Operationalising Community-Led Action (CLA) for COVID-19

Challenges and Successes

June 2021

Contents

Acronyms

Acknowledgements

The Programme Technical Team (PTT) acknowledge the collaboration of MEAL in preparing the methodology, and all the staff who were interviewed and gave their views and their time for this review.

Executive Summary

- GOAL implemented Community Led Action (CLA) as the foundational **social behaviour change community engagement approach** in response to COVID-19 in 11 countries,[1] reaching 3,733 communities.

- GOAL decided to use community engagement during Phase 1 of its response to COVID-19 because with 85% of COVID-19 cases expected to be asymptomatic or mild, people would need to quickly understand the importance of using masks, social distancing and handwashing to prevent spread within their communities. CLA for COVID-19 was designed using the lessons learned from the **Ebola response in Sierra Leone**, and with an understanding of the daily constraints that COVID-19 would put on individuals and communities.

- CLA maps communities into neighbourhood units of approx. 15 households and trains Community Mobilisers who, using three participatory learning and action tools,[2] conduct awareness and action planning sessions in each neighbourhood unit. The three tools were designed to **trigger households to take actions** that allow them to protect their families and continue with their daily lives in a context of COVID-19. An overall **community action plan** is also developed that includes actions that community leaders will take to protect the community, such as registering visitors to the community and liaising with district authorities for updated COVID-19 information. CLA is one element of GOAL's Social Mobilisation Action for COVID19 (SMAC) approach.

- From December 2020 to February 2021 a review was conducted to document the challenges and successes of operationalising CLA. This document is a summary of this review.

- GOAL countries implemented CLA within residential communities[3] and also adapted CLA to be used in public locations targeting specific groups, such as market vendors, youth in barber and video shops, motorbike riders, internally displaced camps, emergency shelters[4] and hospital grounds.[5] Both Iraq and Honduras adjusted the tools to conduct sessions with children.

- Over 70% of communities were triggered to develop an action plan following one session, remaining communities received 2-3 sessions before development of their action plans. Household and public handwashing stations, wearing of masks, and social distancing were the three main actions chosen by communities in their action plans.

- The two main advantages of CLA were community ownership and strategic positioning. CLA was reported to be a simple, efficient, and relevant approach that can reach communities with clear and consistent messages allowing people to become active participants in the response rather than passive recipients. The CLA tools were reported as easy to demonstrate, engaging the communities from the outset, with the social mapping tool being particularly useful in assisting

[1] Ethiopia, Honduras, Haiti, Iraq, Malawi, Niger, Sierra Leone, Sudan, South Sudan, Uganda and Zimbabwe.
[2] Participatory-learning-and-action.pdf (intrac.org)
[3] Communities are defined as a group of people who have a common purpose.
[4] People displaced by floods.
[5] People waiting and taking care of relatives so they can spend days in the grounds.

communities to understand the need for lockdowns. Many communities took actions to put preventive measures in place so that services could continue. In some locations savings groups were established to assist vulnerable households. CLA created a strong platform for communities to communicate with health workers and local authorities on what health services were still available and the exact restrictions during lockdowns that the communities needed to follow.

- CLA enabled GOAL to position strategically both at national and district level along-side 'stronger' stakeholders such as UN agencies. GOAL was an active member of the national and/or district technical Risk Communication and Community Engagement (RCCE) working groups in eight countries.[6] In Sierra Leone CLA is being rolled out as the national community engagement approach, in Malawi CLA is now included in two large consortium grants and in both Uganda and Zimbabwe discussions are ongoing with governments and donors on CLA being utilised for other disease outbreaks including the Cholera Elimination[7] programme.

- GOAL's main donors: USAID, Irish Aid, ECHO, FCDO (then DFID) funded CLA implementation. At global level GOAL was invited to become a member of the RCCE working group. BHA requested that CLA be presented at the group's June 2020 meeting,[8] CLA was described by WHO's Global Outbreak Alert and Response (GOARN) as *an innovative approach to community engagement*.[9]

- GOAL's HQ and country-level communications teams greatly assisted external awareness of CLA through the dissemination of stories and tweets.

- Despite CLA being a new approach for several countries the challenges encountered initially were mainly logistical in terms of government restrictions on gatherings and travel. Countries that did not have an established relationship with the MoH and had less experience in responding to emergencies struggled to get started due to competing priorities and having to adjust their ways of working. However, when they did implement CLA they saw the impact that it had in motivating communities; many respondents stated GOAL should make CLA a component of all emergency responses.

- The challenge of sustainability was a concern for some staff, as it was implemented in collaboration with the Ministry but not using community health workers. However, other staff thought that the use of Participatory Learning and Appraisal (PLA) tools and the development of action plans would mean that the community would know what to do in the event of an additional wave of COVID-19 cases. Evidence of this was seen in Zimbabwe in December with staff reporting that communities which were no longer being supported restarted their action plans when a third wave of COVID-19 occurred. Uganda showed that it is possible to implement the CLA through the MoH but in doing so the communities were not reached until six weeks after funding had been received. This was compared to Malawi, Niger and Iraq who reached their communities within 3 weeks.

[6] Iraq, and Haiti were not engaged at national/district level RCCE
[7] GOAL is a member of the Global Community Engagement Working Group.
[8] 24th June meeting RCCE
[9] GOARN meeting 23/07/2020

- Given that all countries reported that CLA was efficient and relevant and placed GOAL strategically, it would now be logical to measure the impact of CLA. There is wealth of data available and given the different adaptation within countries, **a formal evaluation would enable GOAL to refine CLA** and make an evidenced-based decision for its use in future responses. This is particularly important if national governments in Uganda and Zimbabwe are considering this type of approach for their Cholera Elimination Programme as it would place GOAL in a strategic position within this global response. GOAL could also conduct follow-up research using a comparison between Sierra Leone, Malawi, and Uganda to assess the sustainability of CLA in terms of community ability to respond to future disease outbreaks.

Recommendations

- GOAL to conduct a formal evaluation on the effectiveness, efficiency, sustainability and impact of using CLA as a community engagement approach in emergency response to COVID-19. This could look at three countries with local consultants to investigate whether triggered communities had lower infection rates and were able to continue with their daily lives more easily than non-triggered communities. This would need one lead social scientist researcher to pull together all the data and triangulate with the global database, then make recommendations for GOAL in how to use CLA in future.
- PTT and MEAL to conduct a review of the CLA monitoring to assess why the data was not entered for all countries, how to address the gaps, and how it can be used to inform strategy at programme and global level.
- PTT to provide guidance on how countries can continue to build on the CLA and RCCE capacity developed for COVID-19 response to support the Cholera Elimination Programme.
- PTT to support countries to identify how they can maintain or establish strategic engagement on RCCE at district and national levels, to be able to respond to future outbreaks at scale.

Background

Why did we use CLA and what is it?

GOAL decided to use community engagement as part of the social behaviour change response during Phase 1 of its response to COVID-19 because 85% of COVID-19 cases would be asymptomatic or mild, therefore it was expected that people would need to quickly understand the importance of using masks, social distancing and handwashing to prevent spread within their communities. Additionally, people would need to understand how to support their families or other families if self-isolation was required or if there was a 'lockdown' and they were confined to their homes. GOAL had successfully implemented a similar approach, Community Led Ebola Action (CLEA) during the response to the Ebola outbreak in Sierra Leone 2014-2015. Research[10] on that intervention showed the vital importance of engaging and making communities the centre of the response. CLA for COVID-19 was designed using the lessons learned from

10 Bedson J, Jalloh MF, Pedi D, et al. Community engagement in outbreak response: lessons from the 2014–2016 Ebola outbreak in Sierra Leone. BMJ Global Health2020;5:e002145. doi:10.1136/bmjgh-2019-002145

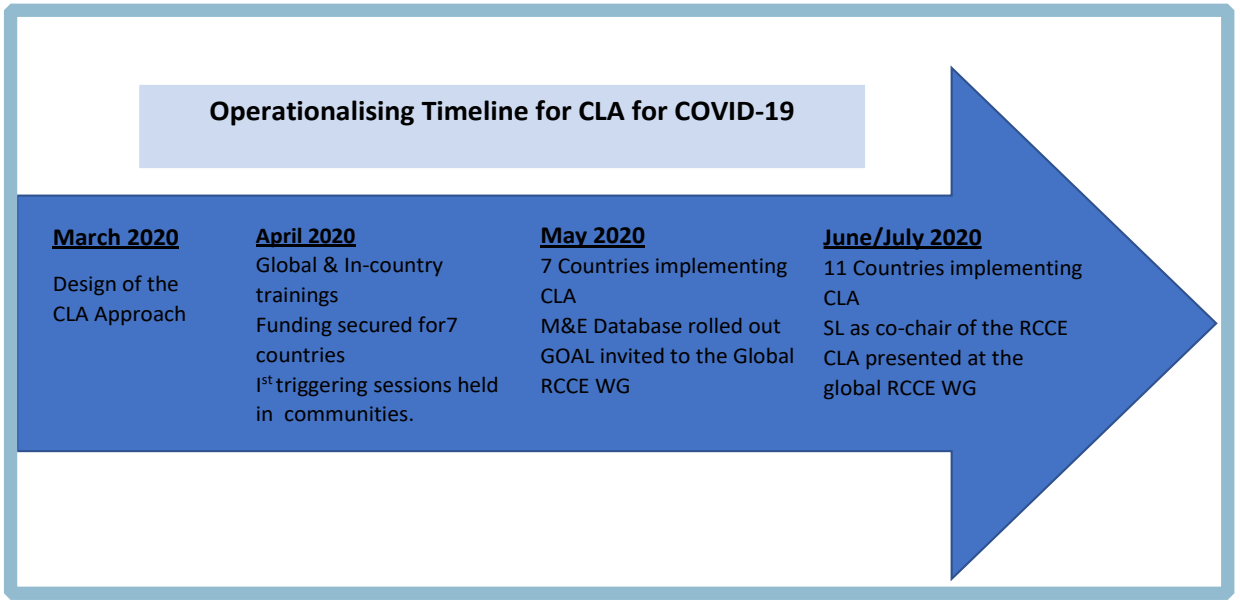
this response, and with an understanding of the daily constraints that COVID-19 would put on individuals and communities.

CLA was designed to engage communities in a facilitated discussion so that they understood the mass and social media COVID-19 information they were receiving, what the information meant for their daily lives and how they could adjust their behaviours to protect their families and communities. In each community GOAL trained community mobilisers who mapped communities into smaller neighbourhood units of approximately 15 households. The mobilisers use three Participatory Learning and Action (PLA) tools to conduct awareness and action planning sessions to guide the discussion. These three tools were designed to trigger households to take actions that would assist them to protect their families and continue with the daily lives in a context of COVID-19. The community mobilisers also work with community leaders to develop an overall community action plan covering additional, community-level actions, such as registering visitors to the community, or how the leaders will liaise with district authorities to obtain and provide updated COVID-19 information. CLA for COVID-19 allows for the nomination of neighbourhood champions who, along with the community mobilisers, support the neighbourhood units as they implement their action plans.

Implementation Timeline

The design of CLA for COVID-19 took place in March 2020 led by the Global SBC Advisor and supported by Katherine Owen[11] and the PTT. A Resource Manual and Operational Guide were developed to support the country implementing teams, and several global Trainings of Trainers were conducted by the Global SBC Advisor during April 2020. This training was then cascaded downwards to the community mobilisers by the country trainers. GOAL's Emergency Response Unit (ERU) secured three months funding through the Irish Aid Emergency Funding Response Scheme (EFRS) to roll-out CLA in five countries in April (Malawi, Uganda, Iraq, Niger & Honduras) and in the same month, one year's funding was secured from FCDO (then DFID) by the end for Sudan and South Sudan. Other countries realigned their current grants so that by the end of July, 11 countries were implementing CLA as part of their response to COVID-19.

11 Director of the SMAC Consortium in Sierra Leone 2014 to 2016



Methodology

The objective of this review was to document the challenges, advantages and disadvantages of implementing CLA as GOAL's main community engagement approach to the COVID-19 pandemic, as perceived by GOAL staff. *It was not the intention of the review to look at outcomes or impact.* The review was conducted by Geraldine McCrossan, Global SBC Advisor of the PTT, with support from the Global MEAL Team. See the Terms of Reference here

An online survey was developed using Microsoft forms which was sent to all country teams and departments in HQ involved in various aspects of CLA implementation. Further key informant interviews were conducted with 18 in-country senior programme staff. Donor reports and the global MEAL database was used to cross-reference data as much as possible. One senior programme and one MEAL team member from the implementing countries were interviewed.[12] These Key Informant Interviews (KIIs) took place between December 2020 and February 2021. Interviews were guided by a questionnaire, lasted approximately 45 mins and each interview was recorded with consent. The information was collected under the main headings of implementation, advantages, disadvantages, and challenges. These recordings will be deleted when the review report has been completed. 29 people responded to the online survey 25 of whom were from country teams.

[12] No staff member from Iraq was interviewed as there had been a change of senior programme staff and the current staff had limited information on the implementation. Information on Iraq was obtained from their programme donor report.

Bias & Limitations

The main bias of the review was that it was conducted by the person who led the design of CLA for COVID-19, and the KIIs were with programme and MEAL staff who were responsible for the implementation at country level. To reduce bias the final questionnaire for each key informant and the online Microsoft form was approved by the Head of PTT and the Head of MEAL. A limitation of the review was the that the online survey was only in English and accessed via a GOAL Microsoft account, so not accessible for community supervisors and community mobilisers.

Findings

CLA was designed and rolled out very quickly. Just over three weeks after the global training in April, the first communities were triggered in Malawi and Zimbabwe. By mid-May, six countries were using CLA, and by the July this has increased to 11 countries. Ethiopia, Honduras, Haiti, Iraq, Malawi, Niger, Sierra Leone, Sudan, South Sudan, Uganda and Zimbabwe implemented CLA in line with national COVID-19 strategies in both urban and rural communities. Most countries initially implemented in geographical areas where they already had a presence and a relationship with the zonal/district health authorities, with Malawi, Sierra Leone and Zimbabwe expanding CLA implementation beyond their current geographical areas as funding was obtained. In Sierra Leone, CLA was adopted as the national community engagement approach and GOAL is providing technical support to the National RCCE taskforce to roll out CLA across all 16 districts nationally.

GOAL's programming was already community-focused, meaning existing community networks were in place; seven country teams already had experience of PLA methodologies. Additionally, Malawi, Zimbabwe, Uganda and Sierra Leone had prior experience of using PLA for emergency response over the last five years, meaning they were able to quickly adapt the process to their country context.

As the definition of the community was a 'group of people who have a common purpose', country teams were able to implement CLA within standard residential communities as well as targeting specific groups or non-traditional communities. For example, the Haiti team worked with motor bike taxi owners, and in Malawi urban market holders and youth groups. Honduras also targeted markets and transport sites, as well as emergency shelters[13] and people within hospital grounds.[14] Iraq targeted internally displaced camps and both Iraq and Honduras adjusted the tools to have discussions with children, incorporating games and demonstrations.

CLA was complemented by messaging through mass-media, social media, and vehicle megaphones with GOAL's global MEAL database showing that almost 18 million people received COVID-19 messages in 2020 including 6,533,442 people reached with direct messaging. Although CLA was targeted at communities, the final number of communities triggered is not possible to estimate as some countries counted people reached rather than communities, and others provided data only on number of neighbourhood units reached. The global database shows that just over 6 million people were reached with in-person messaging, and during the KII interviews this was clarified as being mainly from the CLA

[13] People displaced by floods.
[14] People waiting and taking care of relatives so they stay within the hospital grounds

activities and the vehicle megaphones. Zimbabwe alone reached almost 4 million people, mainly through their Promobile project from April to December 2020.[15] Due to various constraints (see section below) only four countries entered data into the global database and this shows 1,423 communities were triggered, however from the KIIs and donor reports another 2,310 communities were reported as triggered between April and December 2020. Three countries - Sierra Leone, Niger and Uganda - entered data on neighbourhood units showing that 6,157 neighbour units were triggered between March and December 2020.

Delays in CLA implementation were mainly due to obtaining permission to move to certain areas due to government restrictions and being able to plan the community sessions so that staff and communities were both protected. For example, in Honduras, there were severe restrictions on movement and staff were quite fearful, therefore they redesigned the CLA tools as animated videos with the hope of reaching participants via social media, however it would have required GOAL to provide funding for people's internet access which was not feasible. Instead, the Honduras team used mass-media messaging and social media especially neighbourhood Facebook pages, for areas that were not accessible to staff. CLA *was* implemented in the northern industrial cities where access was easier for the community mobilisers.

There were initially concerns that COVID-19 restrictions on gatherings would render CLA unworkable and due to connection issues online trainings would not be possible. However, as CLA was adapted to include neighbourhood units this meant smaller numbers could meet; furthermore, as the training for CLA was only two days, programme staff were able to keep the numbers of participants small and repeat the trainings as necessary. Countries also adapted CLA to adhere to restrictions on gatherings, for example in Iraq only five people could meet so the teams went from house to house to explain the tools and then brought five people from that neighbourhood together to develop the action plans. Some countries reported that there was an initial delay as CLA was new, requiring senior programme staff to learn at the same time as they were establishing the procedures and policies of dealing with a pandemic, and trying to secure funding. In countries where there was no existing working relationship with the MoH new connections had to be made and permission sought for GOAL to respond in certain geographical areas.

Community Acceptance

The KIIs and online survey provide evidence that CLA is an approach that assists communities to understand COVID-19 and why the lockdown was necessary, enables community ownership of the response and empowers people to take actions. One respondent stated: *CLA supported urban communities to understand the importance of social distancing and allowed them to come up with their own solutions and actions even though they lived in overcrowded conditions, such as redesigning markets and shops so that people could continue to trade and shop.* In Zimbabwe, communities that were not targeted by GOAL requested support from GOAL's community mobilisers to develop action plans as they wanted to emulate the response of the communities triggered by GOAL. The District Covid-19 Taskforce requested GOAL Zimbabwe for an expansion of the CLA triggering approach to cover all wards after having witnessed how triggered versus untriggered communities were adapting to the pandemic.

[15] Promobile, is a private sector company for mobile community outreach that uses vehicles equipped with state of-the-art sound equipment, microphones, and other technology to deliver education and awareness messages street to street in urban and rural areas. In-person engagement is usually 15 to 20 minutes.

This has contributed to GOAL implementing CLA in 1,204 communities rather than the 675 communities planned originally.

Reports show that across the 11 countries over 70% of communities developed an action plan after the first CLA session and the remaining communities required two to three awareness sessions. Programme staff reported that all the communities implemented their action plans and the global database shows that household and public handwashing stations, wearing of masks and social distancing were the three main actions chosen by the communities; this was also stated in KIIs and the online survey. Actions that some community leaders carried out were the redesigning of critical public spaces to ensure social distancing, hand washing stations erected at entrances of communities, and community visitors' logs. GOAL supplied handwashing stations and soap in most countries. In Uganda and Zimbabwe it was noted by respondents that the interactive radio discussions provided a strong platform for communities to have issues, rumours and myths addressed.

The neighbourhood approach was seen as having created a sense of urgency for all households to create an action plan. Identification of community championships was reported as a critical element in the success of the neighbourhood approach as they were people who motivated individual households to erect handwashing stations, establish social distancing at critical points such as water points, and supported neighbourhood units to acquire or make masks. In Zimbabwe, apartment block neighbourhood units were reported to create a sense of community. Malawi reported that people within the neighbourhood units were seen to take care of each other through assisting the vulnerable, and the starting up of savings groups (a proxy indicator of increased trust). South Sudan reported that the neighbourhood approach meant that households with disabled family members were better supported. In Zimbabwe CLA has not only increasing communities' capacity to fight COVID-19, but also increased reporting of Gender-Based Violence (GBV). Some communities also discussed GBV during the CLA sessions and developed their own measures and actions to address this challenge.

National and Global Strategic Positioning

CLA was rolled out quickly and had good acceptance and response at community level. This was seen by the programme staff to have placed GOAL in a strong strategic position both at national and sub-national levels alongside 'stronger' stakeholders. Programme staff felt that CLA was easy to explain and present to governments and donors leading to further stakeholder interest and funding to expand into additional communities.

GOAL's main donors: USAID, DFID/FCDO, Irish Aid and ECHO funded CLA implementation. In their feedback on GOAL's proposal in Sudan, OFDA (now BHA) stated that *the technical team commended GOAL for proposing actual, real community engagement work.*[16] GOAL is an active member of the national and/or district technical Risk Communication and Community Engagement (RCCE) working groups in eight countries; in Sierra Leone GOAL is the co-Chair of the Taskforce. In several countries government and other NGOs requested training from GOAL on CLA. In Malawi, CLA has been included as the main RCCE approach in two large consortium programmes with GOAL providing the training and technical support to partners. The Ugandan MoH is engaging to promote the SMAC approach as a national strategy and GOAL was approached by the Zimbabwean government to see if CLA could be rolled out as

[16] Email correspondence

part of the Cholera Elimination programme, with GOAL providing technical support. However, neither Uganda nor Zimbabwe have the available funds or technical resources to be able to continue with these partnerships at present. In the last few months WHO began developing an approach similar to CLA called the Family Risk Toolkit, referencing the original CLEA (Community-Led Ebola Action) that was used in Sierra Leone in 2014-2015. WHO's development of this toolkit is an acknowledgement that community engagement must be more than one-directional awareness sessions. GOAL has been requested to collaborate on the development and roll-out of this toolkit.

CLA as the national community engagement approach in Sierra Leone

CLA was adopted by the Sierra Leone COVID-19 National taskforce as the national community engagement approach and was rolled out to all 16 districts, reaching 903 communities. GOAL trained 20 masters trainers and seconded three staff full time to the Ministry (two MEAL and one SBC). This GOAL funded a co-lead of the RCCE working group.

GOAL's external promotion of CLA was greatly enhanced by the work of the HQ communication team who supported countries to document and publish success stories on the GOAL website and on social media. Sudan and Honduras reported that they had developed case studies on implementing CLA in IDP camps and emergency shelters, with BHA retweeting the Sudan story. A collection of photos and stories are available on the GOAL COVID-19 Sharepoint; CLA resources are available on the GOAL website, and GOAL HQ also published several communications pieces on CLA to increase its visibility. GOAL was invited to become a member of the global WHO RCCE working group for COVID-19. CLA was presented at different fora in 2020 including at the DSAI conference.

Resources

A CLA toolkit was developed by the PTT and consisted of a Resource Guide and CLA operational Field Manual accompanied by slide deck. These were shared on Sharepoint and most people who were interviewed and who completed the online survey obtained their copies through the Sharepoint link. The resources provided by the global technical team were considered as sufficient, and it was appreciated that the field manual was available in English, Arabic, French and Spanish. In Sierra Leone, the manual was adapted to become the national community engagement manual and in Uganda further tools were added to address COVID-19 stigma. Honduras developed videos of the tools and had the tools printed on flip charts. In many countries, demonstrations on handwashing and how to use and take care of a mask were also conducted. A PLA tool on taking care of masks was added to the revised national version in Sierra Leone and the Uganda team also added PLA tools on COVID-19 stigma. Country teams appreciate that they were able to make adaptations in the resources to tailor to their context, with the support of PTT.

The Field Manual and Resource Guide were seen as providing good guidance on how to choose and train community mobilisers. All community mobilisers were people who lived within their communities and most countries provided incentives such as phone credit. Two countries highlighted that not paying the community mobilisers and community champions made implementation more difficult in terms of their motivation. Interviews and reports show that just over 7,500 people were trained in CLA, this includes community mobilisers, community supervisors, government staff, other international and local NGO staff, and GOAL staff. A cascade approach was used starting with a two-day online training by the Global SBC Advisor for country trainers who then cascaded the training downwards to other country staff. All countries

availed of the initial two-day global training, and in Uganda, Sudan and South Sudan district level also attended this training. In total 118 GOAL staff were trained via by the Global SBC Advisor.

In Sierra Leone, 20 master trainers were trained by those who attended the two-day global training, and then they in turn provided the training in each district for community supervisors and community mobilisers. In all 11 countries the community mobilisers were trained in-person and district and MoH staff were included in all trainings at district level. All countries included protection and GBV referral pathways into their trainings. Only three countries reported that the training time of two days proposed in the Resource Manual was not sufficient as the concepts were new and difficult for mobilisers. It was also noted that the two-day global training could have incorporated sessions for each country to be able to plan how CLA could be adapted for their context. An example given was that teams did not understand how to design neighbourhood units in camps and urban areas where there is overcrowding, nor were they clear on how to have neighbourhood discussions that split men and woman into two different conversations. One respondent in the survey stated *The manual needs to clarify more clearly how the process can be adapted to different contexts to support the planning in countries.* However, it was reported that the follow-up technical support provided by the ERU, MEAL and PTT to implement CLA was extremely important in all countries.

Reporting

In most countries the community mobilisers reported to GOAL supervisors and weekly reports were then provided to the district health authorities by GOAL. This was intended to allow GOAL to be able to get messaging to communities as soon as possible and not to overburden the existing Community Health Workers active in the areas. However, in some countries staff indicated that the communication flow 'upwards' to GOAL and then from GOAL to the district health authorities caused conflict among the Community Health Workers, Community Mobilisers and district health authorities. Concerns were raised on how training community mobilisers that were not within the health system could affect the sustainability of the approach as when GOAL's stops collecting the data from the Community Mobilisers they then in turn may stop encouraging communities to follow through on their action plans. However, other staff indicated that they were confident that communities would continue and indicated that they believed the community will know the actions to take if there is an outbreak in future. Evidence of this was seen in Zimbabwe in December 2020 with staff reporting that communities which were no longer being supported restarted their action plans during a third wave of COVID-19. In South Sudan it was reported that the established community structures continued their CLA activities with the support of the Community Health Departments and community leaders. In Uganda, GOAL trained village health committee members as the Community Mobilisers and the Supervisors were part of the district health teams. It is not clear if this affected the quality of the action plans, or the data reported upwards to the district teams. However, it is worth noting that by using district health teams Uganda did not trigger their first community until nearly 6 weeks after the programme started, compared to Malawi which had triggered communities within three weeks of receiving funding.

Monitoring

Monitoring processes were developed to include forms for 1) the first session with the community (triggering), 2) the neighbourhood and community action plans and 3) the follow-up on those actions plans. A Knowledge, Attitude and Practice (KAP) survey was also made available and a global database

using CommCare was developed by the global MEAL team. Most of the countries reported that they had successfully collected data on the triggering sessions, action plans and the follow-up. One country reported not collecting information on the action plans as the communities and mobilisers were unable to write and the verbal information was not documented in hard copy. As time progressed and the number of COVID-19 cases did not increase in some communities, it was reported that the community mobilisers and community champions found it challenging to report changes in the implementation of the action plans. It was also suggested that this perception on maintaining level of implementation may have been because GOAL was requesting weekly reports on action plans and in many communities, there was little change in actions on a weekly basis, so teams were demoralised just collecting the same information. The tools for the neighbourhood and community action plans were viewed as duplicative so not all countries reported the data for both entities. Sierra Leone is now just reporting on the community action plans as part of the national implementation of CLA. It was proposed that the PTT and MEAL consider reviewing the reporting timeline and combining neighbourhood and community action plans forms for future CLA programming.

Connecting to the global database was challenging for seven of the countries with only four[17] countries uploading their data as a result. Several reasons were cited for this: CLA implementation had started before the global tools became available (the five countries which implemented initially under EFRS were provided with different M&E tools, however three of those countries did transfer the data to the global database); some countries are not using CommCare; and there were changes in MEAL staff and they did not have time to transfer data onto the global database. Having to complete the data for the community *and* neighbourhood units may also have contributed to staff not having the time to upload onto the database. All the MEAL staff interviewed said that they do have all the data available in-country either in hard copy or excel databases, and that global MEAL team have provided the support to be connected to the global database. Only Sierra Leone conducted the KAP baseline study with the form that was made available in the Resource Guide. However, all countries did conduct baselines for the programme that included CLA and endlines will be conducted in 2021.

No evaluation or research was conducted specifically on the impact of the CLA, although the London School of Hygiene and Tropical Medicine approached Malawi, Uganda and Zimbabwe to conduct a Randomized Control Trial. However, LSHTM did not secure funding so this was not pursued further.

Conclusion

There were two main successes of CLA. Firstly, it is a simple, efficient, and relevant community engagement approach that can reach communities with clear and consistent messages, enabling communities to become active participants in the response rather than passive recipients. Most countries reported that CLA allowed GOAL to quickly and meaningfully engage in the response. Those countries that already had a relationship with the MoH were able to act the fastest. Secondly, in many countries CLA strengthened GOAL's strategic position for disease outbreaks in the RCCE response pillar. In both Uganda and Zimbabwe there are discussions on CLA being utilised for other disease outbreaks including the Cholera Elimination[18] programme; globally GOAL is collaborating on WHO community engagement

[17] Malawi, Niger, Uganda and Sierra Leone
[18] GOAL is a member of the Global Community Engagement Working Group.

approaches. The Malawi team proposed that GOAL HQ support countries to have funds to take a more national role with training and advocacy of government, community-based organisations, and national NGOs in the initial stages of an outbreak/epidemic.

Despite CLA being a new approach for several countries the challenges encountered were mainly related to government restrictions on gatherings and travel. Countries that did not have a prior relationship with the MoH and had less experience in responding to emergencies struggled to get started due to competing priorities and having to adjust their ways of working. However, when they did implement CLA they saw the impact that it had in motivating communities. Many programme staff requested that GOAL make this type of community engagement part of all emergency responses.

The challenge of sustainability was a concern for some staff, as it was implemented in collaboration with the MoH but not using existing Community Health Workers. Programme staff are concerned that if CLA is not integrated into the MoH system it is unclear what happens if there was an outbreak in future, unless GOAL was still present and supporting Community Mobilisers and collecting data. However, other staff thought that the use of PLA tools and the development of action plans would mean that the community would know what to do. Evidence of this was seen in Zimbabwe in December with staff reporting that communities which were no longer being supported restarted their action plans when a third wave of COVID-19 occurred. Uganda showed that it is possible to implement the CLA through the MoH, but this did take a few weeks longer to implement. This was compared to Malawi, Niger and Iraq who reached their communities within three weeks of funding being received. GOAL could conduct follow-up research using a comparison between Sierra Leone, Malawi, and Uganda to assess the sustainability of the approach in terms of community ability to respond to a new wave of COVID-19 cases.

Given that all countries reported that CLA was efficient and relevant and placed GOAL in a strategic position, it would now be logical to evaluate the impact of the CLA response. This could look at three countries with local consultants to investigate whether triggered communities had lower infection rates and were able to continue with their daily lives more easily than non-triggered communities. This would need one lead social scientist researcher to pull together all the data and triangulate with the global database, then make recommendations for GOAL in how to use CLA in future. There is wealth of data available at country level and given the different adaptations within countries, a formal evaluation would support GOAL to refine their CLA approach and make an evidenced-based decision for future responses. This is particularly important if national governments in Uganda and Zimbabwe are considering this type of approach for their Cholera Elimination Programme as it would place GOAL in a strategic position within this global programme.