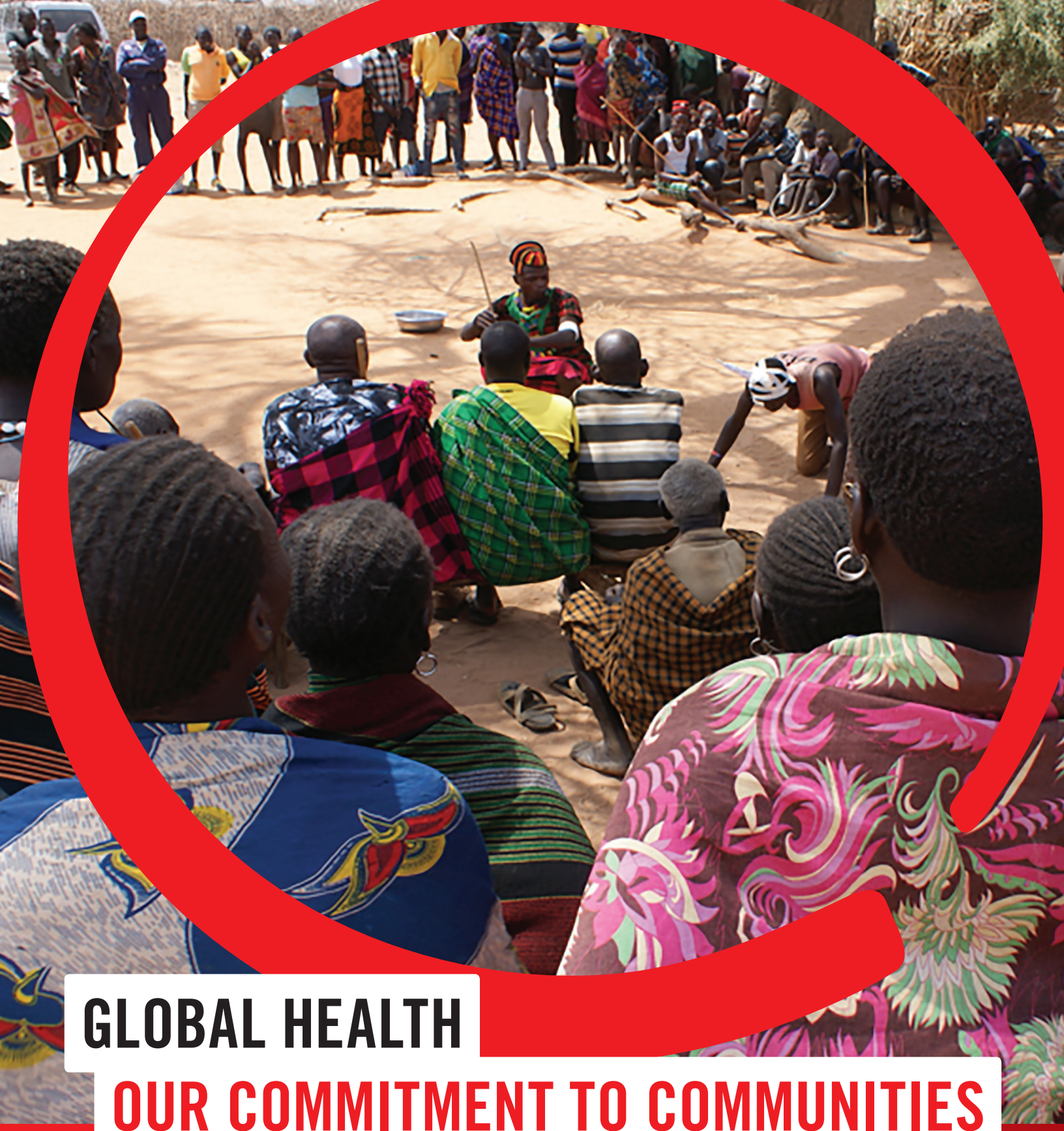

GLOBAL HEALTH
OUR COMMITMENT TO COMMUNITIES

Save the Children
100 YEARS

July 2019

OUR COMMUNITY HEALTH LEGACY

INTRODUCTION

Save the Children's long history of working with communities has made the organization a recognized leader in developing and implementing successful approaches in community health and nutrition. **Our commitment to strengthen community systems and the social support structures and services closest to families and children is rooted in a traditionally strong community development and child rights orientation.** This enables us to address underlying barriers to improved health and nutrition outcomes, social equity, and resilient health systems. Such barriers include individual behaviors, social and gender norms and their inherent power relations, and structural issues related to the quality of, access to and demand for care.

Community Health at Save the Children encompasses the following three components:

1. **Community Service Delivery (CSD):** the provision of a continuum of health promotion, disease prevention, and curative services by a cadre of Community Health Workers and Volunteers (CHWs) and community groups responsive to community needs and context.
2. **Community Capacity Strengthening (CCS):** the process through which communities obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time. Community capacity is the set of assets or strengths that community members individually and collectively bring to the cause of improving the quality of life. Community mobilization (CM) is a central approach to strengthen community capacity, through which community members, groups, or organizations plan, carry out, and evaluate activities to achieve a common goal on a participatory and sustained basis, on their own initiative or stimulated by others[1].
3. **Community Social and Behavior Change (SBC):** the systematic application of interactive, theory-based, and research-driven processes and strategies to address SBC at the individual, community, and social levels, including the cross cutting use of strategic communication. This includes interpersonal communication, group activities, community media, and social media. Community involvement at every step of the process is key (adapted from FHI360 2012: C-Modules).

100 YEARS OF CHANGE FOR CHILDREN

Save the Children has long been on the leading edge of global progress for children. In commemoration of our 100-year anniversary in 2019, we looked back to capture our legacy in three key areas of global health where we have focused our efforts: **Community Health, Newborn Health, and Nutrition**. To do this, we reviewed and documented our impact on women, children and their communities through our global achievements, leadership roles, key contributions, and program learning and results. After a century of progress, our bold ambition for children is clearly within our sights, and we hope to leverage our learning and experience in these critical areas of global health over the past 20 years to continue the unfinished work that lies ahead.

1 Save the Children, *How to Mobilize Communities for Health and Social Change*, 2002.

SC'S COMMUNITY HEALTH APPROACH INCLUDES

1. Strengthening community service delivery (integration with facilities)
2. Community capacity strengthening/mobilization to increase norm change, and address barriers to demand for, access to and use of services
3. Community-centered SBC activities to address and support household level behavior change

HISTORICAL OVERVIEW: A COMMITMENT TO COMMUNITIES

Over the past fifty years, Save the Children recognized the critical role that communities play in children's development and well-being, and in their own development. In the 1970s through the early 1990s, **we developed Community-Based Integrated Rural (and later Responsive) Development (C-BIRD), an integrated approach to programming rooted in principles of community empowerment and self-determination**, which worked with the most vulnerable in geographically limited impact areas. Community needs assessments were broad and led to a wide array of priorities. External evaluation of this approach found that while its infrastructure projects were particularly impressive, the effectiveness of addressing health and nutrition was questionable due to limited technical expertise, focus and access to appropriate technology.

To address this gap, the organization developed a new strategic plan called "Breakthroughs for Children." It called for **high-quality, large-scale programs, with a focus on health, education and economic opportunities, areas that would have the greatest impact on children**. It also became a priority for Save the Children to design more scalable, community-based approaches based on evidence that many mothers, newborns, and children—especially among poor, rural, and marginalized populations—did not have access to basic services.

During the 1990s, our health and nutrition programs were successful at demonstrating measurable impact at scale. Two examples include the ***Community Empowerment in Nutrition Project (CENP)*** in Vietnam, applying a positive deviance approach, and the ***Bolivia WARMI Project*** (1990–1993), where we first developed the Community Action Cycle (CAC), which contributed to a 67% reduction in perinatal mortality. The CAC approach fostered a community-led process through which those most affected and interested organized, explored, set priorities, planned, and acted collectively for improved health. These programs combined the strengths of the former approach of community ownership and capacity building with strategies aimed at achieving specific, measurable results focused around a health goal, with careful documentation and attention to methodologies to replicate with national-level advocacy for scale.

From 2000–2003, an internal analysis reviewed best practices for mobilizing communities and provided an operational definition with a set of common steps, detailed in the *How to Mobilize Communities for Health and Social Change* field and training guide (Health Communication Partnership in 2003).

An additional inventory across multiple sectors demonstrated the effectiveness of the CAC implemented in over 40 countries, with outcomes in the areas of maternal, newborn, and child health (MNCH), adolescent sexual and

THE *WARMI PROJECT*

Save the Children first tested the CAC in 50 communities in Bolivia from 1990-1993 (USAID), with the aim of reducing maternal and perinatal mortality in isolated communities with limited access to health services. Its application, together with other project activities, resulted in a significant reduction in perinatal and newborn mortality, and changes in knowledge and practices related to prenatal care, breastfeeding, immunization, newborn care, and increased use of Family Planning (FP) methods. Women increased their participation in community planning and decision-making, initiated a literacy program, and started micro-enterprises. Communities assessed their own capacity each year, celebrated successes, and identified improvements. The 1994 Bolivian National Health Plan integrated and expanded the WARMI method to over 500 communities, facilitated by a combination of government health workers and NGOs. While this initial approach was resource-intensive and implemented in small geographic areas, later approaches aimed to be replicable at scale.

reproductive health (ASRH), HIV and AIDS, nutrition, basic education and early childhood education.

Save the Children has also effectively implemented integrated **Community Case Management (iCCM)** within our programs. Although we developed innovative and locally feasible ways to overcome many of the barriers to optimal child health, we recognized that training CHWs to detect and provide initial treatment and referral of children for the most common childhood illnesses would be the most effective way to reduce child mortality due to these causes.

We developed another highly successful approach during this time called **Partnership Defined Quality (PDQ), which engages community members and service providers in collaborative quality improvement plans and action**. We institutionalized PDQ through our programs into Quality Improvement Teams at health facilities in Mozambique, Ethiopia, Pakistan, the Philippines, Egypt and multiple other countries.

Save the Children served as the community mobilization partner under the global, USAID-funded, ***Health Communication Partnership*** (2002–2008) project with Johns Hopkins, Center for Communication Programs (CCP) as a prime. Since 2017, we are a principal partner under the global SBC flagship program, ***Breakthrough-ACTION***. This program introduces newer methods into the SBC mix, such as behavioral economics and human-centered design.

Over the last 15 years, Save the Children worked to institutionalize systematic community engagement at multiple levels through linking CHWs with service delivery, supporting community self-organization and collective action to address health issues and structural or social norm barriers to service uptake, and supporting household behavior change. Recently, **we pioneered a comprehensive SBC framework based on a socio-ecological model and theory-based determinants of individual and group change**. Our integrated approach combines SBC with CCS and applies it to community norm and household behavior change, demand creation for services, and country service delivery.

KEY STRATEGIES AND EVIDENCE OF IMPACT

1. Community Service Delivery

Save the Children has been an important contributor to reductions in maternal and child mortality over past decades by working with CHWs, and applying MNCH, family planning (FP) and iCCM.

Capacity Strengthening of Community Health Workers: We focus efforts on strengthening the capacity of CHW, whether volunteers or paid community members, as they implement and sustain strategies to improve

maternal and child health and nutrition. We have been a key contributor in building the capacity of many female community health volunteers (FCHVs) and testing new strategies with them, including iCCM.

In the ***Maternal and Child Health Integrated Program (MCHIP), Egypt Smart Choices for Healthy Living*** (2011–2014), Save the Children had a 98% retention rate of CHWs, and over 149,000 mothers received maternal and child health and nutrition messages. A quasi-experimental study demonstrated the effectiveness of CHWs as change agents, with significant increases in consumption of iron-folic acid supplements during pregnancy, antenatal care (ANC) coverage, use of skilled birth attendants, and exclusive breastfeeding and children fed a diverse diet.

In the ***MCHIP project* in Mozambique** (2011–2015), home visits and outreach by CHWs, along with quality improvement of health services, contributed to a 57% reduction in the maternal mortality ratio in the project area. National Health Information System data and LiST analysis calculated this reduction from 102 Model Maternity Initiative facilities (with coverage of one-third of national institutional deliveries in country).

Positive Impact on Child Health: Save the Children has had decades of positive impact on child health by linking communities to existing health services and strengthening facility capacity for Integrated Management of Childhood Illness (IMCI). Through our many USAID-funded ***Child Survival projects***, important issues of immunization, growth monitoring, nutrition counseling, and early detection and treatment of diarrhea, pneumonia and malaria resulted in increased demand for available child health services. We also identified ways to overcome barriers to service delivery. For example, a completed immunization schedule by a child's first birthday has a powerful impact on reducing mortality. In our ***Child Survival project in Guinea*** (2002–2006), the percentage of children with complete immunization by age 1 more than doubled after providing assistance to local health facilities for effective planning and involvement of Village Health Committees in active case finding of children behind in their immunization schedule ("defaulters"). To ensure project sustainability, Save the Children works hand-in-hand with national Ministries of Health (MOHs) to share strategies and techniques.

Addressing Community Maternal and Newborn Health Needs: As early as 1994, we provided technical assistance (in coordination with the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), PATH, the Nepal Red Cross and other key stakeholders) for the development of the Clean Home Delivery Kit, a commercial product still in use. Additionally, we helped to improve the quality of maternal health services at local facilities and strengthened community use of these services. For example, we provided state-of-the-art programming for best practices by organizing Lifesaving Skills training for midwives from the American College of Nurse Midwives during the ***Child Survival project in Tajikistan*** (2002–2007). The project also assisted communities to organize revolving funds to pay for transport during obstetric emergencies. As a result, skilled personnel attended 95% of childbirths by project end.

Lastly, **Save the Children is globally recognized for getting the "Newborn" into Integrated Management of Newborn and Childhood Illness (IMNCI)**, increasing a focus on the need for interventions to reduce the high mortality rates of newborns. Our ***Child Survival project in Zambia, Lufwanyama Integrated Neonatal and Child Health Program (LINCHPIN)*** (2009–2014), expanded the national protocol for post-natal care (PNC). An article published the approach we tested, in which mostly male CHWs were paired with trained Traditional Birth Attendants as community teams to improve the continuum of care from birth to age 5. Births attended by skilled personnel increased from 36% to 96%.

Community-based Distribution of FP: We have extensive experience with facilitating training and support for community-based distributors of (some) FP methods. In Uganda, our programs documented the effectiveness of a community-based distribution model of injectable contraceptives and expanded it from one pilot district to three, and then to the national level through policy change in 2010. This influenced regional replication in Rwanda, Kenya, Malawi, Madagascar, and Nigeria.

Demonstrating the advantages of iCCM: Save the Children developed innovative and locally feasible ways to overcome many of the barriers to optimal child health. We have worked in such countries as Nepal, where the national government embraced the role of FCHVs. Our current global approach for iCCM of childhood illnesses is an equity-focused strategy to ensure all children have access to cost-effective lifesaving treatment.

Historically, we have worked in partnership with key actors, such as the World Health Organization (WHO) and UNICEF, to build consensus on the need for this approach and to influence policy. We conducted a mortality study in Guinea to investigate the causes of the many child deaths that take place in the home to demonstrate the limitations in access to lifesaving care. Between 2009 and 2011, Save the Children expanded and scaled up iCCM and documented the effectiveness of this approach in such countries as Ethiopia, Nicaragua, and Pakistan. We demonstrated that those trained in iCCM provided quality care at scale in a remote area of Ethiopia, and poor children in Nicaragua accessed curative health services six-fold through iCCM over facility-based services. Our study in Pakistan, which proved the capacity of community-based health workers, such as Lady Health Workers, to administer a first dose of antibiotics to children 2 to 59 months of age with severe pneumonia, contributed to the 2014 change of WHO IMCI guidelines.

REDUCTION OF NEONATAL MORTALITY THROUGH MOBILIZING WOMEN'S GROUPS IN NEPAL

In rural Nepal, MIRA, a local NGO, implemented a Randomized Control Trial from 2001-2003 with 24 village development committees (VDCs) with an average of 7,000 people each. Save the Children used CM with women's groups to reduce high rates of maternal and neonatal mortality. MIRA adapted the WARMI Project methodology to the local context. Results after 30 months showed a 30% reduction in neonatal mortality and a maternal mortality ratio one-fifth of that in control clusters. More than two years after the project ended, 105 of 111 women's groups were still meeting regularly with no external incentives or financial support provided.

Save the Children is the only nongovernmental organization (NGO) member of the global iCCM Working Group that has helped to advance operational research and policy application in multiple countries through the following activities:

1. Lead advisor for the development of the 2010 *CCM Essentials*, a guide for program managers including tools development and documentation of lessons learned.
2. Lead contributor to the 2014 indicator guide for iCCM and the WHO-led *Handbook for Countries to Introduce and Scale up Caring for Newborns and Children in the Community*.
3. Lead author of a special supplement in the *Journal of Tropical Medicine and Hygiene* in 2012, which documented evidence for the quality of iCCM, noted its importance in global efforts to provide equitable care to all, defined the necessary program elements and support, and charted the way forward. By 2016, we expanded iCCM programming to 19 countries.

2. Community Capacity Strengthening (CCS)

CCS is an essential component of Save the Children Community Health. It integrates our **long history of mobilizing communities for health and social change, with focused strategies for improved social norms and behavior change, and increased access to and use of quality health services**. Our emphasis on communities comes with the understanding that lasting positive impact in the lives of children, especially the most marginalized, occurs through community engagement and their ability to drive and sustain improvements over time. In the midst of the dynamic and rapidly evolving local and global contexts, **Save the Children applied a**

systems strengthening approach early on by integrating CCS strategies into existing health policy, government plans and community social platforms. With funding from major donors, and partnerships from academic institutions and programs, we demonstrated how to achieve greater institutionalization and scale, and more sustainable outcomes based on systematic CM models.

In 2013, an internal, multi-sectoral working group reviewed our community mobilization toolbox to refine and expand the application of the CAC, PDQ, and Measure Community Capacity tools and guidance. The resulting *Community Capacity Strengthening Resource Guide* (2013) highlighted capacity-strengthening approaches grounded in our rich CM history.

Community Collective Action – Evidence for the CAC: Over the past decade, over 42 programs in more than 40 countries applied the CAC across multiple sectors with solid evidence in iCCM, maternal and newborn care, FP, child health, nutrition, malaria prevention and treatment, ASRH, HIV and AIDS prevention, care and support, and the Zika response. Over 20 research studies documented improved community capacity and health outcomes through the application of the CAC for CM, either on its own or in combination with service delivery platforms and social and SBC interventions. A meta-analysis by the WHO specifically references Save the Children's efforts in this area, some of which are below.

We realized improvements in child health outcomes under the Zambia *LINCHPIN Project* by strengthening Neighborhood Health Committees to apply the CAC. The evaluation noted that in addition to the application of iCCM, the CAC was essential in achieving results for which key community stakeholders raised resources to sustain viable emergency transport and build maternity waiting homes. Statistically significant findings in family health practices include:

- ANC visits increased from 55% to 78%;
- Births attended by skilled personnel increased from 36% to 96%; and
- Increase in children with fever, 0-23 months, who received artemisinin-based combination therapy within 24 hours increased from 11% to 55%.

Through the ***Access to Clinical and Community Maternal, Neonatal, and Women's Health Services (ACCESS)*** initative (2006–2009) in Bangladesh, Malawi, and Nigeria, Save the Children applied the CAC to strengthen the Household to Hospital Continuum of Care by integrating CM approaches into national, regional, and district health plans and budgets, and building skills of implementing government and NGO partners. Some of the results CAC contributed to include:

- In Malawi, deliveries by skilled birth attendants increased from 54% to 72%;
- In Bangladesh, 61% of Community Action Groups (CAGs) generated sustainable emergency transport funds; and
- In Nigeria, community-based advocacy through civil society resulted in improved staffing and management of local health facilities, including drug and insecticide-treated bed net availability.

Recognizing that geographic and financial limitations and stigma hinder access to post-abortion care (PAC), USAID introduced a PAC model in 2003 that included "community empowerment through community awareness and mobilization" as one of its core components to reduce stigma in accessing PAC services. The CATALYST Consortium piloted the first phase of the community PAC model in Bolivia based on our CAC. It was then successfully adapted and scaled up in Peru, Egypt and Bolivia to validate the importance of community participation in increasing women's access to PAC services. Under the ***Ethiopia HIV and AIDS Care and Support Program (HCSP)*** (2009), application of the CAC contributed to increased adherence to Antiretroviral Therapy.

Social Accountability through PDQ: To address the persistent barriers poor health service quality presented for families and communities' demand for health services, Save the Children developed the PDQ approach in 2003.

DEMAND CREATION RESULTS OF COMMUNITY MOBILIZATION AT SCALE

In Ethiopia, the Saving Newborn Lives project (SNL) in collaboration with the MOH developed a *Maternal, Newborn, and Child health/community-based Newborn Care Demand Creation* strategy implemented in 21 zones. Save the Children evaluated 244 districts through an embedded multiple-cross case study analysis design using mixed methods including assessment of implementation strength. In communities (kebeles) demonstrating a high degree of implementation strength, results included:

- Earlier disclosure of pregnancy status by women (earlier access to ANC)
- Husbands more knowledgeable about MNCH issues and mothers-in-law less fatalistic about newborn survival
- Husbands, mothers-in-law and Health Development Army members indicated increased support for early ANC
- Earlier decisions by mothers to seek care for newborn danger signs after symptom recognition
- Changed attitudes related to immediate and exclusive breastfeeding and appropriate care of umbilical cord

The CAC was an important component for success, dependent on a strengthened community kebele command post local, and existing community platform.

PDQ fosters social accountability to address improved access to respectful and quality healthcare services. It engages community members and health service providers in collaborative quality improvement analysis, joint planning, action and monitoring.

We applied the PDQ approach in more than 20 countries with documented improvements to service quality and utilization, including at scale in Mozambique, Zambia, Pakistan and the Philippines, through adaptation by national MOHs into quality improvement guidelines, facility-based teams, and accompanying training manuals. The CORE Group's SBC working group *Maximizing the Effectiveness of Partnership Defined Quality Report* documented increased access to quality health services, strengthened community to facility linkages, and increased social accountability and respectful healthcare services through PDQ application.

In the USAID ***Pakistan Initiative for Mothers and Newborns (PAIMAN)*** project (2004–2010), we integrated PDQ at scale in 73 Department of Health, facility-based Quality Improvement Teams. Measured changes in service utilization included significant increases in the number of antenatal check-ups; delivery in a health facility; new mothers who sought PNC within two days of delivery; and health providers who administered diarrhea treatment (proxy indicator for diarrhea care seeking).

In addition, recent results from the USAID-funded ***Maternal and Child Survival Program (MCSP)* in Tanzania, Ethiopia, and Mozambique** (2014–2018) indicate that social accountability approaches, such as Community Scorecards and PDQ, can play a vital role in improving the quality of health services and increasing health facility utilization. In Mozambique, Save the Children integrated PDQ and community scorecards into government health facility Quality and Humanization Committees. Membership expanded to include community representatives. Action plans increased institutional deliveries; acceptance of CHW referrals by health facilities; improved timely service delivery; reduced commodities sold outside the health system; and initial acceptance of male partner presence during ANC services.

Recognizing the value of this approach, the 2007 *PDQ for Youth* (PDQ-Y) toolkit was field tested in Nepal with research on modifying the PDQ methodology specifically for adolescents. In addition, we finalized the 2008 *Partnership Defined Quality for Youth, A Process Manual for Improving Reproductive Health Services through Youth-Provider Collaboration*. In 2010, the CORE Group and USAID supported us to develop the *PDQ Youth Guide, with Monitoring and Evaluation*. Finally, Save the Children used the PDQ-Y in Bolivia, Ethiopia, the Republic of Georgia, Malawi, Haiti and Nepal, and adaptations for youth within PDQ programs applied in Guatemala, Mozambique and the Philippines.

Community Capacity at Scale: Over the past decade, Save the Children focused on **institutionalizing CCS at scale by integrating into existing health systems** through supportive policies, tools and approaches at the national, district and primary healthcare levels. Through strategic partnerships with NGOs and community-based organizations, the CAC has also been scaled in multiple countries. Working at the community level no longer equates to working only at a geographic community level, but leveraging health systems and civil society to adopt appropriate community engagement policy, guidelines and support to engage and reach communities in a meaningful way at scale.

The 2007 Save the Children documents, *Taking Community Empowerment to Scale – Lessons Learned from Three Successful Experiences,* and *De-Mystifying Community Mobilization*, consolidated design methods and implementation processes to apply community capacity at scale. We led the PEPFAR-funded program ***Ethiopia Positive Change: Children, Communities and Care (PC3)***, applying the CAC at scale through four international partners and 35 local NGOs, and building the capacity of 560 community-based organizations to successfully integrate care and support service provision to over 500,000 orphaned and vulnerable children. Through the USAID-funded ***Zambia Health Communication Partnership Program*** (2005–2009), we brought the CAC to scale in 22 districts, institutionalizing community empowering processes into the District Health Management Team functions. We documented significant improvements in intervention areas compared to non-intervention areas, including an increase in the use of HIV testing services from 7% to 14% in sexually active men, and from 25% to 40% among sexually active women, and from 24% to 39% in the use of insecticide-treated bed nets among pregnant women.

MEASURING COLLECTIVE ACTION IN ZAMBIA

Key to the Health Communication Partnership Zambia CM approach was building the organizational and planning skills of Neighborhood Health Committees and respective communities. A quantitative endline survey revealed statistically significant changes in capacity in all intervention districts compared to control districts.

Changes included collective efficacy, participation, conflict management, effective leadership, and social cohesion. Findings also demonstrated that individuals who lived in communities that worked together effectively were more than twice as likely to use a modern contraceptive method. They were two times more likely to have received an HIV test and to know the results of the test, and were 1.5 times more likely to have their youngest child sleep under a bed net to prevent malaria.

Our work in Bangladesh provides a model that sustains CM at scale. We moved from implementing a project based on an intensive project-led CM model working through local NGOs, to achieving scale through institutionalizing CM activities within communities and existing government structures. The **USAID-funded *MaMoni Integrated Safe Motherhood, Newborn Care, and Family Planning project*** (2009–2013) built upon the achievements of the ACCESS project by expanding beyond communities to include facility-based service improvements and project efforts to increase CAC facilitation skills of Community Volunteers. The project introduced community microplanning meetings as a direct interface between community members and the health system. It also began engaging local government to mobilize resources for improving public sector facilities. Building upon the success of the first MaMoni project, the follow-on ***MaMoni Health Systems Strengthening*** (2013–2018) further institutionalized community microplanning meetings and increased involvement of local government to address barriers to service utilization.

Measuring Community Capacity: Today there is continued pressure on community capacity approaches to generate evidence for health outcomes, but also to genuinely strengthen communities' resilience to prepare for and effectively respond to emerging risk and infections. However, measuring progress in CCS is a relatively new and growing field. Save the Children has undertaken efforts to consolidate the social science literature on CCS and adapt indicators to measure community strengthening efforts in the field.

From 2006-2009, Save the Children's Technical Working Group on Measuring Community Capacity consolidated *Tools for Monitoring and Measuring Community Capacity* into the *Community Capacity Strengthening Guide, 2012*. Our literature review and subsequent community capacity research identified 10 domains as common themes for strengthening and measuring community capacity. In our newly integrated framework on SBC and CCS, we consolidated these domains into the set of determinants of SBC. To advance measuring the association between CCS and social change outcomes, Save the Children conducted field research in Vietnam, Uganda, Nicaragua, Zambia and the Philippines. The programs addressed health, education, and HIV and AIDS using a range of strategies, including improving an enabling environment for positive change. The research hypothesized that increasing community capacity is an important strategy for communities to achieve and sustain results. The peer-reviewed research in Zambia, published in the *International Quarterly of Community Health Education* (2013) was the first of its kind to establish a direct association between an increase in community capacity and health outcomes.

3. Community-Centered Social and Behavior Change

Community SBC employs a multitude of approaches and best practices. These include: community consultation and formative research to inform the development of SBC strategies; SBC and advocacy strategies working through existing community structures, harnessing the role of traditional and faith-based leadership; and capacity strengthening of civil society organizations, CHWs, volunteers and other influencers on behaviors to enhance dialogue and inter-personal communication at household levels, and within and among different community groups to provide social support for household decision-making.

Integrated SBC Campaigns: Due to its ability to work across development sectors, Save the Children has significant experience in the development of integrated programming combining SBC strategies with CCS approaches and with large SBC campaigns integrated with community programming. In 2015-2016, the Malawi Ministry of Health and our ***Saving Newborn Lives (SNL)*** project piloted the "A Baby is a Gift" campaign in two districts, targeting pregnant women, mothers of pre-term babies, their male partners, and others that influence their behavior. Based on formative research, the first phase disseminated branded images to shift attitudes and community norms to prioritize the value of newborn lives. The tactical phase used an intense community engagement and social mobilization component to promote specific health behaviors, such as Kangaroo Mother Care for pre-term or low birthweight babies, and encouraged family and community support. Recall of specific messages was significantly higher among women in communities receiving the comprehensive package, which included community-based activities, compared to those in communities receiving the basic package, with campaign materials, mass media, and facility-based approaches.

The comprehensive and innovative campaign developed under the ***Cambodia NOURISH Program*** (2014–2019), "Grow Together," aimed to improve nutrition practices through an integrated stunting prevention campaign. Spanning nutrition, health, WASH, and agriculture, the campaign focused on 13 key behaviors that require urgent action to reduce chronic malnutrition. The design includes a strong community engagement component by community change agents, linked with mass media and innovative print materials. The midterm evaluation demonstrated that those who received high-dose exposure through print, TV, and community activities were more likely to practice key stunting prevention behaviors. The endline results showed a 6.5 percentage point reduction in stunting (or 19%) from 34.3% to 27.8%. A significant association was also found between high exposure to the campaign, and treating drinking water, safe disposal of child feces, four or more ANC visits, continued breastfeeding at 6-8 months, and the presence of a home garden.

Male Engagement: We successfully used community approaches to address gender norms, notably with adolescents, to promote male engagement. The Model Husband School approach, which combines SBC with CCS in Niger and Burkina Faso, resulted in members of the Model Husband Schools as the main driving force of local initiatives to create their own community action plans and to raise money for projects to improve health. Model Husbands also learned about the importance of ANC, assisted childbirth, PNC and the benefits of FP. An evaluation found that discussion among family members resulted in Model Husbands being more inclined to discuss sensitive

Photo: Victoria Zegler / Save the Children

In Nepal, 16-year-old Sonu, right, sits beside her father inside of her family home. Sonu participated in Choices, Voices and Promises where she was trained to be a facilitator in her community to promote gender equality and a girls right to an education.

topics (e.g., FP, ways to reduce women's workload) with their family and include their wives in decision-making.

In the ***Responsible, Engaged and Loving (REAL) Fathers Project*** (2014–2017), led by the Georgetown Institute for Reproductive Health (IRH) and designed and implemented by Save the Children in Northern Uganda, fathers improved parenting practices and reduced violence in the home. REAL Fathers combined home visits with small group sessions with young fathers and their mentors. This was accompanied by community posters purposefully sequenced and displayed over time to stimulate discussion and reflection with community members. From baseline to long-term follow-up, there were significant declines among men in intimate partner violence, from 66% to 37%, and in use of physical punishment, from 68% to 50%.

Approaches to Reach Adolescents: Our work in ASRH includes innovative and evaluated approaches that use small-group based dialogue and discussion models coupled with parent, community, and service provider engagement. For example, ***The Gender Roles, Equality and Transformations (GREAT) Project*** (2010–2016) funded by USAID, developed and tested lifestage-specific strategies to promote gender equitable attitudes and behaviors among adolescents and their communities with the goal of reducing gender-based violence (GBV) and improving ASRH outcomes in post-conflict communities in Northern Uganda. *GREAT* is a set of participatory activities to engage adolescents and adults in discussion and reflection about violence, gender inequality, and sexual and reproductive health. Project activities included the CAC, radio drama, Village Health Team service linkages, and a toolkit for community groups and school-based clubs.

We also developed a Gender Norm Package for very young adolescents, including three interventions: 1) ***Choices*** engages boys and girls in dialogue and reflection through a structured curriculum; 2) ***Voices*** engages parents in discussions through emotion-based videos and facilitated group discussion; and 3) ***Promises*** uses a mass media approach to catalyze community-wide normative change. Evaluation of *Choices* found statistically significant differences in gender attitudes and behaviors between control and experimental groups, where girls reported feeling empowered to talk to their parents about continuing their studies and avoiding early marriage; brothers advocated with parents for their sisters' education and delayed marriage; and adolescents were able to recognize inequitable gender norms.[2] *Choices* has been adapted to Bangladesh, Bolivia, Egypt, El Salvador, Ethiopia, Malawi and Zambia.

Media Supported Community Dialogue: Under the USAID-funded ***Ethiopia Empowering New Generations to Improve Nutrition and Economic Opportunities (ENGINE) Project*** (2011–2016), with technical assistance from the Manoff Group, Save the Children implemented the Enhanced Community Conversation (ECC) approach. This includes a virtual facilitator with pre-recorded audio, behavioral demonstrations, and games to promote the adoption of optimal maternal and child feeding practices, and a transformation of gender roles. A comparison of baseline to endline results found statistically significant outcomes of the overall ECC package of SBCC materials and peer group activities on infant and young child feeding, maternal and child dietary diversity and handwashing practices. Focus group respondents reported changing spending habits to purchase nutrient-dense foods and to save home-produced nutrient-dense foods for family consumption. Men who participated in the ECC increased support for their wives, especially when pregnant or breastfeeding. *ENGINE* worked in 116 woredas across the Amhara, Tigray, Oromia, and SNNPR regions of Ethiopia.

Under the USAID-funded global ***Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING) Project*** (2011–2018), we worked with local leaders in southwest Uganda to develop a series of video testimonials for communities by local mothers, fathers, and grandmothers advocating for the benefits of maternal, infant, and young child nutrition behaviors, followed by interaction with Village Health Teams and CAGs. Despite a one-year implementation timeframe, the intervention reached one-quarter of mothers and nearly one-fifth of fathers and grandmothers. In an external evaluation, participants demonstrated strong recall of key messages from the videos, and credited their knowledge and self-reported behavior improvements in exclusive breastfeeding and care seeking to project activities. Currently, Save the Children is experimenting with short community trigger videos, which depict a situation in need of a solution.

SBC with Community Leaders: Save the Children involved traditional and religious leaders as important stakeholders in SBC approaches. For example, under ***ENGINE in Ethiopia***, we held an unprecedented meeting to discuss the impact of religious doctrine on fasting on optimal maternal and child nutrition. This led to a nutrition sermon guide to assist religious leaders who wished to communicate special exemptions from fasting for vulnerable women and children. Endorsed by the Ethiopian Orthodox Church, we rolled out the guide in 20 districts. In the ***LAHIA project*** in Niger, faith leaders supported Save the Children's WASH programs through the training of traditional and religious leaders in Community-Led Total Sanitation and latrine construction, faith-based messaging at local radio stations, and involvement of religious leaders in Village Development Committees. This led to improvements in hygiene, including construction of tippy-tap handwashing stations, handwashing with soap, and water treatment.

SBC in Pastoralist Settings: We successfully reached pastoralists, semi-pastoralists and ex-pastoralists in a variety of settings, notably through the work of livelihoods and nutrition projects in Ethiopia. Participatory learning and action processes promoted effective participation and catalyzed pastoralists' innovativeness and adoption of technology that results in large-scale impact. Evaluation of the ***Pastoral Livelihoods Initiative Phase II project*** (2009–2013), led by Save the Children in the Somali Region of Ethiopia, found improved use of MNCH services and increased awareness of HIV and AIDS and use of available HIV prevention services. Two important lessons learned cited in the evaluation

2 Rebecka Lundgren, Miranda Beckman, Surendra Prasad Chaurasiya, Bhawna Subhedi & Brad Kerner (2013) *Whose turn to do the dishes? Transforming gender attitudes and behaviours among very young adolescents in Nepal, Gender & Development,* 21:1.

were: (1) multiple community-based BCC approaches help reach large and various segments of community, and (2) empowering and including women and girls in BCC and CM is crucial.

In the USAID-funded food security project, ***Apolou*** (2017-2022) in the Karamoja region of Uganda, Save the Children developed an integrated SBC strategy to support increased adoption of inclusive and gender-equitable norms, attitudes, and behaviors for effective governance, improved nutrition and health, improved WASH and livelihoods. Based on a positive deviance approach the Eyok Kiyan ('our discussion' in Karimojong) campaign works through experiential marketing activities (Manyatta Wagon), silent trigger videos, a radio magazine program and various community platforms to elevate existing community self-organization, increase skills and collective efficacy to practice new behaviors and to discuss harmful myths and traditions, which are forming barriers to social change.

THE UNFINISHED AGENDA FOR COMMUNITY HEALTH

1. Community Service Delivery

With increasing global disasters and chronic and acute conflicts, access to healthcare for affected populations remains a high priority. **Save the Children's iCCM in emergency programs focus on vulnerability reduction by adapting it as a response intervention during an acute emergency**. For example, in Ebola-affected countries of West Africa in 2015, we supported CHWs to provide iCCM services, treating more than 91,000 children in nine months. As there is a paucity of experience with iCCM in emergency settings, we continue to work with partners to build the evidence base for the most effective approaches.

Save the Children supported the expansion of the role of CHWs and other health workers to address maternal and child health needs. **We are steadily building the evidence base for the institutionalization of newborn case management into the iCCM package at the global level to increase application**. This includes documenting and disseminating training results, conducting trials on the treatment of possible serious bacterial infection in newborns, advocating with national governments for policy change and scale up, and contributing to the development of the WHO-led *Handbook for Countries to Introduce and Scale up Caring for Newborns and Children in the Community*.

2. Community Capacity Strengthening

In light of emerging global trends, **our commitment to CCS remains a priority, highlighting the need for communities to respond, adapt and become more resilient**. Migration and urbanization have led to the breakdown of some communities, causing diminished social support and potential opportunities to develop new ways for community members to interact. The decentralization of government functions, budgets and decision-making offer opportunities for communities to advocate for and better address their own needs. Opportunities in this area require:

- Continued investment in design thinking to better address social and structural barriers for behavioral change through non-communication applications;
- Implementation at scale through strategic partnerships; and
- Commitment to refined and continued monitoring, evaluation, and documentation.

Programs will be required to monitor and evaluate not only health outcomes, but also pathways to outcomes, including dosage and integration of selected CCS approaches. Also essential is further research and documentation

of the social normative changes and impact on health and development outcomes due to CCS. In addition, normalizing measurement of community capacity via consistent application of CCS outcome and process indicators in program evaluation is required. Our social accountability frameworks provide important opportunities to apply approaches such as PDQ and scorecards to increase equitable access to quality services for the most marginalized.

In addition, the rapid development of and increased access to information and communication technology offers new opportunities for communities to connect, collaborate and learn from each other and a broader network, including those outside their community. Advancing access to/use of health data and information by communities and use of CAC, PDQ, and other CCS processes through the application of mobile technology will require further understanding and research. However, it has the potential to build and link community social networks to advance collective efficacy for improved health and well-being.

3. Social and Behavior Change

Looking ahead, Save the Children will support behavior change by **integrating behavioral thinking into community programs and linking CCS and participation to behavioral outcomes** while keeping a stronger community orientation when using strategic communication. This includes addressing social norms as well as lacking social support for change at community levels for long-term SBC. We adopted this model to apply evidence and theory-based approaches. The goal is to support our country programs to refine the design, implementation, and especially their ability to better monitor and measure their programs. We plan to strengthen consensus on a tested process and set of key determinants that support measurable and lasting positive change in health practices and social norms for individuals, households, and the community. Our strength in applying SBC and using it to link various programming sectors including education, livelihoods, and resilience programming needs to be further documented and results clearly measured.

Application of more systematic and measurable SBC is also crucial to implement our Emergency Health and Nutrition response package. These include: 1) improved reproductive health and FP in conflict settings; 2) identification and treatment of children with acute malnutrition; 3) promotion of breastfeeding; and 4) protection of infants and children. Lessons learned from the Ebola and Zika crises have shown the importance of CM and SBC to respond to and prevent further infections. Adding SBC determinants and indicators to resilience measurement will also help to fill the gap between identifying community resilience capacities and actualizing them for effective responses to crisis, environmental shocks and emerging infectious diseases.

Lastly, CM takes on different forms in urban versus rural communities, and experience shows that mobile health or social media can play a larger role. CM strategies need to better document insights and experiences to adjust previously successful strategies to growing urban communities. In collaboration with the Urban Working Group, our Emergency Health and other teams, the SBC team will position Save the Children to **mobilize urban communities for health and emerging infections and other humanitarian situations**.

ONGOING AND FUTURE WORK

Save the Children's work over the past few decades led to global recognition by donors and implementing partners alike, who often applied or adapted our best practices in CM and CCS. We demonstrate our long-standing experience, extensive implementation networks and technical capacity to lead community health programs in several USAID-funded global projects (*MCSP, Passages, and Breakthrough ACTION*) and international working groups, fora, and conferences. There are many results and lessons learned, which will continue to shape our ongoing and future work.

Our work to strengthen community systems and networks, and the social, cultural and support structures and services closest to families and children allowed us to improve health and nutrition programming. It did so by also

addressing important underlying social and structural barriers, social norms, and household practices.

Going forward and based on our integrated SBC framework, this combination of CCS, CSD and community-centered SBC can be developed and implemented more systematically, using quality standards and tools, including an online tool (FOCUS) to develop SBC strategies and plans.

In order to support Save the Children's work in humanitarian settings, in preparedness for emerging infectious diseases or other shocks and stresses, we have added a set of community resilience determinants. These are based on a literature review and are currently being tested in field programming.

Such broad experience, using SBC and effective community health approaches in integrated programming across health, livelihoods and other development programming is indeed one of Save the Children's strengths, and we are committed to continue innovating, testing and adapting our strategies in the future.

GLOBAL PARTNERSHIPS

- ***MCSP Global Project*** (2013-19)**:** Lead implementation partner of the CM component
- **CORE Group:** Co-chair of the Community-Centered Health Systems Strengthening Working Group
- **WHO Partnership:** Participate in the Quality, Equity and Dignity (QED) network and Expert Review Group on CHW program implementation guidelines; active contributor to the Social Behavioral Community Engagement Global Evidence Map
- ***Breakthrough ACTION*** **Global Project** (2017-22)**:** Principal partner in USAID's SBC flagship project that introduces newer methods into the SBC mix, such as behavioral economics and human-centered design
- ***PASSAGES Project*** (2015-20)**:** Implementing partner of the USAID global project led by Georgetown University IRH on social norm change and its measurement
- ***READY*****:** Developing effective community approaches in emergencies as part of SBC strategies for the Office of U.S. Foreign Disaster Assistance (OFDA)-funded project designed to augment capacity to respond to major outbreaks
- **Global Alliance on SBC:** Founding member with UNICEF, Johns Hopkins Center for Communication Programs, USAID, BBC Media Action and many others
- **UNICEF Community Engagement Indicator Advisory Committee:** Member with WHO and others
- ***Every Newborn Action Plan (ENAP)*** **SBC Sub-Group:** Since 2018, with WHO and USAID
- **Global and Francophone SBCC Summit:** Planning Committee Member with several presenters in 2018 (Indonesia), 2019 (Cote D'Ivoire) and 2020 (Morocco)

Save the Children
100 YEARS

Save the Children believes every child deserves a future. In the United States and around the world, we work every day to give children a healthy start in life, the opportunity to learn and protection from harm. When crisis strikes, and children are most vulnerable, we are always among the first to respond and the last to leave. We ensure children's unique needs are met and their voices are heard. We deliver lasting results for millions of children, including those hardest to reach. We do whatever it takes for children – every day and in times of crisis – transforming their lives and the future we share.

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