
# Piloting the Community Score Card in Malawi for a more equitable vaccine roll-out and COVID-19 response: Learning Report from Cycle 1 of CSC (May-June 2021)

## Table of Contents

## Acknowledgements

This learning report draws upon practical experiences and suggestions from community members, public health service providers, CARE Malawi staff members and CARE USA technical support team. This pilot was conducted at the Kandeu Health Facility and the Chigodi Health Facility in the Ntcheu district and in Ngolowindo in the Salima district. CARE recognizes the valuable inputs and insights they made.

Special thanks go to the CARE Malawi CSC Consulting Group for implementing this pilot and for assisting in the development of this learning report, including:

- Thumbiko Msiska, Technical Director of the CSC Consulting Group
- Tapiwa Munthali, Technical Coordinator of the CSC Consulting Group
- Patience Mgoli Mwale, Advocacy Manager of the CSC Consulting Group
- Kriss Chinkhota, Assistant Manager of the CSC Consulting Group

This learning report was produced by CARE USA's technical support team: Anushka Kalyanpur, Janna Safran, and Emily Janoch with guidance and input from Christina Wegs, Ninon Ndayikengurukiye, Dora Curry, Caitlin Shannon, Ryan Derni and Abbey McDaniel who tirelessly contributed to the development of this learning report.

## Accountability & Trust in COVID-19

Vaccine hesitancy is complex, dynamic and refers to the "delay in acceptance or refusal of vaccines despite availability of vaccine services." The significant amount of misinformation surrounding COVID-19 has deteriorated trust in governments and health systems, leading the World Health Organization to claim it as an "infodemic." As the massive vaccine efforts launch, systematic trust-building and social accountability approaches are vital for civil society to hold governments accountable for equitable and people-centered vaccine roll-out that reaches the last mile, including those facing overlapping vulnerabilities due to geographic isolation, sexual or gender identity, race or ethnicity or legal status. CARE knows that epidemics, like COVID-19 and Ebola, start and end with communities, which is why we are working to build meaningful citizen engagement into national vaccine roll-out frameworks to increase trust, accountability, and information dissemination.

## CARE's Community Score Card

Created in 2002 by CARE Malawi, the CSC has contributed to strengthening gender-equitable and gender-sensitive service provision, strengthening relations between community and health systems, community and state, and other diverse partner relations in the health, food and nutrition security, water and sanitation, environment, and education sectors. Since CARE began tracking impact data in 2014, 102 projects have used the CSC tool and have impacted more than 8.2 million people in 33 countries. These impacts range from better health care to stronger food systems to safer justice systems that protect women from Gender Based Violence (GBV). Over time, the CSC approach has and continues to be strengthened in several ways. For instance, in 2019, CARE piloted the use of an app called Kwantu, which digitizes CSC data collection to inform real-time data visualizations. Reinforcing mutual accountability has also created power-shifting dynamics between civil society organizations (CSOs) and duty bearers.

The CSC was developed by CARE Malawi to address local challenges and has been recognized globally as an important tool for accountability and community engagement, power-shifting, and improving service quality and trust in a variety of sectors (including but not limited to health, education, food systems, WASH) as well as between community members (particularly of women, girls and people of all genders who typically face greater challenges accessing services) and government officials and other powerholders. One of the most powerful things about the CSC is that the process is intentionally inclusive by identifying and bringing together stakeholders and including marginalized populations. This enables citizens to exercise their rights by identifying issues of concern and working collaboratively to come up with action plans to address those issues.

The CSC provides a safe platform for marginalized groups (who may be overlooked or excluded from discussions about service provision) to exercise their voice and agency. Service users feel empowered during the CSC process as they can build their agency, feel ownership over service delivery and demand accountability from service providers/duty-bearers, and help ensure public services are responsive to their needs, thus increasing utilization of those services. Service providers adopt the CSC because it helps them do their jobs better by providing higher quality, more responsive services, it builds trust and strengthens relationships with community

members, and increases efficiency. Governments choose to scale the CSC due to its ability to receive and produce real time data, which informs responsive and relevant decisions for policy and program.

## CSC for Vaccine Roll-Out Pilot

When COVID-19 arrived in Malawi during March 2020, CARE, at first, adapted and piloted the use of remote CSC. CARE set up an SMS platform and WhatsApp group through which groups of men, women, youth, community and religious leaders, and service providers could voice their concerns and hesitancies about the vaccine and other health services. The CSC helped to identify major concerns around the vaccine and aided stakeholders in creating locally driven solutions to combat vaccine hesitancy, and misinformation. Building on the CSC adaptation to COVID-19, CARE sought to channel this learning in a pilot project to support efficient and equitable Covid-19 vaccine roll-out to three pilot locations in three districts within Malawi from May to June 2021. This pilot- part of CARE's *Fast & Fair* COVID Vaccine Delivery global campaign- aims to contribute to an equitable, systems-focused COVID-19 vaccine roll-out in which the most marginalized can access the vaccine.

CARE's Global Fast and Fair campaign includes four pillars of work:
1) facilitation of support to the government health system and multilateral partners to provide operational support to the government health system prepare for and roll-out vaccine delivery within the existing health and immunization service infrastructure.
2) mobilization to promote community ownership, engagement, accountability, and transparency;
3) protect and empower frontline health workers (70% women) by enhancing their capacity and leadership as well as addressing gender-barriers to vaccine access; and
4) advocacy for rights-enabling policies, citizen-driven monitoring and accountability to ensure equitable and effective vaccine roll-out, and policy/structural change "build back" more inclusive, accountable and resilient health systems.

## Objectives of the pilot

The CSC pilot sought to build social accountability during the COVID-19 vaccine roll-out through the following objectives:

- Adapt and test the application of CSC to three contexts in Malawi
- Surface the gaps in perceptions and facilitate dialogue and trust-building between communities, health personnel and government decision makers
- Enhance women, girls and youth leadership in the CSC process to ensure their voices are heard by duty-bearers.
- Support responsiveness of government policy and planning on COVID-19 to community voices, particularly those of women, girls and youth through co-creation of locally-driven solutions
- Digitize data from the CSC to inform decision-making

## Setting and Stakeholders

The CSC was piloted for a Fast & Fair COVID-19 Vaccine roll-out in three locations in Malawi: the Kandeu Health Facility and Chigodi Health Facility communities of the Ntcheu district and the Ngolowindo community in Salima. CARE chose these communities due to existing relationships, networks, and history of implementation of the CSC. However, the locations had varying levels of CSC experience. For example, CARE has a long history of implementing CSC in Chigodi, while Kandeu had relatively limited experience, and CARE is currently implementing a nutrition project in Salima where some staff had previous CSC experience. Moreover, these two districts represent a range of settings, as Salima is peri-urban[1] and the Ntcheu district is rural.[2] It is important to note that the New Hope Clinic in Salima is still new and without electricity yet, and therefore unable to store vaccines at the community level. Because it is still considered a new facility, not all the supplies and equipment have arrived at the clinic.

In terms of key stakeholders, in all three locations groups of women, men, youth, community leaders (chiefs and religious leaders), district health management teams (for the interface step) and health personnel (including health surveillance staff, health facility staff in-charge, and the health center management committee) were engaged in the CSC. Youth leaders with previous CSC experience facilitated the COVID-19 CSC in Chigodi and nearby Kandeu. Action planning and dissemination involved all stakeholders mentioned thus far along with district and national level government officials and other Civil Society Organizations. CARE Malawi CSC team led the implementation of the pilot with support from CARE USA and digital support from an external partner, Kwantu. To see an overview of communities, please see Annex 2.

### Process

The CSC follows five phases: (1) planning and preparation; (2) conducting the score card with the community; (3) conducting the score card with service providers; (4) interface meeting where all parties present their findings in the presence of local government officials and then jointly develop action plans; and (5) implementation, monitoring of the action plans, and evaluation of the overall process. These five phases constitute one cycle of the CSC. Communities often go through several cycles to raise new or ongoing challenges, identify better, more gender-equitable solutions, and monitor implementation and outcomes of action plans.

The pilot followed all five steps of CSC. A few adaptations and learnings to highlight include:

- Due to the short time period of this pilot, combined with the urgency of COVID-19, it was vital to have constant communication between community leaders and district health

[1] Peri-urban: Refers to a town or commonly known in the United States as sub-urban. The Salima district is about 107km, or a 1.5 hour drive from Lilongwe, Malawi's capital. Community members can access public transportation- buses or taxis- to access the city.

[2] Rural: The Ntcheu district sits between two large cities- about 163km from Lilongwe (2.5 hour drive) and 171km to Blantyre (2 hour drive). However, due to poor roads, Ntcheu is primarily inaccessible by vehicle.

officials to organize the meetings, reflections, and disseminate information. One of the biggest challenges conducting the CSC process was finding the time to hold the sessions in which everyone could participate in. In previous CSC cycles, all reflections would only be shared at the pre-interface or interface meeting. However, in this particular pilot, updates were shared after each and every activity process to ensure quick response and actions were taken to the generated issues and concerns. By reflecting after each activity/phase, it also helped to minimize the loss of participants in future follow up meetings.

- The use of the Kwantu Go-App significantly helped to provide real-time feedback and report what was happening at both the primary health center and community level. This data enabled leaders to check the progress of the process at district and community levels. The digitization of data further enabled actions to be taken in real-time rather than waiting weeks or months.
- Youth facilitation and implementation helped to increase the inclusivity of the process, engagement of other youths and marginalized voices, and create a safe space for expression and trust-building.


For step-by-step detailed information on how CSC was piloted in each of the three locations, please see Annex 3. To learn more about the CSC process, please refer to the CSC Toolkit.

## Key Perspective Indicators Generated from the CSC Process

Due to the short time frame of this pilot during the pandemic, the rest of the report highlights data only from Kandeu in Ntcheu and Ngolowindo in Salima (as data from Chigodi is forthcoming).

| # | Key Indicators | Description of Indicators | Ntcheu District Scores determined during interface meeting<br>% of people satisfied with indicator | | Salima District Scores determined during interface meeting<br>% of people satisfied with indicator | |
|---|---|---|---|---|---|---|
| | | | Service Providers | Service Users* | Service Providers | Service Users* |
| 1 | Availability of information on COVID-19 | Refers to information disseminated via radio, public announcement systems, posters, community meetings, health center meetings, push messages from the MoH, and posters. | 95% | 40% | 100% | 50% |
| 2 | Management of suspected COVID cases and confirmed COVID cases | All individuals experiencing symptoms and those who recently travelled into Malawi were suspected to have COVID-19 and were tested. Cases of COVID-19 were confirmed via testing conducted by the district's COVID-19 response team. | 97% | 50% | 50% | 50% |
| 3 | Availability of COVID vaccine | Availability of the vaccine at the primary health center in the area as well as outreach clinics. | 100% | 90% | 5% | 10% |
| 4 | Acceptance of COVID vaccine in communities | This indicator represents the fear, misinformation, and rumors that factor into a person's trust, confidence in, and efficacy of the vaccine. | 25% | 30% | 10% | 10% |
| 5 | Commitment of health workers when it comes to safe motherhood and COVID | The extent to which staff members are doing their jobs | 75% | 40% | 90% | 80% |
| 6 | Male involvement in family planning | A husband's willingness and support of his wife to receive family planning including long-acting methods. This includes, emotional support, financial or transportation support to/from | 40% | 40% | 30% | 20% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | the clinic, men accompanying women to the clinic, men getting a vasectomy, and use of contraceptives such as condoms. | | | | |
| **7** | Availability of resources at facility | General resources available at the facility including: space, transportation, electricity, running water, number of beds available, equipment, medicines, contraceptives, vaccines, and PPE. | 70% | 60% | | 70% |
| **8** | Access to MNH | Including supplies, medications, number of beds available, equipment, outreach services, counseling done by service providers | 70% | 50% | 80% | 80% |
| **9** | Availability of extension workers in community | Refers to specialized individuals that work in the community, such as health assistants, nutrition assistants, agricultural advisors, national resource management, and community development assistants. | | | | 70% |
| **10** | Adoption of crop and animal production | The application of what has been learned/disseminated | | | 60% | 50% |

*Note: Service users is an aggregate score across men, women, youth, and community leaders.

## Key Implications from Round 1 of the CSC Pilot

Opinions all people share:

- About 30% of people trust the COVID-19 vaccine in Ntcheu, and in Salima, this percentage is as low as 10% amongst both health providers and community members.
- Service providers are just as hesitant, if not more hesitant, than community members to trust the vaccine, which is consequently reducing service users' trust in and acceptance of the vaccine.
- Most people do not believe they are at risk of COVID-19 and many do not believe the virus is real. This reduces their willingness to get a vaccine as revealed from qualitative data.
- More than half of the population surveyed (57.22%) think the COVID-19 vaccine is available to them if they want it

Women's Specific Challenges:

- In Salima, women are 4 times less likely to trust the vaccine than men, especially because of concerns that the vaccine causes infertility. This further reduces women's willingness to seek other services such as family planning and maternal health to avoid taking the

vaccine. Some women fear that they would be forced to take the vaccine under disguise of an alternative medication, particularly an injectable contraception.
- Roughly 61% of women highlight gaps in health services.
- Women generally give the lowest satisfaction scores of all people, especially regarding access to COVID-19 information and service providers' commitment to family planning
- Rural women have less access to information than urban women do - with only 30% of rural women receiving COVID-19 information (particularly as information often does not trickle down beyond the chiefs).

Youth Present Opportunity and Face Challenges:
- Youth are most likely to accept the COVID-19 vaccine (70%) in Ntcheu from the Kandeu health facility catchment area, which is 30% higher than the other groups.
- Young people give low scores regarding service quality and access to information.

## Discussion

**Disparities in perceptions of COVID-19 information access**

*Service providers and service users:* In Ntcheu and Salima, 95% and 100% of health providers respectively believe that COVID-19 information was accessible through government supported messages on the radio and on posters in hospitals. In comparison, only 40% and 50% of service users in Ntcheu and Salima respectively expressed that COVID-19 information to be accessible. This finding reflects disparities in the perceptions of health providers and community members.

*Rural and urban areas:* There are stark differences in women's access to COVID-19 information comparing perceptions of women in Salima (peri-urban) and Ntcheu (rural): 100% of women in Salima said information was accessible while only 30% of women in Ntcheu. Similarly, it should be noted that 50% of community leaders in Salima say access to accurate information is limited. For example, one leader says, "Many people do not have information in the villages." This indicates that although Salima is considered a peri-urban area, more geographically isolated communities lack access to accurate information. Unlike urban areas like Salima, where the radio line runs along main roads with condensed populations, the majority of residents in Ntcheu and rural parts of Salima do not live along the radio line and thus don't receive information being disseminated on radio. Furthermore, due to the absence of transportation and poor road infrastructure, Ntcheu is unable to consistently receive information from health providers or have access to vaccines. This causes many individuals to travel long distances, often walking hours each way, to reach a health facility that may or may not have vaccines available. This can be extremely detrimental in further decreasing the uptake of vaccines as those who traveled are unlikely to return and may report misinformation to their communities upon return. Others choose not to travel the distance given the time spent away from work amidst the existing economic crisis. Through the CSC, Ntcheu community members have advocated for the investment in infrastructure (roads and facilities), ambulatory care and referral systems, and stronger communication and coordination from community health workers that travel from urban facilities to rural communities (including a scheduled day and time).

**Vaccine Hesitancy**

Universally high levels of vaccine hesitancy were found among health workers and disproportionately among women and youth. However, only 25% of providers and 30% of users accept and trust the vaccine. In Salima, only 10% of both service providers and users accept the vaccine. This is a clear indication that availability does not equate to acceptance due to extreme lack of trust in the health system. Moreover, this indicates that the vaccine information and risk communication community engagement is not being delivered in accessible formats or circulated in communities at leadership levels. Therefore, it is integral that social mobilization tackling vaccine hesitancy must start with healthcare providers. This level of hesitancy is likely related to the significant levels of mistrust, misinformation and myths around COVID-19 often perpetuated by key influencers. For instance, qualitative data captured from the pilot indicates that many churches in both districts are strongly advising or strictly forbidding against vaccination. One service provider in Ntcheu believes that "when vaccinated you may not be able to enter heaven." Many other community members believe that the vaccine is connected to "underground demonic powers."

Moreover, the government is requiring a different vaccine card for COVID-19, while all other vaccinations (Malaria, TB, HPV) are listed on the same card. While the government may have done this as a quick-cost efficient solution, many service users have interpreted this to mean the COVID-19 vaccine is unique and the government is withholding information on the vaccine, which has further contributed to a lack of trust and fear. The failure to provide information necessary to understanding the vaccine has consequently resulted in lack of trust, thus further fueling the rumor that the vaccine is a population control mechanism meant to track individuals (chip insertion), sterilize women, or wipe out certain groups (political, religious, etc.). In Salima, *women are 4x less likely to trust the vaccine* (10%) than men (40%) due to fears regarding infertility and population control. Some women fear that instead of receiving their planned contraceptive shot, they would unknowingly receive the vaccine.

Furthermore, even though several government officials have publicly taken the vaccine, this information has often not traveled to marginalized communities. Furthermore, mistrust has been exacerbated, not only because COVID-19 is seen as a "foreign disease," but there have also been concerns about governments from the Global North sending expired vaccines for distribution in Malawi.

**Perception of Disease Susceptibility on Vaccine History**

In both Ntcheu and Salima, there are circulating beliefs that COVID-19 is a white person's disease and Black people are immune to it. Moreover, when COVID-19 is compared to other viruses in the area, such as TB, it is not perceived as severe for two reasons: (1) COVID-19 does not have identifiable symptoms and can be asymptomatic and (2) communities have seen higher infection and mortality rates from other diseases. Since perceived risk associated with COVID-19 is low compared to for other infections or diseases, prevention is not perceived as urgent or critical. In Ntcheu, a service provider claimed that COVID-19 was made up because hospitals needed the

money. In Salima, one respondent said he demanded cash in exchange for receiving the vaccine, as no one in his community had had COVID-19. Overall, for a variety of reasons, most service providers and users do not believe that COVID-19 is real and therefore do not perceive the vaccine as vital, thus forecasting low vaccine uptake, if and when it becomes widely available.

**Access to MNH Care & Frontline Health Workers' Commitment to MNH Service Delivery**

There was a stark contrast in scores between service providers (75%) and users (25%) on provider commitment to provide MNH services in Ntcheu, once again demonstrating the lack of trust in the health system. One health service provider mentioned that "there is no change in services rendered" while multiple female community members have argued that "doctors are usually busy on their phones" and that some "women deliver in bathrooms and they are charged money as a punishment." The CSC process also lifted-up pre-existing tension around the lack of male support in family planning access and the need for addressing gender and social norms that hinder access to SRHR including MNH.

**Availability of General Resources at the Facility**

Women in both Ntcheu (40%) and Salima (50%) possess the highest percentages for identifying gaps at facilities. Women noticed the lack of contraceptive methods available, medications (causing many women to purchase drugs on the street), testing kits for endemic diseases, patients' ward, poor hygienic standards for service provision (such as lack of running water), latrines, and cold chain storage for the COVID-19 vaccine. Considering most men do not participate in family planning, it is often the women who spend the most time at facilities for themselves and looking after the children. Given the poor quality of the facility and the distance (average of 10kms), combined with the lack of trust towards service providers, many service users, particularly women, choose not to seek care at a facility.

**Disproportionate impact of COVID-19 on women and young people & importance of leveraging their expertise**

Women and youth have such different perspectives and experiences compared to those of providers and men. Therefore, 1) surfacing those experiences is critical to developing effective solutions to tackle vaccine hesitancy and access and 2) women and young people are important champions for and participants in these solutions.

Of the nine indicators in Ntcheu, based on perspectives expressed by women, they seemed to score significantly lower or the lowest compared to men, leaders, and health providers in four categories: availability of COVID-19 information[3], management of suspected and confirmed

[3] Availability of COVID-19 information (Ntcheu, Salima): women (30%) compared to chiefs (100%), service providers (95%), and men (80%).

cases[4], commitment of health workers when it comes to safe motherhood and COVID-19[5], and availability of resources at the facility.[6]

Similarly, data from Ntcheu indicates that young people's perceptions differ greatly from other groups and generally have the lowest scores, especially in: availability of information on COVID-19[7], management of suspected and confirmed cases[8], availability of COVID-19 vaccine[9], and availability of resources at the facility[10]. It is important to note that these four indicators are linked to similar indicators that women scored extremely low in as well, thus indicating the marginalization and exclusion of both community groups in these areas. Despite qualitative data indicating concerns of side effects and infertility, young people had the highest scoring percentage of 70% on acceptance of the vaccine, which is at least 30 percentage points greater than the other groups. This indicates the critical nature of creating inclusive and safe spaces for these groups to share their views and co-create solutions.

## Additional Reflections & What's Next in Malawi

Building on the implementation of the first cycle of CSC, CARE will revisit the community's action plan every three months for another two cycles in collaboration with women, youth, men, community and religious leaders, health personnel and government officials. Should the community continue to use the CSC without CARE's support, the action plan will be reviewed every six months. A few examples of key actions co-created through CSC are: supporting an ambulance at Kandeu health center for life-saving MNH & COVID-19 case management in collaboration with the District Health Office, strengthening risk communication and community engagement on COVID-19 in collaboration with health surveillance assistants, increasing youth and women's groups and religious leaders in both locations, advocating for additional health surveillance assistants to be deployed in Salima. Please see Ntcheu's and Salima's action plans for further details (Annex 2 and 2b).

**Real-time data sharing, accountability and trust-building:** At the community-level, the CSC process has already facilitated some immediate action demonstrating the value-add of bringing community members together in inclusive, safe and constructive spaces and working towards trust-building. For example, there were a few individuals from South Africa that entered the pilot locations who were not adhering to COVID-19 protocols which created fear

[4] Management of suspected and confirmed cases: women (50%) compared to chiefs (100%), service providers (97%), and men (90%).
[5] Commitment of health workers and MNH: women (25%) compared to chiefs (100%), service providers (75), and men (40%)
[6] Availability of resources: women (40%) compared to chiefs (70%), service providers (70%), and men (60%).
[7] Availability of COVID-19 information: youth (20%) compared to chiefs (100%), service providers (95%), and men (80%)
[8] Management of suspected and confirmed cases: youth (10%) compared to chiefs (100%), service providers (97%), and men (90%)
[9] Availability of COVID-19 vaccine: youth (50%) compared to chiefs (100%), service providers (100%), and men (70%)
[10] Availability of resources: youth (50%) compared to chiefs (70%), service providers (70%), and men (80%)

among community members. The CSC provided community members a safe, inclusive space to share their concerns. In real-time, community leaders liaised with authorities to support contract-tracing and isolation of the new arrivals. CARE Malawi has also been sharing real-time data with decision-makers at the district and national levels on an ongoing basis to advocate for policy and planning recommendations to contribute to a more fast, fair and equitable national vaccination framework in Malawi. Another example of immediate action came from Kandeu Health Facility, where community members and health staff had been aware of the lack of water due to a broken water pump for months and CSC helped to push community members and health staff alike into action by identifying responsible individuals and identifying funding sources.

**Digitizing vs. Remote CSC:** Building on ongoing work with a digital firm, Kwantu, the pilot allowed for testing the digitization of CSC data in the Salima location. One of the major advantages of digitization is quicker processing of data and therefore the ability to create relevant data visualizations to be shared in real-time with district-level officials, clusters, and international stakeholders. The digital platform will eventually also enable data to be aggregated, analysed and shared beyond local levels in order to address accountability at scale and to see trends over time. CARE will continue to expand testing for digitizing the CSC data in the next two rounds of the CSC.

In Chigodi Health Facility in Ntcheu, we are also building on experience from 2020 to utilize the remote application of CSC using SMS-based service Telerivet. This process enabled participation of a much larger group of partners, and it is likely that this approach will enable reduced financial and operational costs. However, we are cognizant that this may exclude those without a cell-phone and that the reduced face-to-face interaction may affect the process of trust building. In addition, it will be more challenging to address myths, rumours, and take immediate action remotely. For this reason, our recommendation for scaling of the CSC remains only digitizing data while the CSC process will continue to involve in-person, face-to-face meetings.

## Key Recommendations

- **Budget for accountability and adaptation—including Community Score Card as a cornerstone of the National Deployment and Vaccination Plan:** This pilot highlighted that citizens want their voices heard and considered. Without that, trust will falter, and mistrust around COVID-19 is already high. Without trust, people, including providers, will not seek vaccines -even when they are available. Moreover, CSC allowed for real-time assessment and feedback on the government's COVID-19 response system, highlighting the critical need for sharing real-time feedback on discrepancies between policy and practice, service bottlenecks and quality and equity gaps in COVID-19 vaccine roll-out, as well as disruption of other essential health services (e.g. SRHR and routine immunizations.) Ongoing feedback and co-creating solutions are a cornerstone

for the government to identify gaps and adapt its policies and programs to be more responsive to the communities they serve. Investing in scaling solutions, such as the digital CSC, is key for efficiency and impact.

*As a ministry, we are doing so much around COVID-19 from prevention to curative but not much has been done to generate or gather feedback from our clients (general public) this tool has helped us to get this feedback which is important for decision making and advocacy. – District Medical Officer, Ntcheu District Hospital*

*"COVID-19 pandemic is a new environment; Community Score Card has proved to be an effective tool to help service providers and users to learn together looking at what our challenges are and together propose solutions to address issues". – District Medical Officer, Salima District Hospital*

- **Create information and deliver strategies that reach ALL people—especially at the last mile:** COVID-19 and vaccine information and services must be designed to reach the "last mile." In addition to reaching the geographically isolated communities, a strong gender and equity lens that goes beyond engaging only the chiefs and health personnel, but rather leverages women's rights organizations and youth leaders is critical to ensuring accurate information reaches communities. Furthermore, investment in mobile outreach clinics and health extension workers is essential for addressing this gap.

- **Diversify communications channels and create space for feedback in local vaccination plans:** Plan, produce and disseminate accurate information on availability of vaccines for free, and provide the locations and times they are available. Highlight contact persons, toll-free helplines, or other resources where community members, including women and girls, can follow up for clarification or further information. Utilize these channels for two-way communication not only to share information but also to listen to and address feedback, concerns, myths and misinformation.

  *"Understanding the importance of getting the vaccine by community members was different among members, some communities chased health workers (stoning their vehicles) while others demanded for cash ($5) in exchange for the jab". DHMT, Ntcheu DHO*

- **Leverage positive deviants among health providers, religious, women and youth leaders to serve as COVID-19 vaccine champions:** Due to the lack of trust in government and health systems, it is vital that people in positions of power and leadership serve as role models and publicly take the vaccine to promote its effectiveness and safety.

- **Monitor, prioritize and invest in Sexual and Reproductive Health and Rights (SRHR) as part of COVID-19 efforts to avoid reversal in gains**. To avoid the reversal of gains made on SRHR in Malawi in recent years, it is critical to include SRHR in ongoing assessments and accountability efforts. The CSC reinforced the importance of risk communication

and community engagement to address myths and misinformation on the relationship between vaccines and infertility, highlighted the need for adequate investment in family planning supplies and further emphasized that male support for family planning is more critical than ever due to the misinformation and mistrust in the health system.

# Annexes

## Annex 1. Pilot Snapshot

| | Kandeu Health Facility, Ntcheu District | Chigodi Health Facility, Ntcheu District | New Hope Clinic (Ngolowindo community), Salima District |
|---|---|---|---|
| Rural v. Urban | Rural | Rural | Urban |
| Provision of vaccines | Yes | Yes | No (only available at secondary level) |
| Distance from secondary level facility | 40 kms | 60kms | 10kms |
| Health facility population catchment area | 25,000 | 14,000 | 10,000 |
| Traditional CSC v. use of digital | In-person | Hybrid (with SMS) | In-person with digital app |
| | *All locations had CARE programming and/or had previously implemented the CSC | | |

## Annex 2. Action Plan: Ntcheu

| # | Agreed Actions | Responsible Person | Time Frame for action to be done |
|---|---|---|---|
| 1 | Fixing water pump and borehole to improve infection and prevention control | Health Centre Management Committee (HCMC) | 25th June 2021 |
| 2 | Ambulance at health center for lifesaving MNH & COVID-19 case management | Administrator at DHO | 1st September 2021 |
| 3 | COVID-19 vaccine availability at primary. Health center level and in the community (ex. through outreach and mobile clinics) | DHO, youth, YCBDAs led by HSAs | September 2021 |
| 4 | Risk community and community engagement; sharing accurate information on COVID-19 in the community | HSAs, youth, and religious leaders | On-going |

| | | | |
|---|---|---|---|
| **5** | Addressing mistrust and supporting free and informed decision-making in family planning through capacity building of health providers and sharing of accurate information on FP side-effects with community | FP coordinator | On-going |
| **6** | Information on family planning tailored to men; community sensitization meetings | HSAs, chiefs, religious leaders, and youth | August |

## Annex 2b. Action Plan: Salima

| # | Agreed Actions | Responsible Person | Time frame for action to be done |
|---|---|---|---|
| **1** | Availability of COVID-19 vaccines supplies at Hope Clinic | EPI Coordinator from District Health Office | 5th July 2021 |
| **2** | Address vaccine-readiness (storage, delivery) at Hope Clinic | Medical Assistant at Hope Clinic in collaboration with EPI Coordinator | On-going |
| **3** | Addition of health surveillance assistant extension workers for RCCE/outreach and information sharing on COVID-19 vaccine at community level | District Council and other stakeholders working within the area | On-going |
| **4** | Strengthen enforcement of COVID-19 related laws at community level by increasing literacy on these laws among policy and chiefs/community leaders | Police and Chiefs in collaboration with District Commissioner and Magistrate | 22nd July 2021 |
| **6** | Support building of maternity wing at Hope Clinic | Area Development Committee Senior Group, CARE, District Health Management Team | On-going |

## Annex 3. CSC Process In-Depth

| **Phase 1; Step 1** | **Planning & Preparation/Buy-In (1 week)** | | |
|---|---|---|---|
| | **Kandeu Health Facility Ntcheu 1** | **Chigodi Health Facility Ntcheu 2** | **New Hope Clinic. Salima** |
| Process | Conducted with government at district and central level by phone, district (first phone, then in-person), and cluster levels; facilitated by the CSC CG team. Then, conducted with targeted communities and health providers | | |

| | | | |
|---|---|---|---|
| Participants at community level | Women, men, youth (including existing youth networks), traditional leaders (including religious leaders, chiefs and other influential individuals), health workers | | |
| Facilitators | Youth leaders and young people from neighboring Chigodi who now run their own CSC programming (with CSC CG support) | Young people from existing youth groups (with CSC CG support) | Health extension workers and CARE 1FNS team (with CSC CG support) |
| Key differences per location | Buy-in undertaken together at district level, health center level<br><br>Key difference: greater involvement by youth leaders in Chigodi given previous knowledge of CSC | | |
| **Phase 2&3, Step 1** | **Issue Generation (1 week)** | | |
| | **Kandeu Health Facility Ntcheu 1** | **Chigodi Health Facility Ntcheu 2** | **New Hope Clinic. Salima** |
| Process | 8 hours per location with each group separately (2-hour session with each group mentioned above x 4 groups: women, men, youth, traditional leaders) | | |
| Traditional v. digital | In-person | Telerivet SMS | In-person but using Kwantu Go-App for inputting data |
| **Phase 2&3, Step 2** | **Indicator Development (2 days, about 4-6 hours per location)** | | |
| | **Kandeu Health Facility Ntcheu 1** | **Chigodi Health Facility Ntcheu 2** | **New Hope Clinic. Salima** |
| Process | In-person | | |
| Participants | Youth groups, government health surveillance assistants (health personnel) and CSC CG team | | Government, health personnel, health extension workers, community development assistants, and CSC CG team |
| **Phase 2&3, Step 3** | **Scoring (3 hours per location, over 1 week)** | | |
| | **Kandeu Health Facility Ntcheu 1** | **Chigodi Health Facility Ntcheu 2** | **New Hope Clinic. Salima** |
| Process | In-person | Telerivet SMS, inputted into Kwantu Go-App<br><br>(No in-person scoring) | In-person but real time data entry into Kwantu Go-App |
| Participants | Community members (4 groups) | Individuals who participated in | Community members (4 groups) |

| | | | |
|---|---|---|---|
| | Separate health provider group (similar to issue generation) | interface (from their homes) | Separate health provider group (similar to issue generation) |
| Facilitators | Same as issue generation | | |
| **Phase 4** | **Interface & Action Planning (1 day per location)** | | |
| | **Kandeu Health Facility Ntcheu 1** | **Chigodi Health Facility Ntcheu 2** | **New Hope Clinic. Salima** |
| Process | In-person | | |
| Participants | Community members and health providers (with some representatives from District Health Management Team) together with facilitators | | |
| Facilitation | Same as issue generation | | |