How to Mobilize Communities for Health and Social Change

Participant Manual

Breakthrough ACTION South Sudan

TOGETHER FOR EACH OTHER

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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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INTRODUCTION

Save the Children's (SC) long history of working at the community level has made it a recognized leader in developing and implementing innovative approaches to community mobilization, in particular, those which strengthen community-based responses at the household and community level. These approaches have now been applied at scale with positive outcomes for large numbers of children. Community mobilization is now being more systematically applied to the health issue funded program(s), in order to establish a supportive community environment through which change can be realized and sustained.

Breakthrough ACTION and its partners recognizes that health for communities can be achieved through successfully designed, implemented, monitored and evaluated programs. Achieving and sustaining positive change through these programs also requires advancing social change which empowers families, communities, government and non-government stakeholders.

WHY USE A COMMUNITY MOBILIZATION APPROACH?

Community mobilization will help you apply empowering development principles to achieve positive health outcomes. You can apply sound community mobilization approaches to achieve the following:

- Application of appropriate development principles to funded program(s).
- Entering and working with communities in a culturally appropriate manner so that a foundation for partnership is established
- Ongoing dialogue, reflection and action amongst community's members related health issues.
- Create or strengthen community groups aimed at improving specific health outcomes
- Community capacity built to explore, plan, act together, leverage and manage resources, and monitor their collective action toward health goals.
- Assist in creating an environment in which individuals can empower themselves to address their own and their community's health needs.
- Promote community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by health issues.
- Work in partnership with community members in all phases of a project to create locally appropriate responses to health needs.
- Identify and support the creative potential of communities to develop a variety of strategies to improve their health status.
- Create linkages between communities and external human and financial resources, as well as, other communities achieving success.

Community mobilization approaches bring multiple benefits to health programs. These include:

- Improved understanding by communities of health issues that are critical to implement programs in their community
- Increased community, individual, and group capacity to identify and respond to key health needs

- Improved program design
- Improved program quality
- Improved program results
- Improved program evaluation
- Cost-effective way to achieve sustainable results
- Increased community ownership

HOW TO USE THIS COMPENDIUM

This compendium will help you apply sound community mobilization approaches when designing, implementing, monitoring and evaluating your health programs. Materials in this compendium are designed to help community level facilitators mobilize communities for improved health outcomes for individuals, families and communities. Community mobilization facilitators may be Breakthrough ACTION staff, NGO and Ministry partners, and others who work directly with communities.

While the material included is not intended to be a *detailed* guide to carrying out community mobilization, it will help you consider key issues to be addressed at different steps in the process, as well as within the particular context of Sponsorship. Approaches in this compendium are drawn from the Save the Children, *"How to Mobilize Communities for Health and Social Change"* Field Guide[1].

PARTNERSHIP DEFINED QUALITY PILOT

This guide was developed combining the Community Action Cycle and the Partnership Defined Quality, a pilot approach for the Breakthrough ACTION South Sudan project. The Partnership Defined Quality is a methodology to engage communities and community health service providers to explore quality issues, first individually and then together as two groups, and to identify how to bridge the gaps identified in quality, together. Select members of the community and health service providers form a group to develop community improvement plans to address the prioritized issues, together.

For this guide we are mostly following the CAC approach but are using tools from the PDQ for phase 3, where communities define the issues, and explore and prioritize those they will address.

[1] *How to Mobilize Communities for Health and Social Change Field Guide*, Grabman and Snetro, 2003, Health Communication Partnership

OVERVIEW OF SOCIAL AND BEHAVIOR CHANGE, COMMUNITY MOBILIZATION AND WHERE WE ARE TODAY

DEFINING THE DIFFERENT DISCIPLINES

To understand CM better, we need to learn about the key conceptual framework on Social Behavior Change.

The following are definitions of SBC, SBCC and BCC.

- **Social Behavior Change** encompasses a broader spectrum of activities or interventions, which are grounded in a number of different disciplines, including Social and Behavior Change Communication (SBCC), Social Marketing, Advocacy, Community Mobilization/Engagement, Behavioral Economics, or Human-Centered Design. See the toolkit, below, for a visual representation of this. SBC is therefore not just campaigns, posters, or communication but a wide spectrum of activities and strategies that address issues such as lack of information, but also structural barriers and norms.
- **Social Behavior Change Communication:** is the strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs and behaviors. It refers to the coordination of messages and activities across a variety of channels to reach multiple levels of society, including the individual, the community, services and policy.
- **Behavior Change Communication**: is an interactive process with communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviors; promote and sustain individual, community and societal behavior change; and maintain appropriate behaviors.

These concepts have evolved over time when practitioners realized that human behaviors are complex and are determined by various factors including various social determinants that communication alone cannot totally address. Information, Education, Communication (IEC) was the concept in vogue until evidence showed that BCC was more effective. After more evidence showed inadequacies, practitioners agreed that SBCC more accurately represented what the discipline stands for, however very recently SBC is the more preferred term as it more broadly encompasses the needs when working with communities to enable and create behavior change.

THE SOCIO ECOLOGICAL MODEL

There are different levels of influence to create behavior change at the individual, household, community/social levels, and because of this, IEC and BCC, which focused on the individual level was not enough to create actual, sustainable change. We learned that we cannot only focus on the individual.

Social change, on the other hand, focuses on the community as the unit of change. It is a process of transforming the distribution of power within social and political institutions. For behaviors to change, certain cultural practices, societal norms and structural inequalities have to be considered and addressed. In light of this, various practitioners have designed guidance to carry out SBC, including C-Change, SC's Integrated SBC Framework, and the P-Process.

DEFINING COMMUNITY MOBILIZATION

The Community Mobilization Approach (CM) is a proven development approach that has helped people around the world identify and address pressing health, education and development issues. Community mobilization not only helps people improve their lives, but also by its very nature strengthens and enhances the ability of the community to work together for any goal that is important to its members. The result of a successful community mobilization effort is not only a 'problem solved' but also the increased capacity of communities to plan, manage, monitor and evaluate their own response to development issues.

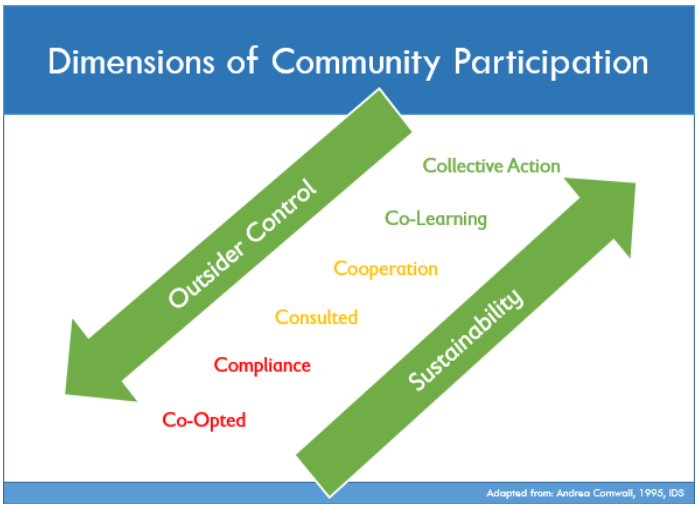
"Community mobilization" is a much used term and has been used to describe community-based activities – from vaccination 'campaigns' to 'sensitization' on youth sexual and reproductive health. However, SC's definition is much more of a sustained process in which community members participate in all aspects and phases of a program.

SC'S COMMUNITY MOBILIZATION DEFINITION

"Community mobilization is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health, education, and other needs, either on their own initiative or stimulated by others."

It is also important to discuss what community mobilization is *not.* It is not a campaign, for example, nor a series of campaigns. Nor is community mobilization the same as social mobilization, advocacy, social marketing, participatory research, or non-formal or popular education. However, community mobilization, may use or incorporate many of these strategies to be successful.

Key elements of community mobilization include participation, ownership, equality, sustainability, community and dialogue of knowledge. Participation is one of the most fundamental elements of community mobilization. As such, it is important to consider the degree to which health programme promote community participation. The following graphic illustrates the relationship between the various degrees of community participation and the resulting sense of ownership and prospects for sustainability.



The definitions for each of the degrees of community participation are as follows:

- **Co-option:** token involvement of local people; representatives are chosen, but have no real input/power
- **Compliance**: tasks are assigned, with incentives; outsiders decide on agenda and direct the process
- **Consultation**: local opinions are asked; outsiders analyze and decide on a course of action
- **Cooperation:** local people work together with outsiders to determine priorities; responsibility remains with outsiders for directing the process
- **Co-Learning**: local people and outsiders share their knowledge to create new understanding and work together to form action plans with outsider facilitation
- **Collective Action:** local people set their own agenda and mobilize to carry it out, in the absence of outside initiators and facilitation.

With USAID support in 2002, SC compiled its experience in mobilizing local communities into a field manual entitled, *"How to Mobilize Communities for Health and Social Change*" (Grabman and Snetro, 2003). Numerous SC staff and partners have been trained as trainers using the accompanying *CM Trainers Guide and CD-ROM.* The manual is written for program managers of community-based programs and their teams and guides users through all phases of community mobilization process.

The **Community Action Cycle** (CAC) is the process through which communities themselves mobilize to organize for action; explore the development issues and set priorities; plan, act, and evaluate successful programs. SC provides guidance and support to communities throughout the cycle. The process of community mobilization empowers communities and enhances self-reliance and sustainability.

An *appreciative community mobilization* approach is often applied in which these Phases are addressed by focusing on community strengths and building on them. An appreciative methodology developed by Case Western uses a 4-D Cycle (Discovery; Dream; Design; and Delivery).

CM Characteristics:

1. Developing an ongoing dialogue between community members regarding health issue(s).
2. Creating or strengthening community organizations aimed at improving health outcomes
3. Assisting in creating an environment in which individuals can empower themselves to address their own and their community's needs.
4. Promoting community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by the health issues.
5. Working in partnership with community members in all phases of a project to create locally appropriate responses to health needs.
6. Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve education/health status (even interventions that may not have been recommended by Donor and other external actors).
7. Assisting in linking communities with external resources to aid them in their efforts to improve health.
8. Committing enough time to work with communities, to accomplish the above (normally, this process is not suitable for short-term projects of less than two years).

COMMUNITY MOBILIZATION APPROACHES

Save the Children (SC) has developed several Community Mobilization (CM) approaches that have been applied at scale and demonstrated positive results for large numbers of children and communities. One of those CM approaches, the Community Action Cycle (CAC), has become a foundational and proven CM methodology for fostering sustained community participation in achieving health and development outcomes. Over the past decade, the CAC has been applied across multiple sectors to more than 42 global programs in over 40 countries. This broad-scale application has produced solid evidence to support the CAC as an effective approach for delivering positive and sustainable development and health outcomes, most notably in supporting child health, nutrition, family planning and reproductive health, HIV/AIDS prevention, care and support, and maternal and newborn care.

The CAC consists of a series of seven phases (see below) and recognizes that participation, ownership, equality, sustainability, community, and dialogue of knowledge are key elements to mobilize communities. The CAC, as a focused CM approach, recognizes participation as the most fundamental element through stressing the notion, particularly for external stakeholders, that effective "community mobilization is not just something done *to* the community, but something done *by* the community[2]." Such an understanding and appreciation for the participatory role of the community has allowed the CAC to be a powerful tool with the ability

[2] See page 7 of L. Howard-Grabman and G. Snetro, *How to Mobilize Communities for Health and Social Change: A Field Guide*, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Health Communication Partnership [HCP], 2003

to elicit the potential of individuals and communities to effect meaningful and sustainable change.

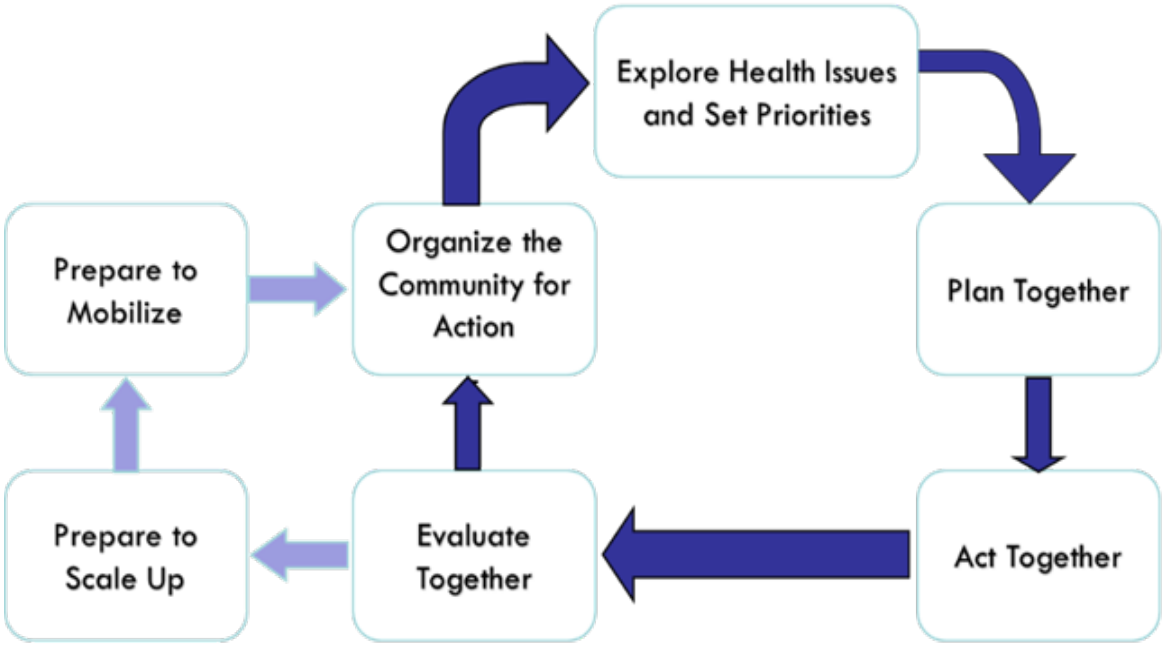
COMMUNITY MOBILIZATION TOOLKIT

This manual is one version of several in the Community Mobilization Tool Kit, designed to help trainers, community workers and volunteers understand the community mobilization process and empower community members to be their own agents of change and thereby support measurable improvements in the health and well-being of their families and communities. The toolkit has three versions:

1. **The Original CAC:** which consists of the original seven phases of the CAC, could be used in areas where there has been no previous CAC.
2. **The adapted CAC**: this document – an adapted version of the CAC, has 5 phases. This version of the CAC can be used in circumstances where the original CAC has previously been implemented and the program team wants to do a quicker/shorter version; or for those programs with limited time to implement.
3. **CAC for Emergencies**: the CAC adapted and streamlined for emergencies (especially for COVID-19), whereby the user can quickly apply community mobilization, following key steps from the CAC to ensure engagement of communities during an emergency response.

This version is the adapted CAC, for quicker implementation, though the expectation is that there is already some trust and relationship that exists with communities, and that there has been some community mobilization carried out with these communities previously. This is also appropriate for projects with limited resources and time for implementation. However, it is recommended to refer to the field guide "*How to Mobilize Communities for Health and Social Change"* for deeper understanding of community mobilization and CAC.

THE ORIGINAL COMMUNITY ACTION CYCLE



COMMUNITY ACTION CYCLE PHASES & STEPS

Each phase of the **Community Action Cycle** has detailed steps, which can be integrated into the health program design, implementation, and monitoring and evaluation cycle.

PHASE 1 - Prepare to Mobilize

Step 1. Put together a community mobilization (CM) team
Step 2. Develop your CM team
Step 3. Gathered information about community resources and constraints
Step 4. Develop a community mobilization plan to guide you forward.

PHASE 2 - Organize the Community for Action

Step 1: Orient the community
Step 2: Build relationships, trust, credibility and a sense of ownership with the community
Step 3: Invite community participation
Step 4: Develop a 'core group' from the community

PHASE 3 - Explore health Issues and Set Priorities

Step 1: Explore health issues with the core group
Step 2: With the core group, explore health issues with the broader community
Step 3: Analyze the information
Step 4: Set priorities for action

PHASE 4 - Plan Together

Step 1: Determine who will be involved in planning and their roles and responsibilities
Step 2: Design the planning process
Step 3: Conduct/facilitate the planning process to create a community action plan

PHASE 5 - Act Together

Step 1: Define your team's role in accompanying community action
Step 2: Strengthen the community's capacity to carry out its action plan
Step 3: Monitor community progress
Step 4: Problem-solve, trouble shoot, advise and mediate conflicts

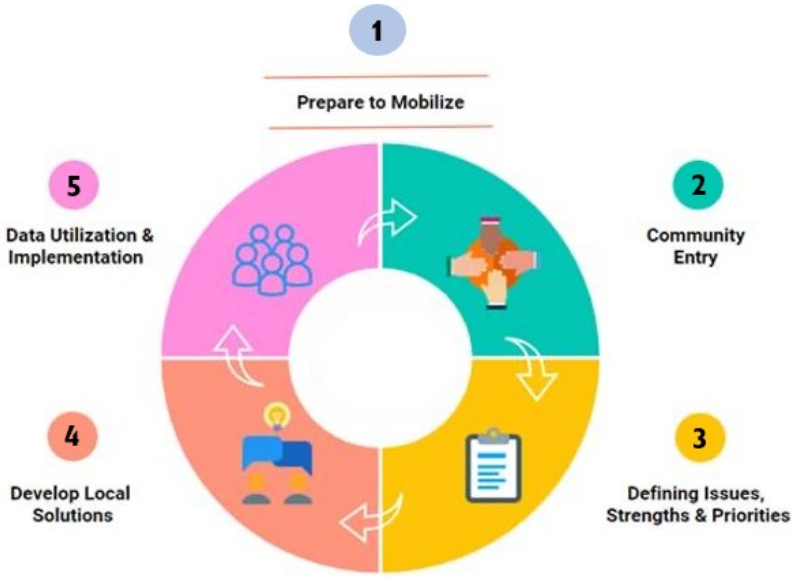
PHASE 6 - Evaluate Together

Step 1: Form a representative evaluation team with community members and other interested parties
Step 2: Determine what participants want to learn from the evaluation
Step 3: Develop and evaluation plan and evaluation instruments
Step 4: Conduct the participatory evaluation
Step 5: Analyze the results with the evaluation team members
Step 6: Document Lessons Learned and provide feedback to the community

PHASE 7 - Prepare to Scale-up

Step 1: Identify communities of promising practice
Step 2: Provide opportunities for community-to-community exchange and learning
Step 3: Utilize lessons learned to consolidate and refine approach to prepare for scale-up
Step 4: Develop a scale up plan including roles and responsibilities of implementing partners

The Adapted CAC



THE ADAPTED CAC STEPS AND PHASES

Each phase of the adapted **Community Action Cycle** has detailed steps which are similar to the original CAC. These can be integrated into the health program design, implementation, and monitoring and evaluation cycle.

PHASE 1 - Preparing the Program Team to Mobilize Communities

Step 1. Put together a community mobilization (CM) team
Step 2. Develop your CM team
Step 3. Gather information about community resources and constraints
Step 4. Develop a community mobilization plan to guide you forward.

PHASE 2 - Community Entry

Step 1: Visualizing positive change – community orientation and partnership
Step 2: Build relationships, trust, credibility and a sense of ownership with the community
Step 3: Invite community participation
Step 4: Gender equity and diversity in community action groups
Step 5: Develop a 'core group' from the community

PHASE 3 - Communities Defining the Issue, Exploring Strengths, and Setting Priorities

Step 1: Understand how to hold participatory meetings with communities
Step 2: Using participatory and HCD tools to collect data from and with Communities
Step 3: Conduct Root Cause Analysis and prioritization of determinants
Step 4: Validate data and prioritize determinants with communities

PHASE 4 - Communities Develop Local Solutions

Step 1: Determine who will be involved in planning and their roles and responsibilities
Step 2: Design the planning session
Step 3: Conduct/facilitate the planning process to create a community action plan

PHASE 5 - Implementation and Data Utilization for Decision Making

Step 1: Define your team's role in accompanying community action
Step 2: Strengthen the community's capacity to carry out its action plan
Step 3: Support community groups to monitor progress and utilize data to inform their microplanning and collective action

WHO ARE THE ACTORS

When implementing the adapted CAC with communities, it is important to understand who the actors are throughout implementation.

1. **The Community Mobilization Team**: this is composed of those actors who are working with the community to implement community mobilization, for example a project or program team, national and/or district health workers from the Ministry of Health, or members of an NGO. For Breakthrough ACTION, the CMT might be the MoH District Health Workers in some areas, CBO', and HCC in other areas.

2. **Community Action Group**: the core members of the community who will be working with the team to carry out the activities of community mobilization. These are members of the same community who would include community leaders (religious and traditional), members from women's, men's groups and youth groups, community health workers, community development committees, and should include representation from members of vulnerable groups like artisanal miners, tobacco farmers and those most affected by the health issue. They will also include members of their local health facility, like community nurses. There should be an equal amount of health service providers and communities in the CAG.

3. **Broader community**: the community at a larger scale, who do not necessarily drive community mobilization, but who the Community Action Group would engage with to ensure they are representing the needs of the community.

PHASE 1: PREPARE TO MOBILIZE

Steps:
Step 1. Put together a community mobilization (CM) team
Step 2. Develop your CM team
Step 3. Gather information about community resources and constraints
Step 4. Develop a community mobilization plan to guide you forward.

The Prepare to Mobilize Phase is intended to strengthen *your team's* skills on how to enter and work with communities and be a more effective mobilizer. Normally, the overall goal of the health program has already been decided upon. It is now time to:

Step 1. Put together a community mobilization (CM) team
Step 2. Develop your CM team
Step 3. Gather information about community resources and constraints
Step 4. Develop a community mobilization plan to guide you forward.

The resource materials and tools in this section will help strengthen your team's skills and abilities to be an effective participatory facilitator of the community mobilization process.

Step 1: Put Together a CM Team

Preparing to mobilize should not be the work of one person. Before you begin working with communities you will need to put together the team of people who will support the health initiative. This team of people will need to be well prepared to begin work on health issues with communities. Some skills they should have in common include:

- Understanding how communities are organized; customs; political and social structures and history

- Ensuring staff and partners share the same values and principals and can apply sound community development practice at the community level
- Orientation of community members to Breakthrough ACTION, Ministry and/or other partners health program goals
- Building community trust and ownership over sponsorship operations and programs

The CM team composition may change as you move through the various stages of community mobilization, with different skills needed at different times. This team is usually made up of key people from Breakthrough ACTION, ministry and/or NGO partners.

How do you decide who should be on the CM team? In the end, it may all come down to practical considerations, such as who has the time or interest, or to considerations beyond your control, such as the preferences of donors or other outside organizations. If you have the opportunity to choose some or all of your own team members, you should consider the following criteria:

- Expertise in the health issues.
- Understanding of the political, socio-cultural a community and macro environment).
- Basic community mobilization skills: communication and facilitation skills, program design and management skills, organizational behavior/group dynamics skills, capacity-building skills, planning and evaluation skills, knowledge of participatory methods.
- Personal attributes, such as openness, flexibility, patience, good listening skills, diplomacy, and most importantly, belief in people's potential.
- Language skills and respect in the area

But even from the beginning, the wider the variety of perspectives represented on your team, the less likely you will overlook important issues.

Step 2: Develop your CM team

*Conversation with the people requires a profound rebirth" (*Paolo Friere)

Skills of a Mobilizer:

Your team will need to be well prepared if they plan to apply a community mobilization approach to their health program. This preparation should begin *prior* to initiating contact with the community, as it is important to consider the type of first impression that you would like to make. A bad first impression is difficult to overcome. What you wear, how you act, which language you speak, what you say and how you say it, even how your arrive – in a car, which

almost no one in the community owns, or on public transportation which almost everyone uses – all these things will be noticed and discussed by community members when you leave.

If you are not familiar with local community protocol, it is important to learn about it early on. You can talk with people who are working in the community or who know about local protocol to find out which people you will need to contact first, and what will be expected of your first visit.

Some things to consider when entering the community:

- Know and apply local customs and protocols for meeting leaders and others.
- Ensure that someone on the team speaks the local language and dialect.
- Prepare materials before the visit (a short description of the program, information on your organization)
- Be honest and don't promise things that you can't deliver
- Be respectful of people's time and schedules

There are other skills which your team will need to have in order to effectively apply community mobilization approaches. Let's review some of these now.

Key Competencies:

All team members should have the following competencies*:*

- Understanding of the definition of community mobilization
- Knowledge of the Community Action Cycle Phases and Steps
- Ability to articulate the health program's *goal* in local language
- Know how to enter communities and undertake a situational analysis that includes gathering information on how communities are organized, their history, values and customs
- Know how to facilitate dialogue and reflection using non-formal learning techniques
- Be a facilitator not a teacher – understand behavior change theory
- Value and respect local knowledge and capacity
- Test their own assumptions and beliefs and admit that some are wrong
- Listen – "Seek first to understand and then to be understood"
- Work to build community capacity
- Share power

A basic CM Training workshop can be organized to review what is community mobilization, the community action cycle, and all Phases and Steps to the process. It is recommended that the team be trained together in order to harmonize CM approaches in the field. This workshop can also be an opportunity to build skills on how to learn about the community, how it's organized, history, customs and values. These skills and more can be learned from the *Community*

Mobilization Trainers Guide[3], which is a compendium to the *How to Mobilize Communities for Health and Social Change* field manual.

As you *Prepare to Mobilize*, defining team members' roles and responsibilities will be important. You will look at the tasks you've set for yourselves and decide who will be responsible for what. It is expected that team members will work together with communities to assure a unified approach. Team members will often have multiple roles. Here are some possible roles related to community mobilization:

- **Catalyst/Mobilizer**: facilitate the implementation of the Community Action Cycle with leaders and community groups to stimulate action on The health issue
- **Organizer:** Forms new organization/groups or brings existing organizations together around an issue.
- **Capacity-Builder/Trainer**: Helps to build community capacity to achieve CM goals.
- **Partner:** Complements local organizations in a joint effort.
- **Direct Service Provider**: Provides a health or education service
- **Liaison:** Links communities with resources and partners, builds networks

Team Values:

Sound team values are also highly important if community mobilization efforts are to be successful. Once your team is formed, it may be useful to brainstorm the values that your team feels are important. Be sure to involve all persons engaged in sponsorship including program and *administrative* staff.

Malawi Program Team Values – 2008

Create and build trust in communities	Do no harm
Ensure the broader community is well oriented before initiating child registration or programs	Admit when you don't know something and seek to understand
Don't make promises that cannot be fulfilled	Understand your role and responsibilities
Respect community members	Promote child participation
Know the Health Program Goal and Intermediate Results and be able to articulate them in local language in a way that is easy to understand by everyone in the community and is mobilizing to communities	

[3] Health Communication Partnership/Save the Children, Grabman and Snetro, 2003. Also can be found on the SC Savenet.

Becoming a Participatory Facilitator

What is participatory facilitation?

Participatory facilitation is a learning methodology that engages participants actively in the educational process, incorporating their needs and questions, their capacities, their reflection and analysis, and their strategies for change. The skills of a participatory facilitator are not only needed for training, workshop design and group meetings, but are called upon throughout the Community Action Cycle in order to effectively support an empowering community mobilization process.

Becoming a participatory facilitator requires practice, and there are basic learning theories and facilitation methods that will help you develop the skills to become a learner-centered facilitator. It is only through practicing and openly receiving feedback from colleagues that you can become a better participatory facilitator who supports a process of positive change through honoring everyone's contributions, recognizing each individual's creative resources and creating a supportive learning environment.

The foundation of facilitation: non-formal learning theory

An initial step to becoming a participatory facilitator is to have a better understanding of non-formal learning theory. Traditionally, learning has been viewed as a transfer of expertise from teacher or trainer to learner. The teacher defines what the learner needs to learn. This approach to learning is based on the belief that the teacher holds the key to knowledge and the learner is seen as an empty container waiting to be filled up by the teacher's knowledge. With this approach, learners play a passive role and are expected to learn what the teacher teaches.[4] This teaching approach gives total control over the learning process to the teacher or trainer and discourages learners' active participation. The trainer does everything from defining the objectives to evaluating the learner. This type of training is often referred to as the "banking approach." Brazilian educator Paulo Freire saw the banking approach as a root cause for oppression and contrary to a process that empowers poor and marginalized groups.[5]

Some major assumptions of the banking approach to learning are:

1. New knowledge by learners will automatically lead to action, or change in behavior.
2. The trainer *owns* the knowledge and can therefore transmit or impart it as an *instructor*.
3. Learning depends essentially on the trainers' capacity to teach and the learners' capacity to learn.
4. Training is the responsibility of the trainer and/or the training institution.

The Banking Approach:

- The 'teacher' is seen as possessing all the important information.
- The learner is an "empty vessel' needing to be filled with knowledge.

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[4] Society for Participatory Research in Asia. (1995). *A Manual for Participatory Training Methodology in Development.* Society for Participatory Research in Asia.

[5] Freire, P. (1997, reprint). Pedagogy of the Oppressed. New York: Continuum Press.

- The 'teacher' talks.
- The learner listens passively.
- The 'teacher' chooses the program content and the villagers must adapt to it.
- The 'teacher' confuses the authority of knowledge with his or her own authority, which he/she sets in opposition to the freedom of the learner.
- The 'teacher' is the subject of the learning process while the 'learner' is the object.

Over the second half of the twentieth century, an alternative view of learning evolved--from learning being viewed as *transfer of expertise*, equated with *imparting* knowledge, into learning as a process of *discovery* and *growth*. The focus of this process is on reflection, examining one's own values, attitudes, and orientation; on discovering one's assumptions and patterns of behavior, and on questioning, rethinking, and relearning.

Non-formal learning is sometimes referred to as popular education or adult learning (although it may be applied with children as well). It is an ongoing process through which both facilitators and participants learn from each other. This approach to training is intended to build the learners' confidence and their capacity to observe, analyze, criticize and understand their own behavior, reality, interests, issues, and concerns. Through this process, learners begin to cooperate rather than compete and are encouraged to explore their own reality on the basis of their own experience and voice their own ideas as they work to solve their own problems. Non-formal education is often defined as out-of-school learning that is planned and agreed upon by both facilitator and participants. This non-formal approach is learner-centered and experience-based.

The non-formal approach to learning is based on several assumptions:

1) People cannot be developed; they develop themselves.
2) New knowledge does not automatically lead to action or changed behavior--individuals first need to understand and internalize the importance of change.
3) Learners are a rich and diverse source of information and knowledge about the world.
4) Collective reflection and experience is a powerful tool for learning and change.

The Non-formal Education (NFE) Approach:

- The learner is active.
- The learning is practical, flexible, and based on the real needs of the learner.
- The purpose of NFE is to improve the life of the individual or community, rather than to teach isolated skills or knowledge.
- NFE emphasizes trust and respect while encouraging questioning and reflection.
- Facilitators and participants are partners in learning

The Experiential Approach to Training

The "Experiential Learning Cycle", is a training method developed by the Training Resources Group (TRG)[6]. Specifically, it outlines a process which facilitators can use when working with individuals and groups involved in learning and/or promoting collective action through community mobilization. The learning cycle requires the learner to move through four different phases of the learning process: "Experience"; "Process"; "Generalization"; and "Application".

Experiential learning is exactly what the name implies--learning from experience. The experiential approach is learner-centered and allows the individual participant to manage and share responsibility for his/her own learning with their facilitators. Effective community mobilization strategies that use experiential learning approaches provide opportunities for a person (or a group) to engage in an activity, review this activity through dialogue and reflection, gain some useful insight or knowledge from this reflection, and apply what is learned in a practical situation in life.

The nature of each phase is driven by the goals of the training or group objective. Once the goal and objectives are defined, then the session can be designed using the model as a framework. The role of the facilitator is to create a safe and respectful space for the group of learners and to help them through the following processes of learning:

Experience: Provides the participants opportunities to "experience" a situation related to an objective of the training session that is similar to a real life situation. This "experience" is structured to enable the participants to become actively involved in "doing" something. Doing, has a broad definition and includes a range of activities such as: case study, skit/drama; role play; demonstration; small group task; site/field visit; skill practice. The participant's experience will evoke feelings and thoughts and which will begin the learning cycle.

Process: Once the experience stage is completed, the trainer or facilitator guides the group into the 'process' part of the cycle. During this phase, participants reflect on what they did during the 'experience phase', and are encouraged to share their reactions with the group. Participants are encouraged to link these thoughts (cognitive), and feelings (affective) together in order to derive some meaning from the experience. The 'processing phase' is an opportunity to challenge learners to think, and to analyze the activity they just experienced from a variety of perspectives. Many times facilitators place a great deal of effort on creating an experiential learning activity without paying enough attention to preparing a set of processing questions to help the learner gain the most out of an experience and to build a foundation for the generalization phase.

Examples of processing questions:

- What are your observations about_____?
- Where did you have difficulties?
- What surprised you?
- What worked?
- How did you feel about _____?

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[6] Ibid.

- What were your reactions?
- What strategies were used?
- What were turning points in the experience?
- How does what you said relate to…..or differ from…..?
- What are some similarities that you notice in what people have said?

Generalization: The generalization stage helps participants develop conclusions and generalizations that might be derived from the first two phases of the cycle. During this phase, participants step back from the immediate experience and draw conclusions that might be applied to "real life".

Some sample generalization questions:

- What have you learned about….?
- What conclusions about _____can we draw from this?
- Have you gained any new insights about….?
- Are there any lessons to be learned?
- What general advice could we give about_____?
- What principles can we develop from this?
- What are some significant points to remember from this section of the course on_____?
- From this session, the readings and the discussions we have had all week, what insights do you now have about_____?
- If you were to synthesize all that we have been addressing in this unit, what would you say are the two most important conclusions you have reached about_____?

Application: In the application phase participants draw upon insight and conclusions reached in the previous phases to incorporate into their lives more effective behavior in the future. The facilitator encourages participants to place themselves in their everyday life situations and identify what they will do better/differently as a result of what they have learned.

Some sample Application Questions:

- How can you apply _____?
- How can you use _____?
- As a result of our work on _____, what will/can you now do differently when you return to your job?
- Identify at least three 'ways' that you will/can become more effective at _____?
- What do you (or the group) still need to work?
- What are some ways that you can change your approach to_____?
- How can the group help to support your efforts to change?
- Choose two things you will work on when you return to your family/home…identify how you will undertake these activities….how you will know if you are being successful at them.

A skillful trainer should have the competence to understand what goes on at each phase of the experiential learning cycle and to facilitate the learning process. There are resources that can provide much greater detail on how to effectively use an experiential approach to learning. (See the Training Resources section of these Trainer's Notes, pages __.)

Original source: Lewin, Kurt. (1951). *Field Theory in Social Science*. New York: Harper Collins.

Glossary of Facilitation Methods[7]

- **Brainstorming:** generating ideas in a group by eliciting quick contributions without comment or opinion.
- **Case study**: examining a fictitious or true account of something.
- **Checklist:** selecting items from a prepared list.
- **Contracting**: agreeing to carry out a future behavior and inviting a fellow participant to follow up on the agreement.
- **Creative exercise**: engaging participants in an activity that calls for original or innovative thinking.
- **Debate**: assigning participants to take "pro" and "con" positions to stimulate discussion.
- **Demonstration:** showing participants how a concept, procedure, or skill looks in action.
- **Dyadic discussion**: requesting participants in groups of two to hold a brief conversation.
- **Experiential exercise**: designing an activity that dramatically illustrates training content by allowing participants to experience it.
- **Feedback**: requesting participants to give one another their reactions to the behavior of the other.
- **Fishbowl**: configuring a group by asking a portion of the group members to form a discussion circle, and having the remaining group members form a listening circle around the discussion circle (as if they are looking into a fishbowl!).
- **Game**: using quiz-program formats or playful activity to experience or review training material.
- **Group discussion**: conducting any exchange of ideas with the total group able to participate.
- **Group inquiry**: inviting participants to ask the trainer questions about the subject-matter content after being presented with interesting training material.
- **Guided teaching**: shaping trainer's knowledge and teaching approach by pulling from participants' knowledge of the subject matter.
- **Icebreaker:** helping participants to get acquainted or immediately involved in the training program using a structured exercise or game.
- **Information search**: having participants search for information in source materials or training handouts.
- **Interviewing:** inviting participants to ask one another questions.
- **Jigsaw:** merging the learning of two or more subgroups of participants.
- **Learning tournament**: combining cooperative learning and team competition.
- **Lecturette**: briefly presenting key points about a training topic.
- **Mental imagery**: guiding participants through an event or experience visualized in their minds rather than through real observation.
- **Observation:** watching others, without directly participating.
- **Panel discussion**: promoting an exchange of ideas among representatives of the training sub-groups while others listen and ask questions.
- **Peer consultation**: using participants to provide instruction for one another.

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[7] Silberman, M. L. (1997).*Twenty Active Training Programs, Volume III*. San Diego: Pfeiffer & Co.
Participant Manual

- **Physical continuum**: requesting that participants arrange themselves in a line that represents their relative responses to the trainer's question.
- **Polling:** surveying a group by requesting a show of hands.
- **Presentation:** briefly informing participants about the trainer's objectives and other key areas of information.
- **Press conference:** requesting participants to devise difficult questions to be answered by the trainer.
- **Problem-solving activity**: having participants find solutions to problems posed to them by the trainer.
- **Project:** assigning a challenging activity to participants.
- **Questionnaire:** giving a survey or instrument to participants to complete in order to obtain some form of structured feedback.
- **Quiz:** inviting participants to take a short test (usually self-scoring) to become acquainted with or to review course materials.
- **Response cards:** asking participants to state something anonymously on an index card and sharing that information by passing the completed card around the group.
- **Role play/socio-drama**: having participants act out and thereby demonstrate real-life situations.
- **Self-assessment or self-evaluation**: posing questions that require participants to reflect on their attitudes, knowledge or behavior.
- **Simulation**: engaging participants in an activity that reflects reality in a symbolic or simplified manner.
- **Skill practice:** trying out and rehearsing new skills.
- **Study groups**: asking participants to read and then discuss the contents of a training handout or short written assignment in small groups.
- **Subgroup discussion**: conducting any exchange of ideas in subgroups or "buzz groups" of four or more participants each.
- **Subgroup exchange:** arranging a discussion in which two or more subgroups or teams exchange views and conclusions.
- **Trio discussion or trio exchange**: conducting an exchange of ideas with the subgroups of three participants each.
- **Whip:** rapidly sharing information or ideas by going quickly around the total group soliciting contributions.
- **Writing task**: requiring participants to compose a written response to a training assignment such as an action plan or a learning journal.

Facilitation Skills – Dialogue Creation

Adapted from James A. McCaffery. Training Resources Group, Inc. - TRG

Question asking is a critical facilitation skill. Questions can be asked in two ways; as closed questions and as open-ended questions.

Closed Questions

Closed questions generally result in yes/no or other one-word answers. They should only be used when you want precise, short answers. Otherwise, they inhibit discussion. The closed question can be answered with one word. Example:

Person No. 1: *Do you think that recommendation will work?*

Person No. 2: *No.*

Open-ended Questions

The open-ended question requires elaboration. "Tell me what you liked about that recommendation" seeks information. How? What? Why? Are words that begin open-ended questions?

Person No. 1: *What did you like about that recommendation?*

Person No. 2: *I think it is a good strategy for resolving the issue, one that can be implemented without expending a lot of resources.*

Person No. 1: *What kinds of goals did the group set?*

Person No. 2: *They set a wide range of goals. The first was...*

Paraphrasing

Paraphrasing is simply restating what the other person has said in your own words. The prefix "para" means alongside, as in the word parallel.

The process of paraphrasing is very much like catching a ball and throwing one back except the ball you throw back is your own and perhaps a bit different from the original ball. Nonetheless, it is still a ball. You can throw back the other person's ideas by using such beginning phrases as:

- *You are saying...*
- *In other words...*
- *I gather that...*
- *If I understood what you are saying...*

The best way to paraphrase is to listen very intently to what the other is saying. If, while the other person is talking, we worry about what we are going to say next or are making mental evaluations and critical comments, we are not likely to hear enough of the message to paraphrase it accurately.

It is helpful to paraphrase when you want to make sure you (and others) understand a key point. You can even interrupt to do so, since people generally don't mind interruptions that indicate you are really striving to understand. For example: "Pardon my interruption, but let me see if I am clear about what you are saying..."

Summarizing

The purpose of summarizing is to:

- Pull important ideas, facts, or data together.
- Establish a basis for further discussion or to make a transition.
- Review progress.
- Check for clarity; check for agreement.

By using summarizing in a conversation, you can encourage people to be more reflective about their positions as they listen for accuracy and emphasis.

Some starter phrases to help you begin a summary are:

- *From our work this morning, I conclude that...*
- *Let me try to summarize...*
- *I think we agree on this decision from our discussion, I think what we are saying is that we intend to....*

A real value of summarizing is that it gives you the opportunity to check for agreement. If people do not agree, it is better for you to know during the discussion than to find out later when a task is not completed or a deadline is missed. One of the most common complaints is that some people think an agreement has been reached, yet things do not occur as planned afterwards. In many instances, that is because there was not really agreement during the discussion.

Encouraging

In order to make it possible for others to contribute, or to speak up in either one-on-one or in group situations, they need to feel that their views are valued. What helps in these situations is to enhance the process of asking questions, paraphrasing and summarizing with both non-verbal and verbal cues. Examples are:

- Nodding one's head.
- Maintaining eye contact, open body position.
- Picking up on the last word or two of someone else's sentence.
- Repeating a sentence, or part of a sentence.
- Asking someone “Say more about that.”
- Saying “That's good” “Anybody else got anything to add?”
- Saying “Uh huh.”

Possible Cultural Implications

The use of these Facilitation Skills may vary from one culture to another, in particular those listed under "Encouraging Others to Contribute." By and large, these skills are appropriate, although adjustments may at times be necessary. They may be more or less difficult to do or understand between people who have different cultural backgrounds.

Suggested Open-ended Questions

Background	**Identification of Problems**	**Example**
What led up to _____?		Can you give an example?

What have you tried so far? Can you remember how it happened? What do you make of it all?	What seems to be the trouble? What seems to be the main obstacle? What worries you the most about _____? What do you consider the most troublesome part?	For instance? Like what? What is an illustration you can give us?
Description What was it like? Tell me about it. What happened? How might you describe it in your own words?	**Appraisal** How do you feel about it? How does it look to you? What do you make of it all? What do you think is best?	**Clarification** What if this doesn't make sense to you? What seems to confuse you? What do you mean by ? What do you make of it all?
Alternatives What are the possibilities? If you had your choice what would you do? What are the possible solutions? What if you do and what if you don't?	**Exploration** How about going into that a little deeper? What are other angles you can think of?	**Extension** What more can you tell me about it? Anything else? Is there anything more you would like to discuss? What other ideas do you have about it?
Planning How could you improve the situation? What do you plan to do about it? What could you do in a case like this? What plans will you need to make?	**Predictions and Outcomes** How do you suppose it will all work out? Where will this lead? What if you do - or what if you don't? What are the chances of success?	**Reasons** Why do you suppose you feel this way? How do you account for this? What reasons have you come up with? What is the logical solution to this
Failures, Preparation for What if it doesn't work out the way you wish? What if that doesn't work? And if that fails, what will you do? What are some alternate plans?	**Relation** How does this fit in with your plans? How does this affect your work? How does this stack up with your picture of yourself? How do the two plans relate?	**Evaluation** Is this good or bad or in between? According to your own standards, how does it look? How would you evaluate all of this?
Facilitation Skills, By: James A. McCaffery *Training Resources Group, Inc. -TRG*		

The Conditions of Learning[8]

An environment of active people:

People learn when they feel they are personally involved with others in a learning process.

A climate of respect:

When a high value is placed on individuals and a sense of caring prevails.

A climate of acceptance:

Accepting a person means that s/he can be himself/herself and express her/his beliefs without fear.

An atmosphere of trust: When people have a feeling of trust in themselves and in others.

A climate of self-discovery:

When learners are helped to find out about themselves and to meet their own needs, rather than having their needs dictated to them.

A non-threatening climate: So that persons can confront each other and ideas without fear.

A climate of openness: When personal concern, feelings, ideas and beliefs can be expressed and examined openly.

An emphasis on the uniquely personal nature of learning:

When each individual knows that his/her values, beliefs, feelings and views are important and significant.

A climate in which differences are thought to be good and desirable:

When differences in people are as acceptable as differences in ideas.

A climate which recognizes the right of individuals to make mistakes:

Learning is facilitated when error is accepted as a natural part of the learning.

An atmosphere that tolerates ambiguity: When alternative solutions can be explored without the pressures of having to find an immediate single answer.

An emphasis on co-operative evaluation and self-evaluation: When people can see themselves as they really are, with help from peers.

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[8] Society for Participatory Research in Asia. (1995). *A Manual for Participatory Training Methodology in Development,* Society for Participatory Research in Asia, pg. 13.

Facilitation Observation Guide

Use the following Facilitation Observation Guide with your team members to practice the skills and methods needed to become a participatory and effective facilitator and to provide feedback to each other.

Facilitator's Name: _____

Observer's Name: _____

I. Arrival

_____ Has seating in informal/relaxed configuration, such as a circle or horseshoe shape, etc.

_____ Greets people as they arrive; develops rapport and makes people feel welcomed and at ease

II. Introduction

_____ Formally greets group, thanks them for coming

_____ Introduces self and role as facilitator

_____ Explains purpose of meeting

_____ Has participants introduce themselves

_____ Facilitates appropriate icebreaker* to build comfortable environment

III. Discussion

_____ Reinforces that group has knowledge and he or she is there to help them

____ Begins discussion with opening question or statement

_____ Uses open, probing, redirecting questions (List specific examples)

_____ Paraphrases (List specific examples)

_____ Encourages quiet members (List specific examples)

_____ Regulates overly dominant members in culturally appropriate ways

_____ Handles other difficult participants while maintaining their self-esteem (List examples)

IV. Non-verbal communication skills

____ Uses eye contact to encourage participants

_____ Uses other gestures to encourage participants (smiles, etc.)

V. Verbal communication skills

_____ Speaks clearly, slowly for all to hear

_____ Paraphrases when trying to provide clarity and create dialogue

_____ Uses open ended questions

_____ Uses local language, or easy to understand language if working with translator

_____

* An icebreaker is a creative exercise carried out by the group which builds trust and establishes a safe learning environment among group members. Icebreakers should be culturally appropriate. For example in some cultures touching is prohibited between men and women, therefore an icebreaker needs to be selected which would not make participants uncomfortable with regards to this cultural norms. Also icebreakers need to be of the appropriate time-duration in order not to distract from group work.

VI. Pulls discussion to close

____ Summarizes, or has participants summarize

____ Asks participants what of value has been accomplished

VII. Closure

____ Clarifies next meeting time and date and/or next steps and persons responsible

____ Thanks participants

Modified from materials developed by Peace Corps (*Promoting Powerful People*), USAID, and the Academy for Educational Development.

How does Behavior Change?

As previously mentioned, Social Behavior Change is what practitioners use for support behavior change at the individual, household, and community levels.

SBC uses a combination of strategies and approaches to address the various factors that influence an individual's ability to change or adopt behaviors. These factors, often called determinants align to the Socio Ecological Model (SEM), with different categories of factors for the different levels of the SEM.

Social & Behavioral Determinants for individuals and interpersonal relationships:

- Knowledge
- Information
- Habit
- Motivation
- Ability to Act
- Norms

Community Capacity Strengthening Determinants for community level:

- Skills
- Effective Leadership,
- Social Capital
- Collective Efficacy
- Resource Mobilization

Quality Service Determinants for Health Services:

- Key Care Practices
- Effective Communication
- Products and Services available
- Functional Referrals
- Accountability

Carrying out assessment to understand audiences and these determinants or factors for why individuals and communities have not adopted behaviors, and then designing programming through a combination of various approaches and interventions (CM, SBCC, HCD, etc.) will help to create, enable, and support behavior change.

Step 3: Gather information about community resources and constraints

Before starting community-based programs – learn more about the community! The health baseline study can be a chance to learn more about community structures, how communities are organized; the formal and informal leadership; how decisions are made and who makes them. Program staff and partners will need to know the answers to *these key community organizational* issues before entering communities to implement programs. Beginning community dialog around these issues will begin to build trust and mutual understanding between program staff and communities.

Normally, during a health program's baseline study information is gathered and analyzed on current use of key practices and services; access and availability of information and services; quality of services and demand, cultural practices and beliefs. Also key is who is most affected by an issue and why. As well as where are the most-affected, and what are their socio-cultural characteristics.

The following are three tools which could be considered during (or even after) a baseline study to better understand community organization and dynamics prior to beginning implementation of health activities.

Learning about Communities

Socio-cultural context

- How is the community organized? (Social class, ethnic groups, languages spoken, religion, age)
- What are the traditional groups and organizations? What are their roles and functions? Who belongs to them? How do they relate to each other?
- Who is wealthy? Who is poor? How do you know?
- How is land allocated?
- How do people support themselves and their families
- Data can be collected through interviews with key informants as primary data is collected. Alternatively, secondary data from country, regional, as well as inter-governmental agency research may also prove helpful.

Politics, leaders, and organizations

- What is the traditional organizational structure of the community? Who leads?
- Which groups participate in decision-making?
- Who are the official community leaders?
- Who are the informal/traditional leaders?
- How are community decisions made? Who participates?
- How is official leadership transferred?
- What links does the community have to external political systems outside of the community? (e.g. representation in a municipal, district or regional body)?
- Is the community considered to be a "priority" area by government officials? Or is the community relatively abandoned with little political capital?

- Which groups and leaders are strongest and/or have the greatest support of the broader community?

History

- When was the community established? By whom? Why?
- What is the history of collective action by the community?
- Has the community ever worked collectively on health or education issues before?
- Which issues? What were the results?
- What is the level of capacity/skills (any participation or experience with assessing, planning, action, monitoring/evaluation, decision-making)?

Economy

- What is the current economic situation in the country, region, community (e.g. high inflation, high unemployment, frequent droughts/famine)?
- What is the average income of the families in the community?
- How do most families support themselves?
- What percentage of families are considered poor?
- What is the level of external assistance?

Education and health systems

- How is the educational system organized?
- How is the health system organized?
- How does health care financing work in this setting?
- What role does traditional medicine play?
- What is the coverage and utilization of public/private/traditional health services?
- What are the most significant challenges faced by the health or education system?
- What are the strengths/weaknesses of the health or education system?
- How good is the quality of health care or teaching? From whose perspective?

Gender relations/roles

- What traditionally are men's/boy's and women's/girl's roles?
- What proportion of young girls are directly affected by the issue? Boys?
- Who has access to what? (E.g. information, services, ressources)?
- What are the power relations between the sexes?

Community Profile – Interview Questionnaire

This questionnaire can be used with community leaders and other key informants who are knowledgeable about the community and/or geographic area. You may want to add where and when the interview took place; which community; who was the interviewer; and interviewee (name, contact information).

1. How many years have you lived in this community?
2. What is your current role in the community?

3. What is the population of the community?
4. How is the community organized? What are the traditional and government, social structures? What community groups exists? How do they relate?
5. Who are the formal and informal leaders? How are leaders chosen?
6. What do you see as the most important priorities of this community?
7. What is the community doing to address these priorities?
8. What do you think are your community's greatest strengths?
9. What are the greatest challenges you face as a leader/member of this community?
10. How are decisions made in the community about what the priorities are and how resources area allocated (financial and human)?
11. What are the major health problems for youth and/or educational issues? (depending on the Core Program focus)
12. Have community groups or organizations here ever worked together on these issues? Yes? No? If yes, which issues? Which groups? What did they do? What were the results of these efforts?
13. We are interested in working with interested communities on _____. Do you think that this community would be interested in exploring this issue with us? Why? Why not?
14. If we were to work with this community on this issue, with whom should we work? Which individuals and groups or organizations would be important to include in this effort?
15. How should we approach these individuals and groups? What do we need to do to begin to discuss this program with them?
16. What is important to know about this community as we begin to develop a community mobilization program?

Understanding who is Affected and Why?

1. Who is most affected by the issue that we are concerned about?

2. How many people are directly affected? Indirectly? This needs to be determined in the context of how you are defining the extent of coverage of your effort: one community? Several communities? A district? A region of the country?

3. Where do they live? Do people who are most affected by the issue live close together? Are they near to a source of the problem? (e.g. contaminated water source) Are health and other services available near where they live? Are they difficult to locate because they are not within a specific geographic area but form a community based on other characteristics?

4. What are their socio-demographic characteristics? Do people who are most affected by the issue share similar characteristics (age, sex, income levels, ethnic groups, language, etc.)?

5. Why are these people most affected? This is an important question to investigate and analyze from a variety of perspectives. Your team may want to explore aspects of the health condition itself that makes some people more likely to be affected by it (risk factors

and/or specific practices, etc.). Do they have limited access to information, services, and resources due to discrimination, geographic/social/cultural isolation and many other factors? To what extent do they decide what they do or do others decide for them? Who influences their decisions and practices at the household level?

6. What are current beliefs and practices related to the issue? What do *you* know about this community's beliefs and practices related to the issue? Who decides and/or influences what will be done and how at the community level? How do you know this information? What don't you know? When in doubt, it is always preferable to admit to not knowing. In fact, it is better to be humble and open to exploring multiple perspectives. Communities are not homogeneous and knowledge and practices vary among members. This type of information can be obtained through "Knowledge, Attitude and Practice or Behavior" surveys, anthropological studies, participatory research, and other means. Each method has its strengths and weaknesses and you should be aware of these as you gather information. If you can find little existing information, you will need to develop a more comprehensive process to explore this area.

7. Are they organized around this or any other issue? How? Is there any history of mobilization in the past?

8. What is the level of capacity/skills (any participation in/experience with collective assessment, planning, action, monitoring/evaluation, decision-making, negotiation, etc.)?

9. How do those most affected by the issue interact with the rest of the community? With decision-makers? Do they have access to resources? How have they managed resources in the past?

Step 4: Develop a Community Mobilization Plan

Now that you and your team have gathered information to help understand the setting you will be working in, and community resources and constraints, it's time to develop a community mobilization plan. The community mobilization plan is a description of *how* your team intends to mobilize communities around the core program goal in the designated area you will be working. As such, the community mobilization plan should serve as a *detailed roadmap* for you and your team. Note, this *is not* a community action plan – that will be developed later by communities themselves.

Your team's mobilization plan should focus on the overall health goal and objectives and identify a process that will help interested communities achieve them. As you create this plan, you should always keep the two overriding goals of community mobilization in your mind:

1. To achieve the health goal (e.g. improved health outcomes)

2. To improve the community's capacity to address health issues and sustain their effort over time

Your community mobilization team should draw up the community mobilization plan, headed by Health Program Managers. It should include *key* representatives from government and other local partners. At a minimum, a typical community mobilization plan should contain the following six elements. See the Annex for a sample *Community Mobilization Plan*.

1. **Background Information**: resources and constraints
2. **Program goal**: the overall goal of the mobilization effort
3. **Program objectives**: the overall objectives of the effort
4. **The community mobilization process**: the overall process you and the community will go through to achieve the goal and objectives
5. **A monitoring and evaluation plan**: with benchmarks for successes
6. **A project management plan**: with timeframes and who is responsible

Developing the Background Information of your plan allows your team to do an inventory of resources and constraints you may encounter to mobilization. You and your team should complete a simple worksheet where you list resources according to the following categories:

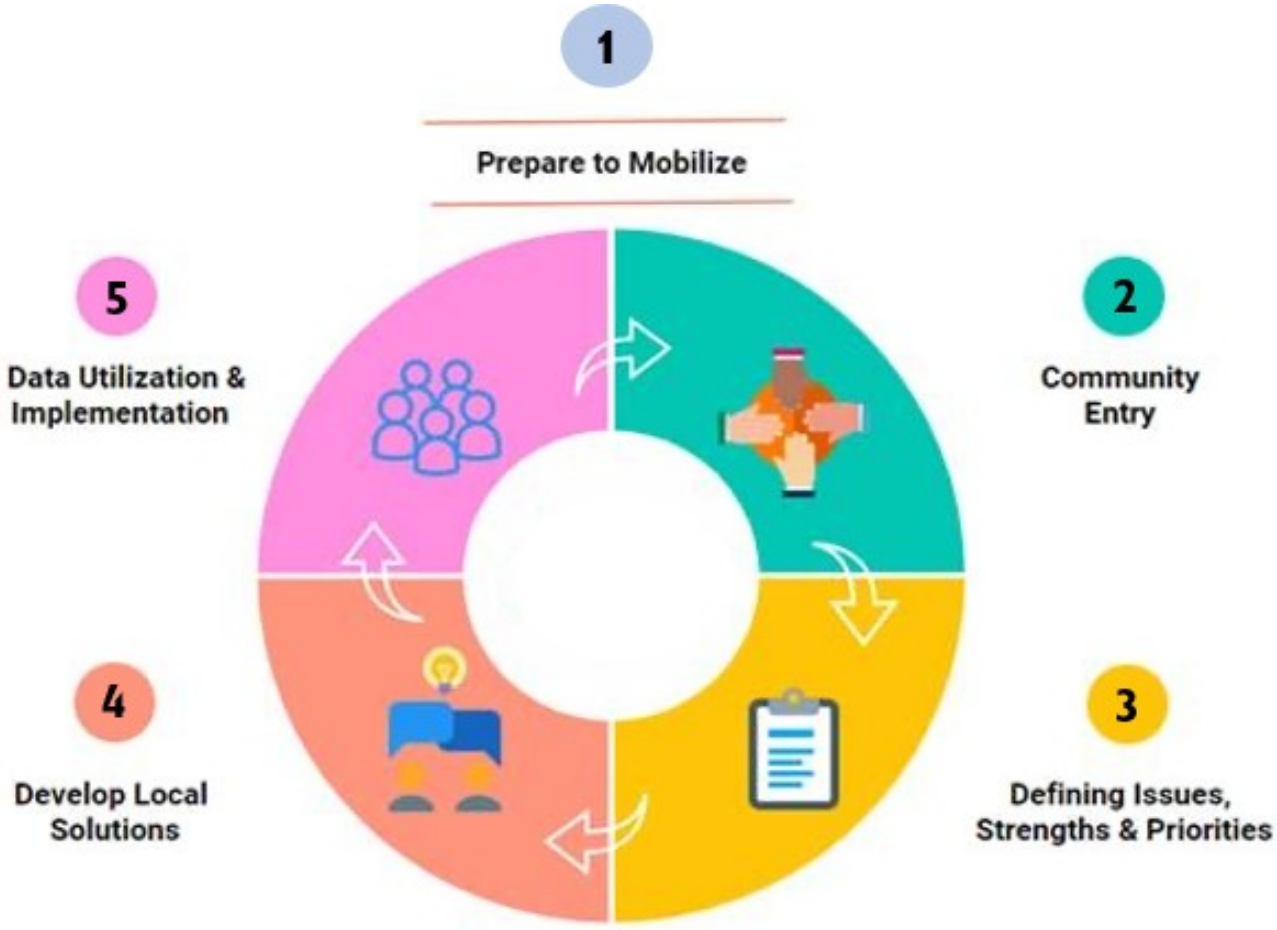
- **Financial resources**: project budget, income from all sources, including municipal government, the private sector, Ministry of Health funds, and nonprofit organizations.
- **Human resources and the types of skills they can contribute**: skilled project staff, collaborating organizations' staff/members, community members willing to work on the project, and others.
- **Material resources**: meeting space, supplies, meals, computers, vehicles, other equipment, office space.
- **Time**.

Some examples of constraints might be that project staff do not possess the skills to do the work, that there is insufficient time to achieve the desired results, or that there are very limited financial or material resources.

Constraints may also arise from seasonal, geographic, political, or logistical difficulties. For example, the communities with which you propose to work are located in a region that is only accessible during six months of the year because floods knock out the bridge during the rainy season. And you may also run into political constraints, cultural constraints, or language-related constraints.
You should not hesitate to adapt your plan in light of a realistic assessment of your circumstances. It's much better to make these changes now, in the early stages of your preparation, than after you have launched the mobilization effort and raised expectations.

Community mobilization plans should be reviewed quarterly by the CM Team in order to highlight and document successes and address challenges.

PHASE 2: COMMUNITY ENTRY AND ORGANIZING FOR COLLECTIVE ACTION



	Steps:
Step 1.	Visualizing positive change – community orientation and partnership
Step 2.	Build relationships, trust, credibility and a sense of ownership with the community
Step 3.	Invite community participation
Step 4.	Gender equity and diversity in community action groups
Step 5.	Develop a 'core group' from the community

ORGANIZE THE COMMUNITY FOR ACTION

During the Organize the Community for Action phase it is time to formally approach the community and invite their participation in addressing health issues. You should have your CM team in place and have developed an overall design (plan) for community mobilization. If the steps in the organize phase are undertaken prior to the baseline, community members can be involved and assist in data collection efforts, analysis and dissemination of results.

Key to communities getting organized is ensuring those most affected and interested in the health issue will participate, have a central role, voice, and will benefit.

The steps for this phase include:

Step 1: Understand how to hold participatory meetings with communities
Step 2: Using participatory and HCD tools to collect data from and with Communities
Step 3: Conduct Root Cause Analysis and prioritization of determinants
Step 4: Validate data and prioritize determinants with communities

Step 1: Visualizing positive change – community orientation and partnership

If you hope for broad community participation and engagement in your health program the CM team will need to carry out a number of introduction and orientation meetings *prior to* undertaking a baseline analysis, *or* engaging in child registration in communities. If communities do not know who you are, or why you are there it can result in miscommunication, mistrust and potentially *a security risk* for staff.

Benefits of Community Orientations

- Provide introduction and background on BREAKTHROUGH ACTION and partners
- Share important data on health and education issues (feedback results of Situational Analysis!)
- A presentation of the program goal
- Begin to learn about the health and/or education issues from the community
- Motivate Interest
- Receive consent to work together
- A brief description of the CM process
- Invite participation and next steps
- Set up an atmosphere of co-learning and partnership

Organize a number of community orientation meetings

It is important that all communities receive an introduction and orientation to your team, organization and program. Once your CM team understands how communities are geographically and traditionally organized they can develop an *orientation schedule* with responsible point persons to ensure coverage. Depending on the size of the population you are working with. The introduction and orientation process can take *two to three months.* While this may seem time-consuming it should be considered part of sound program implementation to create a foundation

of understanding, ownership and interest in the issues being addressed. Remember, even if you have already been working in these communities, the new health program, and CM staff will still need to be introduced.

Create a Mobilizing Goal

In some development contexts teams enter into communities and ask in a generalize way, "What are your needs/problems?" However, in the funding most often the health goal has already been determined based on country level data and previous analysis of health issues affecting communities. Therefore, what are the consequences of not being candid with the community regarding the specific health goal? Could this set up false expectations? How might this possibly patronize and waste community's time and effort? And what might be the advantages of being candid and sharing the focus of the project up front?

It will be important for your team understand the *health program goal* and *intermediate results* and be able to articulate them in local language during the orientation meetings. However, often the goal stated in project proposals is in more scientific terms and may not resonate with the perceived needs of the community. Therefore, before orienting the community to the program it is helpful to first translate the goal into terms that would be motivating for communities. Have your CM team practice with the new, motivating goal in local language! While this might seem easy, it actually helps the team find the most appropriate local words to use.

A Mobilizing Goal

Often our programs have goals that are technically accurate but not necessarily motivating for communities or well-expressed to communities, for example:

"Reduce maternal and neonatal mortality and morbidity through affecting the range of behaviors that influence the outcomes of pregnancy and of the neonatal period."

In developing a mobilizing goal, the CM team will need to look carefully at what would most effectively motivate communities to participate in improving the health issue in *their* community. A more *mobilizing goal* may be:

"Decrease death in pregnant women and newborns"

Entering a Community
Remember – Appearance builds trust!

- Be on time for meetings
- Speak in local language
- Wear appropriate clothing for the field
- No wearing of sunglasses when speaking with communities
- No cell phone use during meetings (or text messaging)
- BREAKTHROUGH ACTION vehicle to be parked at respectful distance from meeting
- No smoking or drinking

Planning for a Community Orientation Meeting

Your team will need to prepare for orientation meetings, including how many meetings will be held within the impact area, and in what communities. The following is checklist to help you plan:

- **Participants:** How many participants are expected? Who will they be? (Consider total number, ratio or men to women, languages(s) spoken, level of education, prior experience working in groups in general and working together in this group, social status/relationship, age, relationships to the issue.)
- **When**: The time, date, and length of the meeting should be convenient for the invitees. Community members should be invited with ample time before the meeting so they can plan to attend. (Invitations should come from respected leadership).
- **Where:** An accessible place, normally where community meetings are held
- **Agenda:** What are the objectives of the meeting? Which topics will be covered? In which sequence will topics be introduced? How much time dedicated to each topic?
- **Speakers/facilitators:** Who will run the meeting? Who will be asked to prepare and/or present information for the meeting (staff; community)?
- **Method/tools:** How will participants be encouraged and supported?
- **Documentation of meeting process & outcomes:** Documenting these meetings is useful for future evaluation records.
- **Materials needed:** Materials needed will depend on the methods used

POSSIBLE TOPICS FOR A COMMUNITY ORIENTATION MEETING

- ✓ Introductions: Participants and BREAKTHROUGH ACTION CM team members and the orientation meeting programme
- ✓ Discussion of the Baseline results, or country-wide data related to the health issue as it affects communities
- ✓ A presentation of the national goals as related to desired health outcomes
- ✓ The role of the community related to the health issue.
- ✓ An introduction to government and other partners what they do/cannot do.
- ✓ A discussion on how the participants will want to work together including a presentation of the Community Action Cycle and how different people will participate at different times in the process.

- ✓ Invite participation of those most affected and interested in the core program issue(s).
- ✓ Determining next steps: when and where the next meeting will be.

Who Might Be Invited

- Influential leaders
- Those most interested and affected by core program issue
- Women of child bearing age
- Grandmothers and Grand Fathers
- Spouses (Fathers)
- TBA's
- Traditional Counsellors
- Traditional Healers
- Religious Leaders
- Extension workers

A Community Orientation Meeting

(an example from SC Malawi Country Office)

Talking points (In local language):

1. Allow community leader(s) to open meeting, and guide discussions
2. Greet community members and introduce each member of the BREAKTHROUGH ACTION team by name.
3. Introduce Breakthrough ACTION.
4. Mention that BREAKTHROUGH ACTION has no religious or political affiliation
5. Mention the other districts where BREAKTHROUGH ACTION has worked over the years (. Also mention that besides working with communities we also work at District and National levels on policy and strengthening service delivery.
6. Share the general BREAKTHROUGH ACTION program areas (health, education, food security, HIV/AIDS).
7. Mention that for the moment BREAKTHROUGH ACTION will be focusing on supporting health in Chikowi TA (Zomba). Share the 'mobilizing goal,' and invite participation from the community to achieve these goals.
8. Share some of the Baseline data specific to the health issue. Select information that would be relevant to that community. Make sure to use culturally appropriate methods for showing numbers/%, e.g. measuring sticks, etc.
9. Ask meeting participants "what are the issues affecting children's ability to receive basic education?"
10. Once meeting participants have had a chance to express these, explain that BREAKTHROUGH ACTION hopes to work in partnership with communities to achieve address these issues.

11. Define BREAKTHROUGH ACTION and community roles and responsibilities. Explain that BREAKTHROUGH ACTION hopes to build capacity within the community to explore the education issues affecting children in their community, plan and act together. And that when BREAKTHROUGH ACTION eventually leaves the area community members will be able to work on their own to sustain basic education for their children. Discuss that BREAKTHROUGH ACTION will not stay permanently.
12. Discuss the process of child registration for sponsorship
13. Ask meeting participants what questions they might have for BREAKTHROUGH ACTION.
14. Remind them that we hope to see great community participation on this effort, and if they are interested in addressing basic education issues to please see them after the meeting.
15. Thank everyone for their time, mention that they will see BREAKTHROUGH ACTION in their communities in the next week working at the schools.

Community Orientation Meetings - Schedule

There are normally a series of orientation meetings at different levels in each community to assure for maximum understanding and broad participation. The following example is from the SC Malawi:

Meeting #1: District Level Education Office
Participants: District Health Office Representatives; BREAKTHROUGH ACTION CM and Education Team
Purpose: Introduction of BREAKTHROUGH ACTION staff & partners; Review of the health issue; Partnership Agreements: Data from Baseline Analysis (existing and needed); Logistics for Baseline study

Meeting #2: Traditional Authorities (TA) – TA Level
Participants: Traditional Chiefs, traditional leaders, BREAKTHROUGH ACTION
Purpose: Introduction of BREAKTHROUGH ACTION staff & partners; request for participation in program
Meeting # 3: Orientation Meeting for Sub- TA level
Participants: Traditional Chiefs; Group Village Headman/women; Ndunas; BREAKTHROUGH ACTION
Purpose:

- Orient community leadership to BREAKTHROUGH ACTION and their history in Malawi
- Share data from Baseline Analysis (secondary or primary data)
- Present education 'mobilizing goal'
- Seek permission and agreement to work within their communities (share agreement with TA and District authorities)
- Learning more about their communities – Interview *key informants* using the Community Profile
- Ask what general questions they may have?

Meeting # 4: Community Orientation Meetings – Village Level[9]
Participants: Village Headman/woman; broader community; Community Development Assistant; Social welfare assistant; Group village headman; BREAKTHROUGH ACTION
Purpose:

- Group village headman calls the meeting and leads the meeting with BREAKTHROUGH ACTION as invited guests to share BREAKTHROUGH ACTION History, Education effort, etc.
- Orient village community to BREAKTHROUGH ACTION and the Core Program(s) 'mobilizing' Goal
- Presentation of Education data and issues from Situational Analysis
- Discussion on the educational issues affecting their children
- Introduction of Education 'mobilizing goal' and Sponsorship approach
- Re-affirm BREAKTHROUGH ACTION as being invited by District Education to work with the community, seek permission and interest from the community to work together
- Discuss roles and responsibilities of BREAKTHROUGH ACTION, schools and broader community, including reference to the CM process
- Invite participation of those interested in addressing basic education in their community
- Seek questions and clarification

Step 1: Build Relationships, Trust, Credibility, and a Sense of Ownership with the Community

It is important for you and your CM team to take time to establish trust and credibility in the community and develop ownership of the CM effort among community members. Trust can be established through transparency of intention, honesty, mutual respect, working side by side, learning from each other, admitting and learning from mistakes, celebrating small successes, and lots of humor.

The "Emotional Bank Account"[10]

Think about how we treat others.
Every time we do something that we promised to do, others will learn that we can be trusted. This is like a "deposit" in an "emotional bank account." Every time we break a promise or mistreat someone, we will be making a "withdrawal" from our emotional account. When we first start working in a community, if we have no prior reputation, we will be beginning with no "money" in the bank.

It is up to us to make sure that we are establishing a positive balance in community members' emotional bank accounts. This means treating people with respect. Only make promises that we know, we can keep, such as being at meetings on time when we say, we will be there. Another example is when community members ask the CM team for assistance beyond what team members are able to provide. The temptation for many field workers is to respond that they would like to help, they are not sure or they will look into it when in fact they know that their organization is not prepared to respond to this request. Instead of building false hopes, it is

[9] This meeting will need to be repeated according to the number of villages and how they are organized.
[10] This term and concept comes from *7 Habits of Highly Effective People* by Stephen Covey.

important to clarify what our organization can and cannot do. There may be other local resources available to which we can refer the community member.

Step 2: Invite Community Participation

Your CM team will need to identify those people and groups who are most affected by and interested in the Health issue and invite them to participate in the program. These people need to be involved in finding appropriate solutions. At *least 60%* of those in a core group should be those who are most affected and interested in the health issue.

Identifying and overcoming barriers to participation is an important job of community mobilizers. The participation of those *most affected* by the core program issue is a key element in successful community mobilization. But those same people are often the ones facing the most barriers to participation. This relates to children's participation especially. Often programs are planned and implemented without children's insight, contribution and involvement in evaluation of impact.

- How will you ensure that people who are most affected by and interested in the health issue know that they are invited to participate?
- What barriers have priority individuals and groups (i.e., those most affected) identified to participation? How can these barriers be removed or reduced?

Tips for Meaningful Child Participation[11]

Ensure that both boys and girls are included. Experience has shown that often it is necessary to meet with girls separately from boys (initially) in order to create a sense of 'safety' and freedom so that girls and boys from different backgrounds can speak. Additional efforts may be needed to convince caregivers about the value of involving girls, and girls should be encouraged to actively participate.

Use different approaches for children of different ages. Children are best able to participate if they are given a chance to express themselves in ways that come naturally to them. Use games, songs, drama, music, dance, puppets, play, video and photos when working with children. These give children energy and a way to express their thoughts and feelings. Drawings and stories are more suitable for younger children. Older children can become much more involved in group discussions or debates.

Ensure that children of all ages are involved but –not necessarily all together. Try to involve all age groups. However, because children of different ages have different interests and different ways of expressing their views, tailor your initiatives to specific age groups: for example, 3-5 year-olds, 5-7 year-olds, 8-12 year-olds, 13-15 year-olds, and 15-18 year-old. In general, five years' difference is the maximum age gap in a group where one wants all children present to contribute.

Use different approaches for different ages. Children are best able to participate if they are given a chance to express themselves in ways that come naturally to them. Games, songs,

[11] Adapted from *Children at the Centre – A Guide to Supporting Community Groups Caring for Vulnerable Children,* Save the Children, 2007

drama, and drawing. Drawings and stories are more suitable for younger children. Older children can become much more engaged in discussion and debates.

Work with children in groups *separate* to adult groups and then bring the two groups together. Allow children to work together in their own group and then feed their ideas and recommendations into an adult group. Allow for their true participation in decision-making by allowing them to vote or amend by-laws. This will increase children's sense of safety and participation.

Make sure that the most vulnerable girls and boys are included. For example, make efforts to invite marginalised boys and girls to participate. Children can be involved in identifying the households in which disabled children live and can make efforts to involve them. Within existing children's groups, encourage boys and girls to reflect upon and invite children in their community who are normally excluded.

Develop a code of conduct for community groups who are working with children. BREAKTHROUGH ACTION staff, partners and community groups should develop a code of conduct and a

child protection policy and response when working with children.

Convince adults of the importance of child participation. As the holders of power in most child–adult relationships, adults can easily find ways to block, ignore or disempower children and stop them from having any real impact on outcomes.
Discuss with adults their attitudes on child participation and encourage strategies to actively involve children.

Step 3: Gender equity and diversity in community action groups

Let's think about the communities and people with which we work. When we are at a community, we can do the following exercise to test traditional gender roles.

Prepare a packet of behavior cards, one for each behavior from the list below. This exercise will examine the behaviors considered traditional roles for men and women:

Behavior cards

1. Attending community meetings
2. Speaking at community meetings
3. Managing money independently
4. Receiving education
5. Performing housework
6. Working outside the home
7. Talking to the opposite sex that is not your spouse
8. Express concerns
9. Have control of property and resources
10. Make decisions that will impact the community

11. Leaving the house during the day without the permission of the spouse
12. Travelling alone
13. Assuming roles of leadership within the community
14. Using contraception
15. Taking care of children

Take a piece of flipchart paper and make four columns. Write *Behavior, Always, Sometimes, Never* on the top.

Behavior	ALWAYS	SOMETIMES	NEVER
Give birth	Women		Men

Ask participants to look at each behaviour, and see if the group can agree where to put the behavior (In the communities where you work do women always, sometimes, or never? How about men?). Add additional behaviours specific to your community or project, if desired by the group.

Ask the groups to share a few of the behaviours and how they categorized them and whether it was easy or difficult for the group to agree.

Mention, that using a social and behavior change lens, which types of behaviors would be the hardest to change (e.g., the ones that are always, sometimes or never)? (Participants will likely say, the always and never behaviors would be the hardest to change).

Explain that it is usually more challenging to promote change in the “always” and “never” behaviors. In many cases these behaviors may be associated with strong social and cultural norms in their community. Therefore, to effectively promote change, it typically works best to start with the middle column – promoting an increase or decrease in a behavior that is already familiar and practiced by some women or men in the community. This indicates that it is probably feasible and acceptable in the community.

Finish the discussion by asking the participants what *sometimes* behaviors could the CAG promote and how. Ask a volunteer to note all ideas on a flip chart paper.

Step 4: Develop a “Core Group” from the Community

Once individuals and groups have expressed interest in participating in the program, they may decide (and it can be suggested) to develop a "core group" of individuals who will lead the effort on behalf of the community. Developing and then supporting this core group are two of your program team's most important jobs.

It is important to be proactive in identifying individuals who may not immediately come forward. This can be done by consulting community organizations and leaders, and inviting participation at community orientation meetings, through local media and other means.

An important decision you may have to make at this stage is whether or not to work with an already existing core group or to form a new one. There are advantages and disadvantages to working with both types of groups.

What is a 'Core Group'

- A group of individuals *most interested* and *most affected* by the core program issue who would like to work together to address the issue
- Acts as *the engine* to increase participation of the broader community in the core program issue
- At least 60% of membership made up of the *most marginalized* in the community in order that these voices are heard, and priorities are set based on their felt need
- Responsible for carrying out the Community Action Cycle
- Monitors and shares results with the broader community
- Usually 15-20 members, based in the community

A Common Purpose

In order for a Core Group to achieve its' goal it is important during the first meetings to create a clear foundation of purpose and establish what the group has in common:

- Establish the purpose of the group so that all members know the goal they are aiming to achieve (mobilizing goal, based on the health program goal)
- Do an exercise for group members to introduce themselves and get to know each other.
- Help group members express why they are interested in the core program issues. Encourage them to tell their stories about how poor health affects them.
- If the group is shy, the facilitator can also come prepared with a real story or two from the district about how problems specific to the core program issue (affected people in the district)

Core Group Roles, Responsibilities and Norms

Part of the process of developing the core group includes establishing norms for working together. Below are some questions your team and the group members may want to discuss.

- How will they make decisions (e.g., consensus, vote, leaders decide)?
- Do they want to elect official leaders of the group? How will they assign roles and responsibilities?
- How will they communicate with each other? How often will they meet?
- What role do members want to play in relation to your team?
- What norms do participants want to set for the group?
- How do members of the core group want to document their meetings, activities and results?

Why work with groups?

There are times when programs opt to provide information directly to individuals and families through mass media messages. The message provides defined, unified and targeted information. The working assumption is that individuals have the power and the means to make a decision about how they will behave to improve their education and health status and that what is lacking is access to relevant information. Once the information is available, the individual is expected to act accordingly. This may in fact be the most direct, efficient and effective strategy to take in some settings.

However, there are many other situations in which the working assumption above is not valid. These situations require complementary strategies and approaches. One of the most powerful strategies used by community and mobilizers is community or group organizing. Why? Some of the reasons follow:

- Collective action often creates more power to advocate for changes in policies, relationships, resource allocation, access, etc.
- Collective action can help bring to life inactive or ignored policies, procedures and systems that are supportive of healthy communities.
- Combined resources can be stronger and more effective than uncoordinated individual resources.
- Collective action builds community members' awareness that they are not alone in their concern about and experience with the CM health issue.
- Participation in supportive groups may reduce stress and even *prevent* some health problems by reducing feelings of social isolation and by increasing social connectedness—factors that are believed to contribute to a strengthened immune system (Israel, others—get cite).
- Group experiences can create conditions for new leaders to emerge and for leaders and other group members to practice new skills.
- Individual members' skills can be complemented and enhanced by the skills and abilities of other group members (team work).
- Working with existing groups may strengthen these groups' capacity to effectively address health issues.
- Newly established groups may evolve into local organizations or institutions that continue to work on the health focus or similar issues.

An old group or a new group?

An important decision you may have to make at this stage is whether or not to work with an already existing core group or to form a new one. The BASICS project has had considerable experience with pre-existing groups and has learned some important lessons along the way (Green, 1998). The advantages and disadvantages are summarized below for your consideration.

The *advantages* of using existing groups include:

- Avoidance of delays in start-up. Extra time is not needed to organize new groups and give members time to become acquainted.

- Group cohesion. In existing groups the group dynamics have already been worked out. The group is usually stable and cohesive and can turn its attention to new topics.
- Trust. Over the course of years of working together, group members develop a common bond and learn to trust each other. This trusting relationship enables them to have a more open discussion about the realities of their lives.
- Altruism. Group members have demonstrated their interest in giving support to others.

Using existing groups also has certain *disadvantages*:

- Inflexibility. Groups may not be open to taking on new issues or different approaches.
- Dependence on incentives. Groups that were formed to receive some tangible benefit, such as food supplements, may not be motivated to attend group meetings when concrete incentives are not provided.
- Dysfunctional structure. Some groups may be structured in ways that discourage the active participation of all group members and that restrain members from divulging personal information.
- Unequal structures. The existing structure of a group may perpetuate inequities. When minority subgroups are excluded from participation in existing groups, for example, their issues are not included on the community agenda and their needs remain unarticulated and unmet.
- The same old solutions. Existing groups may have fallen into patterns that discourage new ways of thinking and problem solving. The group arrives at the same solutions in the same way; when these solutions are not effective, the group is unable to generate new ideas. Changing the dynamics of group composition may help the group get out of the rut.

Strategies for identifying and recruiting "core group" members

If you decide against using a pre-existing group or no appropriate group is available, then you will need to devise a strategy for identifying possible group members. The BASICS child survival project has also had experience in this area and has found success with the following strategies (Green):

- **Self-selection**. Ask people to divide into small groups, based on their personal preferences. For instance, the Child Health Institute in Haiti set up women's groups by asking one mother to choose one friend; the two women then chose a third, the three chose a fourth, and so forth (Storms, 1998). Women who know and trust each other may be more comfortable participating in group discussions and more willing to provide assistance to other members. On the other hand, cliques can develop and some community members may feel excluded and rejected. When the topic is highly personal—for example reproductive health—some members may prefer the anonymity of a group composed of relative strangers, if this is possible.

- **Common characteristics**. Recommend group participation to women receiving prenatal care at a health center. Organizing pregnant women into groups provides them with much-needed social support during pregnancy, delivery, and infancy. Having children of the same age group could facilitate education regarding the nutritional needs of children of various ages. Mothers with children of the same age serve as an important reference group as mothers adapt to children's different developmental stages.
- **Recruitment by volunteer leaders**. Identify volunteer leaders and ask them to form groups. Volunteer leaders can inspire people to join their groups. These groups are likely to be based in a small geographic area. A study in Honduras found that most volunteer breastfeeding advocates had contact with women who lived within a three-mile radius of their home (Rivera et al., 1993).
- **Nominations by community leaders**. Ask community leaders to suggest candidates for core group membership. This approach may be subject to favoritism and thus not assist women most in need of support groups. To nullify the favoritism factor, the CHPS program in Ghana has established a policy that nominees of community leaders must receive approval at a general community meeting or "durbar" (Fiagbey et al., 2000).
- **Public promotion**. Hold a public event and recruit group members from among the attendees. This strategy opens up group membership to a diverse audience, but finding common ground may be more difficult in such a diverse group.

Avoiding Tokenism – Active Child Participation in Groups

Orphan and vulnerable children (OVC) committees in Mozambique decided to have equal representation of children, men and women in their group. However, when this was reviewed the committees found that:

- Children's participation was tokenistic; they were present but not confident enough to contribute and not listened to by other members
- There was little information shared with other children in the community on decisions and activities of the committee
- It was not clear what children's roles were on the committee

The committee agreed that a children's group need to meet separately from adults to allow children to express themselves. To increase active participation from children the committee split into two separate sub-committees, one for adults and another for children. A third leadership committee was formed with equal representation from adults and children (six members from each sub-committee). Children selected their own committee members and elected their own leaders to represent them on the leadership sub-committee.

Now out of a total of 95 committee members in eight OVC committees, more than half are children. In this new model more of the activities undertaken are suitable for children, such as use of sports and theatre. Leadership skills are also being developed among children and youth, leading to youth preparing funding proposals and actively advocating for improved services.

The Tuckman Model of Group Development

Your group may want to think about the general stages which the literature says most groups go through as part of their development. The Tuckman Model of group development (1965) presents four stages of group development: forming, storming, norming, and performing. A fifth stage, adjourning, was later added by Tuckman and Jensen (1977). A brief description of each stage is presented below (Kormanski, 1985):

Forming. This stage orients the group members to the group goals and procedures. Group members become more aware of the issues and begin to establish working relationships. During this stage, dependence (What can I do? How can I get the support I need?) is of primary concern. (Typically, the "forming" stage of group development occurs in the Organize the Community for Action and Explore the Health Issue and Set Priorities phases of the CAC.)

Storming. When orientation and dependency issues are resolved, the group moves on to define tasks and assign responsibilities. This process can create conflict and, at times, hostile relationships. Group members may resist or challenge group leadership. If conflict is suppressed, group members may become resentful; if conflict is allowed to exceed acceptable limits, group members may become tense and anxious. Some conflict is healthy for the group and helps the group to move forward. (The "storming" stage often occurs at the end of the Explore the Health Issue and Set Priorities stage and/or during the Plan Together phase of the CAC.)

Norming. The group becomes cohesive and cooperative. Group members communicate, share information and express their opinions. Group unity develops around achieving the CM goal. (The "norming" stage often occurs at the end of the Plan Together phase of the CAC when plans are being finalized and coordination mechanisms put into place.)
Performing. The group becomes productive. Members emphasize problem solving, meshing of functional roles, and interdependence. Members are simultaneously independent and dependent. (The "performing" stage often occurs during the Act Together and Evaluate Together phases of the CAC.)

Adjourning. This is the planned or unplanned termination of the group, its tasks and relationships. Planned adjournments involve acknowledging participants for their achievements and allowing people to say goodbye to the group. ("Adjournment" may occur at the end of the Evaluate Together phase of the CAC. At this point, group members may renew their commitment to the same health issue and determine whether they would like to maintain the same structure, roles and responsibilities, and composition or change the make-up of the group.)

Core Group Roles, Responsibilities and Norms

(an example from HCP/Zambia)

Role	Key responsibilities

President or Chairperson	Day-to-day running of the group Disciplinary action Attending to community disputes regarding children Liaison with partners Chairing meetings to review progress and activities
Vice President	Supports president in his or her absence
Treasurer	Keeping a record of financial donations, disbursements and expenditures incurred by group Responsible for banking and withdrawals (with second signature)
Vice Treasurer (optional)	Supports treasurer in his or her absence
Secretary	Keep meeting minutes Keeps records of all group activities Calls meetings on behalf of president Keeps records of individual children
Vice Secretary	Supports Secretary in his or her absence May have additional responsibilities for record keeping
Representative of local government or traditional authority	Acts as focal point for communication between the group and local decision makers
Resource manager (community volunteer member)	Oversees quality assurance and monitoring; includes a 'logistician' to assist with tracking committee assets such as bicycles, rucksacks, office equipment.
Members and/or other community volunteers who work with CLCs (e.g. activistas)	Individual house visits to pregnant women & families with children < 5 Ongoing support to women, children < 5 and their families Organising activities within the community to carry out Action Plans

Example of Norms/Code of Conduct:[12]

- We will be transparent and open about what we do and why we do it.
- We will be clear about what we can/cannot do, and avoid raising expectations
- We will do what we say, and we will keep all the promises that we make.
- We will respect confidentiality relating to HIV/AIDS and sensitive information.
- We will make sure that all community members are involved in our activities, including people who are often stigmatized or discriminated against.
- We demonstrate respect for everyone at all times.
- We will actively seek to involve children fully by creating space for them to participate and demonstrating respect for and interest in their views.

[12] Adapted from International HIV/AIDS Alliance, 2006, *All Together Now! Mobilizing communities for HIV/AIDS*

- We will be accountable to community members at all times.
- We will strive to challenge harmful attitudes, behaviours or ideas.

All members have read and understood this code of conduct. They have signed this and agree to be kept accountable.

PHASE 3: COMMUNITIES DEFINING THE ISSUE, EXPLORING STRENGTHS, AND SETTING PRIORITIES

Steps:	
Step 1.	Explore issues with CAG
Step 2.	Using PDQ participatory tools to collect data from and with Communities
Step 3.	Conduct Root Cause Analysis and prioritization of determinants
Step 4.	Validate data and prioritize determinants with communities

Communities Defining their Own Problems

During this phase CAG's will begin to explore the perceptions of health issues from the people that provide services, those that use them, and those that never or no longer use health services. To facilitate open and free discussions it is recommended to explore health worker and community members' perspectives separately. Both perspectives must be thoroughly explored, in order to understand where potential barriers to the provision of health care and use of services exist.

This will be important to:

- Gain a better understanding of the community and health worker perspectives on the health issues
- Identify potential problems as well as strengths in the delivery of existing services.
- Establish concepts of client and health worker rights and responsibilities.

The steps for this phase include:

- Meeting 1: CMT and CAG plan the exploratory exercise with communities, and with Health Service Providers. They will discuss how to conduct and facilitate exploration exercise with community members and with exploratory exercise with HSP, the number of group member for exercise will depend on the number of community and their composition. They will discuss how to use the tools to explore health issue
- Meeting 2: CMT and CAGs will use participatory tools to explore health issues with Community Members, and with Health Service Providers.
- Meeting 3: CMT and CAGs will meet to analyze the information from the exploration discussions with communities and with HSP, and prepare to bridge the gap with both groups together
- Meeting 4: CMT and CAG's will hold joint meeting with Community members and with HSP together to bridge the gap, including root cause analysis and prioritization of issues to address in the next phase.

STEP 1: EXPLORE ISSUE(S) WITH COMMUNITY ACTION GROUP

This exploration phase begins with an in-depth examination of the health issue(s) with the Community action group members to learn as much as possible about their current feelings, knowledge, practices, and beliefs related to the issue and their capacity to address their needs. This step is usually carried out in a session or series of sessions with the core group. How many sessions you dedicate to this internal exploration of the issue will depend on:

- The level of trust and confidence that has been established in the group and with facilitators.
- How narrowly or broadly focused your health issue is: with broader issues, there is often more technical content to discuss, so it may take longer.
- Time available: participants' availability to meet, donor constraints, team members' availability.
- Logistical concerns: geographic access, seasonal concerns (rains, planting, harvest), transport, other scheduled community activities.

- Who facilitates the process: if your program team is working with core group members to build their capacity, you may need more time to conduct training sessions and then have new facilitators conduct group sessions.
- The relative value of exploring the issue in several sessions over a period of time versus in one longer session: if participants feel the need to discuss the topic with their families, friends, or others before they set priorities, they may appreciate the chance to do so between sessions. Planning for at least two sessions is usually a good idea as it allows participants time to process what they have heard and experienced, and they may have new insights for the next meeting. This approach is very helpful for those people who need time to think about how they really feel before they can articulate their feelings.
- Attention spans, level of difficulty of processing information: people can get tired or preoccupied with the other things that they need to do.
- Whether you have achieved your objectives for this step. If not, will more time help? Were the objectives realistic? Is there a more effective approach you could use?
- There are many types of participatory tools and methods that you can use for this step. The following pages present some tools and techniques that are recommended for this program as they have been used successfully in many similar programs.

PARTICIPATORY RESEARCH TOOLS & METHODS

There are many types of participatory research tools and methods that communities may use to gather information about issues that they are interested in. The following tools and methods are only a small sampling, but they have often been used by communities that have done similar programs to improve health in many countries, including Malawi. Details on how to facilitate each tool with the community 'core group' can be found in the Explore facilitation guide that follows this section.

Problem Tree

The problem tree is used to show the "root causes" of an issue and the consequences or results of an issue. For example, to do a problem tree related to early childhood education, you would ask group members to draw a tree with roots, a trunk and branches. On the trunk, you write "low attendance at early childhood education centers" (or whatever the problem is). Then you ask group members to think about why there is low attendance at early childhood education centers? Every response they think of is written on a root. They keep asking "Why does this happen?" for each thing they have written on the roots to get deeper and deeper into the roots, until they can't come up with any more responses. They do the same thing for the branches, only this time they ask "what happens as a result of low attendance at early childhood education centers"? Every response becomes a new branch. For each branch, they keep asking and what does that lead to? So that they have painted a full picture of how low attendance affects children's future, their families, community, district, country.

- Reflection
- Role Play
- The Problem Tree
- Focus Group Questions
- Priority Ranking Matrix
- Card Sort

Exercise 1: Why we became health workers (45 minutes)

EXERCISE: WHY WE BECAME HEALTH WORKERS 45 minutes

Often, the farther a person gets in their career, the more distance they find between their original vision for their work, and the realities they face in their day to day duties. The satisfaction felt in daily work may be influenced by the gap between expectations and reality. The goal of this exercise is to achieve reflection on the original vision we had for our work. It can be done as a two part exercise, or either can be done on it's own.

Purpose: To explore issues around our motivation to become health workers, and our original vision of our jobs compared to the current reality.

Methods:

Reflection

Preparation

- One piece of paper for each participant
- Crayons for each participant
- Large sheets of paper for the facilitator

Reflection

Think back to the time you were young. When you were a child, what did you want to do when you were older? What did you expect for yourself? When did you first begin to think about becoming a health worker? Was there an event in your life? Did something happen to you or someone in your family? Was there a person who influenced you? When did you decide to seek training?

How was that experience? Was the training as you expected it to be? What was better than you had imagined? Were there things that disappointed you? Now think about your first job as a health worker…what was as you had imagined it to be? What was different? Now consider your work now….how does compare with the vision you had when you were younger?

DISCUSSION:

- Group members should share some of their personal reflections
- Note the similarity in reasons for becoming health workers.
- How does the vision you first had for yourselves as health workers differ from the image you have now? Why?
- Do you feel respected by the community?

KEY POINTS:

- Many people enter into health care with the goals of service and helping others.
- This is influenced both positively and negatively by our experiences and opportunities.
- Morale can be a problem where the system is not functioning well, and where resources are lacking. However, health workers can sometimes work collectively to improve their working conditions.

Written List Suggested time: 15 minutes

Provide each participant with seven piece of paper or index cards. Ask each person to write down three or four characteristics of good quality healthcare. Then ask them to do the same for poor quality.

(Note: If you have more than 10 or 12 participants then it is suggested that you only request two or three responses from each participant. Otherwise the amount of information to sort becomes excessive and repetitive.)

Preparation:

- Six to seven index cards (or paper divided in half) for each health worker
- Hand newsprint or signs with headings
- Keep the headings covered until you are ready to use them, so that you do not influence the responses of the group.

Methods:

- Written list
- Role play
- Categorizing and summarizing responses

Role Play Suggested time: 15 minutes

As an alternative to the written list exercise, the participants can act out a scenario when they received good quality care or provided good quality care. They can do the same with poor quality care. Not all participants need to do the role play but everyone can be involved in the discussion about what elements of quality care were shown.

Categorizing & Summarizing Responses Suggested time: 30 minutes

By this point the facilitator has compiled a list of many different aspects of quality, based on the group responses. Many of these are unique aspects of quality, while others are different variations of the same thing. For example, if someone had listed a characteristic of quality as "having privacy during examination" and another person had listed "no separate exam room" as a characteristic of bad quality, these basically describe the same characteristics which is the need for an a private place for examination. In this session, the group will have the opportunity to review the list, make any changes and summarize the responses. It may be preferable to start without categories, and group the components as you go along. You may want to start with general headings (such as facility and surroundings), and modify them as you gain descriptions from the group that pertain to that element. The facilitator then reads each participant's response cards or list and, with the help of the group, decides in which category the item belongs. It is important to note when the same response has been made by another participant but in the end, only unique characteristics should be listed. The categories are not meant to be restrictive but instead to provide some structure for grouping.

These lists will be used during the exercises that follow.

Exercise 2: Review of technical standards

REVIEW OF TECHNICAL STANDARDS 60 minutes

While the PDQ process is a participatory approach that uses health worker and community perspectives when considering issues on quality, there is also the consideration of technical quality. There are certain basic practices that must be in place for safety and rational treatment of conditions. These must be incorporated when prioritizing activities for quality improvement. In this section, health workers draw on any existing technical standards, guidelines or protocols to enhance the definition of quality health care.

Purpose: To identify and incorporate technical standards necessary for quality.

Preparation:

- Obtain the most recent version of technical standards documents (if available).
- Choose guidelines, treatment protocols, or standards that relate to the particular areas of service that are the focus of the QI efforts.
- Flip charts or large poster size pieces of paper.

Methods:

- Small groups exploration of technical standards
- Large group discussion
- Identifying current documented standards

SOURCES OF THIS INFORMATION COULD INCLUDE:

- **Standards and guidelines**
- **Treatment protocols**
- **Facility check lists**
- **Guidelines of Nursing and Midwifery Association**
- **Job descriptions**

Small Groups Exploration Of Technical Standards – 30 minutes

The participants should be divided into 3 groups, with the assignment to discuss the minimum technical standard for quality. Explain that while the first exercise asked for their personal view of what is good or bad quality, this exercise asks for their understanding of the minimum standards they should follow as professionals. Each group should take one of the three following categories for this exercise:
1-safety, 2-communication/information, and 3-diagnosis and treatment. At the end of the discussion, the groups are asked to write their answers on a flip chart, and post them.

The diagnosis and treatment group should be provided guidance on which practices or interventions they should focus otherwise the category can be too broad. The topics could be particular health areas, such as Family Planning, or general areas such as appropriate examinations and case management.

Large Group Discussion – 15 to 30 minutes

Reconvene the whole group to review each of the small groups' answers. This can happen either as a poster session where other participants circulate for review and comments, or as a general group discussion. All participants are asked to provide suggestions, additions, and/or alterations to the standards proposed by the small groups. However it is done, it is important for the group to review the suggested standards and come to a preliminary consensus on their acceptance as a guideline for practice.

Identifying Current Documented Standards 15 minutes

This step provides the health workers with the opportunity to learn what documented standards are available and how they compare to the list developed by the group.

If available, compare the answers given to the current documented standards.

DISCUSSION TOPICS

- Are the standards available and widely used?
- Areas of discrepancy between standards and practice
- Which ones impact your work?

STEP 2: USING PDQ PARTICIPATORY TOOLS TO COLLECT DATA FROM AND WITH COMMUNITIES

Exercise 1: Problem identification for health issues

PROBLEM IDENTIFICATION FOR QUALITY 55 Minutes

Now that you have lists of quality components – created during "Health Workers Perspectives on Quality" and the "Review of Technical Standards" sessions, the group can explore the barriers that prevent some of these quality elements from being achieved. Even though this step will be revisited during problem analysis and solving exercises in later phases of the PDQ process, this step will help the health workers to understand the process and it's potential benefits. This step should highlight areas of both achievement of standards or elements of quality as well as areas that are lacking.

Purpose: To begin to identify challenges and gaps in service quality from the health worker perspective.

Methods:

- Explain exercise
- Break into subgroups for analysis
- Group discussion of the results

Explain Exercise – 5 minutes

Using the list compiled by the group in the previous exercise, explore what elements of quality health care services are being met and what areas have problems in your area facilities and outreach work. The group can think of the quality characteristics they created as a check list, and apply this check list to their setting. Groups should identify which areas of quality are being met by the health services, and which are areas where improvement is needed. Briefly explore the reasons why there is a gap between the ideal and what typically happens at the facility. Stress that Quality Improvement is a continuous process.

Break Into Subgroups For Analysis 30 minutes

You may want to divide into work groups by health facility, or depending on the time available, each group could be assigned a few of the characteristics of quality as compiled on the lists. Each group should record notes on their discussions.

Group Discussion Of The Results 20 minutes

Have each subgroup report their conclusions to the entire group allowing time for discussion. Depending on the amount of time the facilitator may also suggest that the group select one or two problems for further problem definition. A choice of several more detailed problem definition exercises such as fishbone analysis are suggested in the "Working in Partnership" section. Remind the group that deeper exploration of the causes of the problems will happen in the next step of the PDQ process as well.

FACILITATION TIPS

- **Help the groups state the underlying problem. Sometimes the "problem" listed is really a cause or a potential solution. By starting with the cause/solution first the group may lose the chance for more analysis and creative action later. For example, "not enough health post staff " is suggesting a potential solution. Further exploration could find that the problem really is "trained staff not giving the injections". Using this definition of the problem can reveal other possible solutions beyond hiring more staff. This is covered in more depth under "Tools for Problem Analysis" in the section "Working in Partnership."**
- **Try to help participants avoid assigning blame for problems. "patients don't take their medicine correctly because they don't listen". It would be better to start with "patients don't take their medicine". Once the groups analyze the problems together they may have additional understanding of the causes.**
- **It is sometimes easier to focus on problems that are beyond our control. However, it is hoped through these activities that it will be possible to identify problems for which we can make a difference, or make a difference with the additional support the community partnership can bring.**

Note to facilitators:

1. Some of these concepts are abstract enough that they may be difficult to understand. It is important to take special care to see that they are well translated and explained if necessary.

2. It may not be necessary for all groups to discuss all questions. An alternative would be to have each group select three questions out of a hat.

QUESTIONS TO BE DISCUSSED:

1. What rights do we as health workers have in our practice?

2. What rights or expectations do patients have when they come for services and information? What can they expect from the care that is available? What should they be able to expect?

3. Do clients have a right to information about their health problems? Treatment? How to prevent problems? Is the amount of information they need different than what is normally provided? How should this kind of information be given?

4. How do we take community beliefs and practices into consideration when we provide services to people?

5. Does it matter how the community views our services? Why or why not?

6. What responsibilities do clients have in obtaining better health?

7. What could be gained by including community members in the quality improvement process? What roles could they play?

Large Group Discussion:

What conclusions do we want to make about:

- What rights do we as health workers have in our practice?
- How can this process help us achieve our rights and help communities understand our challenges?
- What are client's rights to quality care?
- What does this mean for health worker job performance?
- Potential roles for community members in the improvement of services.

What Do We Want To Learn From The Community?

This discussion can be introduced with an example of how different people see things differently and how we can benefit from different perspectives. Think about what we have been talking about for the past two days. Are there attitudes or beliefs in the community you would like to understand better? Do they think the same things contribute to quality services as you do? Do communities value the services that you provide? How does your work have an impact on the lives of community members?

What Can We Gain From This Process?

Take some time to brainstorm as a group about what you would like to gain from this process.

The goal is for the participants to realize there are benefits to providing good quality and that the community can help them achieve quality health service provision. These changes could also create a better working environment, and impact their job satisfaction.

Exercise 2: Ice breaker and introduction

ICE BREAKER AND INTRODUCTION 10 minutes

The need to have an ice breaker will vary depending on the culture and the comfort level of the discussion groups. However, it is essential to go through some kind of settling in process – introductions, explanation of the purpose, and clarification of the group "rules".

Discussion Guide:

1. Why we are here?
2. Introductions
3. What is going to be done with the information?
4. The purpose of the recording or note taking

Suggested Rules:

- Everyone's input is important
- There are no wrong answers
- Sincere dialogue does not just happen. There must be trust and respect
- This is not an exercise to find blame
- This is an opportunity to find new ways to solve problems

WHEN YOU ARE THE CUSTOMER 20-30 minutes

Often participants do not feel they have a lot of choice about the quality of services they receive, but they do make choices for quality in material goods. Linking quality to purchasing decisions helps community members see their role in health care services as consumers not just patients. By exploring areas where the concept of quality is more familiar, participants will be better prepared to describe the elements of quality that they value in health services.

Purpose: To help participants think about other situations where they are setting standards for and demanding quality. To help participants realize that they do exercise a right to quality in the market place.

Methods:

Market place discussion

Market Place Discussion

Before we talk about health services, we should think about times in our daily lives when we all have the right to determine what is good quality. Think about the market place –when you are the customer, you decide what is quality.

Think about when you go to the market to buy something, for example, onions (or any other commonly available local food). What is it about the onions you choose that makes you want to buy them? Facilitator probe for specific information, but don't make suggestions – (e.g., color, smell, freshness….)

Review what has been said. Can anyone add anything?

When the group feels satisfied with the list, ask about what they expect from the seller or the vendor?

For instance, if ten vendors are selling the same thing, what makes you go to the one that you do? Are there those you avoid? Why?

PREPARATION FOR BRIDGING THE GAP

THE FOLLOWING ARE SOME EXAMPLES OF CATEGORIES THAT CAN BE USED:

Place/Environment: This covers the physical setting as well as the location for health services e.g. privacy, distance, waiting space, cleanliness, etc.

Supplies and Equipment / Medicines: This includes all the materials that are needed in the clinic - e.g. medicines, equipment, soap, furniture, etc. (medicines may be pulled out into a category all its own)

Providers - Technical Competence: This includes the capabilities of the providers, whether they arrive at appropriate diagnoses and treatment regimens, and whether they practice safe medicine. Appropriate sterile technique would be included here.

Client / Provider Relations: How the provider treats his or her clients is covered here e.g. respect, greetings, openness, discrimination, fairness, confidentiality, tolerance for traditional beliefs, etc.

Systems and Procedures: This includes cost of services – both formal and informal, staff availability, clinic hours, supervision, policies and procedures, etc.

Service Availability: This includes types of services available, whether the needed (or wanted) services are available at all, whether services are integrated or provided on different days, whether people have adequate information about the availability of services, hours of operation, etc.

Communication / Information: This includes whether clients get the information they want or need, whether they understand the information, whether they feel listened to, etc.

Cultural Compatibility / Traditional Beliefs and Practices: This includes everything related to how people's traditional beliefs and practices are accepted by or taken into consideration by the formal medical services.

Group Activity: Categorizing and Summarizing Responses (60 min)

1. Form into two groups.
2. Review the case study below. One group will work on synthesizing the Community Issues, while the second group will work on synthesizing the HSP issues.
3. As a group, defining possible categories. Group observations to better show patterns and key elements and define problems. See list of some possible categories, below.
4. It is important that this grouping and labeling not cause the details provided regarding each issue be lost
5. Place each category the group identified on separate sheet of flip chart paper and place on the walls around the room. Use different colored paper to indicate community versus health worker responses
6. Each team reviews and synthesize their own observations and notes. They will copy one quality element on a colored paper and place the information under the most appropriate category heading.
7. If there is an associated quality problem/issue with this element it can be written below. This way both the quality elements and associated problems can be discussed together.
8. If multiple discussion groups come up with the same observations, it should be noted with a check mark.
9. Each group will write a synthesis of the information that they would present to a group at the beginning of a real Bridging the Gap session with communities. The groups have 20 minutes to write down how they will synthesize the information and 10 min to present.
10. After the groups have completed synthesis of the issues, ask one group to present their synthesized list. Ask them to explain why they made the choices they made.
11. Ask the other group if they have difference in the way they categorized and or placed a quality problem in a different category. If yes, ask them to explain and share their synthesis.
12. Ask the group in plenary the questions.

Quality Perceptions Case Study:

Community defining quality exercises conducted with the following groups separately:

1. Married women
2. Mothers-in-law
3. Husbands
4. Marginalized women
5. Marginalized men

Community Issues Identified:

- Health Workers discriminate by caste

- Health Workers are rude when you can't pay
- They don't take us in order –we have to wait a long time
- Injections are sometimes given by untrained staff
- The facility is not open on time
- You come and nobody is there except the cleaner
- No one available during emergencies
- I could not get anyone to help during the night when my wife was in labor
- There is no queue
- They were rude when I brought my child there yelling at me for waiting so long
- The prices vary for the same service
- They charge me more for the same medicine they gave my neighbor
- There is no drinking water available
- The providers give the same white tablets for all problems
- Health Workers sell the medicine allocated to our health post at their private clinics
- I can't wait all day for the health worker to show up, I have to work
- You have to wait a long time
- Some of the staff is rude
- Long wait for service
- Don't post office hours and change them all the time
- Health workers have the medicine but don't give it out because the sell it to private patients
- Health workers don't come to the facility on time
- They do not respect "our" ways
- Health personnel do not explain clearly about use of drugs and treatment
- They don't really examine me they just give me the same medicine for everything
- I don't get any information
- The health worker never looks at me
- I have to travel a long way to reach the health post
- My husband has to come with me when I go because he doesn't trust the health workers

Health defined quality exercises carried out with:

6. Nurses from the HP
7. Support staff including cleaners is this an appropriate term?
8. Management staff including Health Post In-charge
9. Community Health Volunteers

HSP Issues Identified:

- May not receive salary for several months
- I (cleaner) sometimes am the only one available and they demand I help them

- The roof leaks into our supply during heavy rains
- No supervision
- Don't have proper sterilization equipment
- We do not get equipment that the MOH promised us
- People can be rude
- People want me to be available in the middle of the night – I cannot work for free
- Inadequate supply of drugs
- People want free medicines
- People don't follow instructions so they don't get better
- People come too late for treatment, they wait until they are very sick
- Don't have needed equipment
- Inadequate kerosene supplies for sterilization
- People go to the traditional healers first and don't trust what we tell them
- People are ignorant and they don't understand what we tell them
- I was just sent to this health post last month – this is not where I want to work
- Many clients are not literate so it is useless writing instructions
- They don't listen to me but they will do what the local healer tells them
- The health post needs repair but we do not have any money to fix it
- I need training
- We received money from a donor for medicines but they are all gone now
- People have to travel a long way to get to the health post
- We don't have any emergency transportation services
- We need more space for examinations
- We do the best with the little equipment we have
- People don't trust us- they think we sell the medicine

Possible Categories

- **Place/Environment**: This covers the physical setting as well as the location for health services e.g. privacy, waiting space, cleanliness, etc.
- **Supplies and Equipment / Medicines**: This includes all the materials that are needed in the clinic -e.g. medicines, equipment, soap, furniture, etc. (medicines may be pulled out into a category all its own)
- **Providers - Technical Competence**: This includes capabilities of providers; whether they arrive at appropriate diagnoses and treatment regimens; whether they practice safe medicine. Appropriate sterile technique would be included here.
- **Client / Provider Relations**: How the provider treats his or her clients is covered here e.g. respect, greetings, openness, discrimination, fairness, confidentiality, tolerance for traditional beliefs, etc.
- **Systems and Procedures**: This includes cost of services – both formal and informal, staff availability, clinic hours, supervision, policies and procedures, etc.

- **Service Availability**: This includes types of services available, whether the needed (or wanted) services are available at all, whether services are integrated or provided on different days, whether people have adequate information about the availability of services, hours of operation, etc.
- **Communication / Information**: This includes whether clients get the information they want or need, whether they understand the information, whether they feel listened to, etc.
- **Cultural Compatibility / Traditional Beliefs and Practices**: This includes everything related to accepting and/or taking into consideration people's traditional beliefs and practices by the formal medical services.

Discussion Questions:

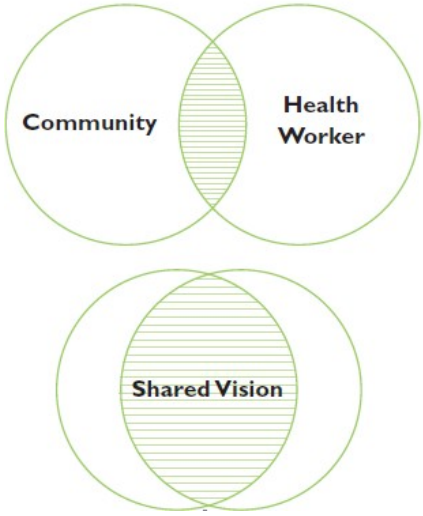
1. How did your group / summarize / synthesize the information that was given to you? List all the answers in a flip chart. Did anyone do any of the following:
    a. Combine similar issues together to come up with just one issue?
    b. Create general headings and/or categories and put similar issues that are grouped together under these headings and/or categories?
2. Did anyone encounter any difficulties? Or did anyone find it difficult to do this activity? If yes, why?
3. After reviewing other decisions that will be required for the Bridging the gap meeting, do you think you are now well prepared to proceed and conduct this next session on bridging the gap? If no, what else do you think you need?

Exercise 3. Develop a shared vision

Developing A Shared Vision For Quality

This may take sometime but it is important that the vision reflect the aspects of quality important to both groups. It may be easier not to go into the causes of why certain aspects and understanding of quality are lacking. But instead develop an integrated vision of quality that reflects each group's viewpoint.

Display the Venn diagram that was created in preparation for this workshop. Be sure it still accurately portrays what has been presented or changed during the last discussions.



DISCUSSION

- **How are the perceptions of quality the same?**
- **Where do the views on quality differ?**
- **How has hearing the presentation from the other perspective affected your thinking on what is important for good quality care? Has anything changed for you?**
- **Now that we have heard quality defined from both perspectives, what would a shared vision of quality include?**

Exercise 4. Problem Identification

PROBLEM IDENTIFICATION

Depending on how the quality presentations were approached, the groups may have already presented both their views on the elements of quality and the problems. (Remember not all elements of quality will be described as problematic.) If the problems with the quality have not been fully discussed, they should be identified now.

Purpose:

1) provide an overview of problems or gaps identified through the exploratory discussions
2) to validate the problems
3) prioritize those that need attention

Methods:

- Introduction
- Review problems

Introduction

Before presenting the problems identified, it may be helpful to review some key points about this process. As problems are discussed, it will be important to remember that exploring problems is as a first step toward solving them.

Key points:

- We all share the same goals – better quality care / better health
- Focus on the problems – not individual blame
- Respect that people can have different viewpoints on the same issue

Review Of Problems

Divide into small working groups. If more than one health service area is participating then you could divide by geographic division with health workers and community representatives from each village or area served working together. An alternative is to divide into groups by category or type of problem.

Within each group, review identified quality elements and any associated problems through exploratory dialogue with community members and health workers.

DISCUSSION

1) Do the problems identified exist in our facilities?
2) Do some problems need to be restated?
3) Are these the main problems?
4) Do you want to add anything?
5) How do the HW and community descriptions of a given problem overlap?
6) How are they different?
7) Are there any trends that we can see in the types of problems that each group has identified?

Regroup and present any changes from the subgroup's discussions.

STEP 3: CONDUCT ROOT CAUSE ANALYSIS AND PRIORITIZATION OF DETERMINANTS

Exercise 1. Prioritizing Issues

What is it: The Priority Ranking Matrix, (also known as a Decision Making Matrix), is a tool that is used to help communities prioritize family planning and reproductive health issues to be addressed through Community Action Plans in the following Phase. The matrix allows you to focus discussions when there are several options to consider. Criteria for choosing priority issues are identified. For each criterion, the issue is given a score. Thus for this tool it is necessary:

- To clearly explain each criteria
- To explain how to calculate the score for each problem
- Explain the totals column
- Give example from a different field and then continue with the group work

How to do it:

- **Step 1:** Inform participants that it is time now to identify their top 6 health problems (priorities) they will be working on. Ask them to identify the top 6 priorities.
- **Step 2:** If they don't reach a consensus after 5 minutes, ask the participants to come up with 3 or 4 criteria, which according to them, signifies that an issue or a problem is important. (Magnitude of the issue; resolution of issues that allows one to solve other problems, local vulnerability of an issue etc.)
- **Step 3:** After coming up with a consensual criteria, tell them that in order to ease the work, they are going to work on small group of 5-8 people using the matrix for decision making.
- **Step 4:** Show how to use the decision making matrix to prioritize between several issues, make sure that everybody have understood the matrix utilization and ask the working groups to go back and identify 3-5 family planning/reproductive health issues to prioritize in their community.
- **Step 5:** After the end of the allotted time, call the working groups for the plenary. After the report of each group, propose a summary on what can be retained as the community top 6 health problems (priorities).
- **Step 6:** Thank the participants for their achievement and inf**orm the**m that it is time to look at the root causes of their top 6 health problems (priorities) in order to look later for solutions.

A template for the decision making matrix is provided below:

Problems	C1	C2	C3	C4	TOTAL
Issue 1					
Issue 2					
Issue 3					
Issue 4					
Issue 5					

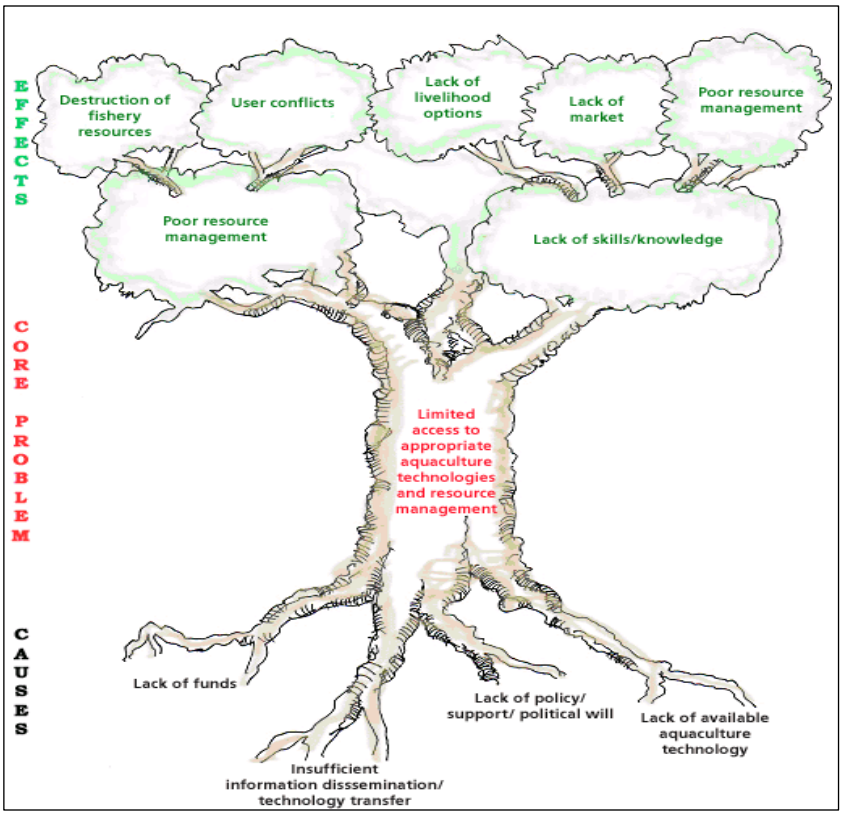
Key:

Criteria 1 (C1) = number of people affected by the problem
Criteria 1 (C2) = problem whose solution will bring about the solution of other problems
Criteria 1 (C3) = capacity to solve the problem locally
Criteria 1 (C4) = cost of solving the problem is affordable
Score: 0 = low 1 = medium; 2 = high
To be inserted

(reproduced from Save the Children, Aug 2009 Draft, mobilising Communities for Education, Health and Social Change):

Exercise 2. Identify Root Causes (1 hr. 30 minutes)

What it is: The Problem Tree is a type of tool we can use to explore the issues in your community, including digging deeper to understand the causes and effects of an issue in a structured manner. Using the problem tree, the problem can be broken down into manageable and definable chunks, and enables a deeper understanding of the problem with the interconnected issues, establishes who and what the actors and processes are, to help with clearer prioritization of factors. A problem tree also helps establish whether further information, evidence or resources are needed to make a strong case, or build a convincing solution. The process of using a problem tree helps build a shared sense of understanding, purpose and action.



How to do it: The facilitator explains that we will simulate this as if participants are the Community Action Group. Therefore we will ask participants to play the role of the CAG during this simulation.

Introduce this tool by saying that the Problem Tree is a type of tool we can use to explore the issues in your community. Let's develop a Problem Tree together.

1. Explain that the problem tree demonstrates the "root causes" and consequences or results of an issue.
2. To do a problem tree related to an issue, ask group members to draw a tree with roots, a trunk and branches. On the trunk, write one of the problems in that community.

3. Ask group members to think about **why** this issue is a problem. Every response they think of is written on one of the roots (add roots as needed).

4. Take one cause at a time, explaining that people can also look at the underlying causes of a problem by asking the question "Why". For example, if the problem on the tree trunk is that pregnant mothers are not aware of danger signs, ask why? And then to that answer, ask why? Continue this until community members feel that all the causes have been discussed, and the roots get deeper and deeper.

5. To help probe more deeply, consider asking prompting questions around the issue. For example, in health programs for increased seeking of health services, the following questions could be asked:
    a. Why might communities not value practices that promote good reproductive health?
    b. Why do communities have low utilization of family planning and reproductive health services?
    c. Are there health centers/health promoting centers (e.g. clubs, football grounds) in our community that are being underutilized? If so, why?

6. Next, ask about a potential result or a consequence if people do not follow the desired practices. Put these as branches. Every response becomes a new branch. For each branch, keep asking: What does that lead to? So that they have painted a full picture of what the effect is to their families, communities, district, and country when they do not follow the practices to prevent the issue.

7. When no further responses are given, ask the following debrief questions:
    a. From this Problem Tree what do we see as the main causes of the family planning and reproductive health issues in our community?
    b. What have we learned overall from the Problem Tree?
    c. Now ask participants to come out of the simulation. Explain that they will now have time to practice developing a 'Problem Tree' for themselves.

GROUP WORK: Develop a Problem Tree

- Split the CAG into smaller groups to carry out the Problem tree exercise. (20 minutes). Place the Issue on the trunk of tree, such as:
    - Low utilization of family planning services
- Once completed, post on the wall in preparation for review by others.
- To conclude this Participatory Tool, ask participants to take a Gallery Walk (as if visiting a museum or art collection) – 30 minutes. Once seated ask:
    - What observations did you make about the sample Problem Trees?
    - What questions do you have about this tool?
    - Would you be able to train a CAG how to use? If so, why. If not, why not?
    - What further questions do you have about this tool?

STEP 4: VALIDATE DATA AND PRIORITIZE DETERMINANTS WITH COMMUNITIES

- Meet with the broader community to share the findings from communities and from health service providers, as well as the prioritized list of issues to address
- If communities agree with the findings and prioritized list, can finalize and continue to next phase. If not, discuss the differences in opinion with the community to find common ground on how to move forward.

PHASE 4 - COMMUNITIES DEVELOP LOCAL SOLUTIONS

	Steps:	
	Step 1.	Determine who will be involved in planning and their roles and responsibilities
	Step 2.	Design the planning session
	Step 3.	Conduct/facilitate the planning process to create a community action plan

COMMUNITIES DEVELOP LOCAL SOLUTIONS

In this phase, the Community Core Group develops a community action plan to address the health issue. It is important to ensure that those most affected by the health issue issues have a central role and voice in developing the community action plan.

The steps involved in this phase include:

1. Determine who will be involved in planning and their roles and responsibilities
2. Design the planning session
3. Conduct/facilitate the planning process to create a community action plan

Step 1: Determine who will be involved in the planning and their roles and responsibilities

Who will participate and how they will participate are critical questions. Equally important is who asks and answers these questions. Often, when groups answer the question, "Who should be involved in planning?" the list grows until the response ends up being everyone. While involving everyone in the planning process may be desirable from a participation perspective, the core group and others involved in determining who should be invited need to consider the advantages and disadvantages of managing a large group versus a smaller, more defined group. Determining who is participating and why will help facilitators better structure the process and will help participants understand their respective roles and responsibilities in the planning process.

In some situations, not inviting everyone in the community might offend those who were not invited, while in other settings it is not expected that everyone would be invited and no offense is taken. This is clearly a potentially sensitive subject that can affect future implementation of the program. It is as important to ask who is not invited and why as it is to ask who is invited.

The CM team should encourage the core group to take on as much responsibility for the planning session(s) as the members can. CM team members are then free to work more as advisors than as organizers and facilitators. However, there may be times when it is better to have a more neutral, external facilitator conduct the planning process. The decision about who should facilitate should be discussed with core group members.

Planning with children not for children

Often what is learned during the Explore Phase about children's priority needs is not brought forward into the planning process.

In Malawi's adolescent reproductive health program youth presented their priority issues on newsprint as part of the planning meetings. Setting their own priorities, separate from adults, and writing down their issues helped give youth a voice in front of adults. Some of the youth priority planning issues were:

- Adults (police, teachers) need to tell 'sugar daddies' to stop harassing girls.
- Creating a community space for recreation and sport for youth so that they will be less bored
- Girl groups to learn about growing up, their rights and how to make good choices in life

Developing a Community Action Plan - Who Should Participate?

The planning process will also have its own objectives. Here are some examples of planning objectives that communities might want to achieve:

- Ensure that key policy and decision-makers, children, community leaders and health/education/vector control providers support and contribute to the program
- Ensure that those who are most affected by the health issue set the agenda and have a meaningful voice in the planning process
- Enlist technical assistance from external organizations that have desired expertise
- Identify and leverage needed resources to carry out strategies and activities
- Ensure that what has been learned through exploration of the program issues is applied to the planning process
- Strengthen community individuals and organizations' analysis, planning and negotiation skills
- Build community confidence to take collective action
- Ensure that opposing points of view can be voiced and discussed in a constructive manner

The following questions will help the community to decide who should participate, where more "yes" responses would indicate that it would be a benefit to include the person/group.

Here are some questions to help the core group and others decide who should be invited to participate in the planning.

Question	Yes	No
Is the person/group directly affected by issue?	lll	lll
Does the person/group have decision-making authority over policies or resources that relate to the health issues?	lll	lll
Is the person a local leader (formal or informal) or key opinion leader?	lll	lll
Is the person very interested in the health issue?	lll	lll

Does the person/group make or influence decisions or access to information or services for those who are directly affected by the health issue?	III	III
Does the person/group possess special skills, knowledge or abilities that could help the group make more informed decisions or implement the action plan?	III	III
If the person/group was not invited, would they try to obstruct implementation of the action plan or create other problems?	III	III
Would strategies require this person's or group approval?	III	III

Step 2: Design the planning session

Now it is time to design the planning process itself. You may also find it helpful at this point to observe how community members plan other activities and incorporate important lessons or activities. In designing any participatory group process, you need to first think about planning from the participants' point of view. The core group should also review its findings and priorities from the Explore Phase of the CAC to highlight key information that needs to be incorporated into the planning session.

In designing any participatory group process, you need to first think about planning from the participants' point of view.

- What are their needs and expectations?
- What have we learned about what participants now know and do in relation to the core program issue?
- What planning and other relevant skills do they possess?
- What are the existing power relations between participants?
- How do participants relate to each other?
- What has been their prior experience participating in groups and with planning processes in particular?
- How does the cultural context in which they live affect how they are expected (or expected not to) participate in collective action (age, sex, ethnic group, socioeconomic class, political or religious affiliations)?
- Is there a wide range of experience or is the group fairly homogeneous?
- Will there be more men or women? Will participants be representing other organizations or individuals or are they participating as individuals?

Generally, participatory planning should build on existing skills and knowledge and help all participants to:

- Know what is happening and why (purpose of the meeting, what the group tasks are).
- Feel safe and comfortable to express themselves.
- Challenge assumptions and think creatively.

- Contribute their knowledge, experience and skills in positive ways that are helpful to the group.
- Share and maximize the collective experience of the group.
- Produce an action plan that clearly states what they want to achieve and how they intend to do it.

A guide to the planning process

The list that follows presents the most common tasks in designing an action plan.

- Task 1: Orient participants to the overall goals of the program.
- Task 2: Clarify the specific objectives of the planning process.
- Task 3: Consolidate and review relevant information.
- Task 4: Develop a consensus on program priorities, objectives, desired results or other indicators of success.
- Task 5: Identify resources, opportunities, challenges and constraints.
- Task 6: Develop a variety of strategies to achieve desired results.
- Task 7: Select strategies with the most potential to address the core program issue
- Task 8: Specify activities, resources needed and how they can be obtained.
- Task 9: Assign responsibilities.
- Task 10: Determine timelines.
- Task 11: Establish or reaffirm coordination mechanisms.
- Task 12: Determine how the community will monitor progress.
- Task 13: Determine next steps and congratulate the group.
- Task 14: Share draft plans with ***broader community*** if appropriate.
- Task 15: Revise plans if necessary based on feedback.
- Task 16: Finalize plans in a formal document.

The challenge for your team now, before the planning session takes place, is to decide which of these tasks/activities in which sequence the group will need to execute, what tools you will need to complete the tasks, who will be responsible for leading/facilitating which tasks, and what other aspects of this planning session need to be arranged for. You will then need to create a simple agenda for your session.

Learning to Plan: Building on what we already know

This exercise demonstrates how participants in a community planning process can apply what is familiar to them using a planting example and a health		
Planning Questions	**Planting example**	**Vaccination example**
What do you want to achieve? (Goal)	*Food to feed my family and income to pay for school fees and other household expenses.*	*All the children in our community will not be sick with diseases that can be prevented by vaccination.*
What will you see when you achieve your goal? (Desired results; objectives.)	*X# bushels of wheat, X# bushels of peas, etc.*	*All children one year and older will be completely immunized.*
What things do you need to keep in mind as you decide how you want to do it? (opportunities, challenges, constraints, resources	*How much land I have, predictions for rain this year, amount of money I have for seed, amount of time it will take, # helpers who know how to plant, etc.*	*How much vaccine we have, # people who can help, time, whether parents will come, cold chain, etc.*
How will you do it? (strategy) (Ideally, you would generate alternatives here first and then select the most promising one.)	*We will plant X# hectares with wheat, X# with peas and will leave X# fallow, etc.*	Work with community groups to increase *awareness.* Vaccinate at the market every week and at health post every day.
Describe step-by-step how it will be done.(activities)	1. *Schedule people to help* 2. *Purchase seed* 3. *Prepare the soil.* 4. *Etc…….*	1. *Ensure that cold chain is in place.* 2. *Meet with community leaders and organizations.* *3. Train vaccinators, etc…..*
What will you need to do it? (resources)	*Money, seed, 3 helpers* *X# hectares of land, etc.*	*Vaccine, 4 vaccinators* *4 thermoses, etc.*
When will you begin? How long will it take? (timeline)	*May 15, 2000* *5 months*	*June 1, 2000- December 31, 2000*
How will you know when you have succeeded? (indicators)	*We will have produced X# bushels of _.* *My family will have 3 meals/day for 6 months.* *I will be able to pay school fees & will have $___ left for household expenses.*	*By December 31, 2000, at least 80% of children one year and older will be completely immunized.*

What Is An Objective, Strategy & Activity?

Objective = What you want to achieve – the desired results of all your effort
An objective should be ***SMART.***

S = Specific

M= Measureable
A= Achievable
R= Realistic
T=Time bound
Example:

- Increase the antenatal care seeking behaviours in the village of Muzula, by mothers from 30% to 80%, by December 2022
- Increase the number of children sleeping under a LLIN every night throughout the night when they sleep from 5% to 80% in Chimpeni Village TA, Dzoole, by November 2022

Strategy: How you will achieve your goal?

Sets forth the direction in which you move toward achieving a specific goal.

Example:

- Organize and strengthen Teen Mothers Clubs
- School governments made up of children to increase child participation in school management
- Increase access to youth-friendly reproductive services
- Youth peer-to-peer educators

Activity = A specific deed, action, function, or sphere of action. **What specifically** you will need to do?

Example:

- Train 50 teen peer educators as reproductive health counselors
- Identifying teenage mothers and invite to form support club.
- Community youth group will develop and perform three dramas showing how early childhood development helps performance in school and life

Techniques for Identifying Strategies

Participants can identify barriers and obstacles to resolving the health problems through acting in a socio-drama or comedy (For example: showing what really happens in the community when there is poor sexual and reproductive health for youth, and identifying what led to this.)

- The participants create a list of barriers and obstacles to resolving the problem and then develop strategies to address these barriers (e.g., Develop Teem Mother's Clubs to support girls to return to school).
- Organizers of the planning session could invite health service providers to share with them what they might do to improve youth friendly services and then discuss and negotiate what are feasible, acceptable, practical and priority

strategies that they could adopt (discuss "recommended practice" or share successful strategies from other communities.)

- Participants could use the "problem tree" exercise (presented in the participant manual in the Explore phase) to analyze underlying causes and contributing factors to poor youth sexual and reproductive health. They then generate strategies based on their analysis.
- When planning participants have developed possible strategies, ask participants the following:
- Do they think the strategy that has been developed will address the problem? If yes, why? If no, why not?
- If no, how would they improve the strategy?
- If they are uncertain and decide that it's best to try out the strategy, then at what point does the community/team decide that the strategy needs to be reviewed and modified?

SAMPLE PLANNING MATRIX

Objectives	Strategies	Activities	Responsible	Resources	Timeline	Indicators of success
(What do we want to achieve specifically?)	*(How are we going to achieve our goal?)*	*(What are we going to do to achieve the result?)*	*(Who is responsible for each activity? (Names)*	*(What do we need to achieve the result?)*	*(When and how long is needed for each activity (From X to X)*	*(How will we know when we have achieved the result)*
	Strat 1	Act 1				
		Act 2				
	Strat 2	Act 1				
		Act 2				

Step 3: Facilitate the Planning Process) To Create A Community Action Plan

The planning team Core Group members and those most affected) will now develop the community action plan. Discuss with your team and the core group ahead of time what you will do if any problems arise during the planning session. If you experience difficulties conducting the planning session(s), review your assumptions about the participants, the planning process and how the community views the health issue.

Challenges during the Planning Process

- There isn't enough time to complete all planned tasks. The facilitator needs to prioritize which tasks are most important and/or cut some time from some tasks. Think about the purpose and objectives of the planning process and let them guide decision-making.

- Participants are coming up with strategies that are not likely to have any impact on the health issue. Is it better to let participants learn from their experience that the strategy is not likely to have an impact? Is it possible that the strategies may have a positive impact but you do not see it because of your own assumptions? Do participants have limited or different knowledge of how to address the problem? Are powerful individuals influencing the planning activities using their personal prioritizes? The team will need to carefully analyze what is happening. Ask participants how they think the strategy will affect addressing the health issue to better understand the thinking behind the strategy.

- The participants have suggested strategies that will impact favorably upon the health issue but they are not within the program budget or technical expertise (e.g. increased municipal waste pick up). You can help participants think about how they can link with other organizations and resources internal or external to their community. Acquiring the knowledge and skills to access and manage valuable resources and relationships is a major achievement of many community groups that go on to apply these skills to further improvements in other aspects of community life.

- Participants cannot agree on a strategy. If after presenting all the reasons for each competing strategy, participants can still not agree, there are several things the facilitator can do. Participants can agree to disagree and decide to try both strategies (if this is feasible). They can try to combine the strategies if possible. They can seek a new strategy that all agree to by determining what they are trying to accomplish and exploring new approaches to it. They can decide to collect more information on each proposed strategy before making a decision.

Facilitation of the Planning Session should include:

- A presentation in some format of the results of the Explore Phase & Priorities Set
- Some analysis of the underlying causes affecting the core issue;
- A process to arrive at what the group desires to achieve are "SMART"
- A process to help them work out strategies and activities to implement; and
- A process to help participants define coordination and monitoring mechanisms.

PHASE 5 - IMPLEMENTATION AND DATA UTILIZATION FOR DECISION MAKING

Steps:	
Step 1.	Determine who will be involved in planning and their roles and responsibilities
Step 2.	Design the planning session
Step 3.	Conduct/facilitate the planning process to create a community action plan

IMPLEMENTATION AND DATA UTILIZATION FOR DECISION MAKING

In this phase, communities implement their community action plans. The role of the CM team is now to strengthen community capacity in areas necessary to effectively carry out the strategies and activities the community core group defined in their action plans. This may include skills in leadership, planning, conflict resolution/decision-making, and resource mobilization and management. At this point, there are often volunteers and community groups working together to carry out activities. Helping communities monitor their own progress, using data for decision-making is essential in motivating ongoing collective action.

The steps in this phase are:

1. Define your team's role in accompanying community action
2. Strengthen the community's capacity to carry out its action plan
3. Support community groups to monitor progress and utilize data to inform their microplanning and collective action

Step 1: Define Your Team's Role in Accompanying Community Action

In the community mobilization process, you can play many possible roles in relation to the communities where you work. These roles, include: mobilizer, direct service provider, organizer, capacity-builder/trainer, partner, liaison, advisor, advocate, donor, and marketer.

CM teams often assume various roles that change over time as the community's needs and capacity change. How a CM team perceives its role influences the way team members and community members relate to each other. A common source of conflict between communities and external organizations is their differing perspectives on what roles each is expected to play. If you are not clear yourself about your role, you will not be able to explain why you act the way you do.

You will need to continually review your role as you move through the various phases of the community action cycle and ask yourself whether you are creating or reinforcing dependency or fostering autonomy.[13]

Step 2: Strengthen The Community's Capacity to Carry out Its Action Plan.

Now it's time to help community groups determine whether and how your team can help them strengthen their abilities and capacity or help identify other individuals and organizations that would assist. In this context, you may want to take stock of your team's strengths and weaknesses before you make any promises of technical assistance. The kind of assistance and expertise the community will need to ensure that it can implement its action plan will depend on what that the plan consists of. Organizing and strengthening the Core Group is an ongoing, dynamic process that will need attention throughout the Community Action Cycle. The more skills, assets and strengths that a community group has, the better prepared they are to achieve their goals and sustain outcomes. Initially it will be important to assess the core group strengths, abilities and challenges.

[13] In the past, many community development workers aimed to promote community self-reliance, assuming that ultimately communities could provide for all their needs without relying on external resources. We prefer the term "autonomy," recognizing that communities can and do benefit from their relationships with external resources.

Key Dimensions of Community Capacity

- The Community Action Cycle and skills for applying
- Key information on Basic Education; Early Children Development and/or School Health and Nutrition
- How to Maintain a Functioning Group
- How to Increase Participation
- Effective Leadership
- Critical Thinking and Planning Skills
- Resource Mobilization and Management
- Maintaining/Rotating Volunteers
- Conflict Resolution skills

Once you and your team have a sense of what skills and knowledge the community may need to carry out the action plan, you will have to answer three related questions: (1) whether you will provide the necessary capacity building and, if so, (2) how much and (3) what kind.
Your answers will be affected by many factors, which vary according to circumstances. Here are some useful criteria to help you make this decision:

- Are there other resources in the community that can meet the current needs?
- Does our CM team possess the necessary expertise?
- What are the short- and long-term pros and cons of us providing this assistance?
- Are there other accessible external resources with the required expertise?
- What are the short- and long-term pros and cons of inviting these individuals or organizations to assist?
- What would happen if no one provided assistance?

There are many definitions of and perspectives on community capacity.
Below are several definitions.

What Is Community Capacity?

In the past, community capacity building has been criticised as being based on a deficit model of the skills and confidence of communities. We believe capacity building should be based on an understanding of the assets that communities have, and that interventions need to be participative and grounded in community needs and aspirations.

Community capacity describes a process that increases the assets and attributes that a community is able to draw upon in order to take more control of and improve the influences on the lives of its members. (Glenn Laverack)

* * * * * *

Community Capacity is "a community's ability to define and solve their own problems" (Doug Easterling, The Colorado Trust).

'Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities.' (Skinner Strengthening Communities 2006)

* * * * *

According to Robert Goodman, et al., there are ten defined factors that contribute to a community group's ability to achieve their goals:

- Leadership
- Citizen Participation
- Skills
- Resources
- Social and Inter-organizational Networks
- Sense of Community
- Understanding of Community History
- Community Power
- Community Values
- Critical Reflection.

For a more detailed exploration of the dimensions of community capacity, please refer to "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement" by Robert M. Goodman, et. al. Health Education and Behavior, Vol. 25 (3): 258-278 (June 1998).

To have the capacity to act, a community organisation needs three things:

* the motivation and commitment to take action
* the resources required to enable the action to be taken, and
* the skills, confidence and understanding needed to take the action.

Community capacity building may include work with;

* Individuals
* Community groups

* Whole communities
* Community networks

With individuals, community capacity building is focused on increasing skills, confidence, and understanding for people involved in community activities of all types. The skills required can be very broad, involving interpersonal skills, leadership, organisational and administrative skills, political skills and many others.

For community groups, the skill sets are similar to those needed for individuals. However, more emphasis would be placed on the skills needed for organisational development and management; for visioning and planning; for working together and for working for change. Community groups also need to be able to monitor and evaluate their work, and in particular, be aware of equalities issues.

Whole communities may also be a focus for capacity building work. Some communities will have an active network of local groups and organisations who work well together, share information and ideas, refer people to each other's services, and work together to represent the interests of the whole community. Elsewhere, there can be poorly developed or inactive groups, conflict between groups, or a failure to tackle issues facing the community. Supported community forums, networks or umbrella groups can be a good mechanism for bringing together local groups, addressing any differences, and working to establish a shared vision. Community capacity building work can be focused on building such arrangements.

The fourth level of community capacity building is with community networks. These may operate at area-wide or national level, and aim to build the recognition and effectiveness of community development work in a given sector or area. They can provide information, help identify and share lessons from experience, and bring together a range of views to inform or influence public policy and service delivery.

http://www.scotland.gov.uk/Publications/2007/12/10132433/5

Assessing Community Capacity

To help the Core Group assess their own capacity to implement their Action Plans, create a matrix that resembles the following chart, and complete. On the following pages are tools to help assess the Core Groups capacity.

Matrix for Capacity Development Plan

Proposed Activity	Knowledge, skills and resources needed	Available in community	Not available in community	How will we develop this capacity?	By whom?	By When?

The following examples of Assessment Guides to be completed with community core group.

Assessment Guide – Example #1

1. Write out the questions below on newsprint and read out-loud. Ask each group member to think about each question and write his/her answer down (or just think about them).
    - What are the skills you can put to work?
    - What are the abilities and talents you can share?
    - What are the experiences from which you have learned?
    - What are the interests and dreams you would like to pursue?
    - What three skills would you like to learn?
    - Are there any skills you would like to teach?
    - When you think about your skills, what three things do you think you do best?
2. Ask the group how they can best apply this inventory of skills to activities in their community Action Plans? (e.g., have each persons skills written down in a notebook and call upon them as the Action Plan is carried out; or ask for volunteers to work on particular activities according to the action plan).

Assessment Guide - Example #2

1. Write out the questions below on newsprint and read out-loud. Ask each group member to think about each question and write their answer down (or just think about them.)
    - **Gifts of the head**: (things I know something about and would enjoy talking about or teaching other about, e.g., birds, local history, music).
    - **Gifts of the hands** (things I know how to do and enjoy doing, e.g., carpentry, sports, planting, cooking, – be specific).
    - **Gifts of the heart** (things I care deeply about, e.g., children, older people, community history, environment).

2. Once everyone has had a chance to think about their responses, ask group members to share their 'gifts' and record this information under the appropriate category on a large flipchart. Review the list of 'gifts' or capacity that was found in the group.

3. Ask the group: Was there anything that surprised or interested you about this list?

Ask the group how they can best apply this inventory of skills to activities in their community Action Plans? (e.g., have each person's skills written down in a notebook and call upon them as the Action Plan is carried out; or ask for volunteers to work on particular activities according to the action plan).

Another possible tool uses the idea of corn or beans *growing* as symbols that communities can use to choose their current capacity. The facilitator would encourage debate and dialogue amongst community members, however they will need to come to a consensus as to their self-assessment. You can keep this tool as a monitoring tool to use with communities in the future to see if their capacity has changed or been strengthened.

Communities can use the following scale to assess their capacity in the ability areas that follow it. For each numerical rating that communities assign themselves, they should provide examples of how they have demonstrated the ability to justify the rating.

- Germination = Has not demonstrated this ability.
- Growing = Has demonstrated this ability with a great amount of external assistance.
- Flowering = Has demonstrated this ability with some external assistance.
- Propagating = Has demonstrated this ability with no external assistance.

Organize the community for action[14] - Level of demonstrated ability to:

- A spirit of cooperation among community core group members
- Community core group (NHC/CBOs) well organized, for example, does it:
  - have a Chairperson, Vice-Chair, Secretary, Treasurer
  - meet on its own regularly
  - make decisions openly and with equal vote of its members
  - have written minutes of their meetings
  - know their roles and responsibilities
  - shared vision and goal
  - know when they will re-elect their Chairs, etc.,
- Members include those most affected and interested in the issue
- Members regularly sharing experience, ideas, and lessons learned
- Good communication between the members
- Members participate equally in group activities
- Members participate in group decision-making
- Group eliciting community and sector perspectives about Core Program issues
- Group continues to represent the perspectives of diverse members of the community (e.g., gender, age, class, ethnicity, socioeconomic status)
- Group engage in strategic planning, and has a community action plan
- Group leadership facilitates coordination and action
- Group regularly evaluates its activities to determine lessons learned
- Group achieving its short-term objectives
- Group raised awareness of Core Program issue(s)?
- Group succeed in carrying out its activities in its community action plan
- Group influenced decision-makers and/or policies?
- Diverse organizations /sectors involved in promoting Core Program issue(s)
- Group successful in mobilizing resources for core program issue (inside the community or outside)
- Group recognized by others outside of the group

Explore the Core Program Issue and Set Priorities Level of demonstrated ability to:

- Openly discuss the issue with others in a public forum;
- Gather information about the Core Program issue(s) using a variety of participatory methods
- Analyze information that has been gathered on the Core Program issue(s).

[14] *Adapted from Igniting Change: Capacity-Building Tools for Safe Motherhood Alliances,* 2004, pp. 63-65.

- Set priorities based on consensus

Plan Together Level of demonstrated ability to:

- Use existing and new information as a basis for decision-making and planning
- Develop desired results/objectives related to the Core Program(s) focus.
- Determine who needs to be involved in planning.
- Identify existing and needed resources.
- Identify potential barriers or challenges to achieving desired results.
- Identify various strategies to achieve desired results.
- Establish coordination mechanisms.
- Assign and accept responsibility for planned actions.
- Identify indicators of success.
- Identify areas of weakness in community capacity and strategies to strengthen

Act Together Level of demonstrated ability to:

- Leverage resources
- Manage resources.
- Carry out action plans.
- Implement effective technical interventions.
- Advocate for policy changes.
- Monitor progress.
- Identify when planned activities or strategies are not leading toward desired results and develop alternative strategies.
- Access relevant information on “best practices”, technical recommendations
- Coordinate, collaborate with other institutions or groups on the issue
- Share information with others.

Evaluate Together - Level of demonstrated ability to:

- Identify the purpose of the evaluation and key questions to address through the evaluation.
- Establish an evaluation team that is representative of stakeholders.
- Determine evaluation indicators.
- Develop an evaluation plan.
- Conduct and evaluation.
- Analyze results.
- Generate recommendations and lessons learned.
- Document and disseminate results.
- Use results for the next community action cycle.

AUTHORITARIAN LEADERSHIP Survival			**CONSULTATIVE LEADERSHIP security**			**ENABLING LEADERSHIP participation**	
Leader makes decision and announces it	Leader presents decision but "sells" it to members	Leader presents decision and invites questions of clarification	Leader presents tentative decision subject to change	Leader presents situation, gets input, makes decision	Leader calls on members to make decision, but holds veto	Leader defines limits, calls on members to make decision	Leader call on members to identify limits, explore situation, make decision
Leader announces his decision with no feeling of responsibility or accountability to share the reasons.	Leader announces his decision and shares the reasons behind it, which were prepared in advance (monologue).	Leader announces his decision but responds as needed with a rationale based on the questions from members. (Dialogue with no expressed willingness to change decision.)	Leader announces his "tentative" decision and announces that he is open to questions of clarification and discussion. (Dialogue with willingness to change decision if necessary.)	Leader identifies situation or problem and moves into a facilitating role to surface assumptions and suggestions, then moves out of facilitating role and makes a decision.	Leader calls on group to identify situation and limitations, explore and make decision contingent on leader's veto power.	Leader shares any "givens" (e.g. funds available, time parameters, etc.) and facilitates a decision by members on a basis of limitations	Leader maintains a facilitating role allowing members to identify situation or problem, identify limits, explore and make decision.

As the Core Group and other community members begin to implement their action plan they will need various resources (human, financial, material) to succeed in their objectives. Listed here are a few examples of resources to be considered, and suggestions for mobilizing resources.

Local Resource Mobilization
Community contributions are important because they help in developing a sense of community ownership and help to keep activities going. This can be in the form of *human resources* (volunteers, labour, etc.) and/or *financial* and *material* resources.

Mobilization of local materials such as sand, bricks, water and labour. Mapping out local resources in the area will help identify what is available. A special committee can be formed to organize local resources. This can be made up of Core Group and community members.

Contribution of Money, Crops or Livestock. Where some money is needed to carry out planned activities the Core Group should decide together with the community how the money will be raised. Community members may decide that each family or person should contribute a certain amount of money. For those who do not have money, a decision can be made that they can contribute crops or livestock which can then be sold.

Income Generating Activities. It may be decided to raise money by starting income generating activities such as gardening, rearing chickens or pigs, providing entertainment through shows or drama, making baskets, sewing, baking or knitting. The materials and money for starting these income generating activities are usually provided by the community themselves.

Mobilization of Community Based Agents. There are a many community-based agents which are trained to support education and health activities in the community. The following is important to know:

- Who are the community-based agents in their communities?
- Where do they live in order to invite them to participate?
- The activities they are doing
- Which community-based agents are still needed so that they can be? Developed and supported

External Resource Mobilization Resources found outside the community such as:

- **Government Service:** Resources might be water purification tablets, teacher training
- **Support from Other Organizations.** A variety of other organizations may have small grant funds which the Core Group can apply for. It is important to know which organizations are working in your district or on the Core Program issue. Communities however will need to know how to write project proposals to ask for this money.

Proposal development skills can help the Core Group raise funds for their proposed action. Here is some simple guidance:

PRE-PROPOSAL CONSIDERATIONS - Things to consider before writing begins:

- It is important to know who the donor organization is, what they fund, and the amount of money available
- Find out if the donor has an application process or forms to complete to apply for money
- It is helpful to involve education/health district staff and other support ministries when developing project proposals
- It is important to have a written action plan to include in the proposal

WRITING A PROJECT PROPOSAL

The Cover Page - The proposal should always have a cover page with the following:

- The Title: This is the name of the project being proposed
- The Name of which group is submitting the proposal.
- The Contact Person: This is the person who will be the link between the Core Group and the funding organization
- The address of where the Core Group can be contacted to receive letters
- The date of when the proposal was written
- The proposed start date of the project
- The proposed end date of the project

Problem Statement - The 'problem statement' includes the health issues that need to be addressed in the community, Steps to help guide the development of this part of the proposal are:

- Identify and state the problem that needs to be addressed
- Describe the problem. This can be done by using the results from the participatory learning and action tools, data from the health centre, or NHC monitoring tools.
- Describe the population that the project will work with such as children under school-aged children, youth, HIV positive people. Include numbers if possible.
- Describe the ability of the Core Group and community to carry out the project.

Community Background- As much as possible include the following information:

- **The Location:** This is where the proposed intervention will take place.
- **Target Population:** List the total number of people who will benefit, divided by men, women, and youth. Include the total number of people in the area.
- **Traditional Practices and culture**: Activities commonly carried out by communities such as initiation ceremonies that may have an effect (positive or negative) on proposed project activities
- **Main Economic Activities** – activities community members do for food or money such as farming, fishing or hunting

Organizational Capacity of Core Group - When it was formed; why it was formed; purpose of the group, number of women/men; brief of past activities or projects and the results or "success stories".
Partners: These are individuals, organizations or people whom the Core Group has worked with or will work with in the area.

Goal Statement - The Goal Statement describes the goal of the project, including the benefits to the population. A Goal Statement example: *To increase the number of men, women and youth who know their HIV/AIDS status and take action to prevent HIV/AIDS.*

Objectives - Objectives describe what we want to achieve. An objective can be measured and is usually time specific. An example of an Objective is: *Increase by 50% the number of youths who have been counselled and know their HIV status.*

Strategies: Develop a cadre of youth peer-to-peer educators who will develop role models who know their HIV status, and who promote dialogue on HIV prevention.

Activities - Identify all the activities to be carried out to achieve each objective. An example of an activity is: *Train community 50 youth peer educators on VCT promotion*

Budget - The budget will show the materials that you want to buy, the quantity or number and the price of each of the activities to be carried out. An example is:

Activity	Materials Needed	Amount Required	Unit Cost	Total Cost	Community Contribution
Sell treated mosquito nets	Treated mosquito nets	100	K25,000	K2,500,000	Volunteer Time x 20 Volunteers

Activity Work Plan – When activities will be carried out over 12 months of the year.

Activity	TIME FRAME – Year 1											
	1	2	3	4	6	7	8	9	10	11	12	
Collect community contribution	X											
Sink 2 boreholes		X										
Train 16 committee members			X	X	X							

Monitoring

- Explain how the progress on the project will be checked, by whom, and how often.
- Explain clearly who will participate in the monitoring such as the Core Group members, health centre staff, and community members
- Explain what information you will be looking for and source that information

Sustainability - Describe how the Core Group and community members will ensure that the project is maintained after the funding has stopped. What activities will the community be involved in to find money for the activities to continue. List the community skills.

Challenges or possible risks- Those challenges that might affect project success.

Additional information - Maps of the area, members of the Core Group, etc.

Once a proposal is granted or the Core Group has raised funds or resources, – managing these resources will become very important. Financial management skills are often needed to help Core Group budget and look after money and resources.

A Financial Plan – allows for a community organization to know how much money they need, how much money they have at any one time, and how much they have spent or will need to spend. It gives an organization control over their financial affairs and makes people accountable.

Usually the Core Group will have a Treasurer who together with the Core Group develop a financial management system and make sure the system is run correctly.

Budgeting

A simple budget includes the activity to be done, the type of material needed, the quantity or amount needed, and the unit cost.

Activity	Material Needed	Quantity Amount Required	Unit Cost	Total Cost

Safe-keeping of Money

- Money that has been donated or coming from income generating activities must always be kept at the bank for safe keeping.
- The Core Group should open a bank account to keep their money safe.
- Where there is not a bank account, money must be kept in a safe or a cash box that can be locked with different locks. Often it takes three people together to unlock a box in order to not burden one person with this responsibility.
- Only one person, most likely the Treasurer, should be responsible for keeping records of the funds – this person normally is able to read and write.

Use of Money

- Records must be kept for all money being spent and money that is received.
- Whenever money is to be spent on any activity, all members of the group should be involved in making the decision.
- It is best if 3 members sign for use of money. The Chairperson, the Secretary and the Treasurer of the Core Group will need to approve the use of money by signing for this to happen.
- The one receiving the money must always sign for it. The Treasurer should show the records to other members of the group during meetings.
- A financial record should always be presented during the monthly meetings.

Sample Financial Record

Date of Activity	Money Received	Money Spent	Balance Cash	Balance at Bank	Chair-person Signature	Secretary Signature	Treasurer Signature	Signature Person receiving

Managing Property and Material

Often Core Groups have property and materials such as sewing machines, grocery shops, chicken runs, goats, etc. or have plans to have property and materials in the future. It will be important to look after these resources and take care of them.

Stocktaking is the process of checking and recording property and materials.

- When property or materials are received they should be recorded in a book kept by the Vice-Chairperson.
- Members of the group should be allowed to look at this book anytime.
- Each material should be written on its own page. At frequent intervals group members will need to check on these materials to see that they match what is written in the book.
- Members of the group will need to agree on when stocktaking should be done.
- For business such as grocery shops, stock-taking should be done very often. Each time a different seller takes over the selling, stock taking should be done.
- The same member should not do stock taking.
- All members of the group as well as communities members should participate to create an open and trusting atmosphere.

Additional Financial Management Tools - As a Core Groups begins to link to outside resources, they may receive funding and resources from various sources. Here are two examples of how these resources may be managed:

Example 1: A Register of Donations

Date	Description of donation	Quantity	Donor	Balance	Date disposed	Quantity disposed	Balance

Example 2: Income and payments document

INCOME												
Sources	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Donor 1												
Donor 2												
Donor 3												
Total income												
EXPENSES												
Recipient 1												
Recipient 2												
Recipient 3												
Total paid out												

Grand total (income – payments)												
Amount over or (under)												

Building Group Maintenance Skills

As community Core Groups become organized, and begin to work together they will need to maintain a well-functioning group. Here are ways to keep a group functioning well:

Group Tasks[15] - Members of a Core Group should always work as a team. A team is a group of people who have come together for a common goal. A team can be nurtured by:

- Having clear roles for each member
- Ensure no member of a group feels more important than the other
- Encourage respect for one another
- Create clear communication lines so that all members can participate fully in activities at all times
- Carry out activities together
- Share information amongst all members of the group

Group Maintenance[16] - Maintaining a group involves being sensitive to the needs of the group members. Here are some tips for doing this:

- Encourage – be friendly, respond to and build on suggestions made by others, show acceptance and appreciation of others and their ideas
- Ask for participation – give a quiet person a chance to join the discussion
- Ask for opinions – good decision-making depends on knowing what all members think and feel about a suggestion
- Support Group Standards – review how the group holds meetings, when they meet, how minutes are reviewed, written, how discussions are held, and how decisions are taken
- Harmonize – help those in conflict to understand one another's views
- Evaluate – create an opportunity for members to express feelings and reactions towards how well the group functions

[15] Training for Transformation, Volume, 2 A. Hope and S. Timmel, Mambo Press, 1984

[16] Ibid.

- Relieve tension – bring a problem out in the open; make a good joke!
- Celebrate success – when the group achieves what they had planned be sure to celebrate successes and praise those who worked hard.

Meeting Minutes

Meeting minutes are the notes taken whenever a group meets. The Secretary of the group is usually responsible for writing these minutes. The minutes should include:

- The date of the meeting
- The place for the meeting. For example, health centre or school
- The title or purpose of the meeting or activities
- The agenda of the meeting
- The names of members present, as well as those absent
- What was talked about
- What decisions were taken, who will be responsible for carrying out the decision, and by what date
- What will be done in the future as follow-up

Usually, at each meeting the minutes from the last meeting are reviewed by members of the group (read out loud by the Secretary) and approved.

Monthly Monitoring Form

For Core Groups a monthly monitoring form can be developed to report on the planned community activities. This form can be completed every month to track progress.

Step 3: Support Community Groups to Monitor Progress and Utilize Data to Inform Their Microplanning and Collective Action

During this phase and throughout the Community Action Cycle monitoring is carried out by various actors on several levels using a combination of formal and informal systems, methods and tools. The following general monitoring questions are appropriate for any group:

- What is the Core Program goal? What are the desired results?
- What indicators do we use to judge progress, success or failure?
- How do we currently assess how we are doing related to this goal and our desired results? What formal and informal monitoring processes currently exist to share observations about progress?
- What do we want to monitor and how will we do this? What kind of tool and/or process do we need?

Specific monitoring tools will need to be tailored to your particular Core Program Issue and community *capacity building* goals. Let's look at the different monitoring needs for all those involved in community mobilization.

Individuals and families monitor and how their child progresses in school, noting how often their child is sick, and use family level tools such as vaccination cards, school performance reports, growth monitoring charts, etc.

Community groups and organizations monitor progress on their action plans, including whether they are carrying out what they planned and their efforts desired outcomes. It is suggested that they review progress achieved against planned activities at least every quarter so that strategies and activities can be adjusted. The following is a simple *Community Bulletin Board* which can help communities monitor their own progress.

Participatory Monitoring tools for low literacy communities – Community Bulletin Board

Monitoring tools must be appropriate to the villagers' level of understanding. In low literacy communities, monitoring tools can be simple and as visual as possible. Communities may use tools such as the "flag" or banner, picture cards to signal various problems and/or interventions, and can use symbols to represent the number of events/people/etc. that the monitoring indicator calls for. Be creative and work with community members to develop a simple monitoring system that works for them. See the pictures above and below of some examples of tools to spark your imagination!

COMMUNITY BULLETIN BOARD

WDC Community Name: Sanu

Total Population: 100

Women 30, (of which 10 are pregnant) Men: 30 **Children Under 5** 40

	July	Aug	Sept	Oct	Nov	Dec
Indicator 1: Number of pregnant women attending antenatal clinic 						
Indicator 2: Number of women who Delivered at the health facility 						
Indicator 3: Number of community meetings held 						

The CM program team monitors overall CM successes and challenges, progress on building community capacity, and the team's community mobilization performance. A *Community Mobilization Team – Monitoring Checklist* is available in the Annex to assist your team. In addition, within Sponsorship Operations and Core Programs there are a number of opportunities to monitor community mobilization successes and challenges, and make adjustments to design. These are outlined in the box below.

Your team and community *core group*s should also monitor *key dimensions of community capacity* such as: participation, leadership skills, resource mobilization and management, social and organizational structure, etc.

The following are illustrative community capacity indicators you and communities can adapt:

Organize the community for action[17] - Level of demonstrated ability to:

- #/% of community orientation meetings conducted in project area
- Community core group (NHC/CBOs) well organized, for example, does it:
  - have a Chairperson, Vice-Chair, Secretary, Treasurer
  - meet on its own regularly
  - make decisions openly and with equal vote of its members
  - have written minutes of their meetings
  - know their roles and responsibilities
  - shared vision and goal
  - know when they will re-elect their Chairs, etc.,
- At least 60% of core group members include those most affected and interested in the issue
- Members regularly sharing experience, ideas, and lessons learned
- Group meeting regularly without outside stimulus of BREAKTHROUGH ACTION or international partner
- Good communication between the members
- Members participate equally in group activities
- Members participate in group decision-making
- Group eliciting community and sector perspectives about Core Program issues
- Group continues to represent the perspectives of diverse members of the community (e.g., gender, age, class, ethnicity, socioeconomic status)
- Group leadership facilitates coordination and action
- Group regularly evaluates its activities to determine lessons learned
- Group achieving its short-term objectives
- Group awareness of Core Program issue(s)
- Group influenced decision-makers and/or policies
- Diverse organizations /sectors involved in promoting Core Program issue(s)
- Group recognized by others outside of the group

Explore the Core Program Issue and Set Priorities Level of demonstrated ability to:

[17] *Adapted from Igniting Change: Capacity-Building Tools for Safe Motherhood Alliances*, 2004, pp. 63-65.

- Openly discuss the issue with others in a public forum;
- Gather information about the Core Program issue(s) using a variety of participatory methods
- Analyze information that has been gathered on the Core Program issue(s).
- Set priorities based on underlying issues affecting change

Plan Together Level of demonstrated ability to:

- Use existing and new information as a basis for decision-making and planning
- Develop desired results/objectives related to the Core Program(s) focus.
- Determine who needs to be involved in planning.
- Identify existing and needed resources.
- Identify potential barriers or challenges to achieving desired results.
- Identify various strategies to achieve desired results.
- Establish coordination mechanisms.
- Assign and accept responsibility for planned actions.
- Identify indicators of success.
- Group has a written action plan
- Group succeed in carrying out its activities in its community action plan
- Identify areas of weakness in community capacity and strategies to strengthen
- Shared action plan with broader community

Act Together Level of demonstrated ability to:

- Leverage resources both inside and outside the community
- Manage resources.
- Carry out action plans.
- Implement effective technical interventions.
- Links with outside resources and technical support
- Advocate for policy changes.
- Monitor progress.
- Identify when planned activities or strategies are not leading toward desired results and develop alternative strategies.
- Access relevant information on “best practices”, technical recommendations
- Coordinate, collaborate with other institutions or groups on the issue
- Share information with others.

Evaluate Together - Level of demonstrated ability to:

- Identify the purpose of the evaluation and key questions to address through the evaluation.
- Establish an evaluation team that is representative of stakeholders.
- Determine evaluation indicators.
- Develop an evaluation plan.
- Conduct and evaluation.
- Analyze results.
- Generate recommendations and lessons learned.
- Document and disseminate results.
- Use results for the next community action cycle

Donors or other stakeholders monitor results to account for their investments and inform future decision-making. Your team should make sure to understand what the donors want to see in the reports and how they want to see it. Monitoring helps us:

- Document and share progress of implementation
- Determine reality versus planned activities.
- Know if we are on track
- Know how we are using our resources
- Determine whether everybody is doing his/her assigned roles
- Know how we are performing

BONUS! PROBLEM-SOLVE, TROUBLESHOOT, ADVISE, AND MEDIATE CONFLICTS

In spite of the best planning, forethought and intentions, things do not always proceed smoothly. Good monitoring systems and regular communication will help to alert participants' to existing or potential problems. However, difficulties may occur for many reasons which may be within or beyond a program or community's control. Every culture has developed strategies to prevent, avoid and resolve conflicts. Some strategies, while they may resolve conflict, can also create ongoing negative feelings and resentment. These types of strategies can usually be characterized as "win/lose" strategies. "Win/win" strategies more often result in better long-term relationships. It can be helpful to discuss with community groups how they have dealt with differences of opinion and conflict in the past, the results of these strategies and the differences between win/lose and win/win approaches to conflict resolution.

In general, it is best to let communities identify and resolve their problems. However, there are times when you may need to intervene, such as when the problem:

- Directly affects your organization, team, or individual team members.
- Concerns mismanagement or misappropriation of program resources.
- Is major and is not identified by the community, possibly because the problem originates from outside of the community, such as a donor withdrawing funding for the project or a major upcoming change in public health policy that will have important repercussions on implementation.
- Concerns major differences of participants' opinion on strategy that could benefit from outside mediation and/or additional information or experience.
- Concerns important ethical issues that your organization or team cannot or will not support and that ultimately could jeopardize the overall program (e.g., coercion or violence to force compliance).

How you intervene in these cases will depend on the role(s) that you want to play in relation to the community, your organizational responsibilities, and your overall approach to the program.

CAUSES & STAGES OF CONFLICT

Causes of conflicts

- Differences in information
- Differences in perception or opinion about the same information
- Differences in values and beliefs
- Differences in role
- Perceived scarcity of resources
- Competitiveness
- Self-centeredness
- Counter-dependence
- Lack of trust
- Fear

Stages in the Evolution of conflicts

- Anticipation- We expect that when a change or issue is introduced, there will be differences of opinion.
- Conscious but unexpressed differences- One or more people disagree, but don't openly express disagreement. Conflict may be expressed indirectly by withdrawal, sarcasm, cynicism, humour, etc.
- Discussion- Differing opinions begin to emerge openly. They may be implied by questions asked and language used. Differences may be expressed indirectly and tentatively.
- Open Dispute- Differences are expressed as arguments and counter arguments. Differences sharpen into clearly defined points of view.
- Open Conflict- Disputants are firmly committed to particular positions. They attempt to increase the effectiveness of their argument and undermine the influence of the opposition.
- Common Program challenges
- An individual or group tries to block actions, usually because action threatens this individual or group's power or interests.
- The community does not have sufficient capacity to take an action.
- A proposed action does not improve health status.
- Participants lose interest in the program.
- External project funding is diminished or cut altogether.
- Communities want to engage in activities that do not directly or indirectly contribute to the health goal.
- Other organizations "compete" for community participation by offering incentives."

Steps to Facilitate the Resolution of Conflict

- Summarize the Disagreement- Be objective and focus on the issues, not personalities. List the points of conflict. If possible reduce these points into sub-points that are easier to deal with.

- Confirm accuracy- Ask for confirmation or correction. This encourages individuals to take ownership. It may even lead to their resolving the conflict without further intervention on your part.
- Establish the last points of agreement- This focuses individuals and the group on the issue in dispute.
- Create a shared vision- Have each side express their desired goals, objectives or visions. It may be helpful to keep asking 'Why do you want..?' Try to stimulate self-knowledge and knowledge of the others' ambitions, motives and attitudes. Have each side identify common goals or a shared vision.
- Generate possible solutions- Use brainstorming or other techniques like the Margolis Wheel. May be necessary to bring in a third party to move the conflict toward solution.
- Get agreement to implement and assess a solution- Ask the disputants either to collaborate or compromise in choosing a solution. Explore how they will know whether the solution is successful.

Strategies for Dealing with Conflict

Strategy	Appropriate when…	Inappropriate when…
Avoiding	The issue is relatively unimportant. The potential damage of confronting the conflict outweighs the benefits of resolution.	Surfacing the issue may lead to more important issues that need to be addressed.
Accommodating	The issue is much more important to them than to you. You wish to demonstrate good will.	Your commitment is required and you will not be able to commit to their choice. Your input is required for an effective outcome.
Forcing	Quick, decisive action is vital. You need to implement an unpopular choice for which commitment is not required.	The cost of forcing this issue outweighs the benefits of getting your own way.
Compromising	Goals are mutually exclusive.	Giving everyone some of what they want doesn't satisfy anyone.
Collaborating	Working through hard feelings. When different perspectives could lead to a superior solution. When commitment to the solution is important.	When time is urgent.

BONUS! EVALUATION

The evaluation of the program provides a unique opportunity for communities to learn about the success of their collective action and what work remains to be undertaken. Often the evaluation process is undertaken by external evaluators with data also being extracted and not always shared with communities themselves. The Evaluate Together phase provides an opportunity for community members to participate in the evaluation process, learn how to evaluate, analyze results, share results with the community, and apply lessons learned to future program efforts.

The steps involved in this phase include:

Step 1: Form a representative evaluation team with community members and other interested parties

Step 2: Determine what participants want to learn from the evaluation

Step 3: Develop an evaluation plan and evaluation instruments

Step 4: Conduct the participatory evaluation

Step 5: Analyze the results with the evaluation team members

Step 6: Document Lessons Learned and provide feedback to the community

During the Evaluate Together phase it is important to focus on core program outcomes (e.g. number of children enrolled and retained in school). It is also important to evaluate the level of *community capacity* built in order to know if communities will be able to sustain these outcomes as well as current levels of participation once BREAKTHROUGH ACTION and its partners complete work in that community. Some potential outcome indicators for measuring community capacity include are highlighted in the box below.

Potential CM Outcome Indicators

- #/% of community groups well organized and working on core program issues
- #/% of community groups comprised of 60% or more most affected/vulnerable community members
- #/% of communities with their own action plans to improve health outcomes
- #/% of communities with Action Plans that have achieved at least one of their desired results as specified in their Action Plans
- #/% of communities actively using data to inform action plans and motivate broader community action
- #/% of community core groups accessing resources/funds both within and outside the community
- Documented increase in child participation in exploring the core program issue and helping to set priorities, action planning and monitoring outcome of activities
- Documented increase in marginalized groups, including women in leadership positions within community core groups.
- #/% of communities who have demonstrated the ability to advocate for improved health with health authorities, or other policy/decision-makers
- % increase in capacity of core groups in leadership; conflict resolution; group organization; planning; and resource mobilization and management

Located in the Annex is a sample *Qualitative Evaluation Tool for Measuring Community Action* developed with the Health Communication Partnership/Zambia. *A Quantitative Endline Survey Tool* was also developed to measure perceived change in community capacity as a result of community mobilization. Community capacity indicators were generated by communities themselves and then validated before being included in the quantitative endline study. This can be found on SaveNet.

ANNEX: EVALUATING COMMUNITY CORE GROUP COLLECTIVE ACTION

(Adapted from Health Communication Partnership/Zambia)

The Following checklist will be used with key informants from community core groups (e.g. school management committees, ECD committees, etc.). (The checklist should be used with leaders from the core group, who have information about the activities of the core group and have access to core documents (e.g. Chairperson, Secretary and Treasurer). In order for the interviews to be as informative as possible, each checklist must be conducted with a group of two or three core group leaders at the same time. The checklist will be used as an interview guide in collaboration with a records review and the core group will be the unit of analysis. Check the appropriate records to verify what they are reporting. Key Records: Minutes of meetings; meeting attendance list; membership and committee register; action plans; budget and expenditure records; activity reports, HCP recording forms, etc.

Name of Village: _____ Type/Name of Core Group: _____

Name of Interviewer_____

Date: _____

NO.	QUESTIONS	RESPONSE	RECORDS REVIEWED AND COMMENTS
1	RECORD POSITION OF INTERVIEWEES IN CORE GROUP AND THEIR GENDER	1…… GENDER… 2. …… GENDER… 3. …… GENDER…	
2.	Name 3 priority core program topics in the core group Action Plan (Seek Verification/ ask to see the listing of these in Action plan):	1…… 2…… 3……	

Community Action	Yes	No (Why not)	RECORDS REVIEWED AND COMMENTS	
			OBSERVED	COMMENT
1. When was this core group formed? RECORD YEAR				
2. Has the core group received training? If so when?				

3. Who provided the training? (Provide Space for responses)				
4. Does the core group have written rules for its operations (e.g. By-laws, written roles & responsibilities; leadership Structure; constitution, organization chart, etc.)				
5. Does the core group have a written Action Plan?				
6. In the past 6 months has the core group conducted any activities that are in the action plan? (Verify what activities and why this instruction should go to all questions, place it at the top)				
7. How many members are there in the core group?				
Adults	**Female**	**Male**		
Youth				
8. Are there any women in leadership positions in your core group? Make provision for indicating Yes or No (indicate the positions and check the record, i.e. Chairperson, Secretary, Other specify)				
	YES	**NO**	**OBSERVED**	**COMMENT**
9. a) How often does your core group hold				

meetings? (probe: do you hold monthly, quarterly, etc. meetings) (Yes/No response not appropriate to this.)				
b) When was last meeting held? (ask for minutes of last meeting)	Date: …….			
10. Number of persons attending last (monthly /general) meeting				
	F	**M**		
Adults:				
Youth:				
11. (a) Do you have written minutes for the last 3 core group meetings? Make provision for indicating Yes or No (ask for minutes of last three meetings)				
(b) Were there any activities that were reviewed related to the 3 priority areas during the last 3 core group meetings? Make provision for indicating Yes or No (check minutes)				
(c) Were the reviewed activities planned? (record of core group monitoring forms and Activity Plan)				

12. a) Did your core group and the community mobilize resources to address the				
	Internal			**External**
	a.			a.
	b.			b.
	c.			c.

three priority areas in your action plan. 12. b) What types of resources did you mobilize (including financial, material and in-kind). 12. c) Who provided these resources	d. e.	d. e.
13. a) How many people altogether participated in core group activities dealing with the 3 priority areas in the last 6 months? 13. b) What type of people participated in these activities 13. c) What services did these people provide to the core group? (physical labor, contribute money, in-kind contribution, technical expertise, etc.)	Priority Area 1:_____ Priority Area 2:_____ Priority Area 3:_____ 1. Volunteers:_____ 2. NHC members:_____ 3. Hired labor:_____ 4. Other:_____	

14. Has the core group prepared any proposals for support in the last 12 months? If yes, how many have been:			
▪ Written?			
▪ Submitted?			
▪ Funded (successful)?			
15. Does the core group have a system in place for managing Financial Records and administrative matters (e.g.			

lock boxes, bank records, cash books)?			
16. How does the community benefit from core group activities? (Record all benefits and verify records and physical evidence)			

ANNEX: CASE STUDIES

1. What have you been doing as a core group in the last six months to improve the (basic education; early childhood education; school health, etc.) of this community (what activities have you been undertaking)?

2. How do you decide what activities to work on as a community?

3. What process guides you?

4. Have you heard of the Community Action Cycle? If so, what is it?"

5. What capacity building activities (Training, mentoring, etc.) (if any) has helped you take collective action?

6. Who supported you in building this capacity?

7. What has been the biggest improvement you have seen, if any, after undertaking these activities?

ANNEX: COMMUNITY EXCHANGE VISIT – MONITORING LEARNING

Community Hosting the Visit: _____
Date of Exchange Visit: _____
Community(s) Groups Making the Visit:

1. _____
2. _____
3. _____
4. _____
5. _____

Individuals Who Traveled:
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____
Name: _____ Organization: _____

Key Issues Shared by Hosts:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Key Issues to Be Adapted by Visitors:

1. _____
2. _____
3. _____
4. _____

Write up brief summary of the Exchange Visit:

ANNEX: COMMUNITY MOBILIZATION TEAM - MONITORING CHECK LIST

Name of Community Core Group_____
Location (Village) _____
Date of Visit: _____
District_____
Name of Mentor/Facilitator_____

Phase of the Community Action Cycle (CAC)	Indicator of success	Notes from visit	Action Agreed Upon	Names of people being mentored
Prepare to Mobilize				
All relevant staff/teams are trained & mentored in BREAKTHROUGH ACTION CM Community Action Cycle (CAC), in a phased-in approach that mirrors program implementation.[18]	All staff utilizing CM approaches have been trained and mentored			
Staff/teams who have been trained monitor trainees to ensure sound application of the Community Action Cycle	Core Program has undertaken 100% of the items on this CAC checklist			
<u>CM Teams implementing CM approaches</u>: ▪ Demonstrate understanding of & respect for community and culture ▪ Ensure broad participation & transparency ▪ Ability to identify and bring out the strengths of others ▪ Support those with & affected by Core Program issue	CM Teams undertaken community cultural, historical, **social inventory** in communities, & understand the communities where they work			

[18] SC Community Mobilization Basics or Training of Trainers, *"How to Mobilize Communities for Health and Social Change Trainers Guide,"* Howard-Grabman, L. & Snetro, G.

CM Team has developed a CM Program Plan as a framework for implementation, & integrated this plan & indicators into the overall Detailed Workplan for the program	CM Program Plan (framework) in place and incorporated into DIP [19]			
Getting Organized				
Communities oriented to the Core Program goal	Orientation meetings held with a variety of community stakeholders			
Community understanding & commitment to Core Program goal	Commitment demonstrated by community stakeholders' initiating efforts on Core Program.			
Community Core Group or other relevant group organized to address Core Program issues	Community Core Group Organized with those most affected by, and interested in the issue			
Community Core Group leadership, norms for participation, and by-laws established & functioning	▪ Democratically chosen Chair, Secretary, Treasurer ▪ Core group members ability to articulate & carry out their roles & responsibilities ▪ Written roles, responsibilities & norms of members ▪ Clearly defined 'terms of office' for leadership & promotion of emerging new leaders (through rotation, mentoring) ▪ Core group working according to its norms			

[19] See sample, pg. 39, *"How to Mobilize Communities for Health and Social Change Field Guide"*, Howard-Grabman, L. & Snetro, G.

	▪ Meeting regularly, documenting proceedings and action steps ▪ Core group is recognized by others outside the group			
Core Group take ownership of the Community Action Cycle (CAC)	Core Group implementing the Community Action Cycle			
Participation of those most affected, marginalized and interested in Core Program issue throughout the CAC process	Application of '60/40 rule'[20] for Core Group representation; inclusion of women, those most affected and interested			
EXPLORE CORE PROGRAM ISSUE & SET PRIORITIES				
Core Group exploring Core Program issues amongst members	Core Group gather information on core program issue using a variety of participatory methods			
Core Group explores Core Program issues with the broader community	Core Group gather & share information on core program issue using a variety of participatory methods			
Core Group analyze information gathered & prioritize key problems to address related to Core Program issue	Core Group discovers the 'underlying influences' on core program issue & sets priorities based on these influences			
PLAN TOGETHER				
Core Group has a written Action Plan & budget based on prioritized issues	Written community Action Plan[21]			
ACT TOGETHER				

[20] The '60/40 Rule' refers to the percentage of those affected or marginalized who have joined a community core group. The rule is a rough estimate to allow for the voice of the marginalized to be heard, not just token representation, e.g. 60% of group members represented by marginalized groups, and 40% represented from the general community

[21] Community Action Plans should include: Goal; Strategies, Activities, Persons Responsible; Timeline, Budget, and benchmarks for tracking progress

Core Group implementing its Action Plans	Core Group implementing its Action Plan and meeting targeted priorities			
Core Group foster a sense of reciprocity, belonging and trust in the community	Core Group activities that are non-stigmatizing & inclusive of others			
Core Group monitoring its own benchmarks & using data for decision-making	Core Group regular monitoring of progress on Action Plans & feedback to community at large			
Core Group sustaining & expanding their efforts beyond the life of the program.	Core Group: ▪ Assess, plan implement, monitor & evaluate their collective action ▪ Solve problems ▪ Create linkages to internal & external funding & support ▪ Manage financial & human resources ▪ Manage efficient meetings ▪ Resolve conflicts ▪ Advocate at multiple levels			
Core Group sharing lessons learned with other communities, partners & donors	Community exchange visits held; meetings with partners & donors to share successes & challenges			
EVALUATE TOGETHER				
Core Group evaluating their efforts and re-starting the Community Action Cycle based on learning	Core Group participating in evaluating the program and dissemination of findings			
District, provincial and national levels partners promoting CM best practices	Partners trained on CM & implementing the CAC with community members			

	District, provincial & national policy and documents advocating for community owned responses			
Communities participating in 360 degree evaluation of Save's CM approaches	360 degree evaluation carried out with communities			