLA should be implemented in operational areas with existing community engagement and where there are established relationships with authorities and other stakeholders. Heavily affected and most at-risk or vulnerable areas should be prioritised. These include areas which already have high COVID-19 transmission, or are in close proximity to areas with high COVID-19 transmission (including areas with mobile populations); areas with low population health indicators; areas with a large number of displaced people and other vulnerable groups; densely populated areas with limited sanitation and stretched healthcare services; and isolated and remote areas with limited access to healthcare services and support. Other areas that can be considered are those where local leaders have requested external support and areas where no other NGOs are engaging communities in relation to COVID-19.

3.4. Setting up the Management & Operational Structure

3.4.1. CLA Programme Structure

The size of the management and operational structure needed to support a CLA programme will depend on the size of the operational area and the number of communities - specifically neighbourhood units - to be reached.

As a guide, every CLA programme will need **1 full-time National CLA Manager**, **1 District CLA Manager** per operational district[7] and **1 CLA Supervisor for up to 10 CM Pairs (20 individual CMs)**. If CLA Supervisors manage more than 10 CM Pairs it will be difficult to give them and their communities adequate support, as each CM Pair could be responsible for up to 8 neighbourhood units (see Section 3.6.1). This means a CLA Supervisor managing 8 CM Pairs will be overseeing work and collecting and compiling data from 80 neighbourhood units per week. It is also not advised to task CLA Supervisors with managing more than 10 CM Pairs so that it can still be possible to hold in-person trainings and meetings with CM Pairs (if this is possible) without these events becoming too large.

[7] There are different administrative units across countries. This manual uses area to refer to the level below national at which there is co-ordination. In some countries this would be District, Locality or County.

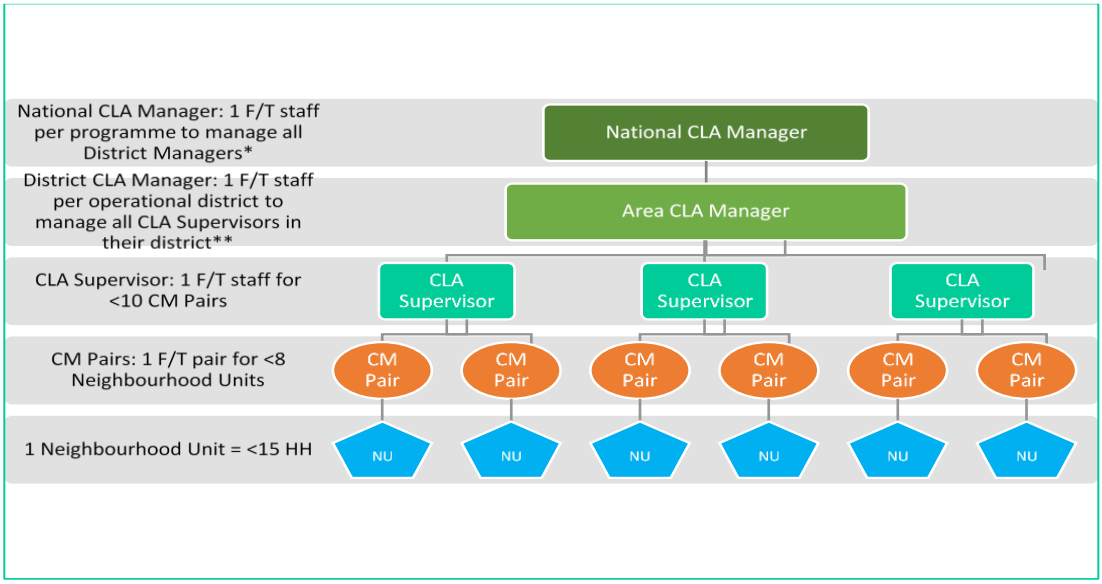


Figure 2 CLA Programme Structure

COs will need to adjust the numbers to suit their particular context. For example, the following should be considered:

- If CM Pairs are part-time rather than full-time, CLA Supervisors could manage more than 10 CM Pairs, but still oversee the same number of neighbourhood units.
- If it is known that supervision meetings will definitely be conducted by phone, it may be possible for one CLA Supervisor to be responsible for more than 10 CM Pairs as they won't need to factor in travel time, and phone calls will likely be shorter than meetings.
- If there are more than 6 district Managers it might be necessary to add an additional management layer, for example, 'Regional CLA District Managers', in between the National CLA Manager and the CLA District Managers so that the National CLA Manager does not have too many direct-reports to give close attention to each district
- If there are more than 10 CLA Supervisors in a district it might be necessary to add an additional management layer, for example, 'CLA Officers', in between the Area CLA Manager and the CLA Supervisors so that the CLA District Manager does not have too many direct-reports to give close attention to all

3.4.2. CLA Programme Roles

The key responsibilities of the required CLA Programme Staff are outlined in Table 1. As much as possible, existing GOAL staff should be appointed who have the capacity for these roles and are already familiar with GOAL systems and processes, know and are known in the communities they will oversee and who are skilled in participatory facilitation and community engagement. The CLA Programme Staff will also be supported **1 MEAL Manager** and **1 MEAL Officer** per operational district.

Table 1: CLA Programme Responsibilities

Staff	Key Responsibilities (non-exhaustive)
National CLA Manager	• Manage and oversee all aspects of the CLA programme • Represent GOAL in the national RCCE response meetings and other relevant national-level meetings (Health and INGO Forums etc.) • Prepare JDs and support the recruitment of CLA district managers and supervisors • Support District CLA Managers to roll-out training for CLA Supervisors • Line-manage the District CLA Manager(s) • Work with M&E team to regularly review M&E data and adjust the programme as necessary. • Check in with District CLA Manager(s) weekly (minimum) to discuss what is working/not working, help problem-solve, and update skills as necessary • Build relationships across the national response pillars and ensure community data and feedback is shared to problem-solve/improve services • Manage the CLA programme budget and high-level procurements • Ensure timely reporting to donor and national response as requested
District CLA Manager(s)	• Manage and oversee all aspects of the CLA programme at the district-level • Represent GOAL in the district RCCE response meetings • Engage district leadership and key stakeholders to secure permission for the programme to be implemented • Ensure that all those who need security passes or clearance approval to operate in the district or move about during lockdowns etc., have them • Roll-out training for CLA Supervisors • Support CLA Supervisors to roll-out training for CMs • Line-manage the CLA Supervisors • Work with M&E team to regularly review M&E data • Check in with CLA Supervisors weekly (minimum) to discuss what is working/not working, help problem-solve, and update skills as necessary • Conduct review meeting with CLA supervisors and CMs every 4-6 weeks

	• Build relationships across the district response pillars and ensure community data and feedback is shared to problem-solve/improve services • Manage the CLA district budget and procurements • Ensure timely reporting to National CLA Manager as requested
CLA Supervisors	• Manage and oversee all aspects of the CLA programme in designated communities • Engage community leadership and key stakeholders to secure permission for the programme to be implemented • Roll-out training for CMs • Supervise the CMs • Check-in with CMs weekly (minimum) to collect community and neighbourhood data, discuss what is working/not working, help problem-solve, and update skills as necessary • Compile community and neighbourhood data and submit to M&E team as requested • Provide emergency support to CMs as needed at community-level • Help to link communities with services - ensure that referrals are made and services meet community expectations, and where they don't share this feedback with service providers, response workers, CLA District Manager etc., and help improve services/advocate for improvements • Foster and share good practices from one community to another and elevate innovative ideas from communities up through the CLA programme and the national response
MEAL Manager	• Ensure high quality and timely aggregation and analysis of CLA monitoring data • Supervise and manage X number of CLA MEAL Officers including training • Reports into Country MEAL Coordinator with dotted line to CLA Programme Manager
District Meal Officers	• Responsible to data collection and management for area of operation • Supports training and roll out of CLA monitoring tools • Troubleshoots MIS issues related to data collection

3.4.3. Equipping CLA Programme Staff

Once recruited, COs will need to ensure CLA Programme Staff are adequately equipped for their roles. As well as the usual contract, salary, and staff benefits, COs should consider any

additional resources needed for staff working at community-level in an emergency context. For example:

- Hard and soft-copies of CLA Field manual
- Country specific COVID-19 Information, Education, and Communication (IEC) guides
- Hard and soft copies of all M&E guidance on the Monitoring Information System (MIS), triggering and follow-up and evaluation tools.
- A smartphone or tablet for data collection using the CommCare app (for CLA Supervisors/Enumerators, not necessary for CMs)
- Access to phone credit and wifi access for follow up calls and uploading data
- Other optional items e.g. raincoats, boots, hand sanitisers.

3.5. Additional Support Requirements

As well as direct programme staff, a CLA programme will need support from operational support teams. For example:

- Human Resources: e.g. Leading on the recruitment of GOAL staff or if seen as necessary, new contracts for repurposing staff. See Table 1 key responsibilities of programme staff.). CMs - new contracts or preparation of the Memorandum of Understanding (MoU) which outlines the roles and responsibilities of GOAL and the CM, including prevision of resources, reporting, conduct, privacy, safeguarding and security.
- Procurement: e.g. Purchase of smart phones or tablets and system for continuous and sufficient phone and wifi credit for CLA Supervisors and CMs. Organising high volume printing and/or photocopying of training materials for many trainings that will happen simultaneously. Purchase of visibility and optional resources for CLA Supervisors and CMs such as t-shirts, hats, rain coats, and boots. Possible purchase of extra transport solutions such as renting of cars, motor bikes etc.
- Finance: e.g. System for payment for many simultaneous trainings, sensitisation, and review meetings with other stakeholders. System for regular payment of stipends for a large number of CMs who may be remote (i.e. via mobile money).
- Fleet: e.g. Ensuring sufficient transport is available at district level for supervision of triggering and follow-up visits in consideration of national restrictions and GOAL's Standard Operating Procedures (SOPs) on staff safety.
- IT: e.g. Support for district and field locations to ensure access to Monitoring, Evaluation, Accountability and Learning (MEAL) data systems, online training platforms where necessary, front loaded computers for District and National staff and a system for continuous IT support.

3.6. Identifying & Equipping CMs

3.6.1. Community Mobiliser Structure

CMs must be selected from within the community which they will trigger. This is to ensure that they are familiar with these communities, trusted by community members, and speak the local language. This also ensures that CMs do not have to travel to conduct triggering and provide ongoing support to the community.

CMs will break their community down into smaller distinct neighbourhood units of **maximum 15 households**. They can then be responsible for up to 8 of these units. It is advised that CM Pairs are responsible for up to 8 neighbourhood units, so that in any given week, they can spend half a day on each neighbourhood unit (whether triggering or following-up with them), and still have one day free for engaging with the community leadership, attending supervisory meetings and refresher trainings, reporting, and dealing with unexpected events and delays.

COs will need to adjust the numbers of CMs to suit their particular context. For example, the following should be considered:

- If communities are small and total less than 8 neighbourhood units, CM Pairs might be recruited on a part-time basis rather than full-time, as they will be responsible for fewer than 8 neighbourhood units (and should not be working outside of their community to cover additional neighbourhood units).
- If there is a need to be able to trigger all neighbourhood units in less than a week, or conduct follow-up visits to neighbourhood units more frequently than once a week, the number of neighbourhood units per CM Pair will need to be reduced.
- If it is known that follow-up visits will definitely be conducted by phone, it may be possible for one CM Pair to be responsible for more than 8 neighbourhood units as they won't need to factor in travel time, and phone calls will likely be shorter than visits.

3.6.2. Profile of Community Mobiliser

CMs should be identified based on their standing within the community but as far as possible, they should also meet other criteria. CMs should ideally:

- Be put forward/ recommended by the local leadership
- Be trusted and well-respected in their community
- Not be of such high community status that others feel intimidated or unable to disagree with them
- Have experience not just in educating communities but in mobilising them and facilitating community discussions
- Have completed secondary school education and/or can read and write

- Be available and willing to move to small neighbourhood units within their community to conduct 1-day-long triggering sessions
- Not have any health conditions which put them in the high-risk category for COVID-19.

3.6.3. Equipping CMs

CMs will need to be trained and equipped to do their job and GOAL should:

- Decide whether CMs receive a salary/stipend or are taken on as volunteers. Expectations (availability, deliverables etc.) of a CM receiving a salary or stipend can be higher, and there is a lot of evidence to show that motivation and retention of community workers is also often higher when they are paid. In addition, it should be remembered that CMs are being asked to work on the frontline in a high-risk environment and so should be treated in the same way as other frontline responders. From GOAL's experience, professionalising and fully supporting CMs who do such essential work is key, so we recommend budgeting for a stipend.
- Provide a clear contract (or MoU for volunteers) and make it and its contents known to stakeholders, community leadership and others. Being as transparent as possible around the relationship between GOAL and the CMs, including roles and responsibilities, payments, and resources provided, will help ensure appropriate conduct of both parties, prevent suspicion and rumours, and make it easier to clear-up any rumours or misunderstandings, and reclaim materials at the end of the response period. In humanitarian emergencies there is often a lot of concern related to how funds are spent and allocated, and how and when people are reimbursed.
- Deliver on responsibilities as stipulated in contract or MoU. This includes ensuring training; having clear safety and security protocols for CMs; making timely payments of salaries/stipends; and providing resources, i.e.:
    - Hard copies of CLA COVID-19 Field Manual for CMs
    - Country specific COVID-19 IEC guides
    - Hard copies of all M&E guidance on the triggering and follow-up forms
    - Access to phone credit and wifi access as needed for neighbourhood follow-up and supervision calls, and online training
    - Other optional items e.g. raincoats, boots, hand sanitisers, visibility items such as t-shirts.

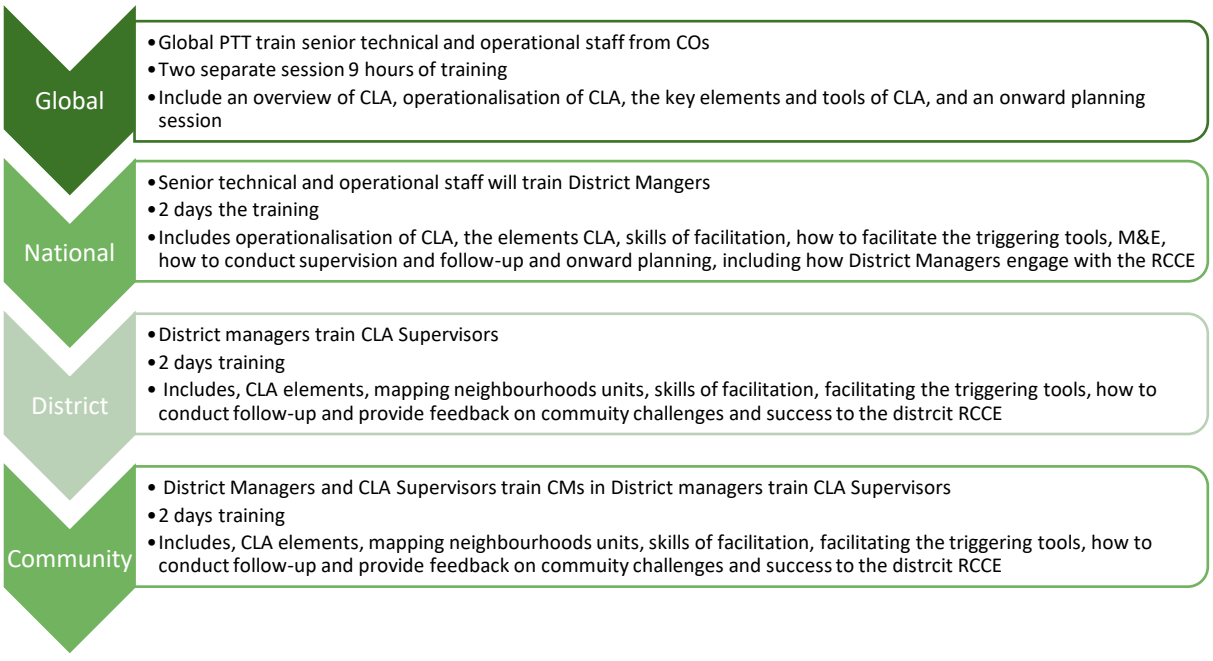
3.7. Cascading Training

3.7.1. Cascade Structure

GOAL will utilise a cascade approach to deliver support and training from the global-level, to the national-level, to the district-level to the community-level. Initially the Global PTT will provide 9 hours of training for senior technical and operational staff from COs. This will be provided online over two separate sessions and will include a 1-hour follow-up discussion for each country and ongoing support by the global PTT as is required.

These senior technical and operational staff will then be responsible for running training in their own CO. This national training should be for district managers and should cover the operationalisation of CLA, the key elements and tools of CLA, and an onward planning session. Those trained should then go on to train CLA Supervisors, who will in turn train CMs. Training or CLA Supervisors and CMs should focus on the skills of facilitation, how to facilitate the triggering tools, and monitoring of the CLA process. All GOAL trainings should include sessions on staff safety and safeguarding (see SOP on staff safety and security and safeguarding section 8 below)

Figure 3: Cascade Training



3.7.2. Training Package

The Global PTT will also provide a CLA training package to support onward training at every level. CLA training has been designed so that it can be delivered in-person or remotely, online. In-person training should only be conducted where it is appropriate and safe to do so, and with strict Infection Prevention Control (IPC) measures in place (**see Section 7**). For remote training each country will have to identify online platforms such as Microsoft Teams or Zoom

that can be used, where licensing is permitted and where participants have sufficient connectivity. GOAL PTT is also exploring interactive tutorial platforms that COs can use for remote participatory training.

The full CLA training package will include:

- CLA for Covid-19 Field Manual for CMs
- A CLA Training Slide Deck and Facilitator guide for CLA Supervisors and CMs' Training
- Instructional Training Videos for use in the CLA Supervisors and CMs' Training
- Information Guides on community-level action that can be taken to prevent the spread of COVID-19, help ensure treatment for sick people, reduce negative impact on livelihoods etc.
- Information Guides on how to continue other essential projects through the CLA process e.g. Family MUAC, or referral for other health services.

GOAL COs will need to adapt the training materials and resources to suit their country and cultural context including, for example, integrating the national government's COVID-19 guidance on:

- COVID-19 case definition
- the point at which patients should seek care/self-isolate
- physical distancing rules
- movement restrictions

COs should also try to develop additional context-specific materials and resources. Informative and motivational audio-visual materials can be shared with CLA Supervisors and CMs on an ongoing basis. They may include updates related to the disease, disease spread, or government control measures (including changes to safe burial processes). They may aim to dispel newly emerged myths and rumours. Or they may aim to showcase examples or 'local heroes', community action, best practices, or words of encouragement from national leaders or celebrities in an effort to motivate teams to continue their work. These materials do not have to be complex to produce, they could be short videos, recorded by GOAL staff on smartphones, for example. Videos and/or audio should be in local languages, and easily shareable (via social media or in-person).

4. Implementing CLA

4.1. Implementing CLA at Community-Level

The CMs will lead the CLA implementation at community level. The Community-Led Action for COVID-19 Field Manual for Community Mobilisers contains the details of this process. The table below shows an outline of the key steps.

Table 2 Key Activities for CMs at community level

	Time	Key Activities
1.	1 day	• Engage community leadership • Secure permission to implement CLA • Establish community point-of-contact • Break-down community into smaller neighbourhood units • Establish neighbourhood point-of-contact
2.	½ day per unit	• Engage neighbourhood units • Secure permission to run triggering sessions • Confirm day, time, specific location and participants for each triggering • Review triggering tools and prepare materials
3.	½ day per unit	• Conduct triggering sessions in each neighbourhood unit • Complete CLA Monitoring Forms for Triggering
4.	½ day per unit ½ day	• In 'ignited' neighbourhood units: • Facilitate the development of Neighbourhood Action Plans • Identify Community Champions • At community-level: • Re-visit community leadership and discuss establishing a Community Committee • Support the development of Community Action Plan
5.	Ongoing	• Conduct follow-up with all neighbourhood units • Conduct follow-up with community leadership/Community Committee • Complete CLA Monitoring Forms for Follow-Ups

5. Linking to the National COVID-19 Response

5.1. Feedback Loop for Communities

The CLA Supervisors will be the link between the community and district taskforces, ensuring that referrals and follow-ups and other pillars of the response are meeting communities' needs and expectations.

Through the RCCE taskforce at district level there will ideally be the establishment of a system for collecting and analysing community feedback (including rumours, concerns, dissatisfaction with services or control measures etc.) and the provision and management of a hotline number for communities to call to report cases, enquire about testing services etc. This will allow frontline workers to respond to misinformation, gaps, quality issues, and manage risk communication more appropriately; responding to communities' concerns in

real-time. It will be particularly important that frontline workers and community leaders can coordinate essential support for the most vulnerable such as provision of food, water and healthcare.

5.2. Recognising Success

Sharing lessons and practical experience from one community to another is one of the best ways to spread good ideas, foster neighbourhood and/or community pride, and build momentum. Regular taskforce meetings at national and district level are a good place to recognise and celebrate community leaders and neighbourhood champions who are implementing creative ideas, or who are particularly strong in executing their action plans. This gives these leaders recognition for their work in keeping their communities safe from COVID-19.

6. Monitoring, Evaluation, Accountability and Learning

The following guidance outlines GOAL's MEAL approach for CLA. Tools and guidance can be adapted according to your country situation and needs. Some elements of the guidance may differ between countries depending on in-country laws, disease prevalence, risk levels, perceptions, and local capacities. This guidance includes necessary indicators, tools and data processes to successfully monitor project implementation.

Recognising that the situation in country offices is changing rapidly, there are various levels of MEAL engagement proposed in this guidance. Staff and community member safety and well-being is the ultimate priority. MEAL activities should only be carried out if proper safety and risk mitigation measures are taken. It is ultimately up to the country team to decide what level of data collection is feasible. This may change over the course of the project as the situation on the ground changes. Staff and community health and safety is the number one priority, and no one should be put at risk for non-essential data collection exercises. Contact your Regional MEL Advisor if additional support or guidance is needed.

6.1. Data Collection Priorities

Figure 4 below visualises the data collection priorities with required donor indicators and Community Complaints and Response Mechanism (CCRM) being the core necessary data to collect. If context and security allow, additional data on the quality of programming such as the baseline and end-line surveys should be collected. Finally, if there is funding and staff capacity, we should make sure to document key learnings for both internal and external audiences so as to better inform future programming.

A sample logical framework is included in **Annex 3** Data priorities are the key data to share with donors.

These three indicators are suggested:

- # of GOAL staff trained (disaggregated by sex)
- # of community supervisors trained (disaggregated by sex)
- # of CMs identified and trained (disaggregated by sex)

If it is possible to collect additional data points, we strongly recommend including higher level outcome indicators, including GOAL Key Indicators, such as:

- % of people affected by crisis consider that they have timely access to relevant and clear COVID-19 information (disaggregated by sex)
- % of target population who can list at least three key means of preventing the spread of COVID-19 (disaggregated by sex)
- % of target population who can correctly identify at least three symptoms of COVID-19 (disaggregated by sex)

Additional indicators are important for our own internal project monitoring and quality control. These are detailed in the indicator bank with definitions and data collection pathways included.

Accountability data though the Community Complaints and Response Mechanism (CCRM) is crucial. These communication pathways need to be maintained and strengthened during the response. Please consult the Accountability section below and reach out to the Accountability Advisor for any additional support.

Figure 4: Data Collection Priorities

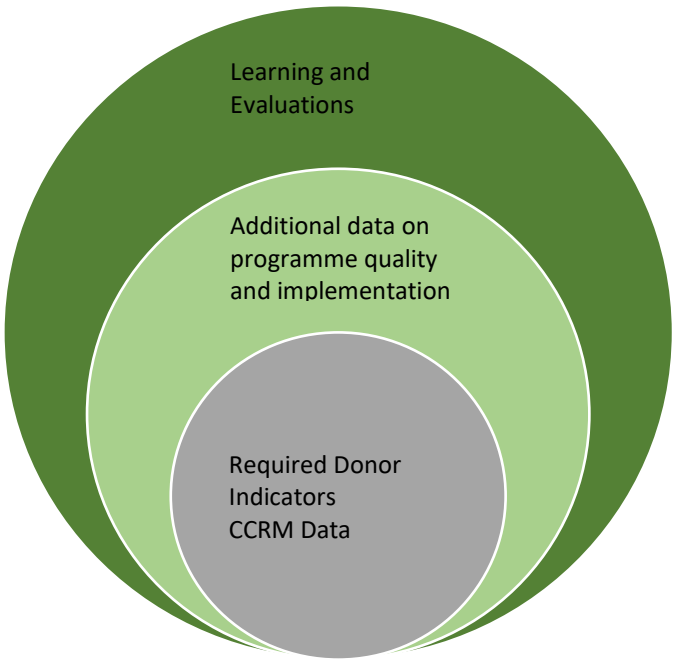


Figure 4: Data Collection Priorities

6.2. Data Management

6.2.1. Data Collection

The Programme Technical Team and Global MEAL team have worked together to develop templates for several key tools for collecting CLA data.

Training Log

- Country offices should have an existing registration/sign in form to use for collecting necessary data on trainings including name, sex and contact information for participants as required.
- Form should be completed for all training sessions (GOAL staff, CLA supervisors, CMs, etc.).

Monitoring Form for Neighbourhood Unit Triggering

- This form should be completed once for each neighbourhood unit, immediately after the triggering takes place.
- Community Supervisors should collect the key data from the Community Mobiliser and completed either the paper tool or the CommCare form.
- Template for the tool can be found in **Annex 4**

Monitoring Form for Neighbourhood Unit Follow Up

- This form should be completed for each triggered neighbourhood unit on a weekly basis.
- Community Supervisors should collect the key data from the Community Mobiliser and completed either the paper tool or the CommCare form.
- Template for the tool can be found in **Annex 5**

Monitoring Form for Community Triggering (if it is a community and not a neighbourhood that is being triggered)

- This form should be completed once for each community, immediately after the community triggering takes place.
- Supervisors should collect the key data from the CMs and complete either the paper tool or the CommCare form.
- Template for the tool can be found in **Annex 6**.

Monitoring Form for Community Follow Up

- This form should be completed for each community on a weekly basis.

- Community Supervisors should collect the key data from the Community Mobiliser and completed either the paper tool or the CommCare form.
- Template for the tool can be found in **Annex 7**.

Knowledge, Attitudes and Practices Survey (KAP)

- The KAP should be completed at baseline and endline when possible.
- The CLA Supervisors/GOAL Employees should complete the tool for the identified number of households based on sample size. The tool can be conducted in paper version but ideally will be completed on CommCare.
- Given the current context, sample sizes may not be statistically significant. This should be decided between the MEAL and programmes teams.
- Country offices need to decide if this level of data collection is safe and feasible.
- Template for the tool can be found in **Annex 8**.

For additional information on data collection approaches during COVID-19 consult the COVID-19 MEAL Guidance.

6.2.2. Data collection scenarios

Table 1 below outlines a variety of different levels of data collection depending on what the current situation is in your country of operations. **Ultimately, this should be taken as recommendations; all decisions on what level of MEAL activities are safe and feasible are ultimately up to the country office team.** The GOALMEAL HQ team is available if you have any questions. For additional information consult the MEAL Guidance. Please contact your Regional MEL Advisor for additional support as necessary. This is an evolving situation and advice and guidance may change over time.

Table 3: Data Collection Scenarios

	Normal Access -No COVID-19 related movement restrictions Taking IPC precautions at GOAL community engagement SOP	**Limited Access -Restrictions in place but NGO staff can still access communities. Social distancing in place, restrictions on gatherings**	**Severely Limited Access -Restrictions in place and very limited access to communities -Communities on lockdown -Restriction on gatherings of people**	**No Access -No access to communities -Limited/no movement for staff -Lockdown**
Training Log	Only one person should fill out the training log for the whole group. Each person should wash their hands before signing and use their own pen.	Consider remote trainings. Document name, sex, contact info of participants	Trainings should be done remotely. Document name, sex, contact info.	Remote trainings. Basic data as much as possible.

Triggering Form	Mobilisers complete either digital or paper form.	Supervisors can contact Mobilisers via phone and complete the triggering too remotely and submit the form on CommCare.	Supervisors can contact Mobilisers via phone and complete the triggering tools remotely and submit the form on CommCare.	Supervisors can contact Mobilisers via phone and complete the triggering tool s remotely; **Consider** limiting data collection to essential questions only
Follow Up	Mobilisers complete either digital or paper form.	Follow-up Data collected remotely by phone and form completed on CommCare. If Mobilisers have smartphones and have training on CommCare they can submit forms directly.	Follow-up Data collected remotely by phone and form completed on CommCare. If Mobilisers have smartphones and have training on CommCare they can submit forms directly.	Follow-up Data collected remotely by phone and form completed on CommCare; **Consider** limiting data collection to essential questions only
KAP	GOAL MEAL Staff or hired enumerators conduct KAP. Use complete version of tool	Supervisors conduct KAP; Shortened version can be used if necessary and sample size can be reduced.	KAP conducted at discretion of MEAL staff; Community supervisors conduct shortened KAP with a limited sample size via CommCare.	It is not recommended to conduct KAP in this scenario. Data from the KAP section follow Up Form can be used instead if available.
CCRM	CCRM Staff trained in-person on COVID-19 Have 2 CCRM personnel at GOAL offices to receive feedback (1 male/1 female) and answer questions Meet regularly with Health team to share feedback, complaints, rumours	Consider remote training Remote channels – accessible by >1 /<4 persons Have 1 CCRM staff member active at each office (if needed, staff member of another gender from separate team to receive comms) Meet remotely with Health team to share feedback, complaints, rumours	Remote trainings Remote channels Meet remotely with Health team to share feedback, complaints, rumours	Remote trainings Remote channels Meet remotely with Health team to share feedback, complaints, rumours

6.3. Management Information Systems (MIS)

The data collection tool templates will be digitised in CommCare. Use of digital data collection tools is recommended but this decision will need to be made on a country by country basis based on capacity, resources and context. **Country Offices that want to use CommCare for data collection should contact their Regional MEL Advisor who will work with the MIS team for support on this process. Please give us as much notice as possible.** Tools will have to be set up in each country office's project space and questions may need to be adapted based on context. Setting up data collection through a mobile platform is more complicated and time-consuming in terms of set up than just finishing a paper survey.

6.3.1. Users

Three main types of user will need to be involved but the staffing of these will differ by country:

Table 4: CommaCare Users Roles & Responsibility

User Type	Role & Responsibility
App Focal Point	To liaise with HQ on deployment and support and be the key person in country with comprehensive knowledge of the app [in addition to the App Admin responsibilities listed below]
App Admin(s)	To manage the app for the country including user management, data cleaning and export as well as training and supporting mobile data collectors
Mobile Data Collector	To enter the information collected from the community into the app

It is recommended that mobile data collectors are previously trained members of staff who are already accustomed to using CommCare. However, if this is not possible, full training on the app and the relevant functionality in CommCare must be provided by country MEAL staff with global MEAL team support. Additional data cleaning efforts will also have to be made by staff to ensure timely and accurate information.

6.3.2. Paper Based Monitoring

It is most likely that CMs will collect information on paper forms first which are then sent on (via phone, internet, or in person) to CLA Supervisors for entry into the app. The paper-based forms contain the same questions as the app, however, there is one big difference and that is where action plan and their action points are recorded. On paper-based forms the action plans are built into the triggering and follow up forms. In the app, action plans and the updating of them are recorded in separate app forms.

6.3.3. Set Up

The country office will need to **provide some details for the app** before it is ready to be deployed in country:

1. Lists of Districts/Provinces and the Chiefdoms/Wards within them as outlined

Districts/Provinces*	Chiefdoms/Wards*
District 1	Chiefdom 1
District 1	Chiefdom 2
District 2	Chiefdom 1

*Or equivalent in your country

2. If translation will be required, the CLA COVID-19 Translation Template will need to be completed
3. If a country wants support in setting up new CommCare mobile workers (people who will enter data), then details will need to be provided as outlined below

Username	System language	Password	Name (first, last)	District / Province*	Chiefdom / Ward*

If CMs are going to be using CommCare (as opposed to GOAL staff), more data protection is going to need to be configured. If just GOAL staff will use CommCare then all CLA data can be open within the app for that country which will make the app work more efficiently. If CMs will be using CommCare then we will need to set up user groups so that only relevant information is shared amongst those in a *particular geographical location. If this is the case, HQ will support the set-up of new mobile workers to ensure data protection.

6.3.4. App Structure

There are eight forms to the app for monitoring data which is divided at the geographic level in which activities are undertaken:

Community	Neighbourhood
Community Triggering*	Neighbourhood Triggering
Community Follow Up	Neighbourhood Follow Up
Create Community Action Plan	Create Neighbourhood Action Plan
Update Community Action Plan	Update Neighbourhood Action Plan

*only occurs when a community is not divided into neighbourhood units.

6.3.5. Data Entry

Figure 5 outlines the stages of information recording for CLA and the order in which data should be entered in the app, relevant for both Community and Neighbourhood monitoring.

Data entry into the triggering tools will only be required once and the Community and Neighbourhood Follow Up forms and Update Action Plan forms will have data entered and updated regularly in accordance with the scheduled follow ups. The green boxes represent data entry in the titled app form. The yellow decision diamonds represent the different forms required to be used dependent on when action plans were developed.

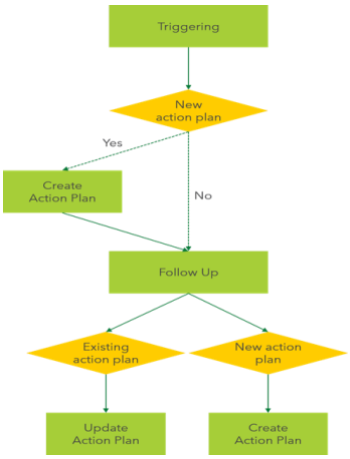


Figure 5: Data Entry

6.3.6. Data Export

The necessary data exports from CommCare will be built into the app on set up. There will be two main types of export:

- Action Plan export focused around the most recent action plans for each community and neighbourhood alongside community/neighbourhood data key for analysis and reporting on COVID-19 responses.
- Health Statistics export from all the relevant data provided in neighbourhood follow ups alongside community and neighbourhood data key for analysis and reporting on COVID-19 incidences.

  These exports will also be integrated into Power BI with set reports by HQ for use by all. For more details on CLA analysis and reporting, refer to the CLA PBI Guidance document.

6.3.7. Storage and Analysis

Data storage will vary depending on which data collection methods are used. This will need to be decided by the country MEAL team based on staffing, resources and access. If using CommCare, data will be stored on-line. Key data points can be set up in a PowerBI dashboard to enable real-time data analysis and engagement. If using paper tools and manual data entry, this can also be linked to a PowerBI dashboard or other data analysis pathway based on country office needs and capacity. If a baseline and endline KAP survey is conducted,

analysis should be conducted by the country MEAL team and an evaluation report should be developed. The MEAL HQ team can provide additional support if necessary.

6.4. Evaluation and Learning

Given the context of COVID-19, traditional learning forums and activities may not be able to take place. Instead, these can be done virtually using Microsoft Teams, Zoom or other online meeting platforms. Communication between the MEAL Team and Programmes Team needs to take place regularly with as much transparency as possible. We recommend carrying out an After-Action Review or other lessons learned activity at the end of the project to document what approached worked and what did not, particularly MEAL methodologies, so we can use this to strengthen future responses. If the CLA approach is done across multiple countries, there is a possibility for comparative analysis between countries. Please make sure to keep your Regional MEL Advisor informed of what data is being collected to so we can investigate broader learning opportunities.

6.5. Accountability

As the CCRMs are already in existence, are known to community members, and have gained the trust of communities, they will be used by interested parties to gain information, share information, or complain about COVID-19 or GOAL's response to COVID-19. As such, GOAL should prepare its CCRMs for the following undertakings. The CCRM could form an important part of any rumour detection process in GOAL's COVID-19 response. Where GOAL is working with, or through, Partner agencies, every attempt should be made to ensure Partners follow the below guidance with the same level or a stronger level of adaptation.

Where possible, alterations to the CCRM Database at country-level should be made to allow for all communications related to COVID-19 and COVID-19 response to be disaggregated, identified and separated from other CCRM Data, allowing for analysis of all COVID-19 communications coming from the community. This can include simple steps such as adding an additional column to the Database with a 'COVID-19/Not COVID-19' option.

Social distancing and community lockdowns mean that face-to-face interactions with CCRM Staff (the favoured means of doing so globally) will become more difficult and less likely to take place. Therefore, country programmes must research all unused means of remote access to their CCRMs that could be enacted as soon as possible. Per specific guidance from CHS Alliance on COVID-19, and under CHS Commitment 4, country programmes should update their communication and feedback channels by increasing the use of technology and remote communication channels. This should include looking into the feasibility of providing the following channels, if not already available:

- Telephone hotline (preferably toll-free);
- A mobile number for receiving SMS texts (preferably the same number as the hotline, if possible);

- A number linked to any available or popular freeware, cross-platform messaging services;[8]
- Social Media (of particular use are Facebook Messenger and Twitter private messaging, if popular). Country Teams may need to clear this with the Communications Department before doing so.

It is important that each of these remote channels are checked by two people or more (ensuring that no one person has sole access and, therefore, power over communications) but no more than 3-4 people (ensuring that only a small, select few persons have access to potentially confidential information). Ideally, at least one male and one female staff member should have access. New and existing remote CCRM communication channels should be advertised to community members as much as is possible, Posters and banners placed at GOAL premises, project sites and public areas are a good way of informing people. In the midst of the COVID-19 outbreak and restrictions on outdoor time and office visits, remote means of communicating about GOAL's CCRM channels should also be used. This can include SMS group texting, social media, and radio communicating, where such actions are feasible and likely to reach a large number of people.

7. Staying safe while providing training and implementing CLA

The safety and well-being of staff, CMs, and community members is of paramount importance. All guidance and regulations from Human Resources (HR) and Security should be followed. Latest staff safety guidance can be found through the GOAL COVID-19 Site.

When conducting CLA training and activities, strict IPC measures must be put in place to ensure that risky environments, where COVID-19 transmission is more likely, are not created. During all in-person trainings, community meetings, triggering sessions, follow-up meetings, supervision sessions, monitoring sessions, and other activities, CLA programme staff must:

- Ensure adherence to national guidelines on travelling distance allowed, number of people allowed to travel together at one time, and use of face-masks;
- Where possible, meet people outside and not in an enclosed space;
- Meet people in sparsely populated, not densely packed or crowded, areas;
- Ensure everyone has access to clean water and soap (or sanitiser) and enforce handwashing on arrival;
- Ensure people are at least 1 metre apart;
- Regularly sanitise equipment and surfaces being touched by more than one person, including laptops, smartphones, marker pens, door handles etc.;
- Avoid using paper tools as much as possible.
- Practice and promote and encourage good personal hygiene by everyone including:

[8] Such as WhatsApp, Viber, Kakao, LINE, Signal, Telegram

- Washing hands regularly with soap and water for at least 20 seconds. If soap and water are not available, then sanitiser.
- Avoiding touching eyes, nose, and mouth.
- Covering mouth when coughing or sneezing.
- Throwing out used tissues or Kleenex immediately. Washing hands after use.
- Not shaking hands or having any other physical contact.
- Practicing social/physical distancing - staying at least 1 meter or more away from other people.
- Not sharing pens, pencils, utensils, cell phones, drinking vessels, etc.

If these IPC measures can't be ensured, then the training or activity should not be conducted in-person. (See GOAL SOP on Community Engagement).

8. Ensuring Safeguarding

GOAL has minimal safeguarding requirements for all GOAL activities during COVID-19 response

- GOAL's Child and Adult Safeguarding Policy and the Code of Conduct should be circulated and staff and CMs reminded of the need to comply.
- Initial or refresher trainings should be provided outlining key areas of our policies for both GOAL staff and CMs.
- HR practices in emergencies (as outlined in our Global Background Check SoP) are followed for all new staff hires, volunteers, CMs etc.
- In addition, community members should be made aware of the expected behaviours of GOAL staff and partners. This can be done by conducting brief awareness raising and/or through IEC materials (such as posters, flash cards etc.) which highlight key messages on safeguarding and display our reporting mechanisms either through our CCRM or Speak Up channels.

9. Budgeting for CLA

The following table outlines budget considerations for CLA implementation and note does not include direct personnel costs for the staff outlined in Section or remuneration costs for CMs

Activities	Items	Comments
External **meetings (Sensitisation, review, and/or feedback sessions for district authorities/stakeholders)**	Meeting Room Hire - Food & Beverages	Ensure social distancing and handwashing facilities
	Meeting materials	Projector, Flip chart paper, Flip chart stand pens, notebooks and markers
	Stipend	
	Communications	Phone credit, wifi access for staff.
	GOAL promotional material	
	Hire of meeting Room - Food & Beverages	Ensure social distancing and handwashing facilities

Internal Meetings (reviews among programme staff – possibly including CMs and MEAL	Meeting materials	Flip charts (paper, stand), pens, notebooks, markers
	Stipend	
	Communications	Phone credit and wifi access
Trainings **(National training of District Staff -Training of CLA supervisors - Training of CMs)**	Training Room Hire -Food & Beverages	Ensure social distancing and handwashing facilities
	Translations, Printing and photocopying	IEC materials, Training Manuals and agenda etc.
	Transport allowance	Trainings (following strict IPC)
	Per diems/stipends	
	Workshop materials	Flip charts (paper, stand), pens, notebooks, markers
	Communications	Phone credit and wifi access for facilitators
	Accommodation	Note there should be no overnight accommodation unless strict IPC can be followed. This is allowed for senior staff who have to travel from the national level to the district.
MEAL Activities	Hiring and training of Enumerators for KAP study baseline and endline	
	CRRM training and roll- out and reporting	
	Tablets and/or smart phones with phone credit for wifi access	
	Reams of paper for the forms	
	Dissemination of results to stakeholders	Items as per external meetings above.
Equipment & Communications	Computers for National CLA/District CLA staff	
	Smart phones and Phone credit for calls and wifi access for CLA supervisors and CMs. Phone credit for neighbourhood champions	Follow up calls between supervisors and CMS data collection. Follow-up calls between neighbourhood units and CMs Follow-up skills videos for supervisors and CMs
	Sanitiser for smartphones and tablets	
Visibility items	T-shirts and/or hats/ bags for CLA supervisors, CMs and neighbourhood champions	
Additional Equipment for CLA Sups/CMs	Rain coats and boots, notebooks pens etc.	
IPC materials	Safety Items for CLA and CMs - Soap and/or hand sanitizer	For meetings, trainings, cars staff
Transport	Adequate transport for CLA supervisors	To move from community to community
RCCE support	Small amount for support of the district RCCE	

10. Annexes

Annex 1: Other Resources

Further reference material and programme guidance for COVID -19 is also available to further support the implementation of the CLA process and utilise the neighbourhood units as a platform to provide other life-saving and life sustaining interventions.

Annex 2: Elements of Risk Communication

The RCCE taskforce at national and sub-national levels allows the coordination of key stakeholders and partners to operate as a team and to provide coherent and consistent information sharing on the outbreak with community engagement building on that strong risk communication process. Technical staff within GOAL COs should engage with the national and sub-national RCCE taskforces to influence the development and coordination of social behaviour change communication and community engagement strategies.
These strategies will include,

- Ensuring that COVID-19 messages provided through mass media, social media and traditional media is culturally appropriate, simple and easy to understand, consistent while still providing the relevant information for informed decision making by those most affected.
- That key influencers are engaged such as gatekeepers, decision makers, religious leaders, community leaders, traditional healers who are usually the most knowledgeable about their own communities' priorities and provides the essential two way communication between communities and frontline responders.
- Messages are disseminated through appropriate and trusted communication channels so that they reach a large audience and are accessible for those who often have poor access to information such as, rural HH, women, people with sensory or intellectual disabilities.
- Support the RCCE to establish clear links with other pillars of the response such as health care and surveillance so that risk communication strategies and interventions can be targeted according the epidemiological maps cluster of cases to prioritise communities most at risk

Annex 3: A log frame for a CLA project

Overall Impact of Project/Programme: To reduce the impact, severity, and resource implications of a large-scale epidemic of COVID-19 in [Country].						
Outputs and Outcomes		**Key Indicators**	**Baseline (Qualitative & Quantitative)**	**Target**	**Sources Means of Verification**	**Assumptions**
Outcome 1	Target communities in [District/Province] are enabled to respond to the potential spread of COVID-19.	% of communities and people affected by crisis consider that they have timely access to relevant and clear information on COVID-19			Signed awards	GOAL will be able to continue to operate during COVID-19.
Output 1.1.	GOAL staff and community mobilisers trained on CLA.	# of GOAL staff trained (gender) # of community supervisors trained (age and gender) # of community mobilisers identified and trained (age and gender)			Training Records/ Attendance logs	Community Mobilizers have access to their community GOAL is able to train and support Community Mobilizers
Output 1.2	Targeted neighbourhood units are triggered and empowered to take action.	# of neighbourhood units triggered using the CLA approach % of triggered neighbourhood units with action plans % of neighbourhood action plans implemented			CLA Triggering and Follow Up Forms	

Annex 4: Neighbourhood Unit Triggering Form

Neighbourhood Unit Triggering Monitoring Form					
Section A: Demographic Information					
A1. Names of community mobilisers:					
A2. Name of supervisor:					
A3. Form completed by:	*Select one…* a) Mobiliser b) Supervisor c) Other (please specify): _____				
A4. Date of triggering:					
A5. District/Province:					
A6. Chiefdom/Ward:					
A7. Name of community:					
A8. Name of neighbourhood unit:					
A9. Total number of households in neighbourhood:					
A10: Estimated number of people in neighbourhood:					
A9a. Male – 5 and over:					
A9b. Female – 5 and over:					
A9c. Male – under 5:					
A9d. Female – under 5:					
Section B: Health Statistics					
IN THE NEIGHBOURHOOD, IN THE PAST WEEK…	Male Adult (over 18)	Female Adult (over 18)	Male Child (under 18)	Female Child (under 18)	
B1. Number of confirmed cases of COVID-19:					
B2. Number of confirmed deaths from COVID-19:					
B3. Number of deaths in total:					
B4. Number of people buried following traditional procedures:					
B5. Number of people buried by the community following COVID-19 adapted procedures or by an external burial team:					
B6. Number of people in the neighbourhood self-isolating:					
Section C: Neighbourhood Triggering Outcome and Observations					
C1. Did you identify a neighbourhood champion to be a point of contact?	*Select one…* a) Yes b) No				
If yes, provide details of champion:					
B1a. Name:					
B1b. Position:					
B1c. Phone number:					
If no, who is your primary link in the neighbourhood?					
B1a. Name:					
B1b. Position:					

B1c. Phone number:	
C2. What are the most common concerns expressed by members of this neighbourhood related to COVID-19?	*Select all that apply…* a) Stigma against aid workers b) Stigma against health care workers c) Stigma against sick people, survivors, etc. d) Lack of water, hand soap, etc. e) No access to medical treatment f) Poor quality of medical care g) Lack of food and other goods at market h) Livelihoods i) Government restrictions j) Other (please specify): _____
C3. What are the concerns about rumours or false information around COVID-19?	
C4. What else did you hear in the neighbourhood discussions that you think is important to note?	
C5. Do you have any concerns about the neighbourhood's capacity to carry out the action plan? What might be some of the obstacles?	
C6. Did the neighbourhood develop an Action Plan during the triggering process?	*Select one…* a) Yes b) No
If no, form completed here. If yes, move onto next section…	
Section D: Neighbourhood Action Plan	
Who has ownership of the Neighbourhood Action Plan and responsibility for its implementation?	
D1a. Name:	
D1b. Position:	
D1c. Phone number:	
Enter action points and details on page 3	

Action Point	**Lead**	**Deadline**	**Status** (Not started / Ongoing / Completed / Delayed / N/A)	**Comments**

Annex 5: Neighbourhood Unit Follow-up Monitoring From

Neighbourhood Unit Follow Up Monitoring Form					
Section A: Demographic Information					
A1. Date of follow up:					
A2. District/Province:					
A3. Chiefdom/Ward:					
A4. Name of community:					
A5. Name of neighbourhood unit:					
A5. Type of follow up:	*Select one…* a) In-person b) Phone call c) SMS / WhatsApp message				
A6: Names of mobilisers:					
A7. Name of supervisor:					
A8. Form completed by:	*Select one…* d) Mobiliser e) Supervisor f) Other (please specify): _____				
Section B: Health Statistics					
IN THE NEIGHBOURHOOD, IN THE PAST WEEK…	Male Adult (over 18)	Female Adult (over 18)	Male Child (under 18)	Female Child (under 18)	
B1. Number of confirmed cases of COVID-19:					
B2. Number of confirmed deaths from COVID-19:					
B3. Number of deaths in total:					
B4. Number of people buried following traditional procedures:					
B5. Number of people buried by the community following COVID-19 adapted procedures or by an external burial team:					
B6. Number of people in the neighbourhood self-isolating:					
Section C: Neighbourhood Follow Up Observations					
B1. This week, what are the most common concerns expressed by members of this neighbourhood related to COVID-19?	*Select all that apply…* k) Stigma against aid workers l) Stigma against health care workers m) Stigma against sick people, survivors, etc. n) Lack of water, hand soap, etc. o) No access to medical treatment p) Poor quality of medical care q) Lack of food and other goods at market r) Livelihoods s) Government restrictions t) Other (please specify):				

	_____
B2. What are the concerns about rumours or false information around COVID-19?	
B3. What else did you hear in the neighbourhood discussions that you think is important to note?	
B4. Were any new taskforces or neighbourhood watch groups developed? If yes, provide details:	
B5. Who answered these follow up questions (provide details of the neighbourhood representative)?	
B5a. Name:	
B5b. Position:	
B5c. Phone number:	
B6. Has the neighbourhood developed an Action Plan?	*Select one…* c) Yes d) No

If no, form completed here. If yes, move onto next section…

Section 3: Action Plan (*Update existing action points and add any new action points on page 3)*

Action Point	**Lead**	**Deadline**	**Status** (Not started / Ongoing / Completed / Delayed / N/A)	**Comments**

Annex 6: Community Triggering Monitoring Form

Community Triggering Monitoring Form	
Section A: Demographic Information	
A1. Names of community mobilisers:	
A2. Name of supervisor:	
A3. Form completed by:	*Select one…* g) Mobiliser h) Supervisor i) Other (please specify): _____
A4. Date of triggering:	
A5. District/Province:	
A6. Chiefdom/Ward:	
A7. Name of community:	
A8. Total number of households in community:	
A9: Estimated number of people in community:	
A9a. Male – 5 and over:	
A9b. Female – 5 and over:	
A9c. Male – under 5:	
A9d. Female – under 5:	
Section B: Community Triggering Outcome and Observations	
B1. Who is your primary link in the community?	
B1a. Name:	
B1b. Position:	
B1c. Phone number:	
B2. Did the community decide to set up a community committee or similar structure?	*Select one…* c) Yes d) No
B3. What are the most common concerns expressed by members of this community related to COVID-19?	*Select all that apply…* u) Stigma against aid workers v) Stigma against health care workers w) Stigma against sick people, survivors, etc. x) Lack of water, hand soap, etc. y) No access to medical treatment z) Poor quality of medical care aa) Lack of food and other goods at market bb) Livelihoods cc) Government restrictions dd) Other (please specify): _____
B4. What are the concerns about rumours or false information around COVID-19?	
B5. What else did you hear in the community discussions that you think is important to note?	

B6. Do you have any concerns about the community's capacity to carry out the action plan? What might be some of the obstacles?	
B7. Did the community develop an Action Plan during the triggering process?	*Select one…* e) Yes f) No
If no, form completed here. If yes, move onto next section…	
Section C: Community Action Plan	
Who has ownership of the Community Action Plan and responsibility for its implementation?	
C1a. Name:	
C1b. Position:	
C1c. Phone number:	
Enter action points and details on page 3	

Action Point	Lead	Deadline	Status (Not started / Ongoing / Completed / Delayed / N/A)	Comments

Annex 7: Community Follow-up Monitoring Form

Community Follow Up Monitoring Form	
Section A: Demographic Information	
A1. Date of follow up:	
A2. District/Province:	
A3. Chiefdom/Ward:	
A4. Name of community:	
A5. Type of follow up:	*Select one…* d) In-person e) Phone call f) SMS / WhatsApp message
A6: Names of mobilisers:	
A7. Name of supervisor:	
A8. Form completed by:	*Select one…* j) Mobiliser k) Supervisor l) Other (please specify): _____
Section B: Community Follow Up Observations	
B1. This week, what are the most common concerns expressed by members of this community related to COVID-19?	*Select all that apply…* ee) Stigma against aid workers ff) Stigma against health care workers gg) Stigma against sick people, survivors, etc. hh) Lack of water, hand soap, etc. ii) No access to medical treatment jj) Poor quality of medical care kk) Lack of food and other goods at market ll) Livelihoods mm) Government restrictions nn) Other (please specify): _____
B2. What are the concerns about rumours or false information around COVID-19?	
B3. What else did you hear in the community discussions that you think is important to note?	
B4. Were any new taskforces or community watch groups developed? If yes, provide details:	
B5. Who answered these follow up questions (provide details of the community representative)?	
B5a. Name:	
B5b. Position:	
B5c. Phone number:	
B6. Has the community developed an Action Plan?	*Select one…* g) Yes h) No
If no, form completed here. If yes, move onto next section…	

Section 3: Action Plan ***(update existing action points and add any new action points)***				
Action Point	**Lead**	**Deadline**	**Status** (Not started / Ongoing / Completed / Delayed / N/A)	**Comments**

Annex 8: Knowledge, Attitudes and Practices (KAP Survey)

CLA COVID-19 Knowledge, Attitudes and Practices (KAP Survey) GOAL April 2020

Introduction and Consent

Thank you for the opportunity to speak with you. I am representing GOAL an NGO. We are conducting a survey to learn more about COVID-19 and other health issues in this community to help us tailor our support to this community. You have been selected (randomly) for inclusion in the survey. The research includes questions on topics such as your personal information, knowledge and awareness on COVID-19 and other diseases. The interview will take about 30 minutes to complete. If you agree to participate in this survey, you can choose to stop at any time or not answer any questions you do not want to answer. Your answers will be completely confidential; we will not share information that identifies you with anyone. In an effort to reduce the spread of COVID-19 we will be observing physical distancing throughout the interview process.

Now I wish to ask if it's ok with you to go on and ask you a few questions.

1. Do you have any questions you want to ask about what I have just said?
   a) Yes (if yes respond to the respondent's questions)
   b) No

2. Do you understand why I would like to talk with you?
   a) Yes
   b) No (if no re-explain to the respondent until they do understand)

3. Do you understand that you do not have to answer any questions that you do not want to and that you can end our conversation at any time or if you feel uncomfortable?
   a) Yes
   b) No – if no re-explain to the respondent until they do understand

4. Is it ok with you, if GOAL shares this information with other organisations? We will take your name off the information so that anyone reading it won't know who you are.
   a) Yes
   b) No – if no explain that the data from this interview will not be shared and used only by GOAL.

5. Is it ok with you, it GOAL shares this information with local, regional and national authorities e.g. District administration, ministry of health, etc… we will take your name off the information so that anyone reading it won't know who you are.
   a) Yes
   b) No – if no explain that the data from this interview will not be shared and used only by GOAL.

I have discussed the proposed research with this participant and witnessed their signature/thumb print, and in my opinion, this participant understands the benefits, risks and alternatives (including non-participation) and is capable of freely consenting to participate in this research. By now continuing with the research I am agreeing to the above statement.

(With COVID-19 we are not collecting signatures, only verbal consent.)

6. Do I have you permission to continue with this interview?
   a) Yes → Continue with interview
   b) No →END

Household Number*	
Team Number	
City Section	
Ward Number	
Household GPS	

* Need to update based on sample size and methodology

Section 1: Demographics

1.1 What is the gender of the respondent?
- a) Male
- b) Female
- c) Non-Binary
- d) Declined to Answer

1.2 What is the age (in years) of the respondent?
- a) 19-34 years
- b) 35-50 years
- c) Over 50 years

1.3 What is the highest level of education of the head of household?

A	Primary
B	Secondary
C	Technical/Vocational Institute
D	Graduate
E	Masters and above
F	No formal education
H	Don't know
I	Declined to answer

1.4 What is your religion?
- a) Islam
- b) Christianity
- c) Other (Specify _____)
- d) I do not hold any religious beliefs.
- e) Declined to answer

Section 2: Knowledge

2.1 Have you heard of COVID-19 before (prior to this interview)?
- a) Yes
- b) No → END
- c) Declined to answer → END

2.2 Is it possible to survive and recover from COVID-19?
a) Yes
b) No
c) I don't know / not sure
d) Declined to answer

2.3 What causes COVID-19?* (choices may vary by country)
(Select all applicable choices; Do not read of the answers!)
a) Foreigners
b) Bats / Pangolins/Monkeys / Chimpanzees / Other wild animals
c) God or higher power
d) Witchcraft
e) Evil doing / Sin
f) Curse
g) Others *(Please specify _____)*
h) I don't know/ not sure
i) Declined to answer

2.4 How does a person get COVID-19? *(Select all applicable choices. Do not read off the answers!)*
a) By air
b) Droplets from coughing or sneezing
c) Bad odour or smell
d) Eating bush meat
e) Body fluids (sweat, tears, blood, urine, faeces, sperm, breast milk, etc.) of an infected person
f) Touching
g) Physical contact with a sick/infected person
h) Physical contact with a dead body
i) Being near an infected person
j) Sharing home/living space with an infected person
k) Mosquito bites
l) God's will
m) Witchcraft
n) Others (Please specify _____)
o) I don't know / not sure
p) Declined to answer

2.5 What are some of the signs and symptoms of someone infected with COVID-19? *(select all applicable choices. Do not read off the options!)*
a) Fever
b) Headache
c) Dry cough
d) Shortness of breath
e) Aches/pains
f) Sore throat
g) Diarrhoea
h) Vomiting
i) Runny nose
j) Other (Please specify_____)
k) I don't know / not sure
l) Declined to answer

2.6 Do you think it is possible for someone to have COVID-19 and not show/report its signs or symptoms?
a) Yes
b) No
c) I don't know / not sure
d) Declined to answer

2.7 Do you know the number to call to report a suspected COVID-19 case or ask questions about COVID-19? (This needs to be updated/removed based on context)

a) Yes (If so, what is the number?_____); ***Enumerator: Correct___ Incorrect___***
b) No
c) I don't know / not sure
d) Declined to answer

2.8 Do you think you and/or your family are at risk of getting COVID-19?
a) Yes
b) No
c) I don't know/not sure
d) Declined to answer

Section 3: COVID-19 Prevention and Treatment

3.1 Which of the following statements do you believe to be true?

(*Read each statement to the respondent in turn. Tick YES, NO or DON'T KNOW to EACH statement)*	*Yes*	*No*	*Don't Know*
One way to prevent myself from getting COVID-19 is by staying at least 1 meter away from people.			
Young people cannot get COVID-19.			
One way to prevent myself getting COVID-19 is by washing my hands with soap and water.			
Spiritual leaders can cure COVID-19.			
Antibiotics can cure COVID-19			

3.2 In your opinion, what are the 3 most important ways of preventing COVID-19 infection?
ASK Question and LISTEN to the responses. DO NOT prompt. Then tick ONLY the 3 (or fewer) responses given.

1) Wash hands several times a day with soap	
3) Stay at least 1 meter away from people.	
4) Wear a face mask.	
5) Stay home and avoid crowded spaces.	
6) Other (Please specify)	
7) Don't know	

3.3 What happens if someone suspected of having COVID-19 goes to the hospital / health facility?
(Select all applicable choices)
a) They won't be able to do anything for him/her and may die there
b) They will take care of him/her (rehydrate, give medicines/food, monitor status)
c) They will definitely cure the person from COVID-19
d) They will find a way to kill the patient so that he/she doesn't spread COVID-19 to others
e) Others _____

f) I don't know / not sure
g) Declined to answer

3.4 Do you agree that if a person has been diagnosed with COVID-19 must be admitted in a COVID-19 Treatment Centre? (Answer/question may be tweaked by country)
a) Yes
b) No
c) I don't know / not sure
d) Declined to answer

3.5 Do you agree that people who have been in direct contact with a person who has been diagnosed with COVID-19 must be quarantined for 3 weeks? (may vary per country)
a) Yes
b) No
c) I don't know / not sure
d) Declined to answer

3.6 Would you go the hospital or health facility if you suspect that you may have contracted COVID-19?
a) Yes
b) No
c) I don't know / not sure
d) Declined to answer

3.7 What would you do if you suspect someone in your family has COVID-19? *(select all applicable choices)*
a) Nothing
b) Help care for the person at home (e.g., clean up their excretions / vomit; help bathe them)
c) Check their temperature by touching their body
d) Avoid all physical contact and bodily fluids of that person
e) Call the hospital / COVID-19 phone line
f) Take the person to the hospital
g) Others_____
h) I don't know / not sure
i) Declined to answer

3.8 Since you heard of COVID-19, have you taken any action to avoid being infected?
a) Yes
b) No **SKIP to 3.10**
c) I don't know / can't remember **SKIP to 3.10**
d) Declined to answer **SKIP to 3.10**

3.9 In what ways have you changed your behaviour or took actions to avoid being infected?
(Answer choices may change based on country context)
a) I wash my hands with soap and water
b) I wash my hands with just water
c) I clean my hands with other disinfectants
d) I try to avoid crowded places
e) I drink a lot of water / juice
f) I drink traditional herbs (e.g. gbangban)
g) I take antibiotics (e.g. penicillin, amoxilin)
h) I wear gloves
i) I wear a mask
j) I try to avoid physical contact with people I suspect may have COVID-19
k) I avoid physical contact with everyone

l) Others_____
m) I don't know / not sure
n) Declined to answer

3.10 What groups are at high risk for spreading COVID-19? (Select all that apply)
a) Healthcare workers
b) Traditional Healers
c) Religious leaders
d) Refugees
e) Schoolchildren and youth
f) Community leaders

3.11 How important are the following groups in building your knowledge, discussing fears and issues, and encouraging positive behaviour for your health?
Go through each group in turn and Tick one box.

	1 Very important source of information and support	2 An important source of information and support	3 Not an important source at all	4 I am not aware that there are such people in my community
Community Mobiliser				
Religious Leader				
Local Leader/Chief				
Medical Professionals/MoH				
Local Radio Announcer				

3.12 Who do you trust to get accurate health information from? (Select all applicable choices)
a) No one
b) Government / Ministry of Health
c) Local leader/chief
d) Community mobiliser
e) Medical professionals
f) The media (internet, radio, etc.)
g) Health and medical professionals
h) Relatives and friends
i) Religious leaders (e.g., pastor, Imam)
j) Traditional healers
k) Others_____
l) I don't know / not sure
m) Declined to answer

Thank you for your time. END