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Final Project Report

SCOPE

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CONTENTS

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ACRONYMS

AIP	Nurse Auxiliary
ASCP	Agent de Santé Communautaire Polyvalent
CBDA	Community-Based Distribution Agent
CCIH	Christian Connections for International Health
CHA	Community Health Assistant
CHMIS	Community Health Management Information System
CHV	Community Health Volunteer
CHW	Community Health Worker
FLE	*Family Life Education*
GEISA	Gender Equality and Inclusion Self-Assessment
HSA	Health Surveillance Assistant
mCPR	Modern contraceptive prevalence rate
MEAL	Monitoring, Evaluation, Accountability, and Learning
MOH	Ministry of Health
MSPP	Ministry of Public Health and Population
OPEN	Organization for Peoples' Empowerment and Needs
OPI	Organizational Performance Index
PHCU	Primary Health Care Units
PNC	Postnatal Care
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBCC	Social Behavior Change Communication
SCOPE	Strengthening Community Health Outcomes through Positive Engagement
SHP	SCOPE Health Promoter
USAID	U.S. Agency for International Development
WRA	Women of Reproductive Age

PREFACE

We are pleased to present the final report of the Strengthening Community Health Outcomes through Positive Engagement (SCOPE) Project. Awarded in 2019 through the U.S. Agency for International Development’s (USAID) New Partnership Initiative, the agreement gave an underutilized partner, World Relief, the opportunity to renew its partnership with USAID and invest in some of the hardest-to-reach communities in Haiti, Kenya, Malawi, and South Sudan. SCOPE is evidence of the significant impacts and success of U.S. government investments in under-resourced geographies, resulting in innovative, locally sourced solutions that engage entire communities.

At the heart of SCOPE lay the vision of making reproductive, maternal, newborn and child health (RMNCH) services readily available at the community level. As a mother and her baby travel along the journey from conception to early childhood, key moments in that path can lead to a healthy, strong life, or to tragic illness and premature death. For too many mothers and children, the path toward receiving adequate health services is blocked by long distances to or limited facilities, cultural or religious misconceptions, unhealthy social norms, or the lack of needed social support. SCOPE was designed to widen and clear the path to service utilization, making it easier for mothers to adopt healthy behaviors and seek the care that is needed, and to ensure linkages to existing health services.

To bring this vision to life, SCOPE harnessed the collective power of community health workers (CHWs), faith leaders, and community groups. SCOPE worked with faith institutions to train and build the capacity of faith leaders to speak to their congregations about critical health messages and encourage care-seeking behaviors. SCOPE also engaged the community through Care Groups and Couples’ Groups and adapted/created innovative curricula that is clear and relatable to the community. Finally, SCOPE trained and provided supportive supervision to CHWs who, in turn, provided health services through village clinics and home visits. Together these community actors strengthened and extended the reach of the health system into communities, women and their babies with little or no access to regular health services.

The impact of the Project over the past five years has been significant. Over 550,000 women, men, and children have been touched by SCOPE programming. SCOPE’s Midterm Evaluation showed evidence of positive impacts of SCOPE. CHWs were now identified as reliable sources of health information. More mothers shared they now nurse their baby within the first hour from birth, a life-saving post-partum practice. Couples reported increased dialogue and joint decision-making around family planning. Faith leaders and community volunteers contributed to the spread of positive health messages and supported CHWs in case-finding and referrals for complications. The impacts were felt throughout the community.

This report is laid out in three distinct sections. First, we explore the Project design and strategic approaches at the global level, including global results. Next, we discuss the work done at each country level and the successes and impacts noted within implementing countries. Finally, we will discuss the global learnings and best practices gleaned from the Project.

We thank USAID for their continued support through this Project, including their generous support and continued technical assistance to World Relief. We are grateful for the support and the opportunity to do this meaningful work.

ABOUT **SCOPE**

Women and children around the world are experiencing remarkable progress in their health outcomes. However, millions more continue to needlessly suffer or die from preventable causes or lack of access to essential health services. This health inequality is especially prevalent in fragile contexts within countries such as Haiti, South Sudan, Kenya, and Malawi. According to the World Health Organization, almost 800 women died daily in 2020 from preventable causes related to pregnancy and childbirth with nearly 95% of those deaths occurring in low and lower middle-income countries.[1] In 2019, 5.2 million children under the age of five died from preventable causes, of which almost half were newborns (under 28 days).[2] These women and children deserve better, and World Relief, through the SCOPE Project, worked to reduce preventable maternal and child morbidity and mortality in these challenging environments in some of the hardest-to-reach areas of the world.

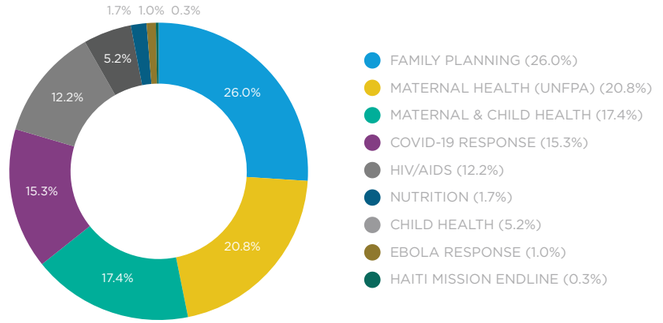
SCOPE was a five-year (October 2019 – March 2024) RMNCH New Partnership Initiative cooperative agreement funded by the USAID. SCOPE aimed to reduce preventable maternal and child mortality and morbidity in Haiti, Kenya, Malawi, and South Sudan by engaging CHWs, faith leaders, and community groups to advance RMNCH. SCOPE focused on technical interventions vital to the wellbeing of women of reproductive age (WRA) and children under five, including family planning and reproductive health, maternal and newborn health, and the prevention and treatment of childhood illnesses.

1 World Health Organization, "Maternal mortality," World Health Organization, accessed January 8, 2024, https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.

2 World Health Organization, "Children: reducing mortality," World Health Organization, accessed January 8, 2024, https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality.

The Project spanned four USAID priority countries, each of which offered a diversity of geographical, political, and cultural backgrounds. It was influenced by Ministry of Health (MOH) stakeholders, epidemiological needs, the absence of similar investments by other partners or donors, and the opportunity to leverage the existing presence of World Relief.

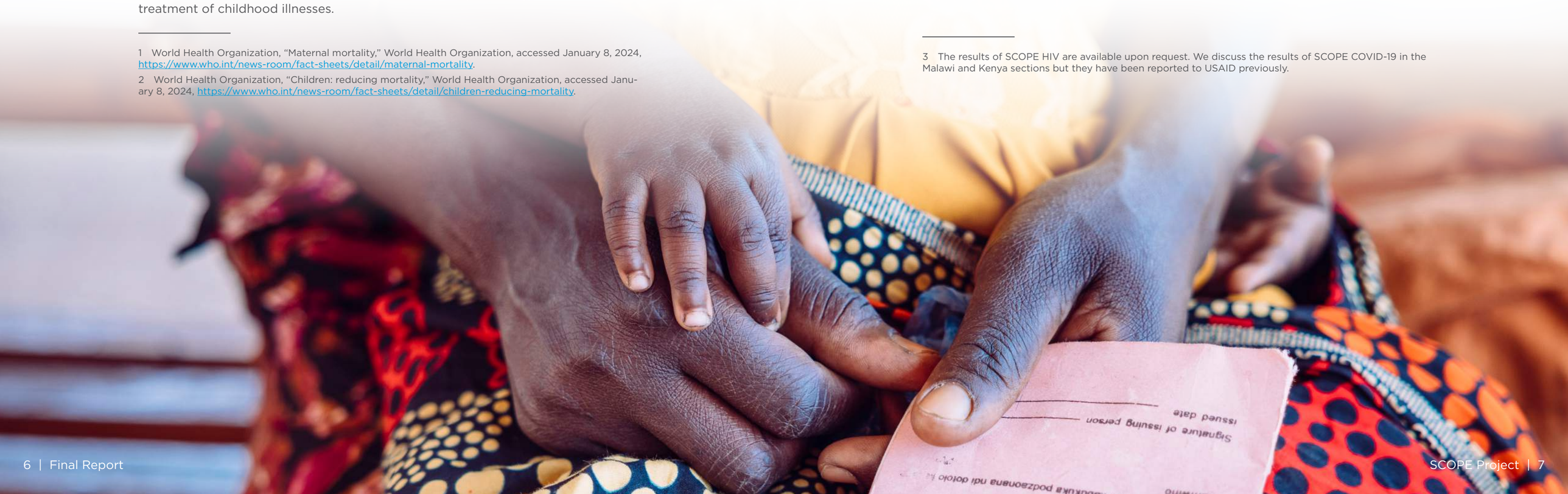
SCOPE FUNDING BY TECHNICAL OR CROSS CUTTING AREA



SCOPE worked in partnership with Christian Connections for International Health (CCIH) (in Kenya, Malawi, and South Sudan), and local organizations based in the Project geographies – Christian Health Association of Kenya (Kenya), Christian Health Association of Malawi (Malawi), and Organization for Peoples' Empowerment and Needs (OPEN) (South Sudan).

SCOPE represents an investment of $28,794,718 million by USAID. In addition to the $20,593,000 million received to support SCOPE RMNCH activities, SCOPE was awarded additional funds of $3,501,718 in support of SCOPE HIV, $4,400,000 for SCOPE COVID-19 and $300,000 for SCOPE Ebola.[3]

3 The results of SCOPE HIV are available upon request. We discuss the results of SCOPE COVID-19 in the Malawi and Kenya sections but they have been reported to USAID previously.



SCOPE BY NUMBERS

Partnering with communities to end maternal and child mortality in Haiti, Kenya, Malawi, and South Sudan

FAMILY PLANNING

172,772 REFERRALS for family planning made by non-health actors (faith leaders and Care Group Volunteers)

192,355 REPRODUCTIVE AGE WOMEN reached with family planning messages, & services

96.5% OF FAITH LEADERS (SCOPE-trained) reported feeling confident & comfortable communicating on family planning/reproductive health

48,749 YOUTH (AGES 10-24) REACHED with family planning messages by a faith actor

MATERNAL HEALTH

43,718 MATERNAL HEALTH REFERRALS by non-health actors (Care Group Volunteers)

7,085 MOTHERS VISITED for postnatal care services within two days of delivery

83.6% OF BIRTHS were accompanied by birth partners

27,154 PREGNANT WOMEN VISITED for antenatal care services

NEWBORN CARE

7,110 NEWBORNS VISITED for postpartum care within two days of delivery

CHILD HEALTH

89,614 CHILD HEALTH REFERRALS by non-health actors (Care Group Volunteers)

34,375 UNDER FIVE CHILDREN REACHED (including referrals or treatment for common childhood illnesses)

STRENGTHENING THE BROADER HEALTH SYSTEM

88 PRIMARY HEALTH FACILITIES serving as a link to facility for referrals & dataflow into the health management information system

62,500 HOUSEHOLDS REACHED by community health workers

21,014 REFERRALS COMPLETED out of 31,667 referrals made by community health workers

875 SCOPE-TRAINED COMMUNITY HEALTH WORKERS received mentoring & coaching as part of overall supervision during life of project

HIGHLIGHTED EVALUATION NUMBERS

mCPR

2X IN HAITI THE mCPR NEARLY DOUBLED FROM 10% TO 18%

IN MALAWI THE mCPR INCREASED FROM 65% TO 80%

IN SOUTH SUDAN THE mCPR INCREASED BY 18%

IN KENYA 89% OF REFERRALS WERE COMPLETED

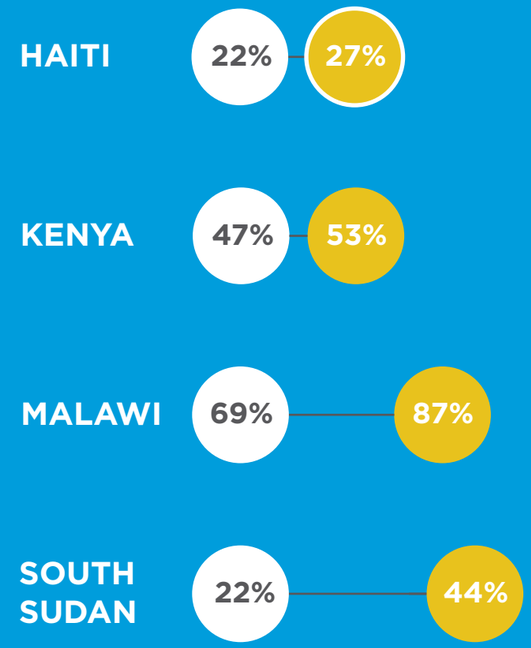
IN KENYA CHW HOUSEHOLD VISITS INCREASED FROM 13% TO 51%

4+ ANTENATAL CARE VISITS

IN HAITI VISITS INCREASED FROM 33% TO 35%

IN SOUTH SUDAN VISITS INCREASED FROM 45% TO 64%

PERCENTAGE OF COUPLES WHO REPORTED DISCUSSING FAMILY PLANNING WITH THEIR SPOUSE IN THE LAST YEAR



Haiti results are from the Endline Evaluation conducted in Year 4. Kenya, Malawi, and South Sudan results were from the Midterm Evaluation conducted in Year 3. Due to funding cuts and budget constraints, an Endline Evaluation for Kenya, Malawi, and South Sudan was not conducted.

PROJECT OVERVIEW

As a mother and her baby travel along the journey from conception to early childhood, key moments in that path can lead to a healthy, strong life, or to tragic illness and premature death. For too many young girls, women, and families with children, the path toward receiving adequate health services is blocked by long distances to facilities, misconceptions, unhealthy social norms, or the lack of needed social support. Those who overcome these barriers frequently find that at the end of their arduous journey, needed services are unavailable or inadequate due to outdated policies, lack of support to implement best practices, an extreme paucity of human resources for health, and a diffusely strained health care system. The SCOPE Project was envisaged to widen and clear the path to service utilization, making it easier for mothers and caretakers to adopt healthy behaviors and seek the needed care, while ensuring that high-quality health services are available for all mothers and children throughout their journey.

SCOPE was designed to affect change through various community actors who reach target clients in a multi-faceted, layered way. The Project's Theory of Change was based on a programmatic approach frequently used by World Relief within remote hard-to-reach areas, where behavior change is supported by multiple community-based actors who have the agency and influence to engender change within their communities. These frontline deliverers of information and services include cadres of **CHWs and their supervisors** deployed by their MOH, and key influential community actors such as **faith leaders** and **community groups (Care Groups and Couples Groups)**. Together they share social behavior change communication (SBCC) messages around RMNCH as well as provide additional linkages and referrals to the health system. SCOPE predicted that when multiple "levers" are being pulled simultaneously – by different actors and at different stages of the project life cycle – a greater shift toward improved health outcomes can be achieved within the community as a whole, leading to more lasting, sustainable change.

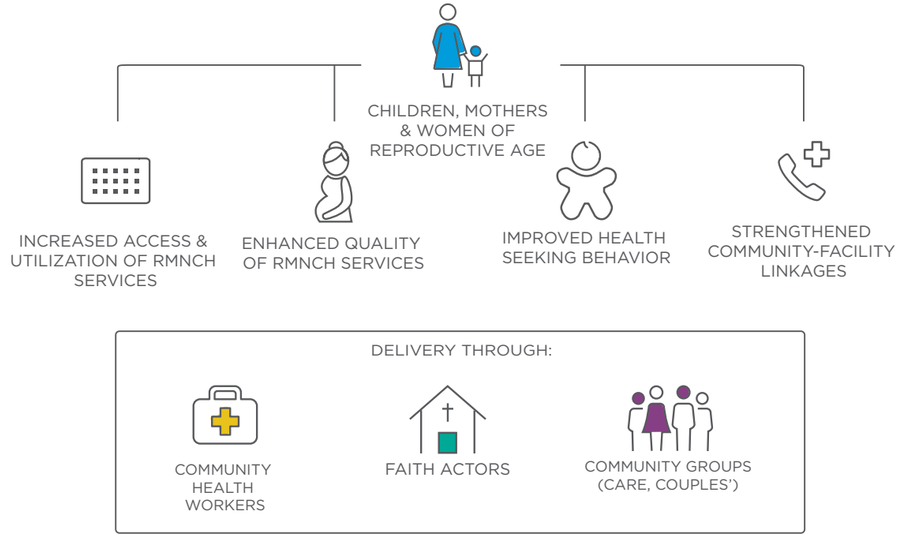
SCOPE RMNCH focused on key technical areas that serve WRA and children under five through a life-cycle approach from pre-conception to early childhood that can drastically improve their chances of survival: (1) community-based family planning/reproductive health, (2) community-based maternal and newborn care, and (3) prevention and appropriate treatment of childhood illness.

FAMILY PLANNING/REPRODUCTIVE HEALTH

SCOPE's strategies of engaging CHWs, community groups, and faith leaders to improve the health of WRA and their young children included a focus on reproductive health. SCOPE utilized different SBCC strategies to address barriers and enablers to the access to and utilization of modern contraceptive methods. The strategies within SCOPE include proven interventions, such as community-based distribution of family planning information, commodities, and referrals for long-acting reversible conception and long-acting and permanent contraception methods, postpartum family planning, community support for family planning, couples' communication, and strengthening individual knowledge, attitudes, beliefs, and self-efficacy.[1]

1 Family Planning High Impact Practices, "High-Impact Practices in Family Planning: List," Family Planning High Impact Practices, accessed January 8, 2024, https://www.fphighimpactpractices.org/briefs/family-planning-high-impact-practices-list/.

SCOPE STRATEGIC APPROACH



MATERNAL AND NEWBORN CARE

SCOPE promoted antenatal care and postnatal care (PNC) visits (early and consistent care-seeking during and after pregnancy) to support healthy pregnancy and safe motherhood. SCOPE interventions directly supported **improved access** to community-based contacts and the **quality of care** pregnant woman received from CHWs. CHWs were equipped to provide timed and targeted messages for pregnant women and those with newborns, as well as home-based PNC and essential newborn care, per MOH guidelines for community-based maternal and newborn care. This included how to identify danger signs during pregnancy, support during the postpartum period, and the care of small and sick babies. If there were complications, they were able to refer women and newborns for further care and ensure referrals were completed through the support of non-health actors. Care Groups (a peer-mother community group) were also a key platform for sharing health messages amongst pregnant women and mothers of young children, and served as additional **linkages to their nearest CHWs.**

PREVENTION AND TREATMENT OF CHILDHOOD ILLNESS

More than half of child deaths are due to preventable or treatable conditions, such as diarrhea, pneumonia, and malaria. SCOPE contributed to **increased care-seeking behavior** for sick children through CHW visits and Care Group lessons that discussed the nature and prevention of common childhood illnesses, and the importance of seeking timely medical care. The Project also trained CHWs on how to administer appropriate treatments at the community level where supplies were accessible.

STRATEGIC APPROACH

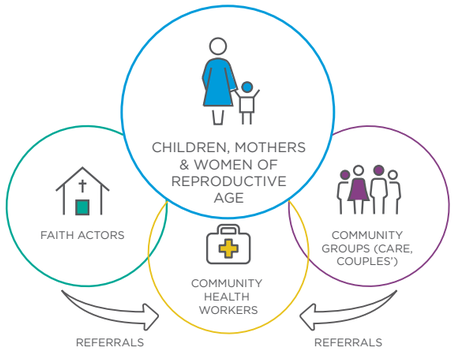
Community health is a critical part of the primary care continuum to address people's health needs. Extending preventive, promotive, and curative health services into communities is a crucial aspect of ensuring access to high-quality primary care. At the Project design phase, SCOPE understood that better integration of community actors within the health system could help achieve global goals to prevent child and maternal deaths.[1] Therefore, SCOPE's objective was to **increase access and utilization of high-quality RMNCH services, improve health-seeking behaviors, and strengthen community health and facility linkages through partnerships with three community-level actors: 1) CHWs, 2) faith leaders, and 3) community groups.**

Each community actor was equipped to become a RMNCH champion within their community and facilitate linking the woman and the child to the local health system. These actors – who will be the *de facto* implementers of any activities that are maintained after SCOPE ends – were engaged throughout the Project to take active steps toward long-term sustainability. SCOPE avoided duplication of existing or recent programming and materials, and both complemented and coordinated with the MOH and other implementing partners (U.S. government and non-U.S. government), contributing to RMNCH and health system strengthening.

COMMUNITY HEALTH WORKERS

SCOPE strengthened **CHW** capacity to improve **access to high-quality RMNCH information and services** through capacity building and supportive supervision. By working closely with MOH stakeholders to train, equip, support, and mentor CHWs, SCOPE's work enabled them to provide essential community-based services in family planning, deliver care for expectant mothers and infants, and prevent childhood illnesses. SCOPE also adopted a coaching and mentoring approach to supervising CHWs to reinforce their skills and knowledge over time. Lastly, SCOPE supported **strong linkages between CHWs and healthcare facilities** by strengthening their abilities in case-finding, making referrals, integrating community data, and facilitating outreach efforts by the MOH and other non-governmental organizations.

DELIVERY STRATEGY



FAITH ACTORS

Faith communities and **faith leaders** play crucial gatekeeping and influencer roles in the success of community-based work in developing countries.[2] However, in regard to health-related issues, faith actors often lack the skills and information needed to engage in helpful ways. Over the past ten years, World Relief has developed a model of faith-led community development that engages faith leaders in building sustainable community structures for health and other social services. SCOPE partnered with local faith institutions to enhance the proficiency of faith leaders in the community to address critical health issues and promote improved care-seeking behaviors related to RMNCH. Each faith actor was equipped to not only communicate and **increase access** to family planning and reproductive information, but also **serve as a linkage** to the health system.

COMMUNITY GROUPS

SCOPE engaged with local communities through **Care Groups** and **Couples' Groups** to disseminate RMNCH messages, foster widespread social norm change, and to further linkages to the health system. Through SCOPE, these Community Groups extended the reach of the health-system all the way down to the household level, ensuring that even the most vulnerable members of the community understood how and when to access services.

LOCALLY IMPLEMENTED, GLOBALLY CONNECTED

Achieving sustainable and equitable coverage of evidence-based RMNCH interventions is part of the SCOPE design. While SCOPE deployed globally recognized, evidence-based best practices in community-based health programming, it took a contextualized locally led approach for effective implementation at the field level. World Relief efforts in Haiti, Kenya, Malawi, and South Sudan are locally operating initiatives which prioritize relationship, local leadership, and trust at the community level as the bedrock of any activity implementation. Under these principles, SCOPE took three steps to ensure that project best practices had maximum impact:

1. The SCOPE Project design was created with the empowerment of the whole community in mind, not just the "woman and child" target group. When women alone are empowered in decision-making, but men and community leaders are excluded, women will not have the needed influence to impact those decisions effectively. SCOPE designed activities that touched on several key constituencies (individual women, women's groups, couples, faith leaders, and CHWs) to gain maximum impact and acceptance of interventions.

2. SCOPE staff were locally recruited among the community (or proximity of the community) where they served. This enabled familiar and trusted supervisors and field facilitators to provide support throughout the life of the project, which was especially helpful during the global COVID-19 pandemic when global travel was limited and local staff were relied upon to oversee activities. Additionally, local staff ensured understanding of local community networks and feedback mechanisms, which enabled SCOPE to receive real time inputs from communities without labor-intensive, externally sourced mechanisms.

3. SCOPE made special considerations for sensitization and engagement before the rollout of any activity. For example, Care Groups began with WASH and hygiene modules, leaving the more challenging family planning content to be introduced last when widespread trust in SCOPE-supported actors had already been established. Before faith leaders were asked to learn/teach about family planning and sexuality, they were trained on broader community development, their role in community health outcomes, and ways to address sensitive health topics. These steps were purposefully put in place to support each intervention for maximum impact and sustainability.

SUSTAINABILITY

SCOPE considered sustainability elements during the project's original design, keeping the end in mind. From the beginning, SCOPE's interventions were designed with these criteria that make an intervention a *high-impact practice:* replicability, scalability (i.e., potential application in a wide range of settings), sustainability, and cost-effectiveness.

SCOPE thus planned for sustainability of high-impact practice and interventions in the way that information and services were delivered through CHWs (a service delivery high-impact practice), Faith Engagement and Care Groups (social behavior change high-impact practice). **SCOPE's work enabled these local stakeholders to play their respective roles effectively, but ultimately the efforts and interactions of these community actors in the local system are what lead to lasting health impact.** We are grateful to have played a small engendering role in the lives of communities in the four SCOPE countries.

1 Sacks, E., Morrow, M., Story, W. T., et al. "Beyond the Building Blocks: Integrating Community Roles into Health Systems Frameworks to Achieve Health for All." BMJ Global Health 3 (2019): e001384. doi:10.1136/bmjgh-2018-001384.

2 Duff, Jean F., and Warren W. Buckingham III. "Strengthening of Partnerships Between the Public Sector and Faith-Based Groups." The Lancet 386 (2015): 1786–94. Published online July 7, 2015. http://dx.doi.org/10.1016/S0140-6736(15)60250-1.

ACCOMPLISHMENTS BY ACTIVITY

HEALTH SYSTEM STRENGTHENING

SCOPE's support of CHWs reinforced health worker capacity and community-facility linkages by strengthening case-finding, referrals, community data integration efforts, and ensuring synergies with other community-based outreach efforts.

SCOPE worked closely with MOH stakeholders to strengthen the capacity of CHWs to deliver community-based family planning, maternal and newborn care, and prevention of common childhood illnesses. This work was informed by a rapid CHW functionality assessment conducted in the first program year. By assessing the functionality of the CHW program in each country, SCOPE learned about CHWs' roles, the resources (equipment, supplies) and incentives available to CHWs, and the capacity-strengthening efforts that were being done by the MOH and other implementing partners. SCOPE also mapped out the referral systems (between community and facility) and how data collection and information management was done at the community-levels. The functionality assessment results helped SCOPE plan for targeted technical support needed to enhance CHWs' capacity in each country.

SCOPE's support for CHWs involved recruitment (where more coverage was needed according to MOH guidelines for health worker-to-population ratios), capacity development in family planning/maternal child health according to national protocols and guidelines, and ongoing coaching and mentoring to ensure post-training skills and knowledge remained high. An additional facet of CHW work included support and training of CHW supervisors, to strengthen supervisory capacity for maximum health worker performance.

HEALTH WORKER CADRE BY COUNTRY

COUNTRY	HEALTH WORKER CADRE	SUPERVISOR
Haiti	Agent de Santé Communautaire Polyvalent (ASCP)	Nurse Auxiliary (AIP)
Kenya	Community Health Volunteers (CHVs)	Community Health Assistants (CHAs)/ Community Health Extension Workers
Malawi	Health Surveillance Assistants (HSAs) and Community-Based Distribution Agents (CBDAs)	Senior HSAs
South Sudan	SCOPE Health Promoters[1]	SCOPE Supervisors

1 Due to the Trafficking in Persons restrictions, in South Sudan SCOPE is working with a CHW cadre of workers not affiliated with the MOH. SHPs are similar to Boma Health Workers in scope/function but are fully paid and supported by SCOPE.

RESEARCH STUDY: CAPACITY-BUILDING OF COMMUNITY HEALTH WOKERS THROUGH AN ALTERNATE TRAINING AND SUPERVISION APPROACH IN IBBA AND MARIDI, SOUTH SUDAN: A QUASI-EXPERIMENTAL STUDY

The **low-dose, high-frequency method** is a capacity-building method that consists of frequent interactive training with many opportunities to practice and receive immediate feedback through supervision, coaching, and mentoring. This contrasts the standard training method, which typically consists of a single, lengthy training with more passive learning approaches, such as reading or lecture, with limited time for practice and receiving feedback. Under the standard method, supervision is usually limited to data quality checks (rather than mentoring/coaching and reinforcement of knowledge and skills). Research on the low-dose, high-frequency method has shown success among facility-based health workers and clinical providers; however, very little research has been done on testing the low-dose, high-frequency approach among community-based health workers.

These literature gaps led to SCOPE conducting a research study that evaluated approaches to training and supervising community-based health workers. The study aimed to compare the low-dose, high-frequency method of training and supervising community-based health workers with the standard method of training and supervising community-based health workers in Ibba and Maridi, South Sudan.

SCOPE partnered with OPEN (a local NGO based in South Sudan) to train and supervise 108 SHP study participants (54 in the comparison group; 54 in the intervention group). The study received institutional review board approval from the Research Ethics Review Board within the South Sudan MOH and BRANY, a US-based institutional review board.

The indicators used to evaluate the change in skills, provider practice, and health outcomes of the intervention were adapted from the Kirkpatrick Framework (a recognized framework used to evaluate training programs). In this framework, four levels are assessed: (1) reaction, (2) learning, (3) behavior, and (4) results. For the research study, SCOPE looked at health workers' satisfaction and perception of their training, knowledge and retention of skills, and behaviors and practices throughout 15 months after SHPs in both groups completed their training. Data was collected through knowledge tests, participant reaction surveys, and direct observation tools.

The results showed positive associations between the low-dose, high-frequency method and higher retention of knowledge and skills when compared to the standard training method. A separate study report containing more detail on the research methodology, results, and conclusion is available.

IMPACT

Reaching the Last Mile
SCOPE's Midterm Evaluation found that CHWs played a key role in the SCOPE program as deliverers of information and services in last-mile, hard-to-reach communities and that SCOPE-supported CHWs felt supported in their capacity development process from the training, coaching, and mentoring received from SCOPE. Across the four countries, 916 CHWs reached 62,500 households.

Supervision of Health Workers
SCOPE worked to ensure that CHWs were remunerated, supervised, supplied, and skilled for maximum impact in remote and resource-deprived communities. After successfully training targeted CHWs in the four countries, SCOPE shifted its focus from training to supportive supervision, focusing heavily on coaching and mentoring through existing sub-national (district-level) MOH supervision structures. Supervision efforts focused on strengthening CHWs' capacity around data reporting, recognizing danger signs for the woman and/or child, and ensuring timely and safe referrals to the nearest health facility. Frequent touchpoints with CHWs can help ensure motivation and that knowledge and skills remain high.

The Midterm Evaluation demonstrated major increases from very low CHW supervision at baseline to high levels of CHW supervision. Furthermore, of those CHWs in Kenya who had supervision visits, 94% reported that their knowledge was updated or strengthened during supervision visits, and they felt more motivated after the visits. In South Sudan, 83% of CHWs said they felt supervision was updating their learning and knowledge, and 87% said that they felt more motivated after their visits. In Malawi, 98% of CHWs said they were learning from supervision, and all CHWs either agreed or strongly agreed that they were more motivated after supervision visits.

Overall, SCOPE's efforts to regularly supervise CHWs using mentoring and coaching approaches focused on knowledge and skills and strengthening the supervisory capabilities of CHW supervisors yielded fruit and should be a standard practice when working with CHWs in remote, rural areas.

Referrals/Linkages
In the hard-to-reach areas where SCOPE was implemented, CHWs were often the primary source of health information and services. Over the course of the Project, as SCOPE worked with various non-health actors on sharing community-based RMNCH messages, these actors began referring their neighbors and members of their faith communities to CHWs or health facilities, thereby strengthening referrals and linkages to the health system. These linkages resulted in tighter case-finding, greater demand, and increased access to services.

HOUSEHOLDS REACHED BY COMMUNITY HEALTH WORKERS

CUMULATIVE GLOBAL OUTPUTS OCTOBER 2019 – SEPTEMBER 2023

	HAITI	KENYA	MALAWI	SOUTH SUDAN
# SCOPE-supported CHWs	60 ASCPs	222 CHVs	444 (358 HSAs/ Senior HSAs, 86 CBDAs)	108 SHPs
# SCOPE-supported supervisors of CHWs	7	45	21	12
# Primary health facilities serving as a link facility for referrals and data-flow into a health management information system	5	45	21	17

Furthermore, CHW visits, sometimes as a result of referrals made by non-health actors, led to increases in referrals to health facilities. The results of the Midterm Evaluation showed that more than 75% of referrals were completed In Kenya, 324 people reported receiving a CHW referral, and almost 89% completed the referral. Of those referred, 58.8% were women. In Malawi, a very small number (n=28) reported receiving referrals, and 100% said they received the services to which they were referred. Women were also the majority of those referred in Malawi, at 64.3%. In South Sudan, 223 people reported receiving referrals, and almost 79% received the services to which they were referred. In South Sudan, males were more likely to report referrals received (58.8% of all referrals). The high referral completion rates indicate SCOPE's achievement in striving to ensure that, as a community-based project, critical linkages were made between the community and the health facility. The results also confirm that working with and through other community actors and influencers is an important strategy for supporting CHW programs.

PEOPLE REACHED WITH FAMILY PLANNING INFORMATION, COUNSELING & SERVICES BY A COMMUNITY HEALTH WORKER

LEARNINGS

CHW Reporting and Integration into Countries' Community Health Information Systems
Reviewing each country's Community Health Information Systems and MOH-mandated CHW monitoring forms was essential, particularly for data fields pertaining to community-based family planning/maternal child health. This exercise mapped the data flow of key family planning/maternal child health indicators and provided insight on how to sustainably gather information on those indicators so that SCOPE-supported CHWs were reporting data that could be used for both the Project and the country's Community Health Information Systems.

COMMUNITY HEALTH WORKER SPOTLIGHT

CHWs in Haiti, called ASCPs, work tirelessly to change people's behavior around family planning, child illness, maternal health, newborn health, antenatal care, and PNC. One such ASCP is Junia Saint-Cyr, a SCOPE-supported CHW who works as a nurse in Les Cayes. Born in the community she oversees, Junia is one of eight children in her family. In her community, there are many misconceptions about maternal health and family planning. Women often do not go to the hospital when they are pregnant or bring their children there for regular care.

In Junia's community, there was a pregnant mother of seven. This mother had given birth to all seven children at home and did not want to change her mind about home birth. She also had never received prenatal or antenatal care, and when Junia tried to talk about antenatal care, the mother refused to engage. After several visits, Junia convinced her to go to the hospital. When she arrived, the doctor assessed her and realized the baby was not growing well in utero and warned she might lose the baby if changes were not made. Through the help of the doctor and the CHW, the mother had a healthy birth. Through her ongoing visits, Junia is ensuring the mother and child remain healthy.

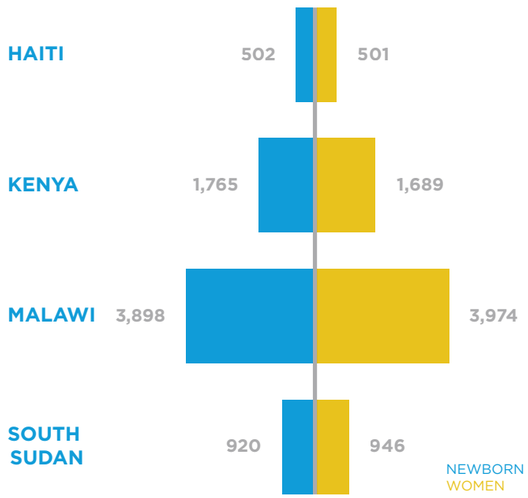
Using Ministry of Health Curriculum and Ensuring Sustainability Beyond the Project

In the Project's first year, SCOPE reviewed the host-country MOH curricula for training front-line CHWs in family planning/maternal child health in each of the four SCOPE program countries. While each country had some minor differences in curricula and training approaches, for the most part, these curricula are vetted by donors and have been used extensively by implementing partners. As such, SCOPE used the MOH-approved national curricula for CHW trainings, provided by MOH-vetted facilitators. SCOPE layered an additional mentoring/coaching component on top of the traditional classroom training to ensure that knowledge and skills retention remained high, even post-training.

By using MOH-approved curricula, SCOPE ensured sustainability in that the SCOPE-spported CHWs were well-positioned to continue working as government resource persons even beyond the life of the Project. Through engagement with each country's MOH (national and sub-national level) and other USAID implementing partners, SCOPE determined what each country had in place for the training and equipping of CHWs in family planning/maternal newborn health (i.e., training curriculum, policies, job aids), and used this information to design the Project's approach to working with CHWs.

To read more about SCOPE's work in Health Systems Strengthening, please see the SCOPE CHW webpage, SCOPE's Technical Brief: Community Health Workers.

WOMEN & NEWBORNS VISITED BY A HEALTH WORKER FOR POSTNATAL CARE WITHIN 2-DAYS OF DELIVERY



COMMUNITY GROUPS: CARE GROUPS

Global evidence[1] has shown the impact of the Care Group model on improving health outcomes. A Care Group is composed of 10-12 Care Group Volunteers who meet regularly for SBCC and related skills-building on health education topics. After receiving the lessons, each Care Group Volunteer cascades information to 10-15 neighbor mothers in nearby households through group meetings and home visits.

In 1995, World Relief developed the Care Group model in Mozambique, and since then, the model has gained global recognition and received significant support through USAID-sponsored programs worldwide. Due to the model's effectiveness, nongovernmental organizations working in over 40 countries have implemented the Care Group model.[2] A Care Group's unique ability to extend a health system's reach through the multiplication of volunteer effort, peer support, and community mobilization makes the model ideal for many projects and programs.

SCOPE established Care Groups in its four project countries, equipping them to implement a SCOPE-developed series of training modules adapted from existing USAID-approved curricula. Promoter manuals and volunteer flipcharts included the latest evidence-based best practices on RMNCH information, each adapted for a particular country and its local communities. Each of the four modules was translated and underwent a contextualization process to ensure the messages, stories, and images were locally relevant. The Care Group model ensures that social behavior change health information is communicated using vernacular language and practiced through simple exercises performed at the household level.

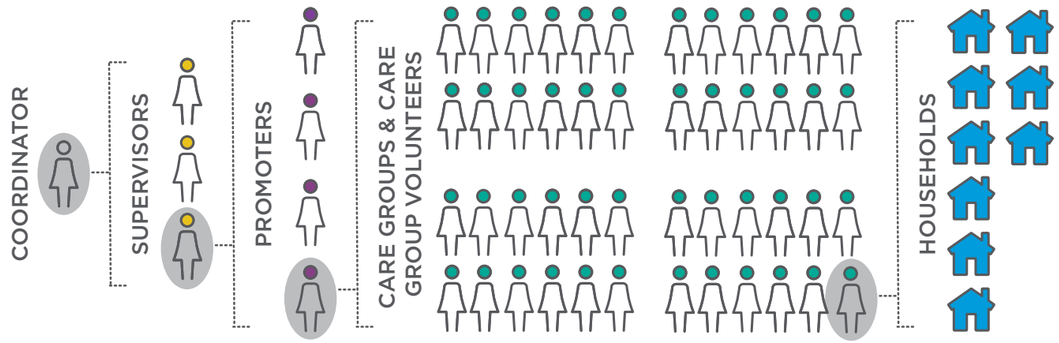
During Care Group meetings, guided discussions are centered around clear learning objectives. To help facilitate discussions with neighbor women at home or during group meetings, each Care Group Volunteer is equipped with a pictorial flip chart to assist in presenting the lessons in a user-friendly and interactive way.

All Care Group resources are available on the Care Group webpage for use by other partners and projects. Resources are also available in Chichewa, Maasai, Kiswahili, Turkana, and Haitian Creole.

1 Perry H, Morrow M, Borger S, et al. Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings. Glob Health Sci Pract. 2015;3(3):358–369. Published 2015 Sep 15. doi:10.9745/GHSP-D-15-00051

2 Care Group. "About Us." Accessed January 8, 2024. https://caregroupinfo.fh.org/about-us

CARE GROUP STRUCTURE



IMPACT

Extending the Reach of the Health System
Care Groups extended the reach of the health system down to the household level, ensuring that those who lived in hard-to-reach areas knew how and when to access health services. SCOPE Care Group Volunteers complemented the work of overburdened CHWs by supporting case-finding and referrals so that CHWs could maximize their time in providing information and health services to the clients who needed them most. Through 18,910 Care Group Volunteers, 192,355 WRA were reached with information to improve RMNCH behavior and practices.

SCOPE CARE GROUP MODULES

- Module 1: Introduction to Care Groups and COVID-19 Awareness (9 lessons)
- Module 2: Child Health (11 lessons)
- Module 3: Maternal and Essential Newborn Care (12 lessons)
- Module 4: Family Planning (8 lessons)

Care Group Volunteers were a vital link between the community and facility services, in that they became a mechanism of the local referral system. Not only did Care Group Volunteers provide information to their neighbor group members, but they could also recognize warning signs among pregnant women and children under five, and thus make the necessary referrals to the CHWs and facilities.

157,958 referrals made for family planning
43,718 referrals made for maternal health (including antenatal and PNC)
89,614 referrals made for child health (including illnesses and well-visits such as immunization and growth monitoring)

Care Group Volunteers were trained to record and report on key vital events such as childbirth, pregnancy, child illnesses, and deaths, as well as provide timely referrals to CHWs who could feed information into existing health information systems. The Care Group model is particularly useful as it can reach a large population while maintaining cost-efficiency, sustainability, and intensive support to Care Group Volunteers and beneficiaries.

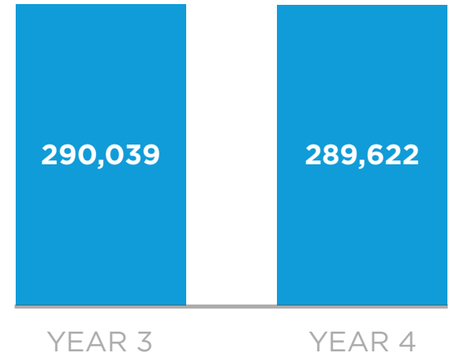
This referral relationship also highlighted the difference between CHWs and Care Group Volunteers: CHWs have a health background and training that Care Group Volunteers do not, so the two should be viewed as an extension of each other rather than parallel entities. Therefore, careful consideration must be made regarding remuneration and incentivization. Many of these volunteers and health workers come from the same communities, and differences in incentives can be a source of conflict.

Care Groups for Improved Family Planning and Maternal Child Health Outcomes
The system of group lesson delivery, home visits, and regular mentoring and supervision of Care Groups fosters peer-to-peer support and facilitates community-wide interest and improved health-seeking behavior among caregivers.

However, Care Groups were not only focused on diffusing messages, but also building their skills to reflect on what they have learned, issues they face, changing behavior, and solving problems together. In several project geographies, SCOPE found that the Care Group approach significantly facilitated positive behavior at scale within communities. Women took action in their households and communities. For example, it was observed that Care Groups across the SCOPE countries improved their hand-washing practices, built tippy taps and latrines using local resources, and grew vegetable gardens.

Despite the challenges from COVID-19 and region-specific political and environmental factors, Care Groups contributed to the positive results noted in the Midterm Evaluation. SCOPE teams reported stories of community members turning their knowledge into action, and rallying around women and young children to advocate for their healthcare needs at local facilities.

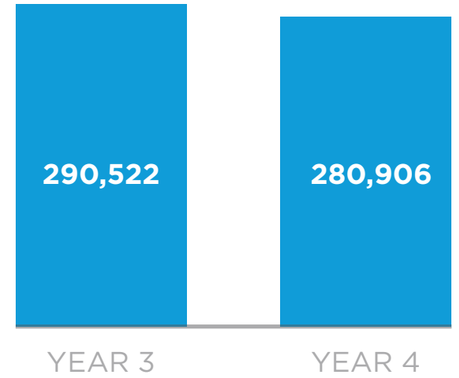
CHILDREN UNDER FIVE REACHED BY CARE GROUP VOLUNTEERS



LEARNINGS

Safe Spaces for Sharing and Promoting Healthy Behaviors
Care Groups, by design, create a space where women feel relaxed and safe and a sense of togetherness and bonding with other mothers and women in similar life stages. When women feel safe, they are more likely to share their experiences, talk openly about their common struggles, identify harmful practices, and consider trying new practices at home. Such a space allows women the opportunity to brainstorm solutions to the challenges they face or ways of practicing new behaviors. Modeling and practicing care and respect (from senior staff to volunteers), regular mentorship, and creating an enabling environment for mothers promoted understanding and motivated the women to share lessons learned through their neighborhood groups. In some cases, women moved away from their traditions of home birth delivery and instead chose a facility-based delivery. In Kenya, SCOPE saw this network of mothers holding each other accountable to practice a new, healthy behavior taught in the Care Group lessons (i.e., immunizations, antenatal care visits, etc.). If a mother missed a prenatal care visit, her group would encourage her to go or call upon the CHW to offer support. This type of accountability is only possible when women feel safe and empowered to make communal changes.

WOMEN REACHED BY CARE GROUP VOLUNTEERS



Improving Program Quality through the Quality Improvement Verification Checklists
The careful and regular monitoring of Care Groups enabled the Project to adapt to face any reported challenges and provide consistent, quality support for people of reproductive age, pregnant women, and caregivers of children under five. Quality Improvement Verification Checklists identified which Care Groups needed support and how to target this support in resource-constrained environments.

Supervisors used the Quality Improvement Verification Checklists to check Care Group Volunteers' quality and delivery of messages to neighbor women. The Quality Improvement Verification Checklists was a tool that assessed how promoters were delivering messages to Care Group Volunteers and, in some countries, how Care Group Volunteers were delivering messages to women. These supervision tools helped identify areas where the delivery of messages could be improved.

To read more about SCOPE's Care Groups, please see the Care Group webpage, SCOPE Technical Brief: Care Groups, Blog post: Four Things We've Learned Working with Care Groups, Blog Post: Partnering with Women through Health Education: Q&A with SCOPE Senior Technical Advisor.

COMMUNITY GROUPS: *FAMILIES TOGETHER*

Couples often face an uphill battle for equal decision-making in household decisions and healthcare, including the use of family planning. The lack of shared decision-making can create a dangerous power imbalance in relationships. The World Health Organization estimates that one in three women (30%) experience intimate-partner violence.[1]

Joint decision-making and increased couple communication around fertility intentions have proven to be effective at increasing contraceptive use.[2] SCOPE implemented *Families Together,* a couples-strengthening program, developed by World Relief. *Families Together,* was developed as a couples' strengthening curriculum which approaches reproductive health from a holistic perspective, addressing the power dynamics within families and helping couples communicate more effectively to improve couple functioning, decision-making, utilization of family planning options, and overall relationship quality.

During the activity, couples' groups (male-female couples) are taken through ten participatory sessions structured around storytelling, role-plays, games, and facilitated discussion. Topics covered in the curriculum include issues of inequality, power and status (at the family and society levels), friendship, trust, mutual sexual pleasure, family planning (contraception methods and decision-making around contraceptive use), communicating with youth, causes and consequences of gender-based violence. and gender roles (division of labor and household decision-making).

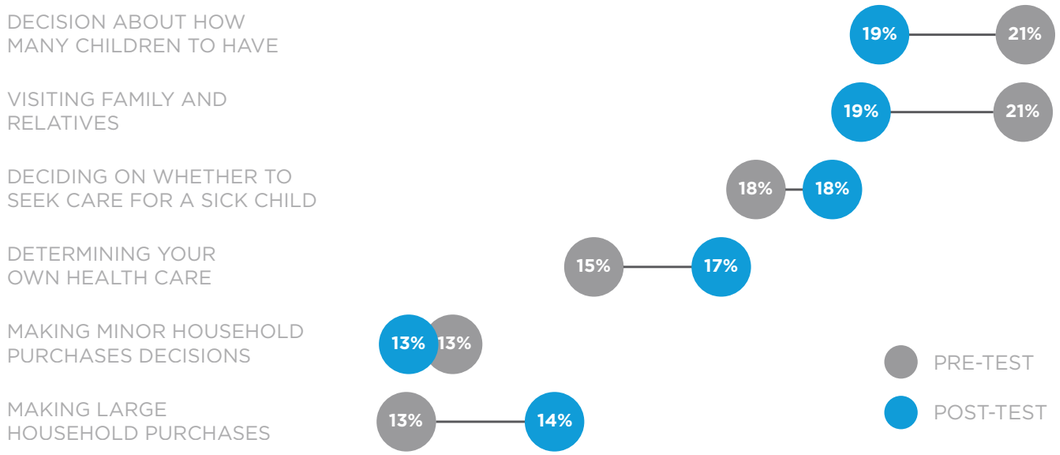
Families Together was implemented in Kenya and Malawi amongst 505 couples in Malawi, and 280 couples in Kenya. Of these, 197 were trained to lead *Families Together* sessions as Lead Couples. The curriculum was contextualized in close collaboration with Muslim and Christian faith leaders.

The *Families Together* Implementation Guide and Facilitator's Guide are available on the Faith Engagement webpage for use by other partners and projects. Resources are also available in Chichewa, Maasai, and Turkana.

1 Statcompiler. Accessed January 8, 2024. https://www.statcompiler.com/en/.

2 Demissie, G.D., Akalu, Y., Gelagay, A.A. et al. Factors associated with decision-making power of married women to use family planning in sub-Saharan Africa: a multilevel analysis of demographic health surveys. BMC Public Health 22, 837 (2022). https://doi.org/10.1186/s12889-022-13251-4

JOINT HOUSEHOLD DECISION-MAKING BEFORE AND AFTER FAMILIES TOGETHER IN MALAWI



IMPACT

Results from pre- and post-tests taken by *Families Together* participants in Malawi show a positive change in perceptions regarding family planning, gender relations, and domestic violence.

Family Planning
Families Together participants noted positive changes in family planning perceptions. As one female participant in Malawi shared,

"I was ridiculed by most of my friends in my community when I told them I had gone to the clinic to get family planning and had decided not to have any more children because my husband and I had decided we did not want any more children. So, what a relief when I learned about family planning methods through the Families Together sessions! I learned that it was okay for me to decide which method worked best and that it was alright to make that decision and I no longer feel condemned because I chose to stop having other children. My friends are now making family planning choices which was not the case before we engaged in Families Together sessions."

Gender Relations
In Malawi,[3] more gender-equitable relations were observed as men and women engaged in weekly participatory couple group sessions. Participant couples spoke of shared gender roles, such as childcare and household chores, and reduced incidences of domestic violence. Male participants in Malawi shared that before participating in *Families Together*, they would not assist their wives with household chores such as dishwashing, food preparation, and taking care of children because these were considered women's chores. However, results have shown that men are assisting their partners with household chores.

Perceptions of Domestic Violence
After the *Families Together* activity, the proportion of participants who disagreed with the statement, "violence against a spouse is a private matter that shouldn't be discussed outside the couple," increased from 63% to 70%. There has also been an increase in the proportion of people who agree that "violence towards a wife is unacceptable" (from 65% to 71%).

3 Results from *Families Together* implementation in Kenya will be available in Spring 2024.

LEARNINGS

Involving Faith and Community Leaders
The orientation and involvement of faith and community leaders in *Families Together*activities ensured project buy-in by community members, the selection of facilitator couples, and the participation of couples in group sessions. Meaningful involvement included contextualizing the *Families Together* manual content to ensure the content was appropriate for local country contexts. This ensured activity ownership and acceptability, which is key for behavioral change.

Organizational Capacity-strengthening in Family Planning Programming
The *Families Together* activity introduced couple-strengthening programming for World Relief Kenya, where it had never been implemented previously. For Malawi, the addition of Muslim leaders and participants was a unique addition to the expansion of couple-strengthening programming (and as a result, more couples were reached).

RESEARCH STUDY: A CLUSTER RANDOMIZED EVALUATION OF THE FAMILIES TOGETHER INTERVENTION IN THE KAJIADO AND TURKANA COUNTIES OF KENYA

Public health experts have recognized couples-focused interventions as having great potential to facilitate health behaviors and foster gender-equitable relationships. SCOPE is conducting a study to evaluate the impact of World Relief's *Families Together* program on couples' family planning decisions and couple functioning in Kajiado and Turkana.

The study is a matched-pairs, cluster-randomized program evaluation employing a mixed methods approach, including quantitative surveys, in-depth interviews, and key informant interviews. SCOPE received international review board approvals from BRANY (US-based international review board) and KEMRI (Kenya-based international review board) for the *Families Together* research study.

The study is being conducted in 20 sites in Kajiado and Turkana. 560 participants (280 male-female couples) have been recruited for the study. Data collection is currently underway. Results will be available in Spring 2024.

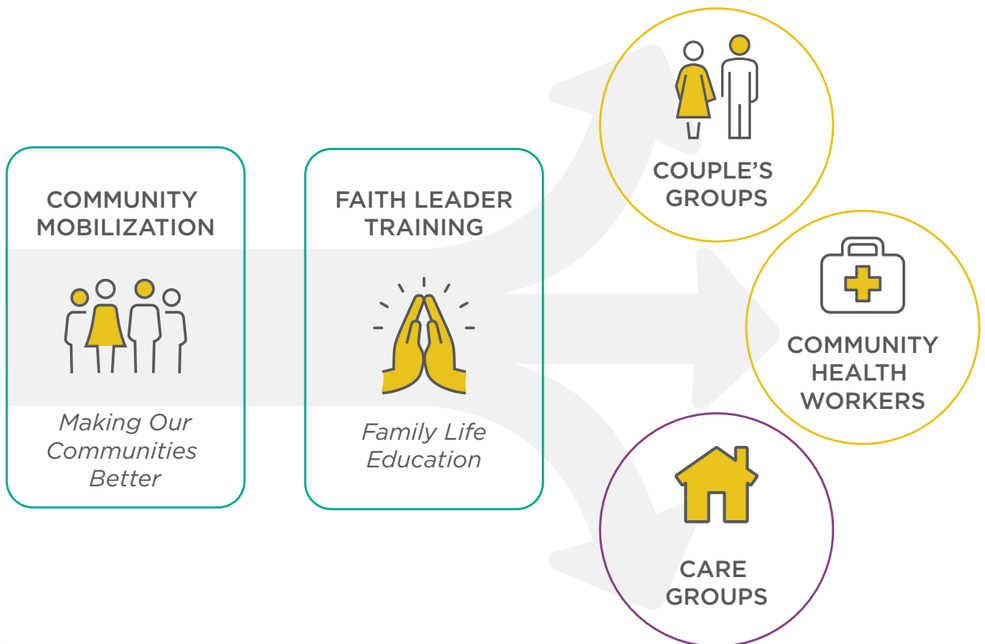
This evaluation will provide valuable data regarding the potential of couples' interventions to increase family planning uptake and gender-equitable decision-making within the couple, and decrease intimate- partner violence. The research will contribute to the small but growing body of evidence documenting linkages between relationship quality and health behaviors for African couples and has the potential to guide future interventions on couple relationship functioning and family planning.

FAITH ENGAGEMENT

Faith leaders are often some of the most influential leaders in their communities and are uniquely placed to identify and meet the needs of those in the last mile. Faith leaders and faith communities often play crucial gatekeeping and influencer roles, helping to determine the success of community-based work. However, regarding health issues, faith leaders often lack the necessary skills and knowledge to engage in helpful ways. The SCOPE Project aimed to engage faith communities in its efforts to increase demand for RMNCH services and create an enabling environment for social norm change related to family planning. When faith leaders are engaged as true long-term partners in this work, they shift from being potential obstacles or bottlenecks to being the best allies and partners on the ground.

To engage faith leaders in their influencer role of shaping behaviors that lead to community transformation, World Relief established a community development model focusing on sustainable health and social services. Building on this model, SCOPE trained faith leaders to convey sexual and reproductive health information. Mobilization began with *Making Our Communities Better,* a vision-casting curriculum that sensitizes and equips faith leaders to leverage their influence in driving community development. After engaging faith actors in this activity, SCOPE provided further training on sexual and reproductive health though the SCOPE-adapted version of *Family Life Education* (*FLE*). This activity aimed to enhance faith leaders' communication skills and their ability to facilitate community dialogues on these sensitive topics. With buy-in from local faith leaders, SCOPE further engaged communities through *Families Together*, Care Groups, and connections to CHWs.

FAITH ENGAGEMENT THROUGH SCOPE



FAITH ENGAGEMENT: *MAKING OUR COMMUNITIES BETTER*

Before implementing project activities, SCOPE began mobilizing faith communities through *Making Our Communities Better*, a World Relief-developed vision casting curriculum. The curriculum was adapted for SCOPE to address maternal and child morbidity and mortality drivers among Christian and Muslim communities. This faith-led community development tool reinforces sustainable community structures for health and other social services that address root influencers of behavior change and transformation.

Vision casting gives faith leaders exposure to community-based development topics and insights into how influential and important they are in speaking to these issues. The goal is for faith leaders to actively motivate community members to seek health services, particularly WRA and mothers of children under five. *Making Our Communities Better* was designed to assist faith leaders in communicating about health issues in a way that affirms the faith values of their community members and emphasizes the importance of community health according to principles of faith. This three-day training engaged faith leaders in peer discussion of real-life case studies designed to inspire a positive response to the health challenges facing women and young children.

The *Making Our Communities Better*Trainers Guide is available on the Faith Engagement webpage for use by other partners and projects. Resources are also available in Chichewa, Maasai, Kiswahili, and Turkana.

> *"Agreeing to work together to address the causes of our time in our communities has been one of the best things that has taken place in our communities. This is new. We have never seen Muslims and Christians come together to do small projects that are addressing our own needs in our communities."*
>
> **IMAM (MUSLIM FAITH LEADER) IN MACHINGA, MALAWI**

IMPACT

Encouraging Uptake of Health Services
After this initial mobilization training, faith leaders encouraged the uptake of health services using their existing platforms, meetings, and services. In some cases, faith leaders worked hand-in-hand with other community leaders to organize community meetings and events. These meetings and events are instrumental in encouraging community members' participation in RMNCH initiatives within their communities. For example, in Turkana, Kenya, faith leaders organized health promotion activities using flipcharts and drawings to reach those unable to read with information related to hand hygiene, environmental sanitation, and other health-related topics.

Unity Among Faith Communities
This vision casting for change in the community's process emphasized the need for unity and collaboration among faith communities. Though there are differences among varying faith traditions (and even among sects within faiths), this training helped faith leaders realize that they are affected in similar ways by health issues and other challenges in the community. In some communities, it had been rare for leaders of different faiths to come together to learn or solve community problems collectively. This work helped faith communities see their role in supporting healthy communities both spiritually and holistically.

Mobilizing Faith Communities for Community Development
The *Making Our Communities Better* workshops helped faith leaders understand the importance of mobilizing their congregations and communities. As a result of participating in this training, faith leaders recognized that they were able to influence a strong force of volunteers able to serve in their communities. Mobilizing their members and other willing leaders in the community became essential when recruiting volunteers for other interventions later in the SCOPE Project.

Moreover, *Making Our Communities Better* promoted using locally available resources to address community needs. After the training, faith leaders, who were organized in groupings called "faith networks," identified community needs they could address without external help. In addition to supporting family planning and reproductive health initiatives, faith leaders also worked with other community leaders to mobilize resources from within their communities to mend roads, build bridges, and encourage girls to return to school.

FAITH ENGAGEMENT: *FAMILY LIFE EDUCATION*

Once faith leaders were mobilized and engaged in broad-based community development efforts, SCOPE introduced the next level of capacity strengthening: to build their communication skills and lead community dialogues on family planning/reproductive health.

This was done using the SCOPE-adapted version of *Family Life Education: Teaching Adults to Communicate with Youth from Christian and Muslim Perspectives*. Originally developed by FHI 360's YouthNet program for Christian audiences, this curriculum was later adapted by JSI's Advancing Partners and Communities project for use in Uganda. SCOPE further refined this resource to speak to both Christian and Muslim audiences using Biblical and Quranic references. SCOPE also broadened the audience so that faith leaders were trained not only to speak with youth but also with members of the wider community about RMNCH-related issues.

Because this curriculum had never been used in the four SCOPE countries, a representative group of over 1,400 faith leaders taken from faith institutions engaged at national and sub-national levels were brought together in a series of workshops to introduce the curriculum, as well as gather feedback to support further contextualization of the material to local contexts. Faith leaders' response to the curriculum was overwhelmingly positive, but they also gave critical, constructive input to strengthen the material. After working collaboratively with these faith leaders in a series of workshops amongst all four countries, SCOPE was confident in the acceptability and buy-in of this training curriculum amongst the 1,469 faith institutions.

After this buy-in and contextualization process, SCOPE trained 5,826 faith leaders to become *FLE* educators across the four SCOPE countries. Faith leaders who completed the training were equipped with the tools and skills needed to talk about highly sensitive issues, such as family planning, sex, and reproductive health, to the youth in their congregations and communities. 96.5% of faith leaders reported increased self-efficacy and confidence after the *FLE* training. *FLE* educators reached 57,578 youth (ages 10 to 24 years) and 75,923 young adults above 24 years.

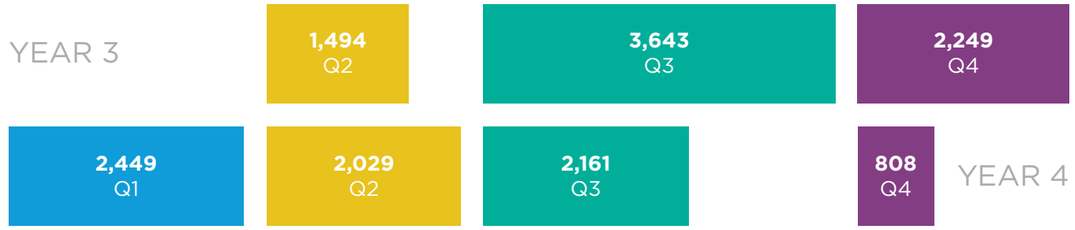
The *FLE* Trainer's Guide and Participant Handbook is available on the Faith Engagement webpage. Resources are also available in Chichewa, Swahili, Turkana, Maasai, and Haitian Creole.

IMPACT

Increasing Demand for Services
Faith leaders often have a critical role in motivating (or deterring) community members to seek and access health services. SCOPE used *FLE* to motivate and build the capacity of faith leaders and faith communities to engage with key RMNCH issues. These tools were designed to deconstruct religious and social barriers to health and equitable gender relations and to equip faith communities to respond compassionately and practically to the serious RMNCH challenges in their communities. As a result, there was increased demand for family planning and sexual and reproductive health services in all communities where the Project was implemented.

Supporting Positive Social-Behavior Change on the Community Level
Cultural and religious beliefs and practices can be barriers to social-behavior change, while faith leaders often have the moral authority to raise awareness and influence attitudes, behaviors, and practices.

NUMBER OF FAMILY PLANNING REFERRALS MADE BY FAITH LEADERS



14,833 REFERRALS FOR FAMILY PLANNING WERE MADE BY FAITH LEADERS

With proper tools such as *FLE* at their disposal, leaders can leverage their authority constructively. The curriculum contributed to breaking some of the harmful beliefs, religious practices, and social barriers that have contributed to serious RMNCH challenges within these communities. SCOPE's curriculum equipped faith actors with the knowledge and skills to support positive shifts in behavior that can have a lasting effect on critical health issues.

Providing a Key Source of Referrals
Once mobilized and trained, faith leaders are a source of linkage between the community and health system, as they become a mechanism of the local referral system. Faith leaders not only provided evidence-based information to their communities, but were also trained to make referrals from the communities to the CHWs and nearest health facilities. In this way, they can speak to the local community's faith and values while acknowledging that trained health professionals best tackle issues related to health and illness. This referral relationship strengthened CHWs' work and highlighted the intersectionality between key influencers who can drive social norm change. Faith leaders are also encouraged to provide linkages to broader community groups such as Care Groups and couples' groups.

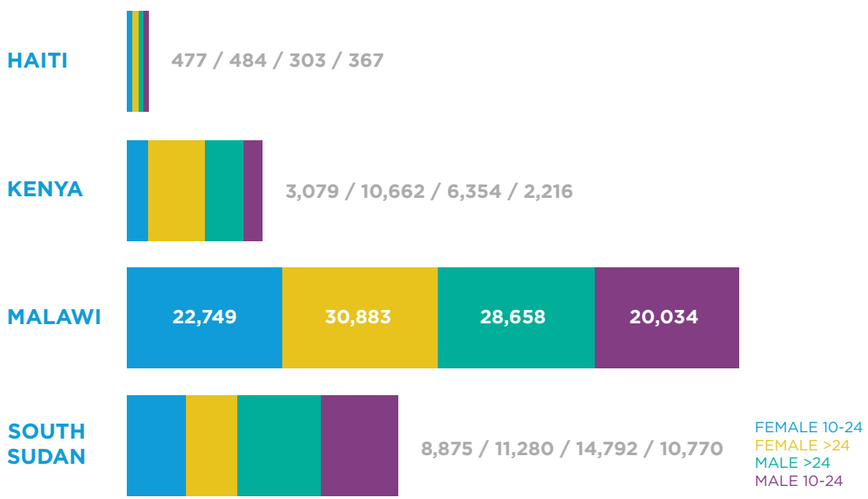
FAITH ENGAGEMENT LEARNINGS

Setting a Foundation for Faith Leader Buy-in Before Project Implementation
Mobilizing faith leaders and community leaders using the *Making Our Communities Better* curriculum increased the success of the subsequent project interventions. The curriculum facilitated the needed mindset and belief-systems change, which are critical to the success of any project in the start-up phase.

Equipping Faith Actors in Social-Behavior Change
Harmful cultural and religious beliefs and practices can hinder social-behavior change, and faith leaders often have the moral authority to raise awareness and influence attitudes, behaviors, and practices. With the proper tools, leaders can leverage their authority constructively. The *Making Our Communities Better* curriculum equipped faith actors to support the positive shifts in behavior needed to address the critical health issues their communities face.

Engaging Faith Leaders Early for Buy-In and Adaption by Context
Contextualizing the curriculum proved valuable as SCOPE worked with each county's national and regional faith leaders to ensure the material was culturally appropriate while advancing the intended key family planning messages. Faith leaders provided input, expressed concerns, and demonstrated significant buy-in and ownership of the SBCC messages. The tool may not have been widely accepted and used without this process.

ADULTS (>24 YEARS OLD) REACHED WITH FAMILY PLANNING MESSAGES BY A FAITH ACTOR



Broadened the Intended Audience

The adaptations of the *FLE* curriculum to include multiple faiths broadened the intended audience. The inclusion of Muslim and Christian scripture ensured that major faiths in project areas were included, and strengthened the capacity of faith leaders to communicate on sensitive family planning and reproductive health topics to community members, including youth. Being able to learn in the context of "faith language," as scripture affords, was self-reportedly a significant incentive for faith leaders to adapt even the more difficult topics and disseminate them within their communities.

Process Adaptation for Low Literacy Facilitators

In some SCOPE communities, finding faith leaders who could read and write was difficult, which could have been an obstacle to facilitating the *FLE* curriculum among faith communities. The selection criteria and process were thus adapted based on the faith leaders' commitment to serving their community. Instead of requiring all *FLE* educators to be literate, the criteria were revised to state that at least one *FLE* educator (one from each faith institution) could read and write in the local language(s). Others who could not read and write but were committed to serving their communities could still be included in the training program. Staff helped lower-literacy faith leaders memorize the key messages of the curriculum and provided them with regular support as they delivered lessons to targeted groups.

To read more about SCOPE's Faith Engagement work please see the Faith Engagement webpage, SCOPE Technical Brief: Faith Engagement, Blog Post: Embracing Uncomfortable Conversations: 4 Lessons We Learned Engaging Faith Leaders in Family Planning.

HAITI

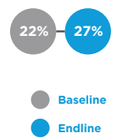
SUMMARY & RESULTS

2X

IN HAITI THE mCPR NEARLY DOUBLED FROM 10% TO 18%

IN HAITI VISITS INCREASED FROM 33% TO 35%

4+ ANTENATAL CARE VISITS



PERCENTAGE OF COUPLES WHO REPORTED DISCUSSING FAMILY PLANNING WITH THEIR SPOUSE IN THE LAST YEAR

GEOGRAPHIC IMPLEMENTATION AREAS

- South Department, Les Cayes: Fonfrede, Laurent and Laborde communal sections
- Southeast Department, Belle Anse: Pichon, Mapou and Bel Air communal sections

STATISTICS

- Maternal mortality rate: 350 deaths per 100,000 live births[1]
- Under-five mortality rate: 59 deaths per 1,000 live births[2]
- Infant mortality rate: 45 deaths for 1,000 live births[3]
- Contraceptive prevalence rate: 34%[4]

HIGHLIGHTS FROM LIFE OF PROJECT

Improved Access to Family Planning

By strengthening the capacities of ASCPs and their supervisors, SCOPE Haiti extended basic health services in the South and Southeast Departments' communities, especially in regard to family planning. Increased access to and utilization of modern family planning methods is a key outcome measure for SCOPE. SCOPE made significant progress in increasing couple communication about family planning and made huge progress on the use of modern contraceptive methods. At the Haiti endline, the mCPR has more than doubled in the target population. These higher numbers testify to the Project's success in increasing mCPR use amongst hard-to-reach remote, rural communities where commodity stockouts are frequent.

Reinforced Health-seeking Behavior through Community-based Health Education

SCOPE Haiti trained faith leaders to share key health promotion messages with their congregants, focusing on hygiene and disease prevention, child and maternal health, and sexual and reproductive health. Faith leaders then disseminated this knowledge to the community, integrating the faith

1 World Bank Group. "Haiti." Gender Data Portal. Accessed January 8, 2024. https://genderdata.worldbank.org/countries/haiti/#:~:text=350%20women%20die%20per%20100%2C000,higher%20than%20its%20regional%20average.

2 UNICEF. "Haiti." UNICEF Data. Accessed January 8, 2024. https://data.unicef.org/country/hti/.

3 UNICEF. "Haiti: Child Survival." UNICEF Data. Accessed January 8, 2024. https://data.unicef.org/country/hti/#child-survival.

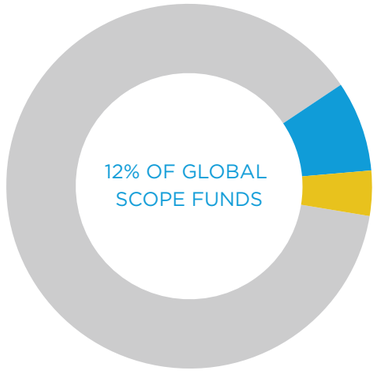
4 World Bank. "Contraceptive prevalence (% of women ages 15-49)." World Bank Data. Accessed January 8, 2024. https://data.worldbank.org/indicator/SP.DYN.CONU.ZS.

community within the community health system. As a result, this community-led approach integrated faith institutions into the broader primary health system, supporting the overall enabling environment for improved health-seeking behavior.

CONTEXT

Haiti faces numerous healthcare challenges, particularly in maternal and infant health. Maternal health is a significant concern due to elevated mortality rates and limited access to quality healthcare. Insufficient access to skilled birth attendants and quality antenatal care services adds to poor outcomes during pregnancy, emphasizing the call for improved antenatal and PNC. Similarly, Haiti encounters substantial challenges in achieving optimal infant health outcomes, marked by the highest under-five mortality rates in the Western Hemisphere. Factors such as malnutrition, poor sanitation, and restricted access to immunization services contribute to infant and child health gaps. The scarcity of health services in the SCOPE Project areas posed a challenge to the health system's adaptability. Additionally, factors such as earthquakes, flooding, and escalating insecurity within Haiti compound these challenges, further straining the health system's capacity. In a responsive health system, supply should be able to adapt to demand. However, the lack of resources in these health facilities hinders the health system's capacity to adapt.

SCOPE HAITI FUNDING



$2.4M (8.4%)
HAITI DIRECT
COUNTRY SUPPORT

$986K (3.4%)
HAITI TECHNICAL
SUPPORT

$25.4M (88.2%)
OTHER SCOPE
COUNTRIES

The fragile socio-economic context of Haiti has become increasingly insecure, especially after the assassination of President Jovenel Moïse in July 2021. Gangs control sections of the national roads connecting Port-au-Prince to the South, thus increasing the risks of kidnapping, robbery, and rape. Daily activities and transportation have become severely restricted for people in Port-au-Prince, which impacts World Relief's operations and programs. The country's inflation rate has also rapidly risen, causing a dramatic increase in prices and making economic activity challenging.

Les Cayes is the capital port city on the southern peninsula of Haiti. While it is peri-urban, most people rely on subsistence agriculture as their main source of income. Les Cayes is prone to hurricanes and other severe storms that can damage buildings and displace communities, including a magnitude 7.2 earthquake near the city that occurred in August of 2021. The earthquake killed over 2,200 people and injured nearly 13,000 people, most of whom were in Les Cayes and the surrounding areas. While this earthquake caused extensive damage, there is still a functioning airport and hospital as well as a major highway that reaches Port-au-Prince, helping to facilitate the transport of goods into the region. Les Cayes has two health centers with beds and one central referral hospital, but it also has several health centers with neither beds nor dispensaries. It is worth noting that most health services are concentrated in the town of Les Cayes.

Belle Anse is generally more mountainous and rural than Les Cayes and remains one of Haiti's poorest areas. The infrastructure throughout this department is very weak, making access to towns and localities by road challenging (some are only accessible on foot). Belle Anse is also susceptible to flash flooding, landslides, and mudslides during hurricane season (June to November). Major flooding and an earthquake in June 2023 cut off many routes to Belle Anse from neighboring departments and cities. The remoteness also contributes to a resource-poor health system; there is only one departmental hospital with a few smaller health clinics or dispensaries throughout the area. Most of the functioning health facilities are separated by difficult terrain.

CAPACITY STRENGTHENING OF WORLD RELIEF HAITI

General Implementation Conditions
World Relief Haiti's leadership discussed the difficulty of the implementation conditions in Haiti in 2019-2023. The significant unrest, lack of security, and deteriorating conditions caused the Project significant obstacles. These included a lack of security for technical support travel and routine monitoring of the Project, a "brain drain" out of Haiti which impacted World Relief Haiti's ability to hold on to qualified project staff, the inability of local staff to travel as frequently as planned at the field-level, and the precariousness of financial and civil society structures which exposed the organization and project to potential fraud, corruption, and lack of personal safety. This, combined with COVID-19 and the general weather-related conditions in Haiti (earthquakes, flooding, drought), caused an extremely challenging implementation environment for SCOPE.

Strengthened Organizational Systems
To respond to the challenging conditions in the country, World Relief Haiti placed resources into implementing geographies to provide better security for staff and reduce the amount of travel required by the Project. Locally placed offices, vehicles, and field coordinators in field-locations of Les Cayes and Belle Anse allowed Project implementation to continue even when travel from Port-au-Prince was limited. World Relief Haiti also strengthened internal staff capacity by providing a medical professional who, in addition to supporting SCOPE's day-to-day activities, also advised staff on wellbeing and health issues. World Relief Haiti's country office capacity was also strengthened by the presence of several technical staff recruited by SCOPE. Although World Relief Haiti consistently recruited qualified technical support to maintain a high standard in meeting donor rules and regulations, attrition remained a problem throughout the life of the Project.

Financial Management
As conditions in the country deteriorated, careful financial management was central in protecting against fraud. Funds were carefully controlled by central staff in Port-au-Prince, and payments were made at the local level by main office support staff using mechanisms for significant checks and balances. The team also relied on routine support from SCOPE global financial staff, who maintained significant oversight of monthly project finances.

Monitoring, Evaluation and Learning Strengthening
Due to insecurity in the summer of 2022, SCOPE Haiti was not able to conduct a midterm evaluation. With the support and advocacy of the USAID Haiti Mission, however, the Project was able to conduct a valuable endline evaluation that revealed the lasting impact of the SCOPE Project.

STAKEHOLDER COLLABORATION

World Relief engaged with a wide array of stakeholders throughout SCOPE's project cycle. SCOPE leveraged existing networks established by World Relief, including collaborating with their Faith Network Committees. Additionally, SCOPE engaged with the local government entities and the Ministry of Public Health and Population (MSPP). Local authorities were also integrated into SCOPE activities. For example, the state representative at the communal level (CASEC) of Mapou welcomed SCOPE's initiative and attended the sessions to become a *FLE* educator. SCOPE worked especially closely with the CASEC during the closeout process to gather feedback and handover any activities to other actors. While security was often an issue, where possible, World Relief Haiti prioritized participation in technical working groups and collaboration with other implementing partners in Haiti. SCOPE implementation yielded new opportunities for World Relief Haiti, including funding from UNICEF and Bureau for Humanitarian Assistance in Belle Anse and Les Cayes. World Relief Haiti plans to continue to build on these investments, SCOPE Project technical design, and the functional working relationship with the departmental health authorities.

HEALTH SYSTEM STRENGTHENING THROUGH COMMUNITY HEALTH WORKERS

In response to the impact of the 2010 earthquake, the MSPP implemented a new model of community health. This model is based on delegating tasks to community health agents known as ASCPs and auxiliary nurses, or AIPs, who supervise ASCPs. This model was designed to offset some of the burdens of healthcare professionals and health facilities on health education and community-level health tasks. Haiti's health facilities are consistently understaffed and struggle to retain healthcare professionals for many reasons, including insufficient funding for the health system, limited access to quality education, challenging geographic terrain, and the cultural norms for healing practices provided by traditional doctors.

To help address the human resource and other community health gaps, SCOPE prioritized the mobilization, awareness, information, and education activities in hard-to-reach communities. SCOPE recruited ASCPs and AIPs and supported them financially through a stipend program as well as through extensive training and supervision mentorship. In collaboration with MSPP, SCOPE trained and supervised ASCPs and AIPs as they carried out community health activities. To improve maternal health and family planning services specifically, SCOPE provided training and supervision to community service providers in the areas of sexual and reproductive health. SCOPE also provided ASCPs and AIPs with supplies and equipment. As a result, ASCPs were able to identify and care for pregnant women who presented with signs of danger, and treat children under five who exhibited respiratory problems. Their efforts also contributed to reducing early pregnancy and increasing the spacing of births.

ASCPs conducted an average of 3,800 monthly household visits and reached 10,255 people per month with family planning messages. 3,147 WRA were sensitized monthly. Community members shared that they appreciated ASCPs and their work in their communities, especially immunization efforts. SCOPE-supported ASCPs set up vaccination stations directly within the community, making essential healthcare services more accessible for children. For example, the Assembly of the Communal Section of Fonfred highlighted that mothers in the region no longer needed to walk for two hours to vaccinate their children.

Going forward, more investment is needed to sustain community health efforts. Although ASCPs and AIPs were trained in the screening and prevention of malnutrition, they were not able to adequately screen women and children due to the lack of supplies. Moreover, under-resourced health centers may not have the ability to treat referred individuals. Pregnant women also experienced high transportation costs and health facility fees (if they visit private facilities that request fees from their patients).

Despite these constraints, SCOPE built the capacities of CHWs. To continue to strengthen the capacity of the community health system, SCOPE identified simple actions for any partner to consider in implementing similar programming: (1) encourage and program for the participation and support of the entire community, (2) advocate for the availability of materials and inputs by all levels of the health system, and (3) practice formative supervision as a performance-strengthening and evaluation tool.

COMMUNITY GROUPS: CARE GROUPS

In Haiti, SCOPE addressed maternal and health gaps in the existing health system through Care Groups (called Outreach Groups in Haiti). Health centers in rural areas are often hard to reach, contributing to low health-seeking behaviors among pregnant and lactating women. For example, many births occur at home in rural areas, leading to harmful practices influenced by superstitions, such as not washing children for several days after their birth or asking a *marabou* (Haitian term denoting someone of mixed race) to cut the children's umbilical cord. These practices sometimes result in newborn fatalities, contributing to Haiti's already high infant mortality rate.

World Relief Haiti engaged 102 Care Groups to share SBCC messages and reinforce the use of community services in Belle Anse and Les Cayes. World Relief Haiti's network of local churches, faith networks, and faith community volunteers were instrumental in mobilizing and training Care Group Volunteers. Care Group Volunteers shared lessons on key reproductive, maternal, child, and newborn health messages with at least six neighboring households. Through the Care Groups, SCOPE Haiti mobilized 292 Care Group Volunteers, thereby reaching 1,248 households. This approach was well-received due to its reliance on trusted community institutions, and led to positive behavioral changes, particularly regarding hygiene, under-five nutrition, prenatal and postnatal visits, and family planning.

Because of the frustration expressed to Care Group Volunteers by neighbor women who were unable to access essential products, such as bed nets or vitamins, community members requested these be distributed during home visits. As a result, SCOPE Haiti advocated with MSPP to ensure additional supplies and materials were available at the community level, supporting ASCPs in their distribution.

Haiti Endline Evaluation focus group discussions revealed that Care Groups played an important role in increasing awareness of sickness and how to access health care instead of traditional medicine or traditional healers. Mothers also reported better food habits, knowledge of family planning, and better hygiene-related behaviors. One mother from Belle Anse was among those who experienced a shift in her own health-seeking behavior. She previously followed traditional practices that made her children ill. Still, her experience with Care Groups led her to make better healthcare decisions for her children:

"Before, children used to get sick more often. Now, children don't get sick easily; we have learned to weigh children in the center. We know how children's health evolves now. We know how to prepare food for children, for their weight gain and loss, and what kind of fruit to give them. We know better about breastfeeding. We become better with the children."

SCOPE's Care Groups helped extend the reach of under-resourced CHWs amid complex and compounded crises. To continue improving family planning and maternal child health outcomes, other implementing partners should consider the following: (1) Improving community health outcomes requires addressing supply chain issues and ensuring that essential health supplies are readily available. Community frustration arose as Care Groups raised awareness about necessary materials, like bed nets or vitamins, that Care Groups couldn't distribute during visits. Residents requested an organized distribution in the community or the provision of products during home visits to address this issue. SCOPE Haiti worked to advocate with MSPP to obtain additional supplies and materials and supported ASCPs to ensure their distribution to more communities where Care Groups operated. (2) Greater engagement with men and partners of WRA supports deeper norm shifting. Data from men showed a willingness to engage with topics related to family planning and maternal and child health. For more sustainable results, SCOPE recommends deeper engagement with male partners of WRAs. (3) Consider how compensation disparities can impact volunteer retention and community relationships. Compensation disparities between Care Group Volunteers and ASCPs in a multi-year project resulted in volunteer dropouts, with a significant wave occurring when volunteers from the same communities began comparing remuneration. A subsequent survey revealed that 74% of volunteers lacked employment opportunities and viewed Care Group roles as a form of compensation to support their families, prompting SCOPE Haiti to address challenges through a dedicated meeting and refresher trainings on program methodology and project scope, after which some volunteers returned to support project activities.

FAITH ENGAGEMENT: *FAMILY LIFE EDUCATION*

In Haiti's rural areas, the Church is often the most respected institution next to community leaders and state officials. Dozens of churches in each communal section bring hundreds of people together every Sunday and throughout the week. Church leaders are often among the few literate people in a community and are often called upon for advice or consulted to resolve conflicts. Faith institutions, including Catholic, Protestant, or indigenous Voodoo, are often the first-line responders to community needs, especially when the government cannot provide a social safety net. Many Christian churches avoid discussing sex, contraceptives, and family planning due to religious beliefs that advocate for larger families and discourage premarital sex. The conservative values of the community, especially within church congregations, often equate discussing sex with sinful behavior. Many parents are unprepared to discuss sexuality with their children, often considering it a taboo topic, and therefore keep silent on the subject within their families. Given that the pregnancy rate for adolescent females is higher in Haiti than in other countries in the region, a key need in rural Haiti is sexual and reproductive health education among youth. SCOPE implemented the *FLE* program to equip faith leaders in communicating about sexual and reproductive health in a faith context.

Through SCOPE, *FLE* empowered church members to become educators for the youth and adolescents in their community. These trained congregants helped train 413 *FLE* educators, who, in turn, provided sexual and reproductive health education in schools, churches, and community gatherings, reaching 1,631 people, including 844 youth. The topics covered included sexual development, menstruation, abstinence, the dangers of drugs and alcohol, family planning, and pregnancy preparation. Discussing sexuality was initially challenging for the trainers, given the social taboo around these topics, but the FLE program captured the attention of local churches and communities.[1] Despite the church's strict doctrines regarding sexuality, most *FLE* sessions took place within the church and were conducted by church leaders and members. They emphasized providing accurate information to counter harmful influences, such as misleading online content. The outcomes of these sessions underscored the importance of *FLE* in the community. Young people learned about expected changes in the body, the origin of sexual desires, the significance of waiting until they were ready for sex, as well as the risks of sex and drug addiction, and how to plan for a family. Unlike traditional ways of discussing this topic, young individuals appreciated that *FLE* presented sex as a normal human desire. These messages, particularly for girls, addressed the pressures they faced regarding sexual activity, educated young men on the concept of "harassment," and helped both sexes resist engaging in sex under pressure or manipulation. Many sexually active youths expressed wanting to practice abstinence until they were economically and emotionally prepared for a committed relationship. One faith leader in Belle Anse shared,

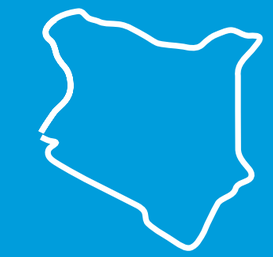
"I feel more comfortable talking about sexual health and family reproduction thanks to the training [FLE]; even young children have come to understand because a lot of young parents are still children themselves."

Faith leaders are critical to shifting behaviors and social norms, especially regarding health behaviors. World Relief recommends that other implementing partners consider linking faith leaders to the community health system to further promote family planning/sexual and reproductive health and healthcare-seeking during pregnancy, delivery, and postpartum.

1 While some churches were reluctant to discuss contraception within their assemblies, they allowed trainers to convey the message in settings outside of the services, while others had no issues sharing all messages within church services and gatherings. The most controversial portion of the training was family planning, as some churches didn't feel comfortable sharing openly about contraceptive methods.

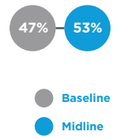
KENYA

SUMMARY & RESULTS



IN KENYA 89% OF REFERRALS WERE COMPLETED

IN KENYA CHW HOUSEHOLD VISITS INCREASED FROM 13% TO 51%



PERCENTAGE OF COUPLES WHO REPORTED DISCUSSING FAMILY PLANNING WITH THEIR SPOUSE IN THE LAST YEAR

GEOGRAPHIC IMPLEMENTATION AREAS

- Kajiado County: Kajiado West and Kajiado North sub-counties
- Turkana County: North Turkana and Kibish sub-counties

STATISTICS

- Maternal mortality rate: 530 deaths per 100,000 live births[1]
- Under-five mortality rate: 37 deaths per 1,000 live births[2]
- Infant mortality rate: 28 deaths per 1,000 births[3]
- Contraceptive prevalence rate: 63%[4]

HIGHLIGHTS FROM LIFE OF PROJECT

Supported the Establishment of Community Health Units

Feedback from County Health leaders applauded World Relief Kenya for its effective implementation of the Kenya Community Health Strategy. Through SCOPE Kenya, World Relief supported the establishment of fully operational community health units within Turkana and Kajiado, which continue to provide a wide range of basic health services. These units have become pillars of healthcare delivery, fostering a profound sense of community ownership and engagement in local health decisions. With SCOPE's support of CHVs and their supervisors, SCOPE's approach bridged the gap between policy and implementation, making the Community Health Strategy a tangible reality. In Turkana, the MOH has recognized the tremendous impact SCOPE Care Groups had in improving health indicators and expanding the reach of CHVs. As a result, the Turkana county government allocated a budget to continue paying CHV stipends (initially paid by SCOPE Kenya during the Project), ensuring the continuation of CHV-led activities after the Project ends.

1 World Bank Group. "Kenya." Gender Data Portal. Accessed January 8, 2024. https://genderdata.worldbank.org/countries/kenya.

2 UNICEF. "Kenya." UNICEF Data. Accessed January 8, 2024. https://data.unicef.org/country/ken/.

3 UNICEF, "Kenya."

4 UNICEF. "Maternal Mortality." Maternal Health. UNICEF Data. Accessed January 8, 2024. https://data.unicef.org/topic/maternal-health/maternal-mortality/.

Integrating Care Groups with Community Health Volunteers
SCOPE Kenya engaged CHVs as Care Group Promoters, allowing the Care Group model to seamlessly integrate into the MOH framework, expanding CHVs' roles and connecting Care Groups to MOH core structures, which improved service delivery in both counties. At the end of the SCOPE Project, the Turkana government committed to replicating the Care Group model, including the provision of stipends for CHVs to continue as Care Group Promoters (which had been covered by World Relief throughout implementation) after SCOPE's conclusion. The county's commitment showcases the Care Group model's potential and underscores its adaptability and transformative impact on the health system.

Fostering Unity Amongst Faith Leaders
SCOPE Kenya fostered unity among a diverse group of faith leaders, including Muslims, Christians, and traditional healers. By acknowledging common concerns, including negative health-seeking behavior, teen pregnancy, and increased substance abuse during the pandemic, leaders were able to unite to engage local resources and community members. SCOPE created an inclusive and open environment for challenging discussions through the *Making Our Communities Better* curriculum. Tackling complex societal issues often necessitates candid and open discussions, especially when deeply held beliefs are at play. SCOPE effectively bridged diverse faith communities, fostering dialogue and mutual understanding.

Health System Strengthening through County Health Department Subcontract
Through a $4.6 million add-on to the SCOPE RMNCH grant, World Relief was asked to incorporate a COVID-19 component to accelerate widespread and equitable access to effective COVID-19 vaccinations, mitigate transmission, and strengthen health systems to prevent, detect, and respond to pandemic threats in the Democratic Republic of Congo, Kenya, Malawi, and Rwanda. Through SCOPE COVID-19, World Relief administered the first USAID subcontract to a county health department in Kenya. The Project was built on existing structures to support vaccine outreach services in remote, last-mile populations. World Relief implemented a government-to-government COVID-19 project with Kenya's Nakuru County Health Department to do the following: train CHWs in community event-based surveillance with a focus on infection prevention and control, procure infection prevention and control and WASH consumables based on needs identified by County Health Departments, plan mobile/express COVID-19 vaccination campaigns and vaccination drives at faith centers and health clinics – in tandem with other relevant ministries and community stakeholders – to reach over 100,000 people with vaccines.

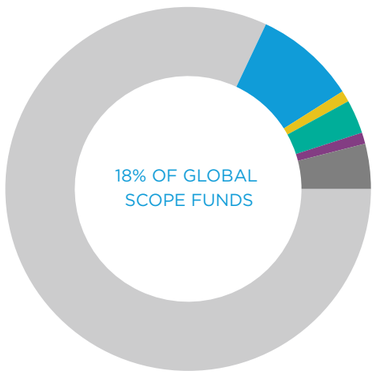
CONTEXT

Over the past three decades, Kenya has shown substantial progress in improving maternal, newborn, and child health indicators, significantly reducing maternal mortality and total fertility rates. The country's fertility rate dropped from 5.4 births per woman in 1993 to 3.4 in 2022, accompanied by increased contraceptive use among WRA. These improvements have also led to a decline in infant and child mortality, as reflected in the 2022 health statistics. SCOPE implemented projects in Turkana and Kajiado, where the rough terrain and long distances to healthcare facilities pose significant challenges to improving RMNCH indicators.

In Turkana, the Project focused on the Turkana North sub-county and Kibish sub-county, which are mainly rural and semi-arid, where frequent droughts impact people's livelihoods and food security. The predominant livelihood is pastoralism, with communities relying heavily on livestock for sustenance and income. The remoteness of Turkana makes access to health facilities challenging, in addition to those facilities being under-resourced. Unlike Turkana's semi-arid and rural settings, Kajiado is a mix of urban and rural areas. SCOPE encountered problems related to urbanization, changes in land use, and the evolving dynamics of community life. The main livelihoods in Kajiado County are herding and farming, showing how this area is changing as it adapts to city influences. In Kajiado North, the SCOPE program was implemented in urban slums, which face major sexual and reproductive health challenges with high rates of unplanned pregnancies, sexually transmitted infections, and poor maternal and child health outcomes.

Cultural practices such as early marriage and giving birth at home are predominant, wherein women are admired for their strength. These practices can make it harder to reach the desired RMNCH outcomes. Notably, Kajiado and Turkana counties are below the national averages across various key indicators, including the low uptake of family planning services, and high maternal and infant mortality rates.[1]

SCOPE KENYA FUNDING



$2.5M (8.8%)
KENYA DIRECT COUNTRY SUPPORT (RMNCH)

419K (1.5%)
KENYA SUBAWARD (RMNCH)

$799K (2.8%)
KENYA DIRECT COUNTRY SUPPORT (COVID-19)

197K (.7%)
KENYA SUBAWARD (COVID-19)

1.1M (3.8%)
KENYA TECHNICAL SUPPORT

23.7M (82.4%)
OTHER SCOPE COUNTRIES

CAPACITY STRENGTHENING OF WORLD RELIEF KENYA

Enhanced Monitoring, Evaluation, Accountability, and Learning Systems
World Relief Kenya's leadership commended SCOPE on using standard indicators, submitting to rigorous ethics review processes, and developing research studies and abstracts as evidence of its commitment to industry best practices. Several of these practices were new to World Relief Kenya and enhanced data quality, programmatic decisions, and project effectiveness. World Relief Kenya also commented on SCOPE's commitment to strengthening existing data systems as well as minimizing the data burden on staff, volunteers, and especially clients.

Strengthened Financial Systems
World Relief Kenya commented on SCOPE's approach to agility in making annual adjustments and realignments (within USAID allowability) based on greatest needs and impact. This practice allowed for resources to be directed where they could have the most positive impact and was strengthened by a commitment to routine budget reviews that enabled timely decision-making. Budgeting in SCOPE was highly detailed, down to the activity level, facilitating easier reporting and expenditure monitoring.

Project Design
World Relief Kenya commended SCOPE on developing workplans and sharing them with the County Department of Health in the early stages of the Project. This approach ensured transparency and set clear mutual expectations. USAID's requirement for workplan co-design and approval by the Mission and County Health Department added transparency and ownership to the process. This collaborative approach ensured project activities aligned with county health strategies and engaged a variety of stakeholders, such as churches, planning committees, and Sub-County Health management teams. It also helped with avoiding duplication of efforts. World Relief Kenya plans to continue future project development in collaboration with all such stakeholders.

1 The DHS Program. "Demographic and Health Survey (2022)." Accessed January 8, 2024. https://dhsprogram.com/pubs/pdf/PR143/PR143.pdf.

STAKEHOLDER COLLABORATION

SCOPE established strong partnerships with various local, community, and national stakeholders to achieve its program goals. The MOH provided consistent support at every program stage through the County Health Management teams and Sub-County Health Management teams, from conducting joint supervision and hosting data review meetings to providing trainers for various technical topics for CHVs. This in-depth collaboration enabled a robust partnership and contributed to positive impacts within the health system itself. A key strategy within SCOPE was linking the health system with other influential leaders, as well as local Care Group Volunteers who cascaded lessons to thousands of neighboring women. SCOPE also engaged faith leaders within the Faith Network Committees and across faiths and denominations. The County Health Management teams, as well as the CHVs, interacted heavily with faith leaders, supporting each other for family planning referrals and other community health outreach events. SCOPE played a coordinating role, ensuring smooth communication throughout the program, leveraging World Relief's trusted relationships with faith leaders and the MOH.

SCOPE also collaborated with consultants based in Kenya for data collection and a consultant based in the United States for study design and analysis of the *Families Together* research study, as well as for the Midterm Evaluation. These partnerships provided valuable expertise and support throughout the program.

External Engagement
Overall, SCOPE contributed to elevating World Relief Kenya's national profile and establishing connections with USAID and other important technical working groups. The Project's impact is evident through sustained engagement in various networks and positive feedback from faith leaders and communities. To leverage for future programming, World Relief Kenya plans to continue its involvement in project networks, technical working groups, and maintaining engagement with USAID Kenya. The Project's success also highlighted the importance of staff capacity building, especially in handling faith-based engagement in future projects.

HEALTH SYSTEM STRENGTHENING THROUGH COMMUNITY HEALTH WORKERS

In Kenya, the community health system is aligned with national priorities and built largely on the national community health strategy policy, which designates that one community health unit should be established per 5,000 population. A community health unit includes CHVs, Community Health Extension Workers/CHAs, and a Community Health Committee.

Before SCOPE, Turkana and Kajiado faced similar challenges in ensuring community health units were functional. Challenges included inadequate financing for community-level health services, an inadequate number of CHAs, a lack of reporting tools, and limited capacity of the CHVs and CHAs – largely attributed to a lack of comprehensive training. The SCOPE Project baseline demonstrated that despite these challenges, CHVs were often cited as the most common source of health information in Kajiado and Turkana, showing that strengthening CHWs' capacity is a key mechanism for driving social and behavioral change communication.

SCOPE evaluated the fundamental operational aspects of CHW programs to garner a deeper understanding of the context and challenges faced by the Kajiado and Turkana community health systems. This resulted in stronger relationships with in-county stakeholders, as well as greater confidence in not only SCOPE, but the CHV program's viability, individual CHV actors, and the community health system overall.

In close collaboration with the MOH, SCOPE began providing in-depth training to CHVs on topics identified as gaps during the initial assessments. CHVs were trained in RMNCH by MOH trainers using MOH guidelines and training materials.

SCOPE then transitioned into a supportive-supervision model, focusing on coaching and mentorship for CHVs. Though supportive supervision is a recommendation of the Kenya MOH's community health strategy, this aspect has frequently been identified as weak or inadequate due to only a small number of CHVs possessing post-secondary education. Since CHVs fulfill crucial roles within the community, SCOPE prioritized supervision and mentoring to foster greater retention of knowledge and skills.

Through the subaward with CCIH, SCOPE partnered with the Christian Health Association of Kenya, a local faith-based organization with multiple clinics in the SCOPE Project area, to expand its reach and facilitate partnerships between public and private health facilities. SCOPE worked with the Christian Health Association of Kenya in training and mentoring 276 CHVs (including 54 from CHAM) linked to their private health facilities.

SCOPE conducted regular supervision of CHVs and health facilities with the MOH, to ensure ongoing mentoring and supervisory efforts harmonized with the MOH's efforts. During this joint supervision, SCOPE staff and MOH supervisory staff provided support to health facilities. SCOPE enhanced the county's health information management system (DHIS2), focusing on community level reporting. In Turkana and Kajiado, there was notable progress in community health units' understanding and accurate use of key MOH reporting forms, reducing reporting gaps and improving overall care through SCOPE's provision of correct reporting tools, supervision, mentorship, and participation in regular data reviews with the MOH. SCOPE played a pivotal role in empowering community health units data management, supporting 25 units in Turkana and 27 in Kajiado. A senior county official in Turkana recognized SCOPE as a committed partner who extended its efforts even to the isolated region of Kibish in Turkana, and as a significant help in improving data indicators from "red" to "green" over the course of the Project. The Project's support at the health facility level, coupled with the integration of Care Groups, expanded the reach and effectiveness of CHVs' work, leading to tangible improvements captured in the DHIS2.

> *"I have been killing animals to heal my child [because that is what we are taught in our community]; but I have never been successful. But when the teachings [by CHV] were introduced, this situation changed for me, now I don't lose my animals. Now things are different, when a child gets sick we call the CHV and he rushes to where we are to attend on that child or refer us for treatment."*
>
> **PROJECT PARTICIPANT, TURKANA**

SCOPE's collaborative approach helped shift the perception of health facility oversight from a policing role to one emphasizing mentorship and support, particularly with regard to CHV supervisors. Joint supervision fostered improved relationships among health facility staff, MOH officials, and community health unit staff, ultimately enhancing the quality of services and health outcomes. Evaluation results showed statistically significant increases in newborn breastfeeding and CHW visits to households, highlighting SCOPE's contribution to increased CHV coverage and performance and improved quality of newborn care.

The tangible effects of SCOPE's work with CHVs are heard through a project participant in Turkana who expressed, *"the CHVs have changed many families on health matters."*

COMMUNITY GROUPS: CARE GROUPS

Community-level care in Kenya faced challenges due to limited availability and high attrition rates of CHVs, which impacted primary healthcare services at the grassroots level. SCOPE employed Care Groups as a cost-effective approach to establishing a sustainable structure, where CHVs remain essential links between healthcare providers and the local community. Unique to Kenya, Care Group Promoters (those who meet with and directly train Care Group Volunteers) also serve as CHVs, requiring a collaborative effort with the MOH and County Health Department for recruitment. Since many community health units were inactive and non-operational, recruiting CHVs was necessary to revitalize the community outreach system. This cascading approach greatly extended the normal reach of the CHV and the community health strategy.

World Relief staff provided training on Care Group Modules to CHVs, who trained Care Group Volunteers who then reached their neighbors (called neighbor women) with the same messages. In areas where health-seeking behavior is historically low, SCOPE noted significant change, as evidenced by the increase in the number of referrals made by Care Group Volunteers. As neighbor women began to embrace and apply the lessons, they experienced a personal transformation which in turn inspired them to share their newfound knowledge with other mothers. Care Groups were also noted as places where listening happens in several ways: women listen to each other and to the Promoters, and Promoters listen to the mothers and work with them to face obstacles. When droughts began to displace families or prompt seasonal migration, CHVs and Care Group Promoters proactively met with communities at common gathering spots instead of expecting them to come to designated locations. In Turkana North, meetings were organized at wells and water points, while in areas near Lake Turkana, meetings were scheduled after fishing boats returned, highlighting the flexibility and collaboration between Care Groups and CHVs in addressing community needs.

> *"There is good interaction between Care Group members. If anyone has a problem, then it can be solved together. In Care Groups, we can ask questions that we are afraid to ask at health facilities because it is comfortable and we can get answers we understand."*
>
> **WOMAN IN KAJIADO, MIDTERM EVALUATION**

Over the course of the Project, 222 promoters reached 6,278 Care Group Volunteers, who then shared the lessons with 34,326 neighbor women at the household level. This led to a notable increase in the utilization of health facility services, including an increase in antenatal care visits (over 90% increase in visits to health facilities were reported between 2021 and 2023 monitoring reports data).

The lessons focusing on child health and integrated community case management prompted changes in behavior. For example, women in peri-urban areas of Kajiado North began to understand the negative impact of disposing of dirty diapers near water sources and changed their practices, and many households in Turkana built tippy taps (including those not directly involved in Care Groups). Discussions on maternal health and essential newborn care empowered women to become advocates for reproductive health in their communities. If someone missed appointments or vaccinations, a peer volunteer offered support and encouragement to complete the recommended visits or request immunizations from CHVs. Some Care Groups expanded to form savings groups, highlighting the unifying effect of Care Groups within the community. Accountability among Care Group members led to improved health-seeking behaviors and an increased uptake of family planning services, as evidenced by the rising numbers of referrals (42% in 2021 to 57% in 2022 family planning referrals) and increased usage of family planning methods documented by CHV summary reports and facility scorecards.

COMMUNITY GROUPS: *FAMILIES TOGETHER*

SCOPE contextualized and rolled out the USAID-approved *Families Together* curriculum in both Kajiado and Turkana counties. The curriculum aims to strengthen, equip, and protect couple relationships and families, especially in making decisions about reproductive health, family planning, and the balance of power within families. Adaptation, based on feedback from Muslim and Christian faith leaders and translation of the curriculum into the local language (Turkana, Maasai, Swahili), ensured the content was relevant and accessible to all participants. *Families Together* is designed as a 10-week couple's group intervention with trained Lead Couples who facilitate participatory group sessions of 5-7 local couples, cascading knowledge and acting as the primary support system for the group. Alongside implementation, SCOPE conducted a research study to evaluate the *Families Together* intervention on family planning outcomes and couple relationship quality. Please see the *Families Together* section to learn more.

After a community-level orientation with local authorities, faith networks, and CHVs, *Families Together* selected and trained 20 Lead Couples from Turkana and Kajiado. The Lead Couples, carefully selected by local leaders, underwent an intensive training program to equip them with the skills to facilitate *Families Together* sessions effectively. The training was designed to create a safe and supportive environment for the Lead Couples to learn the curricula content, as well as practice and refine their facilitation skills. CHVs were also included during specific training days where family planning, decision-making, and methods were discussed. Including CHVs provided a unique opportunity to connect the *Families Together* program with existing healthcare structures, promoting greater collaboration and integration with the community health system. By engaging CHVs in the couple groups' catchment areas, SCOPE ensured that the sessions on family planning were relevant and relatable to the participants' lived experiences. Once Lead Couples were fully trained, the recruitment of the 280 (140 in Turkana, 140 in Kajiado) participating couples began immediately, and the 10-week sessions were held between September and December 2023.

FAITH ENGAGEMENT

Faith actors play a pivotal role in influencing the values and opinions of the community, especially in the semi-nomadic communities of Turkana and Kajiado. Even though many churches and mosques were present in SCOPE's targeted communities, most worked separately from each other and refrained from engaging in "non-spiritual" topics with their congregations. SCOPE recognized that amidst the differences in religious beliefs and practices, there existed a common concern (negative health-seeking behavior, teen pregnancy, and substance abuse) that transcended these boundaries. Since there tends to be many myths and misconceptions around family planning and other health topics, such as sexual development, menstruation, and the risks of drugs and alcohol, families generally avoid these sensitive or difficult topics. Cultural norms also impact joint decision-making and communication around health-related issues. For example, in Kajiado, a predominately Maasai culture, men usually are the main decision makers in families and "hold the final word." Husbands and wives are expected not to show outward affection to each other and, in some cases, expected not to eat together. Adolescent girls and boys are particularly vulnerable due to these communication norms and lack of access to sexual and reproductive health services and information.

Faith leaders are uniquely positioned to witness the negative impacts of such behaviors on their community. Therefore, SCOPE engaged these influential thought leaders to support behavior change initiatives in the Project areas. First, 556 faith leaders were trained in *Making Our Communities Better* and were followed up on implementing the post-training action plans they developed as part of the training. Action plans included projects to support community members in need through community construction of houses, supporting families with food items, and providing means of general hygiene and sanitation. *Making Our Communities Better* helped faith leaders grasp their pivotal role in community development.

The trainings fostered reflection, dialogue, and discovery, and encouraged leaders to envision change, rallied community members for health and development projects, and facilitated improvements in household health, with a special focus on maternal and child wellbeing. By identifying these universal issues, SCOPE teams went beyond religious divisions and united people in creating a welcoming environment where difficult conversations could be initiated. SCOPE acted as a bridge between these diverse faith communities and health service providers, encouraging dialogue and understanding among them. As a faith leader in Turkana North shared after her experience with *Making Our Communities Better*,

"The training helped us realize that we can build our communities with our own hands when we come together."

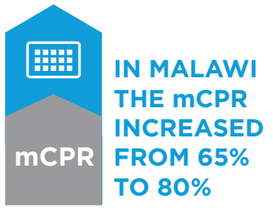
Then, building on the envisioning training from the *Making our Communities Better* workshops, SCOPE launched *FLE* and equipped 1018 faith leaders from 283 different faith institutions (1.71% Muslim and 98.29% Christian institutions) with information on reproductive and sexual health, shared decision-making, and other health topics so they could help congregants make critical choices regarding the health of their families. *FLE* educators developed action plans for sharing the messages and lessons they learned with their communities. Faith leaders shared *FLE* messages at their faith institutions and often at community gathering points – such as under trees, around water points, and at community markets and schools. Before *FLE,* leaders were more hesitant to talk about difficult topics, but with the knowledge and tools gained from the program, their ability to communicate messages on family planning, sexual and reproductive health, and the dangers of drug and alcohol use, significantly improved. *FLE* educators in Kajiado and Turkana reached 22,805 with health-related messages. SCOPE monitoring data indicated that by project end, the majority of messages were being shared about drug and alcohol use, illustrating the faith community had identified a need, and steps were being taken to address it.

To help reframe sensitive topics, SCOPE also engaged family leaders on sensitive topics. In Kajiado, SCOPE saw changes within families as fathers became more open about these topics with their children. Before the program, fathers would not talk to their daughters about topics such as menstruation, while daughters did not know how to ask for help in getting sanitary pads (since this kind of communication was not allowed or modeled). Daughters resorted to other ways of making money to purchase sanitary materials. After *FLE* training, fathers began to see the benefit of more open communication and started purchasing pads for their daughters easily and in the open. In Turkana, where men hold decision-making power, the negative connotations associated with "family planning" were overcome by using the term "family or child spacing." SCOPE worked with the community to engage men in understanding family planning and their role in empowering their partner/spouse and improving their family planning behavior. The messaging highlighted how spacing children could lead to a reduction in risky pregnancies, help the mother recover and prepare for the next pregnancy, provide time to properly breastfeed the newborn (exclusively for the first six months), and how spacing births could help increase resources (including wealth) for better child care, more food for the family, medicines, school fees, etc. This simple shift in language made men more curious and eager to hear about family planning options from faith leaders and other trusted sources such as CHVs. Through SCOPE's multi-layered approach, CHVs began working more closely with faith leaders, and faith leaders became more involved in health re
also informed sources in the community.

Even among local SCOPE staff, there was significan
after receiving the initial training from World Relief'
Technical Advisors. SCOPE staff began to share
decision-making, communicate more openly,
and practice family planning in their homes. The
adoption of practices by local staff was a powerful
example of norm shifters that gave weight to
the lessons being taught. During the very initial
trainings, some men and women would arrive
separately at the workshop, but by the end,
they arrived together, hand in hand. During
implementation, some faith leaders initially were
hesitant to discuss family planning and did not
want to join, but with support from local SCOPE
staff, they began to see the potential benefits of
child spacing and became advocates themselves in
their own communities.

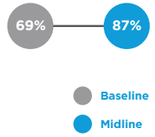
MALAWI

SUMMARY & RESULTS



IN MALAWI THE mCPR INCREASED FROM 65% TO 80%

IN MALAWI 82% OF NEWBORNS RECEIVED BREASTFEEDING WITHIN 1 HOUR OF BIRTH (57% AT BASELINE)



PERCENTAGE OF COUPLES WHO REPORTED DISCUSSING FAMILY PLANNING WITH THEIR SPOUSE IN THE LAST YEAR

GEOGRAPHIC IMPLEMENTATION AREAS

- Lilongwe District: Chimutu, Mazengera, Khongoni, Masumbankhunda, and Malili Traditional Authorities
- Machinga District: Msanama, Nyambi, Kawinga, and Nkowola Traditional Authorities

STATISTICS

- Maternal mortality rate: 310 deaths per 100,000 live births[1]
- Under-five mortality rate: 42 deaths per 1,000 live births[2]
- Infant Mortality Rate: 32 deaths per 1,000 live births[3]
- Contraceptive Prevalence Rate: 65%[4]

HIGHLIGHTS FROM LIFE OF PROJECT

Improved Supervision for Health Surveillance Assistants
SCOPE Malawi made substantial strides in expanding the reach of community-based RMNCH services. The impact of training and supervision by SCOPE Malawi was reflected in Midterm Evaluation results, which showed that 98% of HSAs had learned from supervision, and all either agreed or strongly agreed they were more motivated after supervisory visits. SCOPE supported the MOH by training HSAs as the primary CHW cadre. The Project facilitated a routine supervision system, contributing to high coverage of CHW visits and increased services provided to households. Supportive supervision occurred at multiple levels, from the community to the district to the national level. Importantly, these supervision initiatives were integrated into the functions of the district health offices, bolstering long-term sustainability in coordinated efforts to improve the quality of care for women and children in rural Malawi.

Strengthened Interfaith Relations
Collaboration with Malawi's faith leaders in *Making Our Communities Better* led to the construction and refurbishment of 16 village clinics, using resources mobilized locally by faith and community

1 UNICEF, "Maternal Mortality."
2 UNICEF. "Malawi." UNICEF Data. Accessed January 8, 2024. https://data.unicef.org/country/mwi/.
3 UNICEF, "Malawi."
4 World Bank. "Contraceptive prevalence, modern methods (% of women ages 15-49)." World Bank Data. Accessed January 8, 2024. https://data.worldbank.org/indicator/SP.DYN.CONM.ZS?locations=MW.

leaders. These efforts improved access to integrated community case management and family planning services. SCOPE's engagement also fostered stronger relationships between Christian and Muslim faith institutions, with leaders setting aside religious differences to pursue common community goals. Testimonies from local leaders, government structures, the Muslim Association of Malawi, and the Qadria Association of Malawi affirmed the effectiveness of faith leaders from diverse traditions collaborating on behalf of their communities.

Family Planning Module Developed for Care Groups
Within Malawi, Care Groups are an established government structure at the community level, primarily focused on disseminating positive messages on nutrition behavior. World Relief's Care Group Module 4 on family planning, developed and validated by Malawi's MOH, will be scaled and used nationally. The ministry plans to utilize the module to sensitize rural communities to the importance of family planning services. The MOH has already adapted the module to develop a mass communication tool for the hormonal intrauterine contraceptive device method. This extensive information sharing helps to ensure that the Project's impact extends beyond its immediate scope, fostering a broader understanding of best practices in healthcare delivery.

Reach of Emergency COVID-19 Response Extended
Through a $4.6 million add-on to the SCOPE RMNCH grant, World Relief was asked to incorporate a COVID-19 component to accelerate widespread and equitable access to COVID-19 vaccinations, mitigate transmission, and strengthen health systems to prevent, detect, and respond to pandemic threats in the Democratic Republic of Congo, Kenya, Malawi, and Rwanda. Across eight Traditional Authorities in Malawi, SCOPE provided critical assistance to MOH vaccination efforts by providing mobile vaccination clinics, extending vaccine supply chains at the district level, and supporting door-to-door vaccine messaging and administration through HSAs. Building on existing networks and community structures, World Relief also engaged in extensive risk communication and community engagement with traditional and faith leaders, community gatekeepers, and the general population to increase vaccine confidence alongside service delivery support. Overall, SCOPE COVID-19 was able to directly support the delivery of 301,976 doses of COVID-19 vaccines in Malawi.

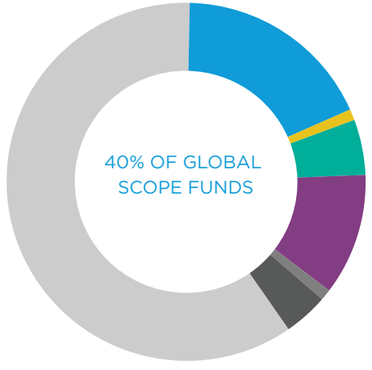
CONTEXT

Malawi achieved significant strides in reducing maternal and child mortality over the past three decades, with a one-third drop in maternal mortality and a 72% decrease in child mortality from 1990 to 2015. In recent years, however, the global COVID-19 pandemic and emerging disease epidemics like polio and cholera have strained its health system, highlighting a limited capacity in quality health service delivery. Malawi has endured the adverse effects of climate change, including cyclone disasters in 2022 and 2023, which caused flooding in implementation areas like Machinga. This disrupted road networks, hindering healthcare access and displacing thousands. In addition, behavior is another challenge to health outcomes, as there is often a delay in seeking early care or a lack of resources to access care. Fear that family planning might cause infertility or the misconception that seeking antenatal care could lead to the loss of pregnancy also poses challenges to accessing RMNCH services in Malawi.

Machinga, a predominantly Islamic district in southern Malawi, grapples with high poverty rates, particularly with 75% living in poverty and 39.2% classified as ultra-poor. The region faces issues such as teenage pregnancies, youth marriages, low literacy, and harmful cultural practices contributing to teenage pregnancies and HIV/AIDS infections. The district also struggles with low contraceptive prevalence, high maternal and neonatal mortality rates, and common child health issues. Because Machinga does not have enough health facilities to serve the size of its population, they are both highly congested, with long distances between them. Finally, Machinga has the highest rate of adolescent pregnancies in the country: 41.1% of girls ages 15 to 19 years have already given birth.[1]

Lilongwe District is primarily Christian and grapples with inadequate human resources for health services. While this is the district where the country's capital is located, SCOPE Malawi only operated in the rural areas, which remain quite poor and hard-to-reach. Here, local HSAs serve a population almost double the recommended ratio of one HSA for every 1,000 people, making it difficult to provide quality services to their communities. The leading cause of child morbidity and mortality in Lilongwe is still malaria, followed by acute respiratory infections and diarrhea, highlighting the importance of maternal and child health programming.[2]

SCOPE MALAWI FUNDING



5.2M (18%)
MALAWI DIRECT COUNTRY SUPPORT (RMNCH)

419K (1.5%)
MALAWI SUBAWARD (RMNCH)

1.4M (4.9%)
MALAWI DIRECT COUNTRY SUPPORT (COVID-19)

2.7M (9.3%)
MALAWI DIRECT COUNTRY SUPPORT (HIV/AIDS)

273K (.9%)
MALAWI SUBAWARD (HIV/AIDS)

1.6M (5.7%)
MALAWI TECHNICAL SUPPORT

17.2M (59.6%)
OTHER SCOPE COUNTRIES

CAPACITY STRENGTHENING OF WORLD RELIEF MALAWI

Enhanced Monitoring, Evaluation, Accountability, and Learning Systems
SCOPE facilitated the development of comprehensive guidelines, standardized resources, and data visualization dashboards, optimizing the efforts of the Country Office's Monitoring, Evaluation, Accountability, and Learning (MEAL) team. They introduced valuable tools such as the "Activity Monitoring, Evaluation, and Learning Plan" template, standardized monitoring protocols, and reporting templates, which were integrated into other World Relief supported projects. USAID's technical reviews and feedback further ensured adherence to best practices. Interactions with USAID teams through data quality assessments and monitoring visits also strengthened World Relief Malawi's MEAL system capacities.

Strengthened Financial Systems
The SCOPE Program was crucial in enhancing World Relief Malawi's financial systems. Frequent reviews of budgets and expenditure reports, along with active engagement with World Relief Malawi leadership in monitoring project finances, led to more robust financial management.

Knowledge Management Capacity
The SCOPE Program provided opportunities for improving knowledge management throughout World Relief Malawi. This involved mentorship in developing case studies from project implementation, reinforcing information dissemination through health and nutrition communities of practice, and participation in other country-level technical forums.

Technical Implementation
SCOPE workplans were collaboratively developed with a variety of stakeholders, including government representatives and the technical SCOPE team, ensuring alignment with all parties' needs. SCOPE also successfully integrated faith leaders and community volunteers into the health system, serving as a model for future initiatives. Client/participant feedback also positively impacted integration into existing community health structures. Tool development, adherence to best practices, and exposure to initiatives such as *Families Together* and *FLE* were key to the Project's success in Malawi.

1 "Malawi Demographic and Health Survey 2015-16." Accessed January 8, 2024. https://dhsprogram.com/pubs/pdf/FR319/FR319.pdf.
2 Lilongwe SEP, 2017 –2022.

STAKEHOLDER COLLABORATION

The SCOPE Project engaged with a wide variety of stakeholders in the planning, monitoring, and evaluation of the Project. SCOPE collaborated closely with the MOH in partnering with District Health Management Teams; quarterly joint supervision and monitoring supported the quality of activities at health facilities and with HSAs. SCOPE also participated in Technical Working Groups and found frequent review and feedback sessions were key to effective programming. The SCOPE Project established strong partnerships with various local organizations, leveraging World Relief's existing relationships with faith institutions and Faith Network Committees, Area Development Committees, and the District Interfaith AIDS Committee. Additionally, the Project collaborated with other USAID implementing partners such as Let Them Grow Healthy (Akule ndi Thanzi), MOMENTUM, and the Tiyeni Project to gain access to resources, broaden community outreach, and build trust across organizations. This collaborative approach ensured the dissemination of knowledge and resources from the national level to local communities, effectively addressing healthcare needs at the grassroots level.

External Engagement
World Relief Malawi's network of partners strengthened both locally and internationally, while their visibility with USAID and the Malawian government also increased. World Relief Malawi has been recognized as a key contributor to maternal, newborn, and child health outcomes in Machinga and Lilongwe districts, enhancing their reputation as a trusted and impactful organization in the implementing country.

HEALTH SYSTEM STRENGTHENING THROUGH COMMUNITY HEALTH WORKERS

HSAs are the CHW cadre in Malawi and form an important extension of primary healthcare points because they provide the essential health care package in the community. HSAs are allocated to a community catchment population to provide health promotion, disease prevention, response and basic treatment services, as well as family planning and child healthcare services. SCOPE improved awareness on health information and created strong linkages to health providers and facilities to improve access to and outcomes of local health services. To improve access, service supply and quality, the Project implemented activities ranging from capacity building and mobilization of HSAs, referrals and supportive supervision, to supporting the establishment of village clinics – aligning implementation principles with the country's Health Sector Strategic Plan II (2016).

SCOPE provided comprehensive trainings to 434 HSAs/Senior HSAs/CBDAs (159 in Machinga and 275 in Lilongwe). HSAs were equipped to provide basic healthcare services, health education, and preventive healthcare interventions in communities with limited access to quality healthcare facilities and resources, often due to geographical, economic, or social barriers. Malawi's MOH facilitated trainings and the Project utilized MOH training materials. To expand the reach and facilitate partnerships between public health facilities and private health facilities, SCOPE partnered with the Christian Health Association of Malawi, a local faith-based organization that has multiple clinics in the SCOPE Project area. A Senior HSA in Lilongwe noted how SCOPE had equipped their team:

"Before SCOPE, the facility had four service providers, but now SCOPE has trained seven which has made people from hard-to-reach areas access the service closer. Also, under community-based maternal and newborn care, previously the facility had four providers, but SCOPE trained another five which has made an increase in antenatal care visits, hence some reduction in maternal and newborn complications."

SCOPE helped to improve HSA coverage and performance through supervision and mentorship, with statistically significant increases in HSAs visiting households found by the Project's Midterm Evaluation. Supportive supervision used a well-structured checklist that included the expected tasks during service delivery and expected minimum commodities to stock at a particular time, which helped improve supervision quality and objectivity. The Project supported Senior HSAs from all of the targeted health facilities to conduct monthly supervisions of HSAs in community-based family planning, community-based maternal and newborn care, and integrated community case management. The supervisions were conducted together with SCOPE Project Supervisors, family planning focal persons, and Assistant Environment Health Officers. Throughout the Project, 413 HSAs have been supervised quarterly in all three technical areas, representing 100% reach. The Project also supervised 85 CBDAs in community-based family planning, representing 86% reach (others had dropped out). By training CHWs, there was an improvement in the quality of services provided, improved documentation, increased access to services by households, increased presence of CHWs in their catchment areas, and improved performance of health facilities, such as the Mkwepere Health Facility in Machinga.

> *"We are thankful to the SCOPE Project for all the support provided. This support has seen Mkwepere improve greatly in terms of its performance. Before SCOPE, the facility was among the least performing health facilities, but now it is among the facilities with an outstanding performance."*
>
> **COMMUNITY-BASED MATERNAL AND NEWBORN CARE COORDINATOR AND MKWEPERE HEALTH FACILITY IN-CHARGE**

SCOPE helped to improve the availability and accessibility of essential healthcare services, especially in rural and remote areas, contributing to an increase in the frequency and quality of maternal care outcomes. SCOPE's evaluations saw newborn breastfeeding in the first hour of life increase from 56% to 82%, and newborn PNC rise from 69% to 71%.

Effective community engagement requires more than improving service delivery. Therefore, the Project focused on building trust and involving community members in decision-making through community-level review meetings, where feedback loops were established. As a result, facility and community leadership helped improve early antenatal care attendance by removing some of the restrictive rules for single mothers, such as requiring male involvement during an antenatal care visit. Building trust in community engagement led to increased participation, better communication, and enhanced positive reputation of HSAs.

Some SCOPE-supported facilities encountered challenges transporting medical supplies in resource-constrained settings. Even if a CHW is well-trained, persistent stockouts can affect the performance of other indicators. For example, if an HSA persistently has stockouts, the households may avoid visiting the village clinics because they know they will mostly get counseling and referral services. To address the challenge of stockouts, SCOPE continually engaged the Lilongwe and Machinga District Health Offices regarding stockouts for possible stock rotation from other facilities and sources. In some instances, the Project provided transport of supplies. In addition, SCOPE worked with program coordinators to facilitate the redistribution of supplies, taking supplies from facilities with larger quantities to facilities with very low stock. Even when faced with stockouts, HSAs were encouraged to conduct village clinics and family planning sessions, as they were still able to provide counseling and linkages to various facilities. The continuous running of village clinics also strengthened community trust. Community members knew there would always be an HSA available to address the needs of sick children or provide family planning services.

COMMUNITY GROUPS: CARE GROUPS

Malawi's Care Group model was adapted to existing government structures, such as utilizing HSAs, the Group Village Headman, and other frontline workers to lead the Care Groups. SCOPE partnered with the MOH and the District Nutrition Coordination Committee to support their Care Group efforts and help extend the MOH reach to the household level.

Care Groups aimed to enhance service demand, improve health-seeking behavior, and foster comprehensive social behavior change. SCOPE trained Care Group Promoters on three Care Group modules and equipped the Care Groups with knowledge of RMNCH services. Through SCOPE Malawi, 12,262 Care Group Volunteers reached 80,725 households with messages on COVID-19, child health, and maternal and newborn care.

To maintain message integrity and effectiveness, SCOPE Malawi, alongside Senior HSAs and Area Nutrition Coordinating Committee members, supervised Care Group Promoters, Cluster Leaders, and Care Group sessions. These supervisory visits were unannounced, instilling a sense of accountability and diligence among the Care Group Volunteers. The supervisory process was conducted systematically using the Quality Verification Improvement Checklist. Over the course of the Project, 539 Care Group Promoters and 984 Care Group sessions were supervised. Supervisor teams also visited 52,438 households to ensure the program's goals were effectively met. Household visits by Care Group Volunteers were a crucial component of this effort, allowing for the verification of lesson delivery and message accuracy at the cluster and household levels.

The Care Group approach was critical in equipping SCOPE Malawi communities with the knowledge and skills to make informed health decisions. It has fostered local ownership of health initiatives by allowing community members to actively participate in identifying health challenges and setting priorities; and as a result has positively impacted health-seeking behaviors and extended the reach of health services to individuals often facing barriers to access. The strength of SCOPE Malawi's Care Groups lies in their community-driven, participatory, and peer-led approach, making it an effective strategy for reaching and positively influencing a broad audience with RMNCH services. SCOPE Malawi observed that Care Groups had a ripple effect in their communities: men were engaged during household-level counseling, while neighboring households enjoyed the positive impact of shared resources such as sanitation facilities. Care Groups also demonstrated a greater outreach to households within a shorter timeframe than HSAs, primarily due to the larger number of volunteers involved.

A significant challenge was the high dropout rate among cluster leaders, primarily due to the lack of incentives. SCOPE Malawi took measures to facilitate the replacement of cluster leaders and offered continuous mentorship to Care Group Volunteers during supervision, emphasizing the positive outcomes resulting from their commitment to the communities. Future programs should consider addressing the issue of incentives (e.g., wrap skirts, stationery, and T-shirts) to sustain engagement and motivation among volunteers.

Despite challenges, SCOPE observed strengthened connections between the community and CHWs, as evidenced by the increased frequency of CHW visits to households and a rise in the number of pregnant women identified and referred to HSAs by Care Group Promoters (8,944 in 2021 to 26,220 in 2023). In the Malawi Midterm Evaluation results, the number of people who reported receiving a CHW visit increased by 113% from the baseline. A Senior HSA at Mpiri Health Center expressed the valuable role of Care Group structures in facilitating their work during the health facility exit meeting:

"The presence of Care Group structures has made our work easier because the Care Group Volunteers are in huge numbers, so they have helped us reach out to several households with RMNCH key messages within the shortest period. Even if SCOPE RMNCH phases out, we will continue to work with them [Care Group Volunteers] in addressing the challenges identified in the Midterm Evaluation results."

COMMUNITY GROUPS: *FAMILIES TOGETHER*

To improve joint decision-making and increase couple communication in Malawi, SCOPE contextualized and rolled out the USAID-approved *Families Together* curriculum. Adaptation, based on feedback from Muslim and Christian faith leaders, and translation of the curriculum into the local language (Chichewa) ensured the content was relevant and accessible to participants. SCOPE initiated a community orientation on *Families Together* targeting local Faith Network Committee members, Traditional Authorities, Area Development Committee members, and two Muslim Associations (Muslim Association of Malawi and Qadria Muslim Association of Malawi). This collaboration ensured quality assurance and built a foundation for effective supervision of the couple groups.

The first key step in the *Families Together* rollout was selecting and training 323 Lead Couples from Lilongwe and Machinga districts. The lead facilitator couples, carefully selected by local leaders, underwent an intensive training program to equip them with the necessary skills to facilitate *Families Together* sessions effectively. The training sessions were designed to create a safe and supportive environment for the Lead Couples to learn the curricula content and practice and refine their facilitation skills. During key training days where family planning decision-making and methods were discussed, community-based HSAs were also included. The inclusion of HSAs provided a unique opportunity to connect the *Families Together* program with existing healthcare structures, promoting greater collaboration and integration of faith leaders within the health system. By engaging with HSAs in the couple groups' catchment areas, SCOPE ensured that the sessions on family planning were relevant and relatable to the participants' lived experiences. Once Lead Couples were fully trained, the recruitment of the 508 (220 in Machinga, 285 in Lilongwe) participating couples began, followed by the coordination of ten weekly sessions, which took place between July and September 2023.

In Machinga, the *Families Together* approach showed a multiplying effect. Similar to the Care Group model, couples who were not formally in the groups recognized Lead Couples as a trusted source for family planning information and counseling. Initial concerns from both Faith Networks and Lead Couples about the husbands'

commitment to ten weeks of sessions, without any financial incentives, proved unfounded. Lessons focused on power sharing and family planning decision-making motivated consistent attendance from the men in the couples.

Families Together profoundly impacted Lead Couples, reshaping their views on relationships and initiating positive change within their communities. Training influenced attitudes and gave new language for discussing relationship quality. A Lead Couple from Traditional Authority Nsanama shared how they rediscovered the importance of small gestures and communication in their marriage. The storytelling method within the curriculum enhanced their ability to communicate more effectively. Not only have the family planning sessions initiated more conversations in families, but women are also reporting more openness in their relationships and sharing that they can have a voice in their desire for intimacy and/or sex with their husbands. The program's participants served as knowledge multipliers, especially regarding family planning, which led other families to seek counseling and share what they had learned during *Families Together* sessions. As one Lead Couple shared in the Traditional Authority Masumbankhunda group,

"The Families Together curriculum is reaching many families, not just our group. More families are coming to our home for counseling because our group members are excitedly sharing what they've learned in the Families Together sessions."

FAITH ENGAGEMENT

Faith leaders are actively engaged in promoting social justice and the welfare of the population. The success of community-based work depends on the attitude, commitment, and engagement of gatekeepers and influencers, but faith communities often lack the necessary skills and information to engage in helpful ways on health-related issues. In Malawi, a large majority of the population is Christian, while about 12% is Muslim, making the inclusion of influential faith leaders in programming critical to success and acceptance.[1]

Over the course of the Project, SCOPE trained 1,165 faith leaders on the *Making Our Communities Better* curriculum from 749 different faith institutions (395 Muslim and 354 Christian institutions). Through this training, faith community leaders were provided with tools to understand and help communities identify ways to improve household health and wellbeing, especially mother and child health.

Since being trained, faith leaders have been able to start various small community-based projects, including mobilizing resources to construct and rehabilitate clinics for children under-five, supporting students in primary schools, and supporting local infrastructure projects. Faith leaders understand the importance of education for teenage mothers and have supported them in returning to school after giving birth. *Making Our Communities Better* reinforced that faith leaders act as catalysts for change across

1 "Malawi Demographic and Health Survey 2015-16."

various aspects of people's lives, extending beyond the spiritual dimension. The engagement approach is pivotal in motivating communities to address their issues and willingly take ownership of interventions. A chairperson for Mkwinda Zonal Faith Network noted that,

"One of the best curriculums that World Relief has delivered is Module 1 [Making Community Better], which is to do with community development work. That curriculum made us realize that we are responsible for the development of our communities such that we no longer wait for people to come and do things for us."

In the early rollout stages, the Project faced challenges related to the commitment of certain faith networks. A strategy was devised to address this, requiring each zone to present its accomplishments during review meetings which inspired previously inactive faith networks to catch up and actively participate in subsequent review meetings. SCOPE framed this not as a competition, but as an accountability mechanism for the action plans they had developed during training.

When communities are mobilized with a shared goal, they set aside religious differences. As a result, leaders began to reach out to one another to take responsibility for meeting their communities' needs, especially when they lacked the means to mobilize resources independently. For example, a Faith Network Committee in Michingwe recognized that the local clinic, which used to operate under a mango tree, was not adequately serving surrounding villages as it was difficult to operate during the rainy season. After participating in the *Making Our Communities Better* meetings, the committee mobilized the community to construct a clinic building.

> *"Women received family planning services from the Health Surveillance Assistant under the tree, without privacy at all. Under-five children received child health services under the tree, which becomes a challenge during the rainy season because the Health Surveillance Assistant does not open the village clinic when it is raining since there is no shelter. At first, we just looked at it, waiting for the government to construct a village clinic shelter for this village clinic, but after receiving the Vision-Casting [Making Our Communities Better] Training, we realized that, as faith leaders, we have a role to play in developing our communities."*
>
> **PASTOR KALENGA**

Building off of the strong partnerships and networks established by *Making Our Communities Better,* the *FLE* curriculum was introduced into the SCOPE program. *FLE* was designed to be the next level of faith leader capacity strengthening, especially to build communication skills and lead community dialogue on family planning and reproductive health. In Machinga and Lilongwe, SCOPE trained 3,978 faith leaders from 1,000 faith institutions on *FLE*, ensuring that faith communities meaningfully engaged on community-based health topics to become advocates for behavior change and stronger health systems within their respective communities. Following the *FLE* training, the faith leaders delivered the key messages back to their community members. In Malawi, these sessions varied by age group and days of the week, so that anyone in the community could come and learn depending on their age. Lessons were shared in various settings, such as choir rehearsals, youth group meetings, in primary and secondary schools, during community events, and other arranged meetings. Throughout the implementation of *FLE*, faith leaders in both districts reached 102,324 people with *FLE* sessions.

FLE also strengthened linkages between the health system and faith leaders. Whenever the *FLE* participants needed further counseling and family planning methods, the faith leaders referred them to HSAs. When the faith leaders had difficulties delivering some of the sessions, they engaged local HSAs or the Health Facility In-Charge in communities where the *FLE* sessions were held closer to a health facility. A concrete example of this collaboration occurred at Chimutu Health Facility in Traditional Authority Chimutu, Lilongwe, where a postpartum maternal death prompted a community engagement awareness meeting involving local traditional and faith leaders. Consequently, all Chiefs within the Traditional

Authority were instructed to provide referrals for expectant mothers and their neonates, ensuring prompt access to care in cases exhibiting danger signs.

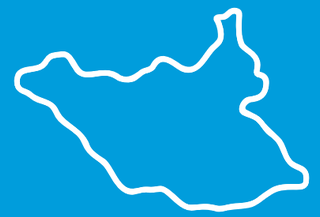
SCOPE provided monthly support for zonal Faith Network Representatives to conduct monthly supervision of *FLE* sessions in faith institutions. To elicit feedback on progress as well as feedback on vision casting (*Making Our Communities Better* follow-up), SCOPE held zonal Faith Networks Review Meetings in all four Traditional Authorities with 261 (181 male, 80 female) faith leaders from 27 Faith Network zones, Area Development Committee members, and Field Facilitators attended. The meetings were led by HSAs and SCOPE Project Supervisors.

FLE also opened more opportunities for faith leaders to address sensitive topics with adolescents. This openness was specifically linked to faith leaders as a source of health information. One faith leader in Traditional Authority Kawinga stated,

"FLE has helped in making our children know and understand themselves better because they know clearly the developmental stages of their bodies. Not only that, but also the lessons have helped our children engage and involve themselves with a good cycle of friends because they have learned the dangers of substance use and abuse."

Another faith leader in Machinga noted the difference in openness about family planning/reproductive health:

"[The SCOPE programs] give [us] the power to elaborate to the community members issues of great importance; issues that [need to be addressed] but were restricted by other faith-based structures. I now advise people on important issues of life such as family planning."



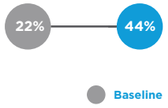
SOUTH SUDAN

SUMMARY & RESULTS

IN SOUTH SUDAN THE mCPR INCREASED BY 18%

IN SOUTH SUDAN VISITS INCREASED FROM 45% TO 64%

4+ ANTENATAL CARE VISITS



PERCENTAGE OF COUPLES WHO REPORTED DISCUSSING FAMILY PLANNING WITH THEIR SPOUSE IN THE LAST YEAR

GEOGRAPHIC IMPLEMENTATION AREAS

- Ibba: Ibba Central, Mankinkara and Madebe Payams
- Maridi: Maridi Central Payam

STATISTICS

- Maternal Mortality Rate: 1,223 deaths per 100,000 live births[1]
- Children Under Five Mortality Rate: 99 deaths per 1,000 live births[2]
- Infant Mortality Rate: 64 deaths per 1,000 live births[3]
- Contraceptive Prevalence Rate: 2%[4]

HIGHLIGHTS FROM THE LIFE OF PROJECT

Increased Utilization of Health Services and Capacity Building
SCOPE South Sudan trained 108 CHWs (called SCOPE Health Promoters [SHPs]) on the Boma Health Initiative curriculum focused on child health, safe motherhood, and general topics of health. These CHWs provided integrated community case management referrals and increased utilization of health services. In addition, through a subaward with a local organization, OPEN, SCOPE South Sudan supported health service delivery in five health facilities and six outreach sites.

Increased Acceptance and Uptake of Family Planning Services
The SCOPE Project made a significant breakthrough in community family planning awareness by addressing misconceptions about family planning/sexual and reproductive health. Misconceptions included myths such as the West wanting to reduce the African population, that family planning is unbiblical, harmful to the health of women, promotes prostitution and immorality, and that family planning/contraceptives reduce libido in women. Working with faith leaders, SCOPE South Sudan contextualized the *FLE* curriculum to encourage community buy-in. By addressing misconceptions, family planning acceptance and utilization increased, as evidenced by large jumps in mCPR from baseline (19.9%) to midline (38.5%).

1 World Bank. "Maternal mortality ratio (modeled estimate, per 100,000 live births) - South Sudan." World Bank Data. Accessed January 8, 2024. https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SS.

2 UNICEF. "South Sudan." UNICEF Data. Accessed January 8, 2024. https://data.unicef.org/country/ssd/.

3 UNICEF. "South Sudan."

4 World Bank. "Contraceptive prevalence, modern methods (% of women ages 15-49) - South Sudan."

Extending the Reach of Health Workers Through Care Groups
SCOPE South Sudan used the Care Group model to deliver family planning and maternal child health information to the communities in Ibba and Maridi. 1,000 Care Group Volunteers, 36 Care Group Promoters, and six Care Group Supervisors were recruited and trained on all four Care Group modules. Using the Care Groups, 10,000 neighbor women were exposed to family planning/sexual and reproductive health-related messages. This intervention extended the SHPs reach, supported the community-based referral system, and disseminated lifesaving information to WRA.

CONTEXT

A prolonged civil war and ongoing ethnic conflicts in South Sudan, combined with severe rainfall and flooding, has led to disrupted settlement patterns. Internal displacement and seasonal migrations due to conflicts and food shortages have made it difficult for the population to access essential health and social services. Eighty-three percent of the population live in rural areas, with 56% living more than one-hour walking distance from a health facility.5 South Sudan has some of the worst health outcomes in the world, including the highest maternal mortality rate in the African region.6 Furthermore, the country has a shortage of healthcare providers. There are 1.5 doctors and two nurses for every 100,000 people, far less than the World Health Organization's recommendation of 180 doctors and 250 nurses per 100,000.[7] Implementing partners are responsible for providing much of the health workforce and a large proportion of healthcare services. Due to the shortage of healthcare providers, community-based health workers are critical to and are often relied upon to deliver health services in South Sudan.

Beliefs and misconceptions, rooted in religion and cultural norms, also play a significant role in healthcare challenges. Some communities adhere to the belief that using modern contraceptives equates to murder, and believe that according to religious teachings, they must "multiply and fill the earth." These attitudes contribute to infant and maternal deaths and hinder family planning efforts.

Ibba County is located in Western Equatoria State, an area considered the country's fertile greenbelt. According to the Office for the Coordination of Humanitarian Affairs, 75% of the population needs humanitarian assistance.[8] Maridi is also located in Western Equatoria, where an estimated 59% of the population requires humanitarian assistance, nearly double the number since 2021 (65,407 people in 2023, up from 34,700 in 2021).[9]

Women and children in these counties often endure long journeys on unpaved roads to access basic healthcare services at the few functioning health facilities. This situation worsened in April 2022 when a key implementing partner withdrew support from 33 primary healthcare facilities in both counties due to funding shortages. Maridi County Hospital serves as the sole referral point, as there are no hospitals in Ibba County. The referral system is fraught with weaknesses, including a lack of emergency vehicles.

5 Ministry of Health. (2016). HMIS data.

6 World Health Organization. "Maternal mortality. Accessed January 8, 2024. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

7 IQVIA. (2022). "Midterm Evaluation of Boma Health Initiative in South Sudan (2019-2021) – Final Report." Accessed January 8, 2024. https://www.unicef.org/southsudan/media/10366/file/Final%20Report_BHI%20Mid%20term%20Evaluation%202023.pdf

8 Conflict Sensitivity Resource Facility "County Profile: Ibba." Accessed January 8, 2024. https://www.csrf-southsudan.org/county_profile/ibba/.

9 Conflict Sensitivity Resource Facilty "County Profile: Maridi." Accessed January 8, 2024. https://www.csrf-southsudan.org/county_profile/maridi/.

STAKEHOLDER COLLABORATION

In achieving its Project objectives, SCOPE engaged multiple stakeholders to enhance communication, coordination, and collaboration with the MOH, CHDs, local authorities, and faith institutions. At the field level, SCOPE maintained collaboration with the MOH through the CHDs, however, due to the Trafficking-in-Persons restrictions, SCOPE primarily worked with a CHW cadre not affiliated with the MOH. At the national level, SCOPE was a regular member of technical working group meetings and consistently attended USAID implementing partner meetings, which supported all of SCOPE's technical work. For key project activities, such as training SCOPE-supported SHPs, World Relief collaborated with AMREF, an international organization running a health institution for clinical officers, nurses, and midwives in Maridi. In both Maridi and Ibba, SCOPE collaborated with AMREF and Health Pooled Fund to provide training supplies and materials. SCOPE engaged the MOH to review and validate curricula that included information on health-related topics. Throughout implementation, SCOPE engaged with the County Health Departments and the County Humanitarians Partners' Coordination Meetings to provide updates and discuss gaps.

A critical component of the community health strategy in South Sudan is the Boma Health Committee, which SCOPE worked closely with, holding regular quarterly planning and review meetings to review, update, and receive feedback on activities. In Ibba County, the Hon. Commissioner commented,

"World Relief is the model organization in my County, I wish all other partners to learn from World Relief's intervention and the community health workers should continue saving lives."

Since by design SCOPE works through a layered approach within the community, the Project worked very closely with the Faith Network Committees, local church leaders, the County Health Department, and local authorities to implement faith engagement activities. Church leaders played an instrumental role in the success of *FLE*, from inception to implementation to routine monitoring. By giving faith leaders encouragement and confidence to discuss sensitive topics that they might not otherwise be able to address with their communities, SCOPE, through *FLE*, has contributed to breaking significant cultural, religious, and communication barriers to family planning within the community.

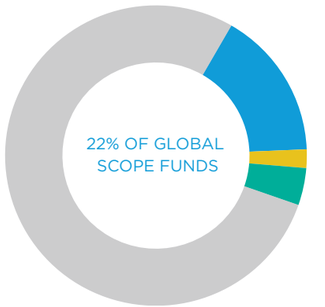
Finally, the SCOPE Project partnered with a national nongovernmental organization, OPEN, to study CHWs in a capacity-building research study. This synergetic partnership was important at the county level, as OPEN could provide health facility clinical care services. Through the partnership with OPEN, SCOPE provided health services in five health facilities and several outreach activities in the community.

CAPACITY STRENGTHENING OF WORLD RELIEF SOUTH SUDAN

Enhanced Monitoring, Evaluation, Accountability, and Learning Systems
World Relief South Sudan leadership reported that SCOPE provided valuable routine technical oversight of monitoring, evaluation, and project implementation. The SCOPE Project carefully followed workplans and timeframes, aligning team efforts in the field with clearly defined objectives. SCOPE's learning element and the early integration of research questions was also applauded. Going forward, World Relief South Sudan will consider how learning, research, and generating new knowledge can be key deliverables for future projects.

Strengthened Financial Systems
The World Relief South Sudan finance team was supported by frequent financial touchpoints from the SCOPE global finance staff. This allowed the Project to remain flexible and responsive to needs arising from the field. One such significant need resulted from the reduction of key health partner operations in the SCOPE

SCOPE SOUTH SUDAN FUNDING



4.7M (16%)
SOUTH SUDAN DIRECT TECHNICAL SUPPORT (RMNCH)

650K (2%)
SOUTH SUDAN SUBAWARDS

1.1M (4%)
SOUTH SUDAN TECHNICAL SUPPORT

22.4M (78%)
OTHER SCOPE COUNTRIES

CHW SPOTLIGHT

Minisare Jenty is a mother of two and a resident of Rastigi Village in Maridi. Every week, she is visited in her home by an SHP, who comes to share various health topics affecting her family. As a young mother, Jenty did not know much about how to care for her children. Jenty shared, *"I did not know how to take care of my baby. Among the lessons they taught me was the importance of immunization as well as following its schedule."* As a young girl, Jenty's mother would not allow her or her siblings to be vaccinated and encouraged her children to do the same with their future children. This was because her mother believed that vaccinations were harmful to children and could kill them.

Because of that fear, when Jenty had her first child, she opted not to vaccinate them. During her second pregnancy, SHPs began meeting with her and encouraged her to begin going to the health facility in her community. There, she completed all of her antenatal care visits. Minisare Jenty commented, *"Thank God I had a safe delivery at the health facility, and this second child of mine has completed his entire vaccination schedule and is growing healthy."* Jenty further noted, *"I want to confess today to my fellow women that vaccination is one of the reasons for the happy and healthy child that you are seeing."*

Project geography. SCOPE was able to continue supporting community health facilities by entering into a sub-agreement with OPEN to extend SCOPE's reach in Ibba and Maridi counties. World Relief South Sudan leadership team identified the complexities and requirements of the sub-agreement process and committed to continued learning about partnership agreements and working with and strengthening local organizations.

Project Design
SCOPE's global design did not follow World Relief's usual project management structure due to the insertion of the home office-based technical/management team. While this team provided the SCOPE team with valuable leadership and technical guidance, the management structure was not without complexities and some friction. World Relief South Sudan leadership expressed the desire to continue developing and improving the management model for future global projects by more clearly defining and delegating organizational responsibilities.

External Engagement
SCOPE enjoyed a strong reputation in Ibba and Maridi due to its size and volunteer network. SCOPE's focus on faith-based engagement brought Christians and Muslims together, greatly extending the reach of its interventions. Overall, the Project laid a strong foundation, especially as it relates to maternal and child health, that will benefit future programs in the area.

HEALTH SYSTEM STRENGTHENING THROUGH COMMUNITY HEALTH WORKERS

Despite the challenges, the country has taken steps to establish and strengthen its health system. In 2017, the MOH launched the Boma Health Initiative as a national strategy to improve access to essential healthcare services at the community level. The Boma Health Initiative strengthens linkages between communities and primary healthcare facilities, works to improve health facilities' governance, and promotes community ownership of the facilities. Despite the MOH's willingness to improve the health sector, the lack of funding, resources, political unrest, and economic crises facing the country have slowed coordinated efforts, affecting the MOH's capacity to implement the Boma Health Initiative package across all of the country's counties.

SCOPE assessed the role of the CHWs in South Sudan and how they fit within the health system. The process helped map out referral systems in the community, informed the CHWs' training approaches, and identified the in-country stakeholder relationships that would be critical to the sustainability of the CHW programs beyond the SCOPE Project.

SCOPE South Sudan used the MOH's curriculum to train project-specific CHWs known as SHPs: 108 SHPs were trained and supervised throughout the Project.[1] Though similar to Boma Health Workers in scope/function, SHPs are fully paid/supported by SCOPE. Because "Home Health Promoter" is also a term used to describe community-based health workers in South Sudan, the Project used the term "SHP" to describe SCOPE-supported health workers who inform and deliver community-based RMNCH services in the Project areas. They were selected and trained using criteria very similar to the South Sudan MOH's criteria to recruit Boma Health Workers.

SHPs worked with faith leaders and Care Group Volunteers to provide information and make referrals to 17 health centers. SHPs also conducted household visits. The Project Midterm Evaluation showed that over the previous three months, the percentage of target population households who received at least one visit from a CHW increased significantly from 25% at baseline to 60% overall. SHPs expanded access and brought RMNCH services closer to households.

OPEN PARTNERSHIP: HEALTH FACILITIES MANAGEMENT AND COMMUNITY OUTREACHES

OPEN was a key partner throughout the SCOPE Project. World Relief South Sudan originally partnered with OPEN to expand its reach and facilitate partnerships between public and private health facilities in Ibba and Maridi counties. OPEN was also a key partner in supporting the research study efforts that SCOPE conducted related to the capacity-building of SHPs.

OPEN's scope of work with the SCOPE Project expanded as needs arose in the counties. In April 2022, a key implementing partner in South Sudan reduced health facility support. As a result, 59% (20 of 34) of the Primary Health Care Units (PHCUs) in Ibba and Maridi were no longer supported, rendering them non-functional. The decrease in functional health facilities led to reduced access, equity, and quality of health services in the SCOPE-supported geographic areas. The community and implementing partners in the area expressed concern about these gaps. Therefore, SCOPE coordinated efforts to meet growing healthcare needs. Through collaboration with the USAID Mission, and in partnership with OPEN, SCOPE determined it was in the best interest of the communities to support local PHCUs and conduct community health outreaches.

From February to August 2023, SCOPE supported five static PHCUs (three in Maridi; two in Ibba) to render them functional, and conducted 26 community health outreaches (14 in Maridi; 12 in Ibba). OPEN recruited 30 staff to implement the health services.

The five PHCUs provided integrated primary health services, including but not limited to outpatient department curative consultations, immunizations, antenatal care services, nutrition screening, and health education. They also provided basic emergency obstetric and neonatal care services. During the implementation period, 26 community outreach clinics were also conducted throughout Ibba and Maridi.

HEALTH FACILITIES AND COMMUNITY OUTREACH ACTIVITIES, OPEN SUBAWARD, IMPLEMENTATION PERIOD (FEBRUARY-AUGUST 2023)

STATIC HEALTH FACILITIES MANAGEMENT	IBBA		MARIDI		TOTAL
	M	F	M	F	
Outpatient curative consultations, diagnosis', treatment of patients, Expanded Program on Immunization services, antenatal care services, nutrition screening, and health education	1523	1779	2760	3263	9,325
Received antenatal care services		244		554	798
Skilled deliveries		60		30	90
Attended post-natal care (PNC1 and PNC2)		164		276	440
WRA and men who received family planning methods	614	49	434	537	1,634
Referrals to health services	20	36	101	133	290
Expanded Program on Immunization coverage	331	315	717	806	2,169
COMMUNITY HEALTH OUTREACHES	**IBBA**		**MARIDI**		**TOTAL**
Community outreach clinics (mobile clinics)	12		14		26

1 Due to the Trafficking in Persons restrictions, SCOPE worked with a CHW cadre of workers not affiliated with the MOH.

COMMUNITY GROUPS: CARE GROUPS

The implementation of Care Groups has helped World Relief meet the needs of health promotion and service access in remote and displaced communities. Because World Relief South Sudan had successfully implemented the Care Group approach in Ibba County during the Ebola crisis of 2019, SCOPE was able to leverage already established Care Groups in the area. The Care Group model was contextualized in consultation with the MOH's County Health Departments and local Faith Network Committees. This inclusive approach significantly contributed to the acceptance of the SCOPE Project within the communities.

Care Groups addressed crucial drivers and factors contributing to poor health outcomes in the Ibba and Maridi counties, many of which are preventable. Through training and receiving targeted health messages from Care Groups, local communities were provided with information that helped them make more informed health decisions and thus modify health-related behavior. Throughout implementation, SCOPE South Sudan observed a multiplication of efforts through these lessons, leading to increased health-seeking behavior and stronger connections to SHPs and health facilities.

"I know my children died because I was not going for antenatal care, my deliveries were all done at home, and my mother used dirty bamboo grass to cut cords. I was malnourished and weak because I was not eating nutritious foods. Now, I am well-equipped with the knowledge from SCOPE and ready to share it with other friends. I am joyful because I have two live children now due to the knowledge from SCOPE."

MAGREAT, NEIGHBOR WOMAN

A total of 1,000 Care Groups (500 in Maridi; 500 in Ibba) reached a total of 20,070 households (11,234 in Maridi; 8,836 in Ibba). On a monthly basis, Care Group Volunteers made an average of 2,496 referrals to a CHW or health facility. In remote areas where CHWs are often overloaded and long distances prohibit frequent touch points with the health system, Care Group Volunteers help engage households with messaging and linkages, effectively extending the reach of SHPs and effecting community-level change. The impact of this approach is exemplified by the story of Magreat, a neighbor woman affected by these lessons after losing five babies in succession due to a lack of antenatal care.

There were some challenges during the implementation of Care Groups to which the SCOPE South Sudan adapted. For example, seasonal migration patterns, particularly during planting and harvesting seasons, presented challenges in reaching some neighbor women for their lessons. To address this, SCOPE South Sudan scheduled lessons when communities returned home, ensuring that all neighbor women received the necessary information through volunteer household visits. In addition, in 2023, families from Madebe and Yosia bomas in Ibba were displaced due to security concerns related to the "Ambororo" nomadic group. Care Group Volunteers diligently followed the relocated neighbor women to provide essential messages and support. Also, initially, Care Group supervision relied on a Quality Verification Improvement Checklist; however, it became evident that low-literacy levels posed a challenge in using Care Group resources, prompting the introduction of cue cards for simplified reporting and information dissemination.

FAITH ENGAGEMENT: *FAMILY LIFE EDUCATION*

Faith leaders are trusted voices in South Sudan, where Christians comprise 60% of the population and indigenous beliefs account for 30% of religious affiliation.[1] World Relief South Sudan has long-term relationships and partnerships with local faith institutions, and SCOPE has enjoyed the benefit of more effective implementation of activities as a result. These relationships are especially important when dealing with sensitive messages and activities, such as are related to family planning, which can be controversial. By engaging faith leaders early and in the design phase of implementation, World Relief has found that collaborating with faith leaders can transform them from being potential barriers or bottlenecks, to the best allies and partners on the ground.

World Relief's long-term partnerships with local churches made it easier for churches to accept the *FLE* program. The faith leaders trained on the *FLE* curriculum have become more holistic in their ministry. As they give more integrated and comprehensive sermons to their congregants, they become instrumental in creating awareness of health issues such as drug abuse, sexual development in boys and girls, gender-based violence, and family planning.

SCOPE South Sudan contextualized and translated the USAID-approved *FLE* curriculum. As part of this process, country teams met with national Christian and Muslim faith leaders in a series of meetings and workshops. In these meetings, faith leaders were oriented on the *FLE* program and asked to provide feedback on the curriculum. This process was key to obtaining buy-in from the faith leaders, and enabled SCOPE to identify what might be the most sensitive topics and how they would be discussed.

In total, 417 *FLE* educators were trained, 45% of whom were women, from 100 local churches in Ibba and Maridi. *FLE* opened discussions on sensitive health issues such as family planning, adolescent reproductive health, and social and legal support, especially as relates to young people.

After training, faith leaders developed commitments and work plans for sharing these messages among their congregations. These commitments included workshops, youth programs, mothers' unions, and individual meetings. SCOPE staff followed up with them for at least 12 months after the completion of the *FLE* workshops, providing support and monitoring the progress of their commitments.

Nwia's experience with *FLE* in his congregation was a wake-up call:

"After hearing all these [the effects of alcohol and drugs], I realized that I was affected more, especially my ability to think properly. I even stopped going to school before getting the lesson on drugs and alcohol because I gave most of my time drinking alcohol and moving with my friends [...] As I speak now, I have stopped taking drugs and alcohol, which are harmful to my body, and I started farming for cash crops to raise my school fees and other basic needs. I went back to school, and I am now a youth and a choir member in the church. I would like to thank the FLE educators for reaching out to our church with this program because it has opened our eyes in so many ways."

1 2022 Report on International Religious Freedom: South Sudan. Accessed January 8, 2024.

PROJECT TIMELINE

EVENT TYPE

- GLOBAL
- COMMUNITY HEALTH WORKER
- COMMUNITY GROUPS
- FAITH ENGAGEMENT

KEY MOMENTS

SEPT
Project Begins

AUG - OCT
Baseline Evaluation

FEB
ICFP Presentation

MAY
CCIH Conference Presentation

JUN
CCIH Conference Presentation

JUL - OCT
Midterm Evaluation

OCT
Core Group Practitioner Conference Poster Presentations

NOV
SCOPE Learning Meeting

NOV
ICFP Presentations

MAR
Community Health Worker Symposium Poster Presentation

JUL - DEC
Haiti Endline Evaluation

MAR
End of Project Learning Meeting

MAR
Project Closes

2019 | 2020 | 2021 | 2022 | 2023 | 2024

IMPLEMENTATION

SEPT 2020 - MAR 2021
Making Our Communities Better

SEPT 2021 - SEPT 2023
Family Life Education

DEC
Project Implementation Ends

JAN 2021 - SEPT 2023
Care Groups

SEPT 2020 - SEPT 2023
Community Health Worker Training, Coaching and Supervision

FEB 2022 to JUL 2023
SCOPE Community Health Worker Research Study

SEPT 2023 to FEB 2024
Couples Focused Research Study

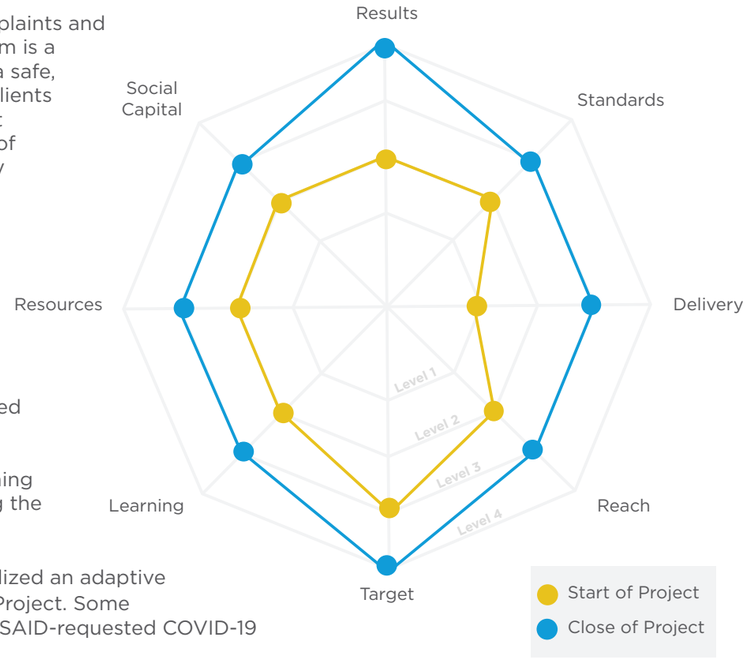
JUN 2023 - DEC 2023
Families Together

ORGANIZATIONAL PERFORMANCE ASSESSMENT

World Relief, as a recipient of a New Partnerships Initiative award, and as an underutilized USAID partner, a key focus of SCOPE was assessing and strengthening the organizational capacity of World Relief. In agreement with USAID, SCOPE utilized the Organizational Performance Index (OPI) to measure improvements against eight domains: Results, Standards, Delivery, Reach, Target, Learning, Resources, and Social Capital. The graph below shows improvements against all the OPI domains during the life of the Project.

Highlighted here are notable domains of performance. Under the **Standards domain**, the SCOPE implementation period coincided with World Relief's pursuit of the Core Humanitarian Standard on Quality and Accountability Certification. Since receiving a validated self-assessed Core Humanitarian Standard Score in June 2021, World Relief has diligently worked to strengthen organizational and programmatic areas so it could become Core Humanitarian Standard Certified. Detailed planning and analysis were completed, resulting in five working areas: Human Resources, Knowledge Management, Finance, Program Quality, and MEAL. As of the end of SCOPE, World Relief is on track with work planning, achieving 72.2% progress toward completion. Examples of Core Humanitarian Standard activities completed include the following:

- The launch of an organizational complaints and feedback mechanism. This mechanism is a formalized procedure that provides a safe, accessible, and effective means for clients and staff to raise complaints, request information, and receive a response of remedy. For World Relief, community feedback mechanisms are important for building trust, protecting program participants from harm during project implementation, and for learning and the continuous improvement of programs.
- The launch of organization-wide MEAL guidance, enabling in-country staff to implement MEAL processes using common, best practices adapted to World Relief's operations and contexts. World Relief sees MEAL as essential for improving its programming and results, and key to strengthening the organization.



Under the **Learning domain**, SCOPE utilized an adaptive management approach throughout the Project. Some examples of this include integration of USAID-requested COVID-19 programming due to the global pandemic, and elements of project redesign in South Sudan when a key partner pulled significant funding for local health facilities. Obligation shortfalls in the final year of SCOPE implementation also required significant adaptation of the Project design.

Under the **Resources domain**, a key result is World Relief's ability to secure additional and new funding from USAID. This has been realized both in the SCOPE project through funding to other technical areas beyond RMNCH such as PEFPAR funds in Malawi ($3.5 million), added funds for SCOPE COVID-19 in Rwanda ($0.7 million) and Malawi ($1.2 million) and SCOPE Ebola funds in Rwanda ($0.3 million). Beyond SCOPE, World Relief has seen an increase in USAID Bureau for Humanitarian Assistance-funded projects in countries such as Haiti and South Sudan. In both countries, SCOPE RMNCH created the infrastructure and relationships necessary for World Relief to transition from the RMNCH work to emergency response as the situation deteriorated. This has been especially evident in Haiti, where World Relief was awarded a $3.5 million USAID-BHA award to respond to conflict and cholera in the neighboring Sud Department.

GENDER

SCOPE did not silo gender as a standalone activity, but implemented the gender mainstreaming approach, integrating gender equality into all activities. To accomplish this objective, SCOPE identified three priorities for the Project. The priorities were selected through the lens of improving gender equality across the SCOPE Project and strengthening World Relief's organizational capacity in integrating a gender strategy into all programming.

Priority 1: To build upon USAID's priorities in family planning, maternal, newborn, and child health; the engagement of male allies and faith leaders in reproductive empowerment, and the elimination of gender-based violence.

- SCOPE implemented *Families Together*, a couple's curriculum that promotes equitable health decision-making and seeks to address power imbalances in relationships between women and men.
- SCOPE implemented *FLE*, a faith-leader curriculum inclusive of youth and young adults.
- All SCOPE data was gender-aggregated and allowed for the dissemination of issues that specifically impacted women and girls at the community level.

Priority 2: To prioritize the tracking, documentation, and dissemination of results from the SCOPE Gender Plan, and link results to global best practices.

- All World Relief offices participated in an Annual Gender Scorecard, which measured how a World Relief Country Office was incorporating gender mainstreaming in all organizational areas. A Gender Action Plan was developed and updated annually based on the Scorecard's result.
- All World Relief staff were trained in all elements of the Gender Scorecard.

Priority 3: To expose World Relief staff to assessment tools such as the Gender Equality and Inclusion Self-Assessment (GEISA) in an effort to build staff members' capacity to identify focal points within the organization where gender programming/ and organizational gender mainstreaming is lacking.

- All World Relief staff receive training on policy on the Prevention of Sexual Exploitation and Abuse, as well as information on community feedback mechanism, and how to speak of these policies and resources with the communities World Relief works with.
- Facilitated by the SCOPE team, World Relief Haiti, Kenya, Malawi, and South Sudan participated in a GEISA Survey

PROJECT CHALLENGES

COVID-19 PANDEMIC

SCOPE launched in October 2019, and by March 2020, most of the world was in lockdown due to the COVID-19 pandemic. The pandemic impacted the SCOPE global support team's ability to travel to implementing countries/geographies, thus impacting the Project rollout. SCOPE increasingly relied on local expertise to provide leadership at the country level and to meet USAID's design and reporting requirements. The capacity of the implementing country offices varied, and travel in years one and two of the Project would have enabled technical training and support, supportive supervision and the ability of the technical team to speak with first-hand experience of the local context. While SCOPE gained ground in years three and four, it is impossible to gauge the impact of the pandemic on project gains. SCOPE recommends incorporating risk factors such as pandemics, natural disasters, and weather events due to climate change into the design and outcomes of future projects, especially while working with local partners at the community level.

REPORTING AND COMPLIANCE REQUIREMENTS

The reporting and compliance requirements on USAID partners are significant. World Relief anticipated this requirement as a new partner through the New Partnership Initiative by recruiting additional staff for the Project. Still, in the first year of implementation, it became evident that the planned staff levels would not be adequate, and additional team members were brought on to support reporting (financial, data, and narrative) and compliance requirements by USAID. As a global project, SCOPE attempted to maintain lower home-office staffing levels to reserve maximum resources for program implementation at the country level. This presented a challenge in meeting donor expectations related to routine reporting requirements. SCOPE recommends that USAID continue reassessing reporting requirements and align Washington Bureau needs with Mission-level needs to avoid duplication of requirements.

On the other hand, USAID had foreseen the added burden on partners and the steep learning curve, and provided ongoing and adequate technical and management support to the Project team. For example, while the bi-weekly calls with USAID DC and monthly calls with country Missions were labor intensive and took significant time from the SCOPE technical team, they provided necessary and needed support throughout the life of the Project. The SCOPE team appreciated that the cooperative agreement required bi-annually instead of the typical quarterly project reports. The Malawi Mission opted for quarterly reporting, which added an additional task to lean technical and country teams. For future projects, SCOPE recommends

that USAID maintain a bi-annual reporting cadence with two written reports annually and more frequent (monthly) check-ins with technical and backstopping teams, enabling partners to maintain greater focus on implementation.

CO-DESIGN PROCESS AND PROJECT APPROVAL FOR NEW PARTNERS

SCOPE participated in a rigorous project co-design and approval process after signing the cooperative agreement. This involved a review of first-year workplans by many stakeholders (both at Washington and Mission levels), as part of the approval process and advocacy for USAID Mission buy-in. This caused delays in the approval of first year workplans and the commencement of implementation. It is easy to see why local Missions would prefer working with larger, more well-known partners requiring fewer process reviews, as it is less labor-intensive for both parties. While SCOPE appreciates and acknowledges significant buy-in and support from local Missions, it came with significant advocacy and effort by SCOPE. SCOPE recommends that even as USAID transitions to broader implementation of its localization strategy, local Missions work early and open-mindedly with smaller partners to provide buy-in and support. Without these factors, new and underutilized organizations face an uphill battle in the start-up and implementation of projects.

A key challenge was the short turnaround time to submit the Project proposal as a new partner. Larger organizations often have larger business development and technical teams who can work to meet USAID's proposal submission deadlines. Releasing requests for proposals of new programs with only four to six-week timelines means that new/underutilized organizations do not have all the necessary inputs to submit a quality product. Moreover, if a program design intends to be inclusive of program participants on the ground, this process takes time for a proposal to be co-designed well. As USAID operationalizes its localization strategy, SCOPE recommends that USAID work more closely with smaller partners and in expanded timeframes to allow adequate time for submitting well-designed proposals that include voices from local communities and partners.

LESSONS LEARNED & RECOMMENDATIONS

REMUNERATION OF COMMUNITY HEALTH WORKERS

Insights gained through SCOPE underscore current research showing indisputable evidence that CHWs improve health outcomes.[1] SCOPE's Midterm Evaluation highlighted that CHWs were a trusted source of information and services. In Kenya, 38% more households reported a recent CHW visit than at baseline, Malawi experienced a 17% increase, and in South Sudan, there was a 35% increase from baseline. A key component of SCOPE's program design was to bring health referrals and services as close to remote communities as possible. While CHWs are often integral to bringing health services to people in very hard-to-reach geographies, they are often also the most overlooked. SCOPE's initial project design and budget did not include the remuneration of CHWs, however, in all four countries, SCOPE learned that while ministries of health are making progress in the professionalization and incentivization of CHWs, many of SCOPE's geographies still lack the resources to provide sufficient remuneration. SCOPE, therefore, sought to and was permitted by local USAID Missions to provide compensation incentives under the guidance of local ministries of health. While SCOPE recognizes that for sustainability's sake, this is not a practice favored by USAID, we are grateful that the Project was able to provide remunerative support to this key cadre of community-based actors. Indeed, best practices reveal that CHWs must be compensated for their time, equipped with the necessary skills, supplied with the necessary resources, and supervised in a manner that strengthens their performance.[2] SCOPE, working in the most remote communities in Haiti, Kenya, Malawi, and South Sudan, is proud to have integrated these approaches early and to provide evidence of the importance of these practices. SCOPE recommends that implementing partners working with CHW cadres do their due diligence and advocacy to ensure that this highly impactful health workforce is adequately salaried, supervised, supplied, and skilled for maximum impact in remote and resource-deprived communities. Additionally, by inviting CHWs to the table as a recognized professional cadre of health workers during program design and decision-making, crucial gains can be made to expand primary healthcare and, ultimately, universal health coverage.

USE OF THE COMMUNITY HEALTH WORKER ASSESSMENT AND IMPROVEMENT MATRIX TO INFORM COMMUNITY HEALTH WORKER PROGRAMMING AND DESIGN

During the Project's first year, the SCOPE team used the Community Health Worker Assessment and Improvement Matrix[3] to understand the baseline status of CHW programs in SCOPE Project areas, identify gaps and needs, and inform project planning. This functionality assessment consisted of document review, key informant interviews, and engagement with national and sub-national stakeholders, including the individual USAID Missions. SCOPE learned about CHW recruitment practices, the role/scope of the CHW cadre, and the equipment and supplies CHWs needed (based on their scope per MOH policy). SCOPE also learned about supervision modalities, other implementing partner efforts on CHW capacity development, and incentives that may affect health worker motivation. Lastly, SCOPE mapped out the local referral systems (between community and facility) and how documentation and information management were functionalized, revealing a number of gaps needing to be addressed. This process also informed our CHW engagement approach and the in-country stakeholder relationships critical to the CHW programs' sustainability beyond SCOPE's time on the ground.

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1 Community Health Workers' Role Grows with Evidence that They Improve Care and Equity. Accessed January 8, 2024. https://ldi.upenn.edu/our-work/research-updates/community-health-workers-role-grows-with-evidence-that-they-improve-care-and-equity/.

2 A Movement to Achieve Health Equity by Making Professional Community Health Workers the Norm Worldwide. Accessed January 8, 2024. https://chwi.jnj.com/news-insights/a-movement-to-achieve-health-equity-by-making-professional-community-health-workers-the-norm-worldwide.

3 CHW AIM Updated Program Functionality Matrix, December 2018. Accessed January 8, 2024. https://joinchic.org/wp-content/uploads/2023/03/CHW-AIM-Updated-Program-Functionality-Matrix_Dec-2018.pdf.

COMMUNITY HEALTH WORKER CAPACITY STRENGTHENING THROUGH COACHING AND MENTORING

After four years of implementing health system-strengthening programming at the primary healthcare level, SCOPE witnessed changes in how CHWs provided community-level services and supervisor engagement. A number of successes were noted regarding the influence of consistent supervision and mentorship of CHWs. For example, frequent touchpoints with supervisors and other mentors (such as SCOPE staff) significantly increased CHW knowledge and skill level, resulting in CHWs being able to provide more frequent and effective community level services. A key activity of SCOPE was CHW capacity building through technical trainings in community-based family planning and maternal/child health, and high-touch mentoring and supervision. Supervision efforts focused on strengthening CHWs' capacity around data reporting, recognizing danger signs for the woman and/or child, and ensuring timely and safe referrals to the nearest health facility (each CHW was linked to a supervisor attached to a linked health facility).

At baseline, SCOPE's project geographies reported very little mentoring or supervision, while the Project's Midterm Evaluation found large jumps in the frequency and quality of supervision of CHWs. CHW Supervisors provided rich explanations of how they had accompanied CHWs on some household visits and helped improve their skills throughout the Project. An average of 92% of SCOPE-supported CHWs reported receiving supervision/coaching/mentoring, and 91% reported the experience was both positive and motivating to their overall performance. In Kenya, for example, of the CHWs who had received supervisory visits, 94% reported their knowledge was updated or strengthened, and that as a result of the visit, they felt more motivated. In South Sudan, 83% of CHWs said they felt supervision was updating their learning and knowledge, and 87% said that they felt more motivated after visits. In Malawi, 98% of CHWs said they were learning from supervision, and all CHWs either agreed or strongly agreed that they were more motivated after supervisory visits. On average, in SCOPE-supported geographic areas, the evaluation confirmed SCOPE's efforts to strengthen the supervision aspect of capacity development in tandem with strengthening the capabilities of CHW Supervisors. Regular, consistent supervision has not only strengthened the quality of CHW services but also strengthened the household trust of CHWs in the communities.

CARE GROUPS AS SOURCES OF REFERRALS AND LINKAGES TO HEALTH SYSTEMS IN HARD-TO-REACH AREAS

SCOPE saw evidence of the significant impact of the Care Group activity when layered with other community health interventions in catchment communities. These results built on the contributions of other recent USAID strategies, which utilize peer-group dialogues to help shape the beliefs, values, and behaviors shown to improve health-seeking behaviors and community wellbeing.[4] SCOPE saw Care Groups strengthen and extend the health system's reach into communities with little or no access to regular services (due to long distances or lack of health system resources) and build stronger linkages to the formal health system through CHWs. Locally contextualized Care Group lessons promoted norm-shifting behaviors and created an environment where mothers are motivated to implement simple practices, such as hand washing, home gardening, and latrine use. Of special note is SCOPE's incorporation of reproductive health/family planning lessons into the Care Group curriculum. In Malawi, the MOH decided to adopt this previously unavailable resource nationally.

FAITH ENGAGEMENT

As a faith-based organization, World Relief deeply appreciates USAID's commitment to lean into our organizational area of expertise in engaging faith leaders to strengthen their own community health outcomes. While both parties remained equally committed to compliance with legal requirements in religious engagement, acknowledging faith leaders' important role in health outcomes was a shared value throughout the Project. This led to developing curriculum that would strengthen the capacity of faith leaders in ways that "advance shared priorities and maximize sustainable development," as outlined in USAID's recent Strategic Religious Engagement Policy. In particular, SCOPE implemented a multi-stage approach to working with faith leaders on family planning/reproductive health topics. First, SCOPE implemented a general community-mobilization approach amongst faith leaders. This helped cast a vision for what faith leaders could do as key influencers within their communities. Only after this process was completed did SCOPE introduce the technical topics of family planning and reproductive health. This implementation and collaboration model provides an excellent case study on best practices in faith partner engagement to USAID and other implementing partners at Washington and local Mission levels.

LEVERAGING NON-HEALTH ACTORS FOR REFERRALS AND CASE FINDING

SCOPE worked with multiple community actors who each played an important role in supporting case finding and strengthening referrals and linkages to health facilities. While CHWs deliver information, services, and referrals at the household level, a "community of referrals" was built through faith leaders and community groups, particularly Care Groups. This strategy was deeply embedded within SCOPE's framework, evident in its curriculum, monitoring indicators, and the active participation of CHWs in Care Group and Faith Leader trainings and workshops. Once mobilized and trained, faith leaders became a mechanism of the local referral system. Faith leaders were equipped to provide evidence-based information to their communities and make referrals from the communities to CHWs and/or nearest health facilities. In this way, they could speak to the faith and values of the local community while acknowledging that trained health professionals best tackle issues related to health and illness. Care Groups also served as connectors linking back and forth between CHWs, health facilities, and other providers sharing health information, services received at health facilities, and reporting vital events. Additionally, Care Groups cultivated an enabling environment conducive to sustainable behavior change. This community of referrals amplified the work of CHWs and highlighted the interconnectedness of key influencers capable of driving social norm change. By working together to generate demand and increase access to services, SCOPE's approach can be replicated to strengthen health systems while improving RMNCH outcomes.

MAPPING OF COMMUNITY HEALTH MANAGEMENT INFORMATION SYSTEM

During the Community Health Worker Assessment, SCOPE identified the reporting mechanisms already in place in each country; this included the referral systems and how documentation was collected and information was being managed. SCOPE also worked with the Community Health Management Information System (CHMIS) focal persons to provide capacity building to CHWs on data management; this included on-site training on documenting referrals, and accurate and timely record keeping.

A key activity conducted by SCOPE was a review of the CHMIS and MOH-mandated CHW monitoring forms in the four countries. For each of the four countries, the team defined the key measures that would need to be collected for project outputs, organized the collection of information required for donor reporting, and assessed how data points pertaining to community-based family planning/maternal newborn child health were reported to District Health Information Systems for each of the four countries. This exercise aimed to map out the data flow of key family planning/maternal newborn child health measures and understand how to sustainably gather information on those measures so that SCOPE-supported CHWs did not have to create a parallel reporting system for the Project. Because a key goal of the Project was to avoid creating a parallel information management system, SCOPE's MEAL system was designed to provide high-quality data for decision-making, allow for adaptive and agile project management, and effectively collect the data needed to evaluate the impact of the interventions, all while utilizing MOH-mandated forms.

4 Passages Project Theory of Change, Updated January 2021. Accessed January 8, 2024. https://www.irh.org/wp-content/uploads/2020/04/Passages-Project-Theory-of-Change_updated_Jan_2021-1.pdf.

SCOPE RESOURCES & PRESENTATIONS GLOSSARY

CURRICULA

Making Our Communities Better
- Leader's Manual

Family Life Education
- Trainer's Guide
- Participant Handbook

Families Together
- Facilitator's Guide
- Implementation Guide

Care Groups
Module 1: Introduction to Care Groups & COVID-19 Awareness
- Promoter Lesson Plan
- Volunteer Flipchart

Module 2: Child Health & Integrated Community Case Management
- Promoter Lesson Plan
- Volunteer Flipchart

Module 3: Maternal & Newborn Health
- Promoter Lesson Plan
- Volunteer Flipchart

Module 4: Family Planning
- Promoter Lesson Plan
- Volunteer Flipchart

PUBLICATIONS

Webpages
- SCOPE
- SCOPE Community Health Workers
- SCOPE Care Groups
- SCOPE Faith Engagement
- SCOPE HIV
- SCOPE COVID-19

Resources
- SCOPE Overview
- SCOPE Technical Brief: Community Health Workers
- SCOPE Technical Brief: Care Groups
- SCOPE Technical Brief: Faith Engagement
- World Relief 2022 Annual Report: Faith and Family Planning

Media
- Blog Post: Partnering with Women through Health Education: Q&A with SCOPE Senior Technical Advisor
- Blog Post: Four Things We've Learned Working with Care Groups
- Blog Post: Embracing Uncomfortable Conversations: Four Lessons We've Learned Engaging Faith Leaders in Family Planning
- Video: SCOPE Malawi Overview

PRESENTATIONS

International Conference on Family Planning, Virtual, February 2021
- Panel session: *Family Planning Lessons from Malawi and Burundi During COVID-19*

CCIH Conference 2021, Virtual, May 2021
- Presentation: *Learning from Challenges in Local Partnerships*

CCIH Conference 2022, Virtual, June 2022
- Presentation: *Uncomfortable Conversations: Learnings from Adapting RMNCH Curriculum with Grassroots Faith Leaders*

CHW Symposium, Liberia, March 2023
- Poster presentation: *Improving Family Planning & Maternal Child Health Outcomes in Hard-to-Reach Fragile Areas through Coordinated Interventions that Engage Key Local Community Actors*

CCIH Conference, USA, June 2023
- Panel session: *How to Motivate Community Volunteers and Workers: With or Without Compensation?*

Core Group Global Health Practitioner Conference 2023, USA, October 2023
- Poster presentation: *Increasing Contraceptive Uptake Amongst Youth by Engaging Faith Leaders Within Conservative Communities in Malawi*
- New Information Circuit presentation: *Equipping Faith Leaders to Respond to Family Planning/ Reproductive Health Challenges in Their Communities: Faith Leader Engagement Tool*
- Poster presentation: *Care Groups to Build Support for Family Planning Use in South Sudan: A Key Strategy for Social-behavioral Change Communication in Fragile Contexts*

American Public Health Association, USA, November 2023
- Poster presentation (by SCOPE Partner CCIH): *Faith Actors & Community Health Workers Serving Hand in Hand in Hard-to-Reach Areas*

International Conference on Family Planning, Thailand, November 2023
- Faith Pre-Conference session: *Equipping Faith Leaders to Communicate on Family Planning/ Reproductive Health: A Newly Adapted Faith Leader Engagement Tool*
- Panel session: *Power of Key Influencers to Influence Social Norms About Family Planning | Increasing Contraceptive Uptake by Engaging Religious Leaders within Conservative Migratory Communities in Kenya*
- Panel session: *Women Care for Each Other | Care Groups to Build Support for Family Planning Use in South Sudan: A Key Strategy for Social-behavioral Change Communication in Fragile Contexts*

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