



Mobilizing Communities for Health and Social Change



Tool kit 2 Participants Manual

Support for service Delivery Integration
Ministry of Health, Malawi



USAID
FROM THE AMERICAN PEOPLE



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Acronyms:

ADC:	Area Development Committee
CAC:	Community Action Cycle
CAG:	Community Action Group
CBDA:	Community Based Distribution Agent
CBO:	Community Based Organization
CG:	Care Group
CHV:	Community Health Volunteer
CM:	Community Mobilization
CMT:	Community Mobilization Team
DEC:	District Executive Committee
DHMT:	District Health Management Team
DHPT:	District Health Promotion Team
EHP:	Essential Health Package
HBCV:	Home Based Care Volunteer
HC:	Health Centre
HCC:	Health Centre Committee
HCP:	Health Communication Partnership (Zambia)
GoM:	Government of Malawi
GVH:	Group Village Head (man/woman)
HSSP:	(Malawi National) Health Sector Strategic Plan NHSSP:
MNCH:	Maternal, Neonatal, and Child Health
MoH:	Ministry of Health
NFE:	Non-Formal Education
NGO:	Non-Governmental Organization
PHC:	Primary Healthcare
SBCC:	Social and Behaviour Change Communication
SSDI:	Support for Service Delivery Integration
TA:	Traditional Authority
TBA:	Traditional Birth Attendant
TRG:	Training Resources Group
USAID:	United States Agency for International Development
VDC:	Village Development Committee
VH:	Village Head (man/woman)
VHC:	Village Health Committee
WALA	Wellness and Agriculture for Livelihood Advancement
WASH	Water and Sanitation
WG:	Women's Group
WHO:	World Health Organization
YG:	Youth Group

How to Use this Manual

This manual will help you apply sound community mobilization approaches when designing, planning, implementing, monitoring, and evaluating SSDI initiatives. Materials in this compendium are designed to help community-level facilitators mobilize communities for improved health outcomes for Malawian families.

While the material included in this manual is not primarily intended to be a *detailed* guide in 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 health and key health indicators in Malawi, including the Essential Health Package. Greater detail can be found in the “*How to Mobilize Communities for Health and Social Change*” Field Guide.¹

Introduction

The Government of Malawi calls for strengthening community engagement in health to ensure that communities at the grassroots level have a say and ability to participate when it comes to issues that involve their health. Community Health, also known as Primary Health Care (PHC), is the first level of contact for individuals, family members, and the community with the national health system. Community Health brings health care as close as possible to where people live and work; it constitutes the first element of a continuing health-care process (WHO, Alma-Ata Declaration, 1978). Primary health care in Malawi focuses on the four aspects of health care: preventive, promotional, curative, and rehabilitative services that form the core components of Community Health.

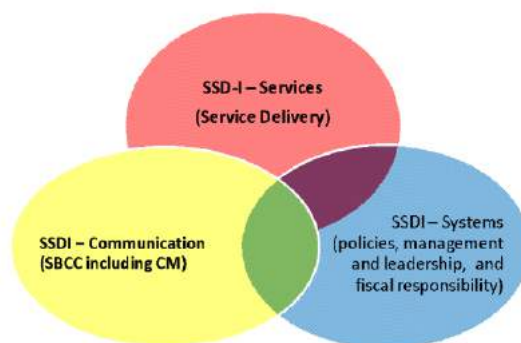
The Ouagadougou declaration on Primary Health Care and Health Systems in Africa (WHO, Ouagadougou 2010), as a follow up to the Alma Ata declaration on Primary Health Care, encourages governments to strengthen the PHC approach. The Malawi Ministry of Health has endorsed in its Health Sector Strategic Plan (HSSP) 2011–2016 to strengthen involvement and participation of communities on issues related to health.

Support for Service Delivery Integration (SSDI)

In 2011, USAID Malawi awarded US \$100 million for the five-year Support for Service Delivery Integration (SSDI) Project, consisting of three separate but interrelated Cooperative Agreements: SSDI Services, SSDI Systems, and SSDI Communication. SSDI Services support the Malawi government’s efforts to achieve improved service delivery; SSDI Systems focus on improving policies, management, and leadership; and SSDI Communication focuses on supporting social and behaviour change communication (SBCC).

¹ Howard-Grabman, L and Snetro G (2003), *How to Mobilize Communities for Health and Social Change Field Guide*, Baltimore: Health Communication Partnership.

5-year integrated health service delivery strengthening consortium



SSDI aims to support the Government of Malawi in its efforts to achieve its vision of improving the health status of all Malawians. The goal of SSDI is to support, in partnership with the Ministry of Health, effective integration and delivery of quality services under the EHP, and to strengthen the national health system in line with the NHSSP (2011–2016). The EHP promotes the provision of a basic, cost-effective package of promotive, preventive, curative, and rehabilitative health services determined on the basis of scientific and practical experience in service delivery. These efforts are designed to have a significant impact on the health status of the majority of people in Malawi.

SSDI is guided by the principles of country ownership and leadership, integration for greater efficiency, and building on existing systems and past achievements. SSDI focuses on a comprehensive program of support in 15 districts (Nsanje, Phalombe, Chikhwawa, Machinga, Mangochi, Mulanje, Balaka, Zomba, Salima, Nkhotakota, Dowa, Kasungu, Lilongwe, Chitipa and Karonga) located in each of the country’s five health zones. This five-year project (October 1, 2011–September 30, 2016) has the central theme, ***‘Together we build healthy families’***.

About the Community Mobilization Approach in SSDI:

Community Mobilization (CM) will be used as a process of building the capacity of communities, individuals, groups, or organizations to plan, carry out, and evaluate activities in a participatory and sustained manner in order to improve their health. CM is recognized as a proven approach to development that has helped people around the world identify and address pressing health-care concerns. The approach not only helps people improve their health and living conditions, but, 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 end results of a successful community mobilization effort, in other words, are not only a “problem solved” but also the increased capacity to solve other problems as well.

The SSDI project will use the Community Action Cycle (CAC) approach focusing on the 6 EHP areas – namely:

- Malaria
- HIV/AIDS and TB
- Water, Sanitation and Hygiene (WASH)
- Nutrition
- Maternal Newborn and Child Health (MNCH)
- Family Planning

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

In Malawi, the MoH, with the support of SSDI and its partners, will mobilize the communities based on the following principles:

- Social change is more sustainable if the individuals and communities most affected **own the process** and content of behaviour-centred approaches.
- Communication for social change should be **empowering** and **horizontal** (versus top-down). It should **give voice** to the previously unheard members of the community and be centred around **local content** and ownership.
- **Parents, families, and communities** should be the agents of change.
- Emphasis should shift from persuasion and the transmission of information from outside technical experts to **support for dialogue, debate, and negotiation** on issues that resonate with members of the community.
- Emphasis on outcomes should shift **away from individual behaviour** to social norms, policies, culture, and the supporting environment.

The community mobilization approach is intended to bring multiple benefits to the SSDI Initiative, including:

- Increased community, individual, and group capacity to identify and respond to key health needs
- Improved program design
- Improved program quality

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

Defining Community Mobilization

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 and other needs, either on their own initiative or stimulated by others.

CM Characteristics:

1. Developing an ongoing dialogue between community members regarding Core Program issue(s)
2. Creating or strengthening community organizations aimed at improving health and Core Program 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 Core Program issue(s)
5. Working in partnership with community members in all phases of a project to create locally appropriate responses to Core Program needs
6. Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve their 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 the Core Program issue(s)
8. Committing enough time to work with communities on accomplishing the above (normally, this process is not suitable for short-term projects of less than two years).

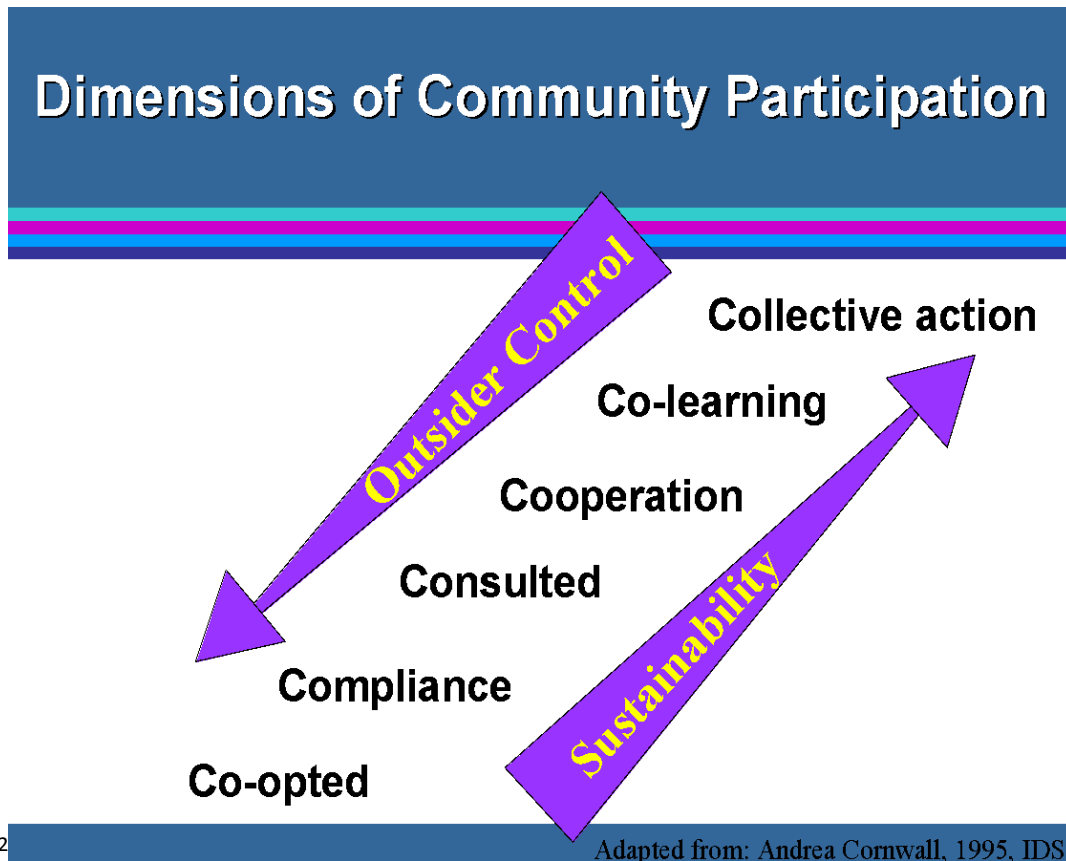
The Community Mobilization (CM) Approach is a proven development approach that has helped people around the world identify and address pressing health, education, and development issues. Community mobilization not only helps people improve their lives, but by its very nature strengthens and enhances the ability of the community to work together for any

goal that is important to its members. The end 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 term commonly used to describe community-based activities – from vaccination ‘campaigns’ to ‘sensitization’ on youth sexual and reproductive health. However, the definition in relation to the SSDI Initiative is much more of a sustained process in which community members participate in all aspects and phases of a program.

It is also important to discuss what community mobilization is *not*. Community mobilization 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 the SSDI interventions promote community participation. The following graphic presentation illustrates the relationship between the various degrees of community participation and the resulting sense of ownership and prospects for sustainability.



2

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

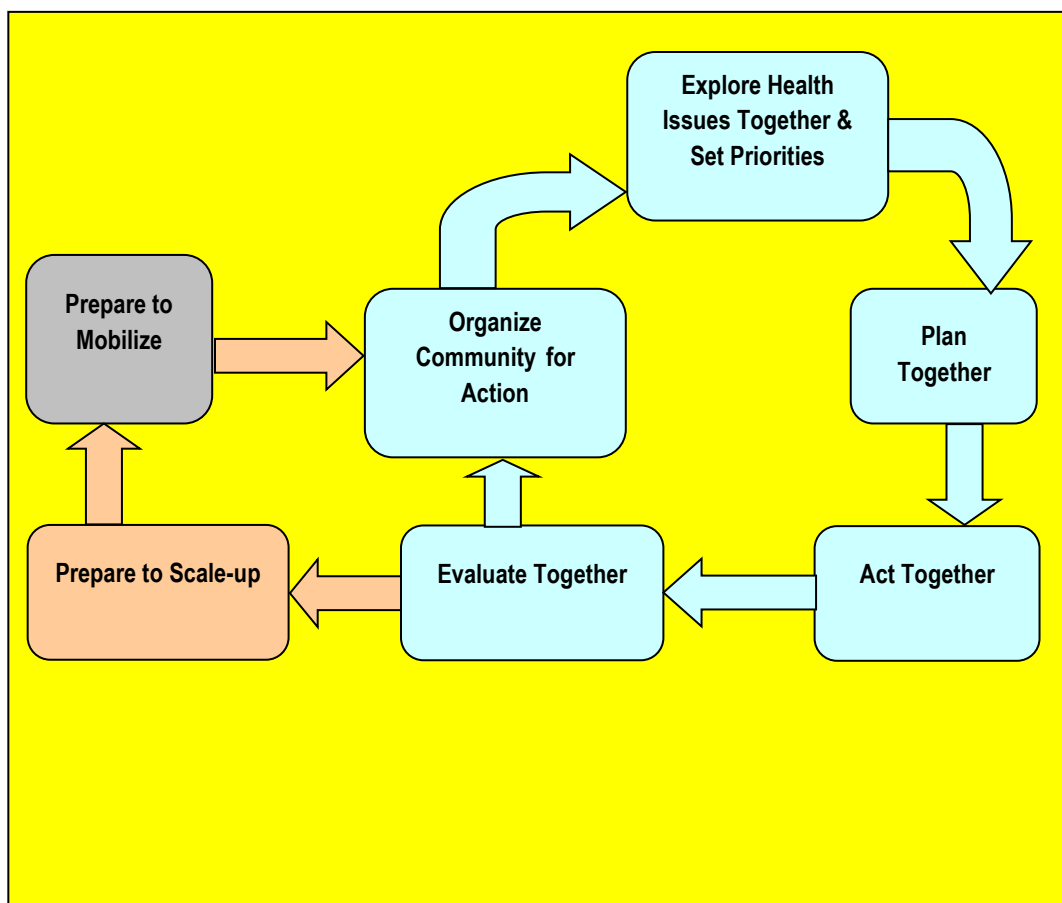
Consultation: local opinions are asked; outsiders analyse and decide on a course of action

Co-operation: 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.

The Community Action Cycle



Community action cycle phases and steps

Each phase of the **Community Action Cycle** has detailed steps (below), which will be integrated into the SSDI Program Cycle.

Prepare to Mobilize

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

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: Form the community action group (CAG)

Explore Core Program Issue(s) and Set Priorities

Step 1: Explore the core program issue(s) with the core group

Step 2: With the CAG, explore the core program issue(s) with the broader community

Step 3: Analyse the information

Step 4: Set priorities for action

Plan Together

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

Step 2: Design the planning process

Step 3: Conduct/facilitate the planning process to create a community action plan

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 if conflicts arise

Evaluate Together

Step 1: Determine who wants to learn from the evaluation

Step 2: Form a representative evaluation team with community members and other interested parties

Step 3: Determine what participants want to learn from the evaluation

Step 4: Develop an evaluation plan and evaluation instruments

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Step 5: Conduct the participatory evaluation

Step 6: Analyse the results with the evaluation team members

Step 7: Provide feedback to the community

Step 8: Document and share lessons learned and recommendations for the future

Step 9: Prepare to re-organize

Prepare to Scale up

Step 1: Have a vision to scale up from the beginning of the project

Step 2: Determine the effectiveness of the approach

Step 3: Assess the potential to scale up

Step 4: Consolidate, define and refine the approach

Step 5: Build a consensus to scale up

Step 6: Advocate for supportive policies

Step 7: Define the roles, relationships, and responsibilities of implementing partners

Step 8: Secure funding and other resources

Step 9: Develop the partners' capacity to implement the program

Step 10: Establish and maintain a monitoring and evaluation system

Step 11: Support institutional development for scale-up

Prepare To Mobilize

Around the time of the Situational Analysis and Program Design steps of the SSDI Program Cycle it will be important to *Prepare to Mobilize*. The Prepare to Mobilize phase consists of all the activities that need to happen before initiating the SSDI interventions with communities. The Prepare Phase is intended to strengthen *your team's* skills on how to enter and work with communities and be more effective mobilizers. Normally, the focus of the SSDI program on working with communities (focusing on key indicators in the EHP) has already been decided upon. It is now time to:

- Put together a community mobilization team (CMT)
- Train your CMT
- Gather information about the community's resources and constraints;
- 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 effective participatory facilitators of the community mobilization process. It must be noted that the Zonal and District Level Team in the SSDI organizational set-up will be responsible for the implementation of this phase of the CAC.

STEP 1: Put Together a Community Mobilization Team (CMT)

"You have to first change yourself, to be able to change the community."

The Koran

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 CM initiative in what is called a community mobilization team (CMT). While oftentimes the partners in the SSDI Initiative (such as NGOs, CBOs, government staff) may work on different issues at the community level, the community mobilization process can bring all these stakeholders together for mutually supportive community-level efforts. There are many points where collaboration at the community level by the partners is essential, and where they will need to work as a team. These include: understanding how communities are organized; understanding local customs; being aware of political and social structures and history:

- Ensuring all SSDI partners and programs share the same values and principals and can apply sound community development practices at the community level
- Orientation of community members to SSDI Program goals
- Building community trust and ownership over SSDI operations and programs.



The CMT composition may change during the implementation process of community mobilization, depending on the different skills needed at different times. This team will be made up of SSDI partners from the level of the Traditional Authority (TA), which is part of the decentralized governance structure known as the Area Development Committee (ADC), or it may include members from NGO partners, CBOs, other organizations, or the government. TA-level staff members from the sub-granted NGO automatically become part of the CMT.

How do you decide who should be on the CMT? 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:

- Whether potential team members are SSDI Employees
- Whether potential team members are Ministry of Health Staff who are conversant with the key areas of focus (EHP)
- Understanding of the political, socio-cultural and economic context (knowledge of the community and macro environment).
- Basic community mobilization skills: communication and facilitation skills, program design and management skills, organizational behaviour/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.

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

STEP 2: Train your CMT

“Conversation with the people requires a profound rebirth”

Paolo Freire (1993)

Key Competencies for the CMT:

All SSDI staff and partners must have the following competencies:

- Understanding of the definition of community mobilization
- Knowledge of the Community Action Cycle phases and steps
- Ability to articulate the SSDI Core Program’s *goal* in the local language
- Knowledge of how to enter communities and undertake a situational analysis that includes gathering information on how communities are organized, their history, values, and customs
- Knowledge of how to facilitate dialogue and reflection using non-formal learning techniques: Be a facilitator, not a teacher.
- Appreciation of and respect for local knowledge and capacity
- Capacity to test one’s own assumptions and beliefs and admit when some of them are wrong

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- Ability to listen – “Seek first to understand and then be understood”
- Willingness to work to build community capacity
- Willingness to share power

A basic CM Training workshop must be organized to review the definition of community mobilization, the community action cycle, and all phases and steps to the process. This workshop can also be an opportunity to build skills on how to undertake a situational analysis that not only gathers information for SSDI interventions, but also learn about the community; how it is organized; and its history, customs, and values.

CMT Roles and Responsibilities:

Here are some possible roles and responsibilities related to community mobilization:

Catalyst/Mobilizer: Facilitates the implementation of the Community Action Cycle with leaders and community groups to stimulate action on Core Program focus

Organizer: Forms new organization/groups or brings existing organizations together around an issue

Capacity-BUILDER/Trainer/Facilitator: Helps to build community capacity to achieve CM goals

Partner: Complements local organizations in a joint effort

Direct Service Provider: Provides a service (such as health service)

Liaison: Links communities with resources and partners, builds networks

Team Values for CMT

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.

An example of a set of values for a CMT:

- Create and build trust in communities
- Be exemplary
- Don't make promises that cannot be fulfilled
- Respect community members
- Admit when you do not know something and seek more information in order to understand.

Skills of a Mobilizer

Your team will need to be well prepared if they plan to apply a community mobilization approach to health and social change. 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 you arrive (e.g. in a car, which almost no one in the community owns, versus by 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 do not promise things that you cannot deliver.
- Be respectful of people's time and schedules.

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

Skills of a Facilitator

“Conversation with the people requires a profound rebirth.”

Paulo Freire (1993)

Below are some of the facilitation skills for CMTs:

- Probing questioning
- Paraphrasing
- Summarizing
- Encouraging participation
- Being patient/ comfortable with silence

- Non-verbal communication skills
- Verbal communication skills
- Conflict resolution
- Problem solving
- Creativity – e.g. Initiating ice breakers, energizers, etc.
- Neutrality/avoiding leading the group or the discussion
- Giving brief and clear instructions
- Time management skills

Notes on some key Facilitation Skills

Adapted from James A. Mc Caffery, 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... Suggest few goals*

1. Background

What led up to _____?

What have you tried so far?

Can you remember how it happened?

What do you make of it all?

2. Identification of Problems

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?

3. Example

Can you give an example?

For instance?

Like what?

What is an illustration you can give us?

4. Description

What was it like?

Tell me about it.

What happened?

How might you describe it in your own words?

5. 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?

6. 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?

7. 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?

8. Exploration

How about going into that a little deeper?

What are other angles you can think of?

9. 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?

10. 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?

11. 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?

12. 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?

13. 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?

14. 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?

15. 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?

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 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.

Glossary of Facilitation Methods³

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

³ Silberman, M. L. (1997), *Twenty Active Training Programs, Volume III*. San Diego: Pfeiffer & Co.

Contracting: agreeing to carry out a future behaviour 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 that participants in groups of two hold a brief conversation.

Experiential exercise/field visit: 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 behaviour 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 activities 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

Lecture: 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

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 behaviour

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

What is participatory facilitation?

Participatory facilitation is a learning methodology that engages participants actively in the learning 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 they are also 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-centred facilitator. It is only through practising and openly receiving feedback from colleagues that you can become a better participatory facilitator who supports a process of positive change through honouring 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 gaining a better understanding of non-formal learning theory. Traditionally, learning has been viewed as a transfer of expertise from a 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 with 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:

- I. New knowledge by learners will automatically lead to action, or change in behaviour.
- II. The trainer *owns* the knowledge and can therefore transmit or impart it as an *instructor*.
- III. Learning depends essentially on the trainers' capacity to teach and the learners' capacity to learn.

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.

IV. Training is the responsibility of the trainer and/or the training institution.

Characteristics of 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.
- The ‘teacher’ talks.
- The learner listens passively.
- The ‘teacher’ chooses the program content and the community members 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 behaviour, 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, analyse, criticize, and understand their own behaviour, 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-centred and experience-based.

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

- I. People cannot be developed; they develop themselves.
- II. New knowledge does not automatically lead to action or changed behaviour – individuals first need to understand and internalize the importance of change.
- III. Learners are a rich and diverse source of information and knowledge about the world.
- IV. Collective reflection and experience is a powerful tool for learning and change.

Characteristics of the Non-formal Education (NFE) Approach:

- The learner is active.

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- 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.

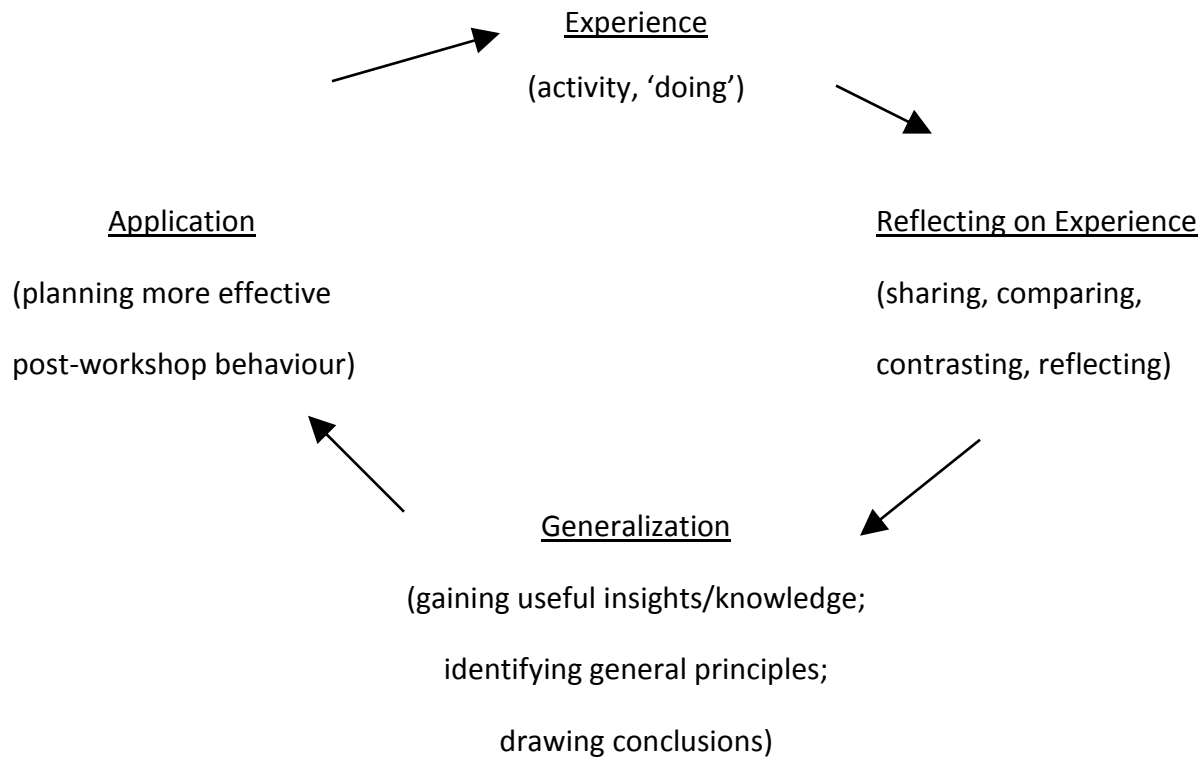
The Experiential Approach to Training

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-centred 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.

⁶ Ibid.

The following cycle represents the experiential approach to learning:



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, skits/drama, role play, demonstration, small group tasks, site/field visits, or skill practice. The participant's experience will evoke feelings and thoughts that will help in beginning 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 analyse 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 _____?
- What were your reactions?
- What strategies were used?
- What were the 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 behaviour 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 skilful 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.⁷

The Conditions of Learning⁸

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:

⁷ Original source: Lewin, Kurt (1951), *Field Theory in Social Science*. New York: Harper Collins.

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

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 that recognizes the right of individuals to make mistakes:

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

Facilitation Observation Guide⁹

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.

⁹ Modified from materials developed by the Peace Corps (*Promoting Powerful People*), USAID, and the Academy for Educational Development.

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^{10*} 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.)

^{10*}An icebreaker is a creative exercise carried out by the group to build trust and establish 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 that would not make participants uncomfortable with regard to this cultural norm. Icebreakers also need to be of the appropriate time duration in order not to distract from group work.

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

VI. Pulls discussion to close

- Summarizes or has participants summarize
- Asks participants what of value has been accomplished

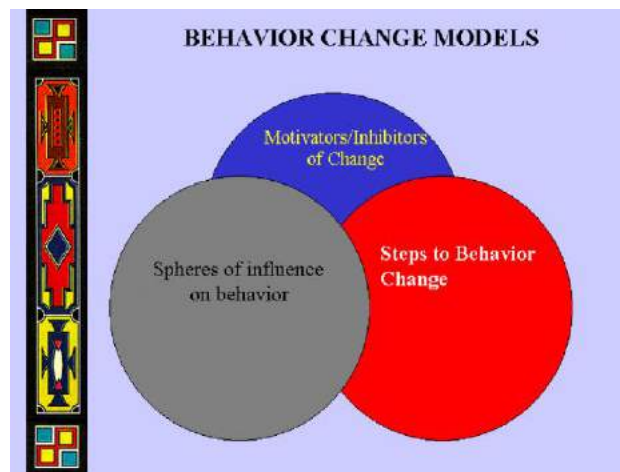
VII. Closure

- Clarifies next meeting time and date and/or next steps and persons responsible
- Thanks participants

How Does Behaviour Change?

In the best cases, community members enter into a dialogue within their community and with external actors to explore ways to improve the core program issue(s). Through this dialogue, effective community mobilization strategies acknowledge and respect indigenous health paradigms while at the same time introducing other paradigms, such as a biomedical perspective.

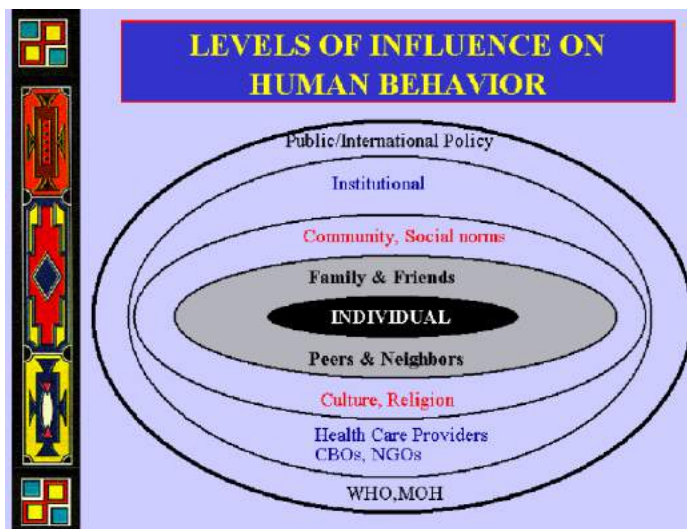
While we know that certain behaviours can lead to improved health status, simply prescribing these behaviours is not likely to lead to adoption or sustained practice if they conflict with existing indigenous practices and values. In some cases, prescribed behaviours may not be possible or practical in a given physical, social, cultural, psychological, or economic context. In other cases, traditional practices may be as effective as, or more effective than, prescribed behaviours in improving health status. Through a respectful dialogue between all the parties, both existing and new paradigms can contribute to new, improved health practices at the individual level and supportive policies at the institutional, community, regional, and national levels.






MOTIVATORS AND INHIBITORS OF BEHAVIOR CHANGE

1. **RATIONAL** THOUGHT
2. **PHYSICAL** SENSATIONS
3. **PRACTICAL** SKILLS and ABILITIES
4. **ENVIRONMENTAL** (social, cultural, religious)
5. **INTERPERSONAL** NETWORKS and RELATIONSHIPS
6. **EMOTIONAL** REACTIONS





SUMMARY OF BEHAVIOR CHANGE MODELS

Courtesy of Chad McArthur, Helen Keller Foundation

Levels of Influence	Steps to Behavior Change	Motivators & Inhibitors
Individual	Knowledge	Rational
Family, friends, peers	Approval	Physical
Community, culture, religion	Intention	Practical
Institutions	Practice	Environment
Policies, Laws, Economy	Advocacy	Relationships
		Emotional

STEP 3: Gather information about community resources and constraints

Before starting community-based programs – learn more about the community!

The situational analysis can be a chance to learn more about community structures, how communities are organized; formal and informal leadership; how decisions are made and who makes them. SSDI 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 the situational analysis information is gathered and analysed on the 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 information about the location and socio-cultural characteristics of those most affected.

The following are three tools that could be considered during a situational analysis to better understand effective community organization and dynamics prior to beginning implementation of SSDI interventions.

Learning about Communities

Socio-cultural context

- How is the community organized (in terms of 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, and 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?

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- 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 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 is 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 system?
- What are the strengths/weaknesses of the health system?
- How good is the quality of health care? From whose perspective?

Gender relations/roles

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

Community Profile – Interview

Part A: General Information

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 exist? 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 priority areas?
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 are allocated (financial and human)?
11. What are the major health problems for youth and/or health issues? (This question may differ 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?

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13. We are interested in working with interested communities on health issues, focusing on malaria, nutrition, WASH, FP, MNCH, HIV/AIDs and TB. Do you think that this community would be interested in exploring these issues 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?

Part B: Understanding who is affected and why

1. Who is most affected by the six EHP areas that we are concerned about?
2. How many people are directly affected? How many are affected indirectly? This needs to be determined in the context of how you are defining the extent of coverage of your effort: Will it encompass one community? Several communities? A district? A region of the country?
3. Why are these particular people or groups most affected? *Probe further on current cultural beliefs and practices.*
4. 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?
5. What are their socio-demographic characteristics? Do people who are most affected by the six EHP issues share similar characteristics (age, sex, income levels, ethnic groups, language, etc.)?
6. Are they organized around this or any other issue? How? Is there any history of mobilization in the past?
7. Was the community involved in any participatory project or intervention? When? How?
8. In the process of gathering information, the CMT can gather more information about the community through transect walk, observation, review health centre data, etc.

STEP 4: Develop a community mobilization plan to guide you

Now that you and your team have a better understanding of the targeted EHP issues that you will be working on; the setting you will be working in; community resources and constraints, it's time to develop a community mobilization plan. This plan is a general description of how your team intends to mobilize communities in the designated area around this particular issue.

Now that you know more about the health issue and the community, you will need to do an inventory of the resources that will be available to the program and any constraints you may face. 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 government, the private sector, Ministry of Health funds, and non-profit 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, etc.
- Time.

After you identify resources, you should then identify what constraints you may face in carrying out the effort and ways to eliminate, minimize, or work around these constraints. In many cases, of course, constraints will be directly related to resources. For example, 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 through a high quality program, 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. Planting and harvesting may rule out work with some communities during three or four months as community members are too busy to attend meetings and engage in other activities. And you may also run into political constraints, cultural constraints, or language-related constraints. Try to anticipate as many of these as you can. After you have identified the resources you will need and the constraints you face, you should decide where you will get the former and how you will address the latter. In making these decisions, you will in some cases have to change or even eliminate certain activities that are simply not feasible given your situation. Alternatively, some programs may face the challenge of managing excessive budgets that can create great pressure on program managers to expend them, regardless of potential consequences, such as unsustainable incentives, inflated community and health service

provider expectations, distortion of the local economy, and other similar problems. 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.

The purpose of the mobilization plan you are developing is to define the overall core program goals and objectives and identify a process that will help interested communities achieve them. This *is not* a community action plan – that will be developed by communities themselves. As you create this plan, you should always keep the two overriding goals of community mobilization uppermost in your mind:

1. to improve the health of the community, particularly those most affected by the issue
2. to improve the community's capacity to address these issues, and other needs

At a minimum, a typical community mobilization plan should resemble what is shown below:

CMT community mobilization planning matrix

Date	Venue	Activity	Objectives	Resources required	Responsible person	Indicators

Organize the Community for Action

During the Organize the Community for Action phase it is now time to formally approach the community and begin their involvement in addressing the targeted EHP issue(s).

You should have your CMT in place and have developed an overall design (plan) for community mobilization. Preferably prior to, or around the time of, the SSDI Program baseline, you will begin to organize the community for action. If this is done 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 that those most affected and interested in the targeted EHP issue will participate, have a central role and voice, and benefit.

The steps for this phase include:

1. Orient the community
2. Build relationships, trust, credibility and a sense of ownership with the community
3. Invite community participation
4. Develop a Community Action Group (CAG) from the community

STEP 1: Orient the Community

If you hope for broad community participation and engagement in your SSDI interventions, the CM team will need to carry out a number of introduction and orientation meetings *prior to* undertaking a baseline analysis, *or* conducting any activities in the 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 an introduction and background on SSDI and its partners
- Share important data on health issues (feedback results of Situational Analysis!)
- A presentation of the program goal
- Begin to learn about the health issues from the community

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- Motivate interest
- Receive consent to work together
- A brief description of the CM process
- Invite participation
- Set up an atmosphere of co-learning and partnership
- Determine next steps

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 CMT 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 targeted EHP areas being addressed under SSDI, the approach to be used, and also the CMT need to be introduced.

Create a Mobilizing Goal

In some development contexts teams enter into communities and ask in a generalized way, “What are your needs/problems?” However, in the SSDI context once the Situational Analysis has been undertaken the main goal for the targeted EHP areas has already been determined. Therefore, what are the consequences of not being candid with the community regarding the targeted EHP 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 with the community regarding and sharing the focus of the project up front?

It will be important for your team to understand the key Health *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 CMT 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:

“Increase regular access to antenatal clinic in order to have healthy children.”

In developing a mobilizing goal, the CMT will need to look carefully at what would most effectively motivate communities to participate in the targeted EHP issue. A more mobilizing goal may be:

“Improve the health status of all Malawians.”

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)
- Project vehicle to be parked at respectful distance from meeting
- No smoking or drinking

Adapted from Save the Children Mozambique Country Office

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 checklist will help you plan:

- a. **Participants:** How many participants are expected? Who will they be? (Consider total number, ratio of 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.)

- b. **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.)
- c. **Where:** An accessible place, normally where community meetings are held.
- d. **Agenda:** What are the objectives of the meeting? Which topics will be covered? In which sequence will topics be introduced? How much time will be dedicated to each topic?
- e. **Speakers/facilitators:** Who will run the meeting? Who will be asked to prepare and/or present information for the meeting (staff, community)?
- f. **Method/tools:** How will participants be encouraged and supported?
- g. **Documentation of meeting process & outcomes:** Documenting these meetings is useful for future evaluation records.
- h. **Materials needed:** Materials needed will depend on the methods used.

POSSIBLE TOPICS FOR A COMMUNITY ORIENTATION MEETING

- ✓ Introductions: Participants and SSDI CMT members and the orientation meeting program
- ✓ Discussion of the Situational Analysis results, and core program issue(s) affecting communities
- ✓ A presentation of the national health goals
- ✓ The role of the community related to health issues
- ✓ An introduction to government and other partners covering what they can/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 key health issue of focus (EHP)
- ✓ 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 childbearing age
- Grandmothers and grandfathers
- Spouses (fathers)
- Traditional Birth Attendants (TBAs)
- Traditional counsellors
- Traditional healers
- Religious leaders
- Extension workers
- Etc.

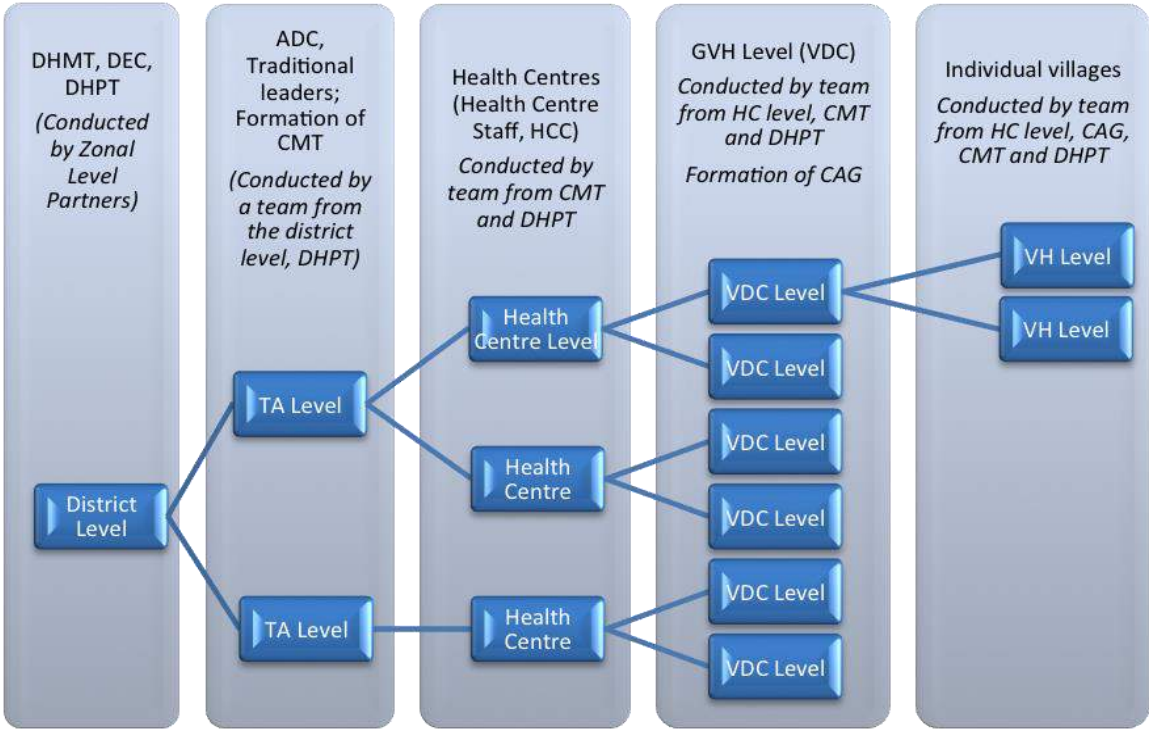
Example of a Community Orientation Meeting

Talking points (In local language):

1. *Allow community leader(s) to open meeting, and guide discussions*
2. *Greet community members and introduce each visiting team member by name.*
3. *Introduce the program you are from (e.g. SSDI), that it is a five year project that is supporting Malawi government to improve the health status of Malawians*
4. *Mention that SSDI has no religious or political affiliation*
5. *Mention the other districts where SSDI is working and areas of focus (EHP both at community and facility level).*
6. *Share the ‘mobilizing goal,’ and invite participation from the community to achieve these goals.*
7. *Share some of the Situational Analysis specific to health indicators data in relation to the EHP. Select information that would be relevant to that community. Make sure to use culturally appropriate methods for showing numbers, percentages e.g. measuring sticks, etc.*
8. *Ask meeting participants “what are the issues affecting EHP conditions in the area*
9. *Once meeting participants have had a chance to express these, explain that SSDI hopes to work in partnership with communities to achieve address these issues.*
10. *Define SSDI and community roles and responsibilities. Explain that SSDI hopes to build capacity within the community to explore the EHP issues affecting MOTHERS, CHILDREN and many people in their community, plan and act together. And that when SSDI eventually leaves the area community members will be able to work on their own to sustain good health status in the area. Discuss that SSDI will not stay permanently.*
11. *Ask meeting participants what questions they might have for SSDI*
12. *Remind them that we hope to see great community participation on this effort, and if they are interested in addressing EHP issues to please see them after the meeting.*

Community Orientation Meetings - Schedule

There is normally a series of orientation meetings at different levels in each community to assure for maximum understanding and broad participation. The following is the model for orientation meetings that will be used in the SSDI Initiative:



The orientation meetings will follow a cascading style in transferring the information from various levels of partnership in the initiative. SSDI and government partners from the zonal level will be involved in conducting orientation meetings at the district level (including the DHMT, the district council, and the DEC). A team of selected members from the district level will be involved in orientation meetings at the TA level. A team from the TA level will thereafter be involved in the orientation meetings at the health centre level, a selection of which will be responsible for orienting partners at the VDC level (a cluster of GVHs), and thereafter at the community (VH) level. Details of the process are contained in the CAC process in the Community Mobilization Strategy.

STEP 2: Build Relationships, Trust, Credibility, and a Sense of Ownership with the Community

It is important for you and your CMT 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 humour.

The 'Emotional Bank Account'¹¹

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 and only making 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 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 3: Invite Community Participation

Your CMT will need to identify those people and groups who are most affected by and interested in the targeted EHP issue(s) and invite them to participate in the CM program. These are the people who need to be involved in finding appropriate solutions. It is often recommended that *at least 60%* of those in a CAG be those who are most affected and interested in the EHP.

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.

Identifying and overcoming barriers to participation is an important job of community mobilizers. The worksheet below will help you with this process:

¹¹ This term and concept comes from *7 Habits of Highly Effective People* by Stephen Covey.

Addressing Barriers to Participation

Purpose: The participation of those most affected by the health issue is a key element in successful community mobilization. But those same people are often the ones facing the most barriers to participation. This exercise asks you to anticipate or identify those barriers and devise means to overcome them.

Instructions: In your group, discuss the possible barriers to participation and what can be done to eliminate them.

How will you ensure that people who are most affected by and interested in the EHP 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?

Barriers to Participation

Strategies to Reduce Barriers

1. 1.
2. 2.
3. 3. Etc.

STEP 4: Develop a 'Community Action Group (CAG)' from the Community

Once individuals and groups have expressed interest in participating in the program, you will need to begin 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. In the SSDI Initiative, this group will be referred to as the community action group (CAG).

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

A Common Purpose

In order for the CAG 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 EHP)
- 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 EHP
- Encourage them to tell their stories about how EHP conditions affect 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 EHP have affected people in the district

Community action Group (CAG) Roles, Responsibilities, and Norms

Part of the process of developing the CAG entails 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., through consensus, votes, allowing leaders to 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?

This is to ensure active participation of those most affected. A particular size for a CAG is usually between 10 and 15 members.

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 use 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 mobilizers is community or group organizing. Why? Some of the reasons are as follows:

- 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.
- 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 CAG or to form a new one. Another previously USAID-supported project in Malawi, 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.

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- 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 CAG 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 centre. 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 the CAG membership. This approach may be subject to favouritism and thus not assist women most in need of support groups. To nullify the favouritism 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.

Selection by community members. **Hold a public meeting with members from the GVH. You can then separate participants according to the villages they are from and ask them to choose a member from their village who will represent them in the CAG. Once they have done this, they can report their choice to the whole gathering. This method allows for even distribution of the CAG members within the GVH.**

The Tuckman Model of Group Development

Your group may want to think about the general stages that, according to the literature, 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.)

Responsibilities of the community action group (CAG):

SSDI considers the GVH as the unit of implementation of the community action cycle. Therefore communities will be encouraged to identify a CAG amongst the existing community structures in order to plan and carry out the community response to the health issues. The existing community structures can be the CBOs, VDCs etc. It is anticipated that the existing CAG could play that role with a capacity building support from the CMTs under the funding of SSDI. In

communities where there is no structure of the like, the Program will support the communities to form one.

The specific responsibilities of the CAG will include:

- Exploring health-related problems in their community (GVH catchment area) and developing action plans
- Being a catalyst for community responses to health-related issues; facilitating awareness-raising activities
- Identifying CHVs and agreeing on the support and motivation arrangements for the CHVs
- Developing internal bylaws
- Leading the process of defining and implementing incentive mechanism for the various volunteers
- Helping to link community initiatives with the health facility and other social services.
- Ensuring that ownership of community initiatives rests primarily with the community
- Ensuring that the minimum required numbers of CHVs, village discussion facilitators, etc. are identified and provide them support
- Developing management systems and structures appropriate to their own capacity
- Building on traditional coping strategies in the community and avoiding over-dependency on external resources.
- Gathering and documenting information/data on health prevention, promotion, and care activities within the community
- Meeting on a regular basis to monitor and document progress achieved and to make any necessary readjustments
- Participating in any training or capacity building activity

The village is the smallest area where all the community response to health-related issues will take place. At that level, SSDI will consider two or three community-level structures and volunteers as platforms through which very specific interventions from the Essential Health Package (EHP) will progressively be implemented. For instance, any three of these will be identified and supported for the implementation of some elements of the EHP: Community Health Volunteers (CHVs), Care Groups (CGs), Community Based Distribution Agents (CBDAs), Home Based Care Volunteers (HBCVs), Women’s Groups (WGs), Youth Groups (YGs), and Peer Educators. SSDI and its MoH counterpart will define a minimum package of services that could be provided by each platform.

CAG Member Responsibilities and Norms

Example

Role	Key responsibilities
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SSDI Community Mobilization Participant Training Manual

Chairperson	Responsible for day-to-day running of the group Responsible for disciplinary action Attends to community disputes regarding core program issues Serves as liaison with partners Chairs meetings to review progress and activities
Vice Chairperson	Supports the chairperson in his or her absence
Treasurer	Keeps 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	Keeps minutes and resolutions from meetings Keeps records of all group activities Calls for meetings on behalf of chairperson
Vice Secretary	Supports Secretary in his or her absence May have additional responsibilities for record keeping
Representative of local government or traditional authority – may be an extension worker (ex-officio)	Acts as focal point for communication between the group and local decision makers
Committee members	Provide support to the chair, secretary, and treasurer in carrying out all activities of the CAG May provide supervision functions for community activities on behalf of the CAG

Norms/Code of Conduct for a Group:

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

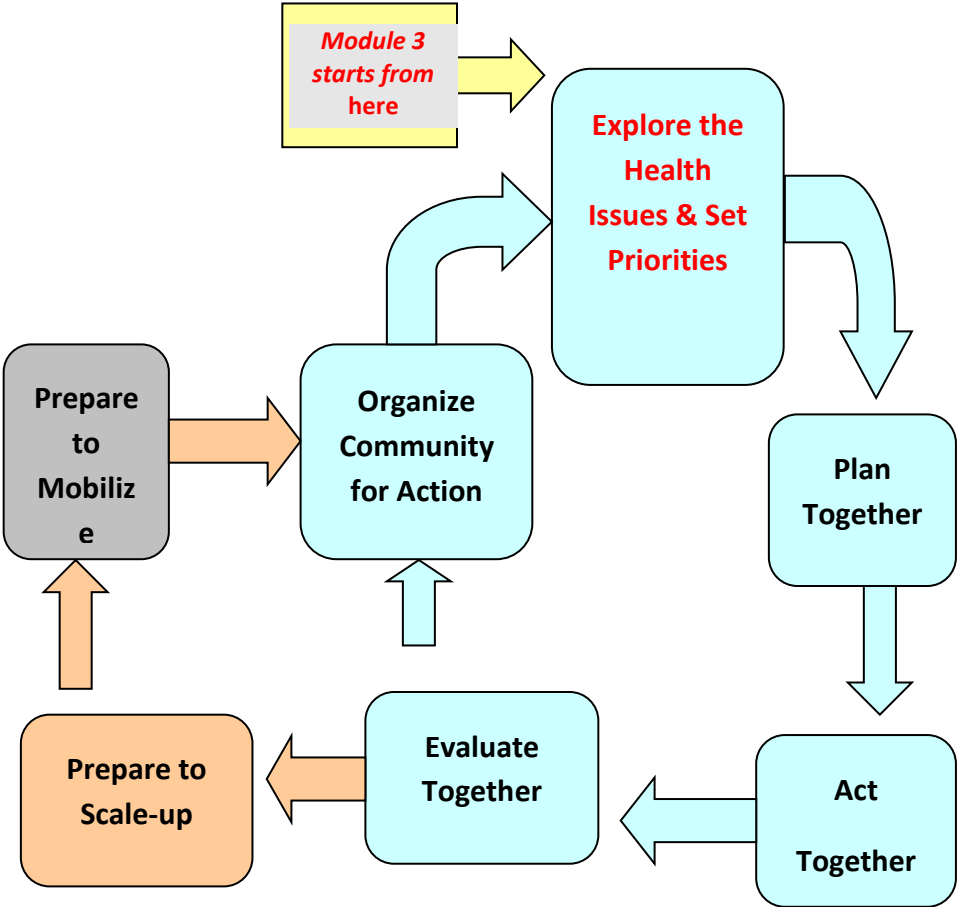
All members have read and understood this code of conduct. They have signed this and agree to be

An Example of Norms/Code of Conduct is provided below:¹²

¹² Adapted from International HIV/AIDS Alliance (2006), *All Together Now! Mobilizing communities for HIV/AIDS*.

Module 3

Explore Health Issue(s) and Set Priorities



Steps followed – Explore Health issues and set priorities

1. Explore the health Issue(s) with Community Action Group (CAG)
2. With the CAG explore health Issue with the broader community.
3. Analyze the information.
4. Set priorities.

Explore Health Issue(s) and Set Priorities

The Explore and Set Priorities phase aims to help community members explore their current knowledge, beliefs, and practices related to the EHP and to learn from each other's experiences as well as from the perspectives of the broader community. The CAG carries out participatory activities that will better inform them and the community about the EHP prior to setting priorities.

The steps for this phase include:

1. Explore EHP issues with the CAG.
2. With the CAG explore the EHP with the broader community.
3. Analyse the information.
4. Set priorities.

Ideally, the Explore Phase is undertaken around the time of the SSDI Program Cycle baseline activities.

STEP 1: Explore Health Issue(s) with the CAG

This exploration phase begins with an in-depth examination of the EHP with the Community Action Group (CAG) 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 CAG. 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, and team members' availability.
- Logistical concerns: geographic access, seasonal concerns (rains, planting, harvest), transport, and 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 and 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 and 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 implemented 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

This tool will be used to analyse core program issues by looking at the root causes of these issues and the consequences of not addressing them. This is a tool that will be used by the CMT together with the community members. In this model the trunk of the tree is the core problem/issue to be addressed by the SSDI initiative, the roots are the root causes of the problem, and the branches are the consequences of the problem. Steps in conducting the problem tree analysis exercise are described below:

Objective: By the end of the session the participants will have identified the root causes of their selected health problems (issues) in their community.

Duration: 1 hour 30 minutes

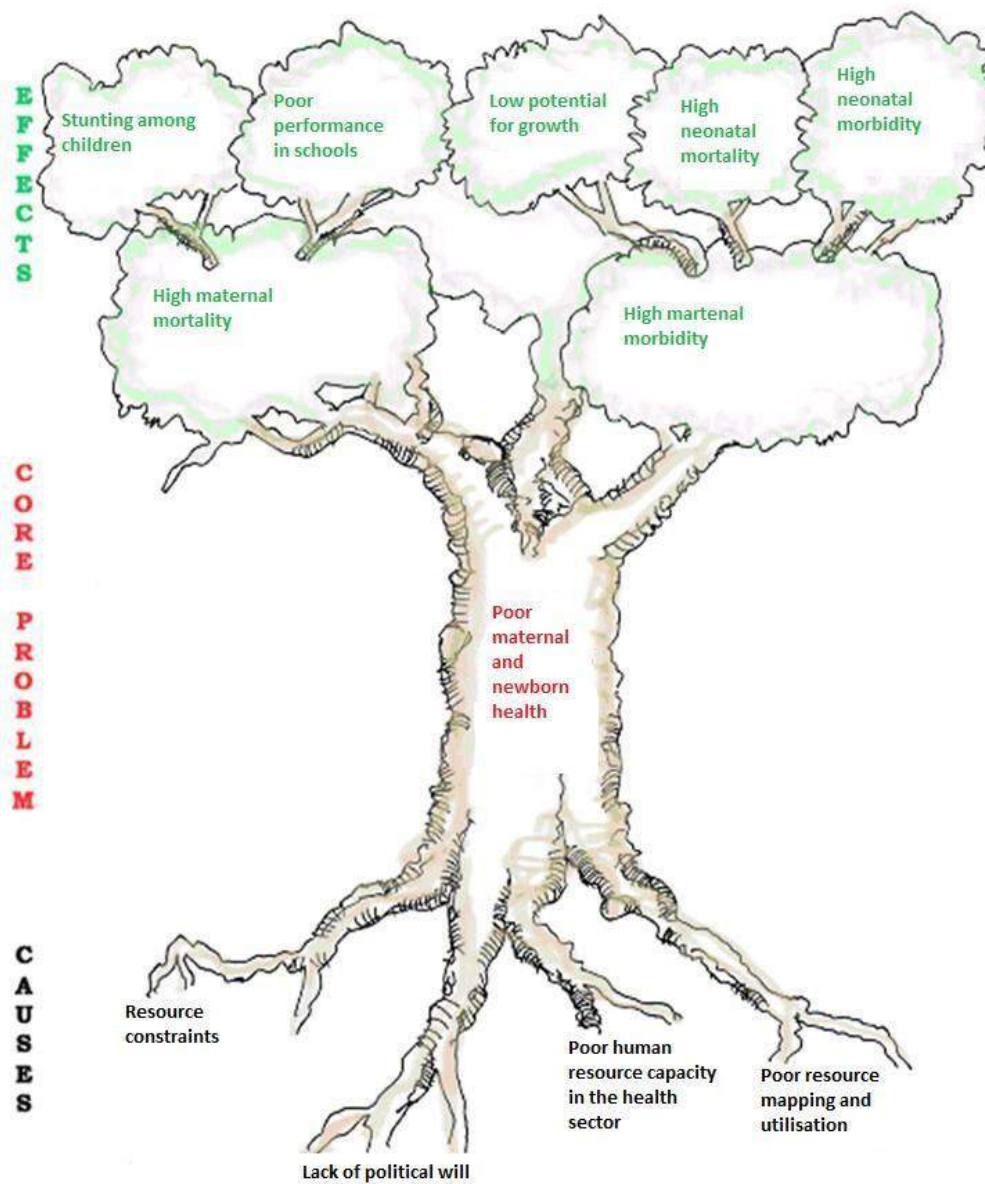
Method: Group work

Material: Flipchart, marker, terms of reference for the group work, handout on problem tree

Activities:

1. Inform participants that in order to solve their health problems (top 6 priorities), it is necessary to seek out the root causes. A volunteer will then be asked to recall the top 6 priorities.
2. Tell participants that in order to make it easier to understand these problems and their causes, you are suggesting that they use a tool called 'the Problem Tree'.
3. Ask 6 volunteers to each draw a tree on the floor, wall, or ground. Each drawing should show the three main parts of a tree: the trunk, the roots, and the branches.
4. Describe the idea of the tree: the trunk stands for the issue being discussed, the roots stand for the underlying causes, and the branches stand for the effects. Participants need to state the priority areas as problem areas: for instance, Maternal and newborn health issues can be rephrased as the problems of poor maternal and newborn health and the problem of a high maternal death rate.
5. Once everyone is clear about how to proceed, form 6 groups and ask each volunteer to be the facilitator in each group and to represent the discussions using a diagram with symbols. Each facilitator should ask his or her group questions such as the following:
 - ***“What are the main causes of this issue?”*** The tree roots should be labelled as underlying causes.
 - Take one cause at a time, explaining that people can also look at the secondary causes of a problem by asking the question “Why?” For example, if the problem on the tree trunk is that mothers are not aware of danger signs, ask “Why?” And then to that answer, ask “Why?” again. Continue in this way until community members feel that all the causes have been discussed.
 - The volunteers should ask colleagues/participants to now consider the effects in the same way. They should ask, ***“What are the main effects of this issue?”*** and then show each effect separately on the branches. Taking one effect at a time, they should explain that people can also look at the secondary effects by asking the question ***“What is the effect of this?”*** Continue with this exercise until community members feel that all the effects have been discussed.
6. At the end of the exercise ask each group reporter to give an overall description of the tree with all its roots and branches.
7. Congratulate participants and tell them that now you all have an overall view of the Priority Health problems and that now you have made a clear distinction between causes and effects.
8. Explain that in a future meeting the community will look in detail at how it can deal with problems such as these and plan for solutions.
9. Discuss a plan for those present to find out from community members who have not attended the meeting today whether they agree or disagree with the ideas that were discussed and to see if those who did not attend have new ideas to add.
10. Thank participants for giving their time for this exercise.

An example of a completed problem tree around the issue of MNCH is shown below



Picture Cards

Picture cards on MNCH, Malaria, WASH, Nutrition, HIV &TB, and Family Planning can also be used to stimulate group discussion about these issues in the community. There are several methods of using them in the exploratory phase of a discussion:

1. The facilitator can lay out all of the cards on the ground and ask participants to choose one that she knows about. The facilitator asks one participant who has chosen a card what the card represents and what they call it in this village.
2. The facilitator can ask probing questions about the issue such as:
 - a. What is the problem called in the local language?
 - b. What happens when the problem occurs?
 - c. Why do they think the problem occurs?
 - d. What do people do to deal with the problem?
 - e. How successful is the treatment in solving the problem?
 - f. What happens if they can't solve the problem? Do women or newborn babies die from this problem?
 - g. How often does this problem occur in this community?
 - h. How might we address this problem in the future?
3. When you have completed discussing all the identified problems, ask the participants whether they know of any other problems that were not mentioned.
4. Picture cards can be used in the “set priorities” step to help participants sort through the various problems and put them in piles (for example, one pile for problems they consider most important to address, another pile for problems that are not as serious, etc.). This technique is called a ‘pile sort’.

Asset Mapping – Resources, Services, & Utilization

There are various types of maps that can be made by community members. Many times maps are made in order to lay out the physical dimensions and resources in a community (identifying, for example, where houses, roads, rivers, and health posts are located). The type of map suggested here can be used to identify and locate the *resources* and *services* available to community members. It will also provide a better understanding of whether or not and why these resources are used. In addition, this mapping process will seek to clarify what new services and resources may be needed.

To undertake asset mapping, draw a child (or beneficiary) in the centre of a piece of paper or in the dirt. If the goal is improved child health, for example, ask community members what services, resources, and assets they already have in the community for child health, and note those things to the left of the child you have drawn. Then ask what services, resources, and assets they have in the community for child health, *but are not yet using*. Note those things to

the right of the child. Underneath the child, note what services and resources the community members say that children still need.

Interviews or Focus Group Discussions:

Conducting interviews and organizing focus groups takes considerable preparation but will provide key information to help communities identify Core Program issues and set priorities. Your main task here will be to design interview/focus group questionnaires on Core Program Issues for a variety of individuals affected by those issues, including:

- Parents – women, fathers, and other influential family members, e.g. mothers-in-law, grandmothers/grandfathers
- Youth
- Teachers
- Community and Facility-based providers
- Other health providers
- NGO staff working on Core Program Issues
- Religious leaders
- Community leaders

You will not need to ask all of these groups about all the Core Program Issue(s), but it will be helpful to get input from a variety of sources.

At the same time interviewers should realize that many of the topics they are inquiring about are quite personal and sensitive; these are not things many people are comfortable talking about, even to other family members – let alone to people they don't know. You should try to allow for as much privacy as possible, separating women from men, young girls from boys, daughters-in-law from mothers-in-law, etc.

Sample Appreciative Questions for Discovering Community Strengths

1. Over the last _____ years when did you feel most proud while working as a CAG member and/or with other members of the community to increase young children's access to health services (growth monitoring, school health and nutrition, etc.)
2. What breakthrough or outstanding results were produced by your group/community in the past year(s) in relation to child health (growth monitoring, school health and nutrition, etc.)? Why was it a breakthrough? What made the breakthrough possible? What was your contribution?

3. Whom do you want to acknowledge for their support or guidance? For what specific assistance, event, result, etc.?
4. What major challenges still stand in the way of achieving the intended result or impact? What will the group/community do together to overcome the possible challenges?
5. Over the last years, what lessons have been learned in working towards child health (growth monitoring, school health and nutrition, etc.)?

STEP 2: In partnership with the Community Action Group, Explore the EHP with the broader community.

In this step, members of the CAG are prepared to go out into the community to learn about and create dialogue around the EHP experiences and priorities of those most affected and others who are interested in the issue. The purpose of this step is to ensure the inclusion of the perspectives of those people the program is most trying to reach. People who have knowledge and experience related to the EHP will be essential to identifying the problems and setting the priorities that the community will work on to improve health.

In this step, committee members will determine which questions they will ask people in the broader community, how they will ask them, and what materials/tools they will use, if any, to stimulate discussion and/or record people's answers. Committee members may decide at this point that they will organize small groups to discuss the issues or conduct individual interviews. Other participatory tools (e.g. picture cards and problem trees) may be used with the community.

Meeting 3 in the facilitation guide that follows presents a methodology that facilitators can use to work with Specific Task Committee members on this step.

STEP 3: Analyse the information

One of the most frequently omitted steps in research and information gathering is making sense of the information that has been so painstakingly collected. In some cases, what is learned in the information gathering phase of the Community Action Cycle does not seem to be applied in the next phase (Plan Together). Sometimes this is because the planners did not participate in the community exploration, but more often it is because people don't take the time to organize the information they have gathered and decide what it means. In this step, then, you will be trying to answer the following questions about the information you have collected:

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- What are the most common underlying themes that are revealed through the results? (What phrases, reflecting attitudes, opinions, beliefs, values, and perspectives do you frequently observe in the data?)
- How are these themes or perspectives the same or different depending on the characteristics of the respondents?
- What do these results say about people’s belief systems (not just individual practices but the interconnected ‘whys’ behind them)? For example, how do women believe their reproductive processes work or how do people believe the body heals?
- Are there any surprising results? Why are they surprising?
- What are the conclusions we can draw from the results?
- Which results have the most important implications for future program efforts?

There are a variety of methods that you can use to organize information that has been collected. The methods you choose will depend on the amount of information you have to analyse, the level of accuracy and complexity necessary or desired for the analysis, the level of education and skills of participants, the extent to which capacity building is an objective, and the time and resources available. Examples include tables, matrices, pie charts, bar graphs, and flannel graphs.

Underlying Themes Discovered during Explore Phase

(From the Save the Children Partnership Defined Quality ‘Bridges’ Project/Peru)

Underlying Themes	Desired Results
● Power	● Create a more equitable balance of power between communities and service providers
● Respect	● Develop mutual respect
● Self-esteem	● Build self-esteem (of both community members and service providers)
● Gender	● Ensure that women have a voice in setting priorities in the project and that men also work to set examples and co-lead on particular issues such as family planning
● Quality (central theme around which to mobilize)	● Shift the concept of quality from service-based to “quality begins at home:... services are only one component of quality care”

<ul style="list-style-type: none"> ● Rights and responsibilities 	<ul style="list-style-type: none"> ● Emphasize shared responsibility for health
<ul style="list-style-type: none"> ● Differing paradigms/belief systems ● (western medicine vs. indigenous knowledge) 	<ul style="list-style-type: none"> ● Encourage acceptance of different perspectives; dialogue to maximize benefits of positive, healthy beliefs and practices regardless of origin
<ul style="list-style-type: none"> ● Team work 	<ul style="list-style-type: none"> ● Encourage development of a team
<ul style="list-style-type: none"> ● Critical self-reflection and objectivity 	<ul style="list-style-type: none"> ● Foster an environment that promotes critical self-reflection and objectivity
<ul style="list-style-type: none"> ● Protagonism 	<ul style="list-style-type: none"> ● Communities and providers set agenda, implement, monitor and evaluate their progress.

STEP 4: Set priorities

Although some program teams prefer to include priority setting in the Plan Together phase, we have chosen to include this step in the exploration phase because our approach is to work with a core group of those most affected by and interested in the health issue. When this group is largely composed of individuals and groups that have little power in the broader community, such as poor people, women, adolescents, children, or others, the risk of moving this step to the Plan Together phase is that priorities will be set by those who have more power but may not be directly affected by the issue and so do not reflect this group’s concerns. It is therefore very important that the CAG ensure that those most affected and who most want to benefit from the program have a voice in setting priorities.

How to set priorities:

To decide which EHP problems the community will address immediately in the upcoming planning phase, participants will need to look again at the EHP issues in light of the information they have just gathered and analysed, and they should then establish criteria for setting their priorities. Some suggested criteria to consider include:

- **Severity.** Is this condition/problem life-threatening? Does it lead to chronic life complications? Or would it lead to consequences later in life?
- **Frequency.** How many people experience the problem or condition? How often?
- **Risk.** How many people could experience it in the future?
- **Impact on the community.** What is the impact that this problem/condition has on our community now? What kind of impact could it have in the future if we don’t address it?

- **Feasibility of a response.** Have any effective responses to the problem/ condition been identified? Is financial, material and resource support available? Do people possess now or could they develop the necessary skills and abilities to make a difference?
- **Commitment.** Is there local political support for this problem/condition/ goal? Is there external interest in addressing the issue? Are community members motivated to do something about the problem?

One way to apply some of these criteria systematically is to use the following matrix to rank the problems. In the first column list the issues which have been raised during the use of the explore tools.

Ask participants to then rank the problems related to EHP, on all the criteria, using a scale of 0 to 5 (0 being the lowest score, and 5 being the highest)

The team and CAG should review the information gathered during the Explore phase to rank the identified problem. There will be discussion and perhaps disagreement, however, the group should eventually come to consensus on the ranking given.

Once the ranking has been done for each issue, total the numbers and identify the top priority problems related to EHP. It is best to try to limit the number of priorities to two or three initially in order to focus the group's effort.

Priority Ranking Matrix

Core Program Problems Identified	Severity	Frequency	Risk	Feasibility of Response	Total

PAIR-WISE RANKING

Pair-wise ranking is a structured method for ranking a small list of items in priority order. It is used to compare items in groups of two and choose between them. This method is a useful way to explore the reasons why people prefer one possibility over the other.

The discussion groups list the items to be compared. Each item is then compared with the others, and the item chosen the most is given the highest rank.

For example, a community can come up with the following Maternal and Neonatal Health (MNH) issues:

1. Pregnant mothers delivering at home (HD)
2. Lack of family planning (FP)
3. Low antenatal care attendance (ANC)
4. Long distance to health facility (Distance)
5. Cultural beliefs (Beliefs)

A pair-wise ranking matrix can be used to rank the five issues as follows:

PRIORITIZING OF MNH ISSUES

	HD	FP	ANC	Distance	Beliefs	SCORE	RANK
Home deliveries (HD)	X	HD	ANC	HD	HD	3	2
Lack of family planning (FP)	X	X	ANC	FP	FP	2	3
Low antenatal care attendance (ANC)	X	X	X	ANC	ANC	4	1
Long distance to HF (Distance)	X	X	X	X	Distance	1	4
Cultural beliefs	X	X	X	X	X	0	5

NOTE: In case there is tie, people can also compare the issues that have tied and arrive at a number one issue.

Some strategies to help set priorities:

- Articulating/debating issues on all sides;
- Setting goals that all agree upon;
- Establishing culturally appropriate communication mechanisms for decision making;
- Mediating;
- Negotiating;
- Determining whether there is a need to agree to disagree.

Strategies for dealing with conflict when setting priorities:

- **Voting** - participants are asked to show by raising their hands or marking a ‘ballot’ which option they think is most important;
- **Rotating priorities** one time to the next; and/or
- **Adding on additional priorities**

Plan Together

In the Plan Together phase, the Community Action Group develops a community action plan to address the EHP. It is important to ensure that those most affected by the EHP have a central role and voice in developing the community action plan.

Supporting the Community Action Group in its efforts to Plan Together is usually undertaken during the Implementation Phase of the SSDI Program Cycle.

The steps involved in this phase include:

1. Determine who will be involved in planning and what their roles and responsibilities will be.
2. Design the planning session.
3. Facilitate the planning session to create a Community Action Plan.

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

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 it includes 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 to structure the process better 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 just as important to ask who is not invited, and why not, as it is to ask who is invited.

The CMT should encourage the core group members to take on as much responsibility as possible for the planning session(s). CMT 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.

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 during this phase:

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

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

	Yes	No
Is the person/group directly affected by the EHP condition?	<input type="checkbox"/>	<input type="checkbox"/>
Does the person/group have decision-making authority over policies or resources that relate to Health or the EHP condition?	<input type="checkbox"/>	<input type="checkbox"/>
Is the person a local leader (formal or informal) or key opinion leader?	<input type="checkbox"/>	<input type="checkbox"/>
Is the person very interested in the EHP condition?	<input type="checkbox"/>	<input type="checkbox"/>
Does the person/group make or influence decisions or access to information or services for those who are directly affected by the EHP condition?	<input type="checkbox"/>	<input type="checkbox"/>
Does the person/group possess special skills, knowledge, or abilities that could help the planning group make more informed		

decisions or implement the action plan when it is completed?

If the person/group were not invited, would they try to obstruct implementation of the action plan or create other problems?

Would strategies require the approval of this person or group?

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 EHP?
- 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 with group participation 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)?
- Does the group represent a wide range of experience or is it 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 about expressing themselves.
- Challenge assumptions and think creatively.

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- 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 the desired results.

Task 7: Select strategies with the most potential to improve health.

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 the ***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 the group will need to execute and in what sequence; 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 in Groups: 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 example:

Planning Questions	Planting example	Vaccination example
What do you want to achieve? (Goal)	<i>Food to feed my family and income to pay for school fees and other household expenses.</i>	<i>All the children in our community will not be sick with diseases that can be prevented by vaccination.</i>
What will you see when you achieve your goal? (Desired results; objectives.)	<i>X# bushels of wheat, X# bushels of peas, etc.</i>	<i>All children one year and older will be completely immunized.</i>
What things do you need to keep in mind as you decide how to work towards this goal? (Opportunities, challenges, constraints, resources)	<i>How much land I have, predictions for rain this year, amount of money I have for seed, amount of time it will take, # of helpers who know how to plant, etc.</i>	<i>How much vaccine we have, # of people who can help, time, whether parents will come, cold chain, etc.</i>
How will you achieve this goal? (Strategy) (Ideally, you would generate alternatives here first and then select the most promising one.)	<i>We will plant X# hectares with wheat, X# with peas; X# will be left fallow, etc.</i>	<i>Work with community groups to increase awareness. Vaccinate at the market every week and at health post every day.</i>
Describe step-by-step how it will be done. (Activities)	<ol style="list-style-type: none"> 1. <i>Schedule people to help</i> 2. <i>Purchase seed</i> 3. <i>Prepare the soil.</i> 4. <i>E t c....</i> 	<ol style="list-style-type: none"> 1. <i>Ensure that cold chain is in place.</i> 2. <i>Meet with community leaders and organizations.</i> 3. <i>Train vaccinators, etc....</i>
What will it take to achieve the goal? (resources)	<i>Money, seed, 3 helpers, X# hectares of land, etc.</i>	<i>Vaccine, 4 vaccinators, 4 thermoses, etc.</i>
When will you begin? How long will it take? (Timeline)	<i>May 15, 2000 5 months</i>	<i>June 1, 2000–December 31, 2000</i>

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<p>How will you know when you have succeeded? (Indicators)</p>	<p><i>We will have produced X# bushels of __.</i> <i>My family will have 3 meals/day for 6 months.</i> <i>I will be able to pay school fees & will have MK____ left for household expenses.</i></p>	<p><i>By December 31, 2000, at least 80% of children one year and older will be completely immunized.</i></p>
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What is an objective? A strategy? An activity?

Objective = What you want to achieve – the desired results of all your efforts

An objective should be **SMART-G**.

S= Specific

M= Measureable

A= Achievable

R= Realistic

T=Time bound

G=Gender sensitive

Example:

- Increase mothers' antenatal care-seeking behaviours in the village of Muzula from 30% to 80% by December 2009
- Increase the number of women delivering at health facilities (H/F) assisted by a skilled attendant from 5% to 80% in Chimpeni Village TA, Dzoole, by November 2008

Strategy = Sets forth the direction in which you move towards achieving a specific goal. **How** will you achieve your goal?

Example:

- Organize and strengthen Pregnant Mothers' group.
- Work with traditional Birth Attendant to increase community acceptance on safe delivery.
- Carry out door-to-door promotion of MNCH practices.

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

Example:

- Train 50 Community Volunteer Health workers in how to facilitate group meetings.
- Community youth group will develop and perform a drama depicting how the traditional practices affect Maternal and new born Health in the community.

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 Teen 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 Strategies

Improve Sexual and Reproductive Health for Youth

- Teen Mother's Clubs
- Youth Peer-to-peer dialogue and health promotion
- Youth Friendly Health Services

SAMPLE PLANNING MATRIX

Mobilizing Goal: _____

OBJECTIVES:	BARRIERS/ OPPORTUNITIES	STRATEGIES	ACTIVITIES	PEOPLE RESPONSIBLE	RESOURCES	TIMELINE	INDICATORS OF SUCCESS
What do we want to achieve specifically related to _____? Core Program	What challenges do we think we will face in trying to achieve this result?	How are we going to achieve our goal?	What are we going to do to achieve the result? (activities)	Who is responsible for each activity (ADD HERE NAMES OF PERSON [S])	What resources do we need to achieve the result?	When? How long is needed for each activity? (from _____ to _____)	How will we know when we have achieved the result? (measurable , observable outcomes)

STEP 3: Facilitate the planning session(s) to create a community action plan

The planning team (CAG members and those most affected) will now develop the community action plan. Discuss ahead of time with your team and the core group 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 Core Program Issue(s). Let us look at some common challenges that facilitators face during the planning session.

- There is not 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 completing all the tasks but are coming up with strategies that are not likely to have any impact on health status. To what extent should the facilitator step in here? 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 on health that you don't see because of your own assumptions? Do participants have limited or different knowledge of how to address the health problem? Is it the process design that is at fault? Are there other agendas that are making their way into the planning process? Your team will need to carefully analyse what is happening here. To better understand the thinking behind the strategy, ask participants how they think the strategy will affect health.
- The participants have developed strategies that will impact favourably upon health outcomes but are not within the health sector (e.g., road improvements to facilitate emergency transport), and your organization only has resources and technical expertise to assist with health projects. 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, and they may go on to apply these skills to further improvements in other aspects of community life.
- The participants are stuck. Should facilitators share experience from other places? This will depend on your approach and philosophy. Generally, it is acceptable and may be desirable for the facilitator to share information if she or he believes that it will help the group. For example, she or he may share another community's approach to help the group get out of a rut or to spark the creativity needed to think of new strategies. The intent should not be to manipulate the group into deciding on a predetermined strategy.

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- 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) to see which one works best. 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. Or they might decide to postpone any decisions until a future date when they may have thought of other options. What other ways can you think of to deal with this situation?

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 of the current health situation;
- A process to arrive at what the group desires to achieve ('desired results'/specific objectives that are 'SMART-G' (specific, measurable, achievable, realistic, time-bound and gender sensitive));
- A process to help them work out strategies and activities to implement;
- A process to help participants define coordination and monitoring mechanisms.

Act Together

In the Act Together phase, communities implement their community action plans. This Phase is usually undertaken during *the Implementation and Monitoring* step of the SSDI Program Cycle. The role of the CMT is now to strengthen community capacity in many areas necessary to effectively carry out the strategies and activities they identified in the planning phase. At this point, there are often volunteers and a working group developing particular strategies and activities, and there is need for good coordination and monitoring of progress.

The steps in the Act Together phase are:

1. Define the CMT's role in supporting and facilitating community action.
2. Strengthen the community's capacity to carry out its action plan.
3. Monitor community progress.
4. Problem-solve, troubleshoot, advise, and mediate conflicts.

STEP 1: Define the CMT's role in facilitating 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.

CMTs often assume various roles that change over time as the community's needs and capacity change. How a CMT 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.

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.

Now it is 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 might 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 plan consists of.

Organizing and strengthening the CAG is an ongoing, dynamic process that will need attention throughout the Community Action Cycle. The more skills, assets, and strengths a community group has, the better prepared they will be to achieve their goals. Initially it will be important to assess the CAG strengths, abilities, and challenges. Key dimensions of community capacity that the SSDI Initiative may include the following: Community history, Participation, Organizational Structure, Leadership, Social Cohesion, Sense of Ownership, Critical Thinking and Skills, Resource Mobilization, and Collective Efficacy.

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 CMT 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?

Community Capacity: Definitions and Perspectives

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 criticized 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.” (definition of *community capacity* by 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 organization needs three things:

- * the motivation and commitment to take action
- * the resources required to enable the action to be taken
- * 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, organizational and administrative skills, political skills, and many others.

For community groups, the skill sets are similar to those needed for individuals. However, more emphasis is placed on the skills needed for organizational development and management; for visioning and planning; for working together and working for change. Community groups also need to be able to monitor and evaluate their work, paying particular attention to the issue of equality.

Whole communities may be the focus of capacity building work. Some communities will have an active network of local groups and organizations that 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 they may have, 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 CAG assess their own capacity to implement their Action Plans, create a matrix that resembles the following chart, and complete it. On the following pages are tools to help assess the CAG's 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?

Community Capacity Self-Assessment Tools

The following examples of Assessment Guides to be completed with the CAG:

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 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).

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 others 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).

Community Capacity Self-Assessment, Continued

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 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.

Organizing the community for action¹⁴ – Level of demonstrated ability to:

- Cooperate among CAG members
- Organize itself effectively, including:
 - Have a Chairperson, Vice-Chair, Secretary, Treasurer
 - Meet regularly on its own
 - Make decisions openly and with equal vote of its members
 - Write and retain minutes of meetings
 - Know roles and responsibilities
 - Share a vision and goals
 - Know when they will re-elect their leadership team members
- Include those most affected by and interested in the issue
- Regularly share experience, ideas, and lessons learned
- Communicate well between the members
- Ensure equal participation by all members in group activities
- Participate in group decision-making
- Elicit community and sector perspectives about EHP

¹⁴ Adapted from Jhpiego, (2004), *Igniting Change: Capacity-Building Tools for Safe Motherhood Alliances*, pp. 63–65.

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- Continuously represent the perspectives of diverse members of the community (e.g. diversity in gender, age, class, ethnicity, socioeconomic status)
- Engage in strategic planning, and has a community action plan
- Facilitates coordination and action through effective leadership
- Regularly evaluate its activities to determine lessons learned
- Achieve its short-term objectives
- Raise awareness of EHP Conditions
- Succeed in carrying out its activities in its community action plan
- Influence decision-makers and/or policies
- Involve diverse organizations /sectors in promoting EHP
- Succeed in mobilizing resources for EHP (inside the community or outside)
- Be recognized by others outside of the group

Explore Health Issues and Set Priorities – Level of demonstrated ability to:

- Openly discuss the issue with others in a public forum
- Gather information about EHP using a variety of participatory methods
- Analyse information that has been gathered on EHP
- Set priorities based on a 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 EHP
- 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:

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- 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 an evaluation
- Analyse results
- Generate recommendations and lessons learned
- Document and disseminate results
- Use results for the next community action cycle.

Building Leadership Skills – Styles framework

AUTHORITARIAN LEADERSHIP			CONSULTATIVE LEADERSHIP			ENABLING LEADERSHIP	
Survival			Security			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 calls on members to identify limits, explore situation, make decision.
Leader announces decision with no feeling of responsibility or accountability to share the reasons.	Leader announces decision and shares the reasons behind it, which were prepared in advance (monologue).	Leader announces decision but responds as needed with a rationale based on the questions from members. (Dialogue with no expressed willingness to change decision.)	Leader announces '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.

Building Resource Mobilizing Skills

As the CAG and other community members begin to implement their action plan they will need various resources (human, financial, and 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 CAG and community members.

Contribution of Money, Crops, or Livestock. Where some money is needed to carry out planned activities the CAG 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 communities themselves.

Mobilization of Community-Based Agents. There are a many community-based agents that 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)?
- What activities are they engaged in?
- Which community-based agents are still needed, and what support do they need?

External Resource Mobilization. Important resources found outside the community include the following:

- **Government Service.** Resources might be water purification tablets, health worker training.
- **Support from Other Organizations.** A variety of other organizations may have small grant funds for which the CAG can apply. It is important to know which organizations are working in your district or EHP. However, communities will need to know how to write project proposals to ask for this money.

Building Proposal Development Skills

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 or name of the project being proposed
- The name of the group submitting the proposal
- The contact person, who will be the link between the Core Group and the funding organization
- The mailing address for the CAG
- The date on which 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, youth, those who are HIV positive. Include numbers if possible.
- Describe the ability of the CAG 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.

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- **Target Population:** List the total number of people who will benefit, divided into 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 CAG – Organizational Capacity has to do with when the CAG was formed; why it was formed; the purpose of the group; the number of women/men involved; a brief review of past activities or projects; and the results or ‘success stories’.

Partners: Partners are individuals, organizations, or people whom the CAG 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 young people who know their HIV status and take action to prevent HIV and 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 young people 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 50 community 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 (e.g. 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 CAG and community members will ensure that the project is maintained after the funding has stopped. What activities will help fund future community activities? List skills in the community.

Challenges or possible risks – These are challenges that might affect project success.

Additional information – This can take the form of maps of the area, members of the CAG, etc.

Building Financial and Resource Management Skills

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

A Financial Plan allows for a community organization to know how much money it will need, how much money it will have at any one time, and how much has been or will be spent. It gives an organization control over its financial affairs and makes people accountable.

Usually the CAG will have a Treasurer who together with the CAG develops a financial management system and makes sure the system is run correctly.

Budgeting

A simple budget includes the activity to be carried out, 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 that comes 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 with their signatures.
- 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 CAG have property and materials such as sewing machines, grocery shops, chicken runs, goats, etc., or they have plans to have property and materials in the future. It will be important to look after these resources and take care of them.

Stock-taking 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 any time.
- A separate sheet of paper should be used to record each item. 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 stock-taking should be done.
- For businesses 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 CAG 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 members of a CAG 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 Tasks¹⁵ – Members of a CAG 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
- Ensuring that no member of a group feels more important than the others
- Encouraging members to have respect for one another
- Creating clear communication lines so that all members can participate fully in activities at all times
- Ensuring that members carry out activities together
- Ensuring that members share information with all other members of the group.

Group Maintenance¹⁶ – 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 how they feel about a suggestion

¹⁵ A. Hope and S. Timmel, Mambo Press. (1984). *Training for Transformation*, Volume, 2. Gweru: Mambo Press.

¹⁶ Ibid.

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- Support Group Standards – review how the group holds meetings, when they meet, how minutes are reviewed and 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
- 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, a 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: Monitor community progress

Monitoring during the Act Together phase and throughout the Community Action Cycle 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 our goal? What are our desired results?
- What indicators do we use to judge our progress, success, or failure?
- How do we currently assess how we are doing in relation to this goal and our desired results? What formal and informal monitoring processes currently exist to share observations about progress?

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- What do we want to monitor, and how will we do this? What kinds of tools and/or processes do we need?

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

Individuals and families monitor how their children's health progresses and note how often their children are sick; they also monitor pregnant women for any signs of complications. They can use family-level tools such as the Health Passport, growth monitoring charts, etc.

Community groups and organizations monitor progress on their action plans, making sure that what was planned is being carried out and that their efforts are having the desired outcomes. However, monitoring only the activities is not sufficient to ensure that activities are contributing to positive changes in health. Groups also need to monitor education and health indicators related to overall goals.

The CM program team monitors the overall program, including progress on the Core Program Issue, community capacity, and the team's performance. Your team and the CAG itself may want to monitor key dimensions of group or community capacity such as: citizen participation, leadership skills, resource mobilization, social and organizational structure, etc.

Donors or other stakeholders monitor results to account for their investments and inform future decision-making. Your team should clarify what it is that 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 in terms of time

Community Mobilization – Indicators for Success

Monitoring Check List

Name of CAG _____

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 SSDI CM Community Action Cycle (CAC), in a phased-in approach that mirrors program implementation. ¹⁷	All staff members utilizing CM approaches have been trained and mentored.			
Trained staff/teams monitor trainees to ensure sound application of the	Core Program has undertaken 100% of the items on this CAC checklist.			

¹⁷ Grabman and Snetro, Save the Children Community Mobilization Basics or Training of Trainers, *How to Mobilize Communities for Health and Social Change Trainers Guide*.

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Community Action Cycle.				
<p><u>CMTs implement CM approaches:</u></p> <ul style="list-style-type: none"> ▪ Demonstrate understanding of & respect for community and culture ▪ Ensure broad participation & transparency ▪ Are able to identify and bring out the strengths of others ▪ Support those with & who are affected by Core Program issue. 	CMTs undertake cultural, historical, and social inventory in communities & understand the communities where they work.			
CMTs have developed a CM Program Plan as a framework for implementation & have integrated this plan & indicators into the overall Detailed Workplan for the program.	CM Program Plan (framework) is in place and incorporated into DIP. ¹⁸			
Getting Organized				
Communities are oriented to the Core Program goal.	Orientation meetings are held with a variety of community stakeholders.			
Communities understand & are committed to the Health goal.	Commitment is demonstrated by community stakeholders, who initiate efforts to improve			

¹⁸ See Grabman and Snetro, *How to Mobilize Communities for Health and Social Change Field Guide*, sample, p. 39.

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	health.			
CAG or another relevant group is organized to address the Core Program issues.	CAG is organized with those most affected by, and interested in, the issue.			
CAG leadership, norms for participation, and by-laws are established & functioning.	<ul style="list-style-type: none"> ▪ Chair, Secretary, Treasurer are democratically chosen. ▪ CAG members are able to articulate & carry out their roles & responsibilities. ▪ Roles, responsibilities, & norms of members are in writing. ▪ ‘Terms of office’ for leadership & promotion of emerging new leaders (through rotation, mentoring) are clearly defined. ▪ CAG works according to its norms. ▪ Members meet regularly, documenting proceedings and action steps. ▪ CAG is recognized by others outside the group. 			
CAG takes ownership of the Community Action Cycle (CAC).	CAG implements the Community Action Cycle.			

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Those most affected, marginalized, and interested in Health issue participate throughout the CAC process.	The '60/40 rule' ¹⁹ for CAG representation ensures inclusion of women and those most affected and interested.			
Explore Health issue and set priorities				
CAG explores Health issue amongst members.	CAG gathers information on health issue(s) using a variety of participatory methods.			
CAG explores Health issue with the broader community.	CAG gathers and <u>shares</u> information on Health issue using a variety of participatory methods.			
CAG <u>analyses</u> information gathered & prioritizes key problems related to Health issue .	CAG discovers the 'underlying influences' on Health issue & sets priorities based on these influences.			
CAG identifies root causes of the identified issues.	CAG discovers the 'underlying influences' on the Health issue & sets priorities based on the root causes.			
PLAN TOGETHER				
CAG has a written action plan & budget based on prioritized issues.	A written community action plan ²⁰ is completed.			

¹⁹ 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 given token representation – e.g. 60% of group members represent marginalized groups and 40% represent the general community.

²⁰ Community Action Plans should include: Goal, Strategies, Activities, Persons Responsible, Timeline, Budget, and benchmarks for tracking progress.

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ACT TOGETHER				
CAG implements its action plans.	CAG implements its action plan and meets targeted priorities.			
CAG fosters a sense of reciprocity, belonging, and trust in the community.	CAG implements activities that are non-stigmatizing & inclusive of others.			
CAG monitors its own benchmarks and uses data for decision making.	CAG regularly monitors progress on Action Plans & feedback to the community at large.			
CAG sustains & expands its efforts beyond the life of the program.	<p>CAG:</p> <ul style="list-style-type: none"> ▪ Assesses plan, implements, monitors, & evaluates their collective action ▪ Solves problems ▪ Creates linkages to internal & external funding & support ▪ Manages financial & human resources ▪ Manages efficient meetings ▪ Resolves conflicts ▪ Advocates at multiple levels. 			
CAG shares lessons learned with other communities, partners, and donors.	Community holds exchange visits, meetings with partners and donors to share successes and challenges.			
EVALUATE TOGETHER				
CAG evaluates its efforts and re-starts the Community Action Cycle based on learning.	CAG participates in evaluating the program and disseminating its findings.			

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Partners at the district, regional, and national levels promote CM best practices.	Partners are trained on CM and implementing the CAC with community members. District, regional, & national policies and documents advocate for community-owned responses.			
Communities participate in 360-degree evaluation of CM approaches.	360 degree evaluation is carried out with communities.			

Participatory Monitoring tools for low literacy communities

Monitoring tools must be appropriate to the villagers' level of understanding. In low literacy communities, monitoring tools should be simple and rely as much as possible on visual aids. Communities may use tools such as 'flag' (or banner) picture cards to signal various problems and/or interventions. These tools 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 for examples of tools to spark your imagination!



Our Community's Child Immunization Record							
_____ (Place for Community's name)							
Total Population: _____ under five children;							
_____ Girls _____ Boys							
(Space for Picture Card)	(Month)	(Month)	(Month)	Month	Month	Month	Month
(Space for Picture Card)							
(Space for Picture Card)							
(Space for Picture Card)							

STEP 4: Problem-solve, troubleshoot, advise, and mediate conflicts

The best planning, forethought, and intentions cannot guarantee that things will always proceed smoothly. Good monitoring systems and regular communication will help to alert participants to existing or potential problems. However, difficulties can occur for many reasons that may be beyond a program or community's control. Every culture has developed strategies to prevent, avoid, and resolve conflicts. Some strategies, while they may resolve conflicts, 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 and what role win/lose versus win/win approaches have played in successful conflict resolution.

In general, it is best to let communities identify and resolve their own problems. However, at certain times you may need to intervene – for example, when the problem does one of the following:

- 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 opinion among participants 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 and 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 roles
- Perceived scarcity of resources
- Competitiveness
- Self-centredness
- 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 person or more disagrees without expressing opposition openly. 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 the action threatens the power or interests of this individual or group.
- 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.*

SSDI Community Mobilization Participant Training Manual

- **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 such as the Margolis Wheel. It may be necessary to bring in a third party to move the conflict towards a solution.*
- **Get agreement to implement and assess a solution** – *Ask the disputants to either 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 from 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	When time is urgent.

	important.	
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Mobilising Communities for Action on Health and Social Change



Tool Kit 3: Organize Communities for Action

Support for Service Delivery Integration
Ministry of Health, Malawi



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Acronyms:

ADC:	Area Development Committee
CAC:	Community Action Cycle
CAG:	Community Action Group
CDO:	Community Development Officer
CBO:	Community Based Organization
CHV:	Community Health Volunteer
CM:	Community Mobilization
CMT:	Community Mobilization Team
DEC:	District Executive Committee
DHMT:	District Health Management Team
DHO:	District Health Office(r)
DHPT:	District Health Promotion Team
GVH:	Group Village Head (man/woman)
HC:	Health Centre
HCC:	Health Centre Committee
MNCH:	Maternal, Neonatal and Child Health
MoH:	Ministry of Health
SSDI:	Support for Service Delivery Integration
TA:	Traditional Authority
VDC:	Village Development Committee
VH:	Village Head (man/woman)
VHC:	Village Health Committee

INTRODUCTION

This tool serves as a guide to the facilitation of the ‘Organize the Community for Action’ phase of the Community Action Cycle. This phase entails orienting the community about the mobilization goal and providing other key information about the program. It is during this phase that you start building relationships, trust, and credibility; and also impart a sense of ownership to the community.

Use this phase to invite community participation in the mobilization process and to develop a Community Action Group with members of the community. This phase is therefore articulated around the following activities:

- Preparing for the community orientation meeting
- Conducting the community orientation meeting
- Putting together a Community Action Group (CAG)
- Orienting the Community Action Group (CAG) on its roles and responsibilities.

For the efficient utilization of this facilitation guide, a minimum of preparation is required prior to the meeting titled ‘Organize the Community for Action’.

PREPARATION

This guide is designed to be your constant reminder to give you direction during the facilitation process of community meetings. Nevertheless, it is not intended to restrict your imagination and creativity to do things more effectively.

Tool 2.1: Preparing for the Community Orientation Meeting

Before the community orientation meeting 'D-Day', the Community Mobilization Team (CMT), which is in charge of conducting the community mobilization, should undertake the following activities:

- Work out the meeting program.
- Translate the tools (e.g. the questions on the mini-drama, the meeting program, an overview) into the local language.
- Copy out the program and important information on the flip chart a day in advance.
- Plan a series of relevant ice-breakers, such as stories, jokes, songs, etc.
- Familiarize yourselves with the content of the meeting.
- Brief the Group Village Headman (GVH) and the VDC chair on the purpose of the meeting and work out the date of the meeting.
- Invite the extension workers, religious leaders, local NGOs in the area, ward councilors, and other influential individuals one week before the meeting.
- Remind the GVH about the meeting two days beforehand.
- Write scenarios for a mini-drama on problems relating to one of the EHP conditions of focus – e.g. a MNCH situation and related practices relevant to the community.
- Prepare the actors for the mini-drama (role-play), and make sure they have had ample time to rehearse the drama and that you have seen it.
- Get ready to facilitate the meeting by reviewing these guidelines and program documents and by anticipating community members' questions and concerns, etc. a day before the meeting.
- Prepare a venue, arrange the necessary inputs including stationery, branding, promotional materials-banners, folders, camera, etc.
- Clearly define the roles of each CMT member and program members during the orientation.
- Wherever necessary, consider the issue of drinks and/or snacks/allowances for the meeting.

Please note: It is important that diverse groups of people participate at this orientation meeting. If the meeting is organized at the GVH level, it is important to find ways of ensuring that the meeting trickles down to the village level under the facilitation of the CMT or through the lead of some village leaders.

Tool 2.2: Conducting the Community Orientation Meeting

Once all the preparations are done and it is time to conduct the community meeting, the CMT should facilitate the meeting using the guidelines below.

Duration: 2 hours

Methodology:

- Lecturing
- Presentation
- Role play
- Questions and answers

Materials:

- Flip chart paper
- Markers
- Mini-drama

Preparation:

- Prepare and write out scenarios for a mini-drama two days before the meeting day.
- Prepare volunteers for the mini-drama and help them rehearse.
- Verify that volunteers for the mini-drama are present and well prepared, and ensure that they have rehearsed properly.
- Ensure that the participants sit in a semi-circle so that they see or face each other.
- Together with the group, develop the norms for the meeting. The norms should be flexible for the participants.

NB: The meeting should not be too long as participants have other things to attend. Two hours should be the maximum time for a community meeting.

Activities:

- The CMT member who is leading should call the meeting to order.
- The CMT member should introduce himself/herself (name, surname, place of origin, and organizational affiliation).
- The lead team members will then introduce themselves and invite the various participants to do the same in groups or individually.

- Ask the Group Village Head to officially welcome meeting participants, thank them for their presence in spite of their various occupations, and give opening remarks.
- The lead facilitator should then introduce the objectives of the meeting and give the participants an orientation to the community mobilization program.
- Announce the mini-drama and ask the already prepared actors to go on stage to act out the play. At the end of the first scene, make a short summary and announce the second scene.
- At the end of the mini-drama (10 minutes maximum) discuss, using the questionnaire provided in the technical note below; the discussion should gradually move from the issues raised in the mini-drama to the realities of the community.
- Rephrase the questions every time the participants do not seem to react to the first question and always look for 2 to 3 different opinions for each question.

Technical Note – Sample questions to ask after the role-play/mini-drama:

(Different questions may be asked depending on the scenario and what you want people to learn from the mini-drama: One member of the facilitation team should be taking notes for the responses to the questions on role-play.)

Scene 1

- What took place in the scene we have just seen?
- What was the problem?
- What are the causes of this problem?
- Does this happen in our area/community? Give or share examples.

Scene 2

- What took place in the play we have just seen?
- How was the problem solved?
- Are there other solutions to the problem?

Summarize the answers given or the discussions following the different questions you have asked. Afterwards, present the overview of the SSDI program found on the next page, in the local language.

SSDI and Health overview

Malawi has poor health indicators. Most causes of poor health in Malawi are preventable. Effective and sustained prevention and improved health can be achieved when the people who are affected participate in improving their health status. The Ministry of Health emphasizes community participation as a means of improving people's health and enabling the community to take control of its health status. The MoH has called upon Donors to assist in supporting the MoH efforts such as SSDI, a five-year project (from September 16, 2011, to September 15, 2016) that is supporting the Malawi government's efforts to improve the health status of Malawians with a focus on 6 EHP areas at both community and facility levels. The areas of focus include maternal, neonatal, and child health; malaria; nutrition; family planning; water, sanitation, and hygiene; and HIV and AIDS.

SSDI has no religious or political affiliation and is working in 15 districts (Karonga and Chitipa in the North; Salima, Nkhosachota, Kasungu, Dowa, and Lilongwe in the centre; Balaka, Mangochi, Machinga, Zomba, Phalombe, Chikhwawa, Mulanje, and Nsanje in the Southern Region). SSDI works with community members to achieve improved health. Participation in this program is voluntary. Some community members will work in a Community Action Group (CAG), which will lead the implementation of community mobilization in the community. The CAG will comprise 40% VDC members and 60% community members, including the marginalized. The Ministry of Health, in collaboration with SSDI, will be happy to work with those who are interested in this kind of voluntary work, and it will invest its time and skills to help using existing community structures.

Lead participants in a guided discussion following the presentation of this summary:

- Allow participants to ask questions and allow time to respond to participants' questions regarding all aspects of the SSDI program and ensure that the important points have been understood. Other CMT members (and the program staff) should help in responding to questions from participants.
- Invite the people to be part of the community mobilization process.
- Introduce the concept of the Community Action Group (CAG), which will be the hub of the mobilization activities at the community level, and orient the community regarding their roles.
- Discuss with the people the criteria for selecting the CAG (60% of the vulnerable people from the community and effort should be made to include literate members [refer to participants manual for the vulnerable people] and 40% of the VDC members). *The group should include 50% men and 50%*

women. Inform the participants that once they commit themselves officially to partner with the program, further discussion will take place.

- Agree with the community how CAG members will be selected at a later date (think about the selection process on the meeting day, date for CAG formation meeting) and people should start thinking of who can be in the CAG.
- Give participants time to ask questions, make comments, and add further criteria if necessary. Emphasize that this is voluntary work and that there will be no payment.
- Finally, thank the participants for their availability and their collaboration and assure them that the process that is beginning with them may bear fruits that will benefit their children, their families, and the nation as a whole.
- While the meeting is going on, count (discreetly) the meeting attendants and note how many participants are men and women, and take note of the pertinent observations and analysis they made.
- Invite the community leaders to take time to digest the information given to them, consult with each other, and decide if they are interested in partnering with the program. Once they have made their decisions, they should inform the CMT so that they can be included in the planning for the next phases.
- The leader of the meeting should also bring the meeting to order and thank all members for coming and participating.
- Ask the GVH to say few remarks at the meeting.
- Since the VDC chairperson opened the meeting, request the representative from the Ministry of Health (e.g. the Health Centre Supervisor or HSA) to say a few remarks and formally close the meeting.
- Evaluate yourselves (facilitators) on how effectively you conducted the meeting.
- Find time a few days after the meeting to go around in the communities or among stakeholders, perhaps making random calls, in order to see how people feel about the program and to get feedback or provide any needed complementary information.

Tool 2.3: Putting together a Community Action Group

Objective: To elect/select a team of people to comprise the Community Action Group (CAG)

Time needed: 2 hours

Materials required: flip chart, marker, masking tape

Venue: GVH Headquarters or any other neutral or convenient place

Preparation:

The CMT should:

- Negotiate the date, time, and venue for the meeting with the GVH and other stakeholders at the community level. Negotiate with the Village Headman to attend the meeting in person.
- Hold a planning meeting prior to the CAG formation meeting to draw up an agenda for the meeting, solicit resources, and decide how to share responsibilities during the meeting.
- Invite community members to the CAG formation meeting through the GVH at least a week in advance.
- Invite individuals and groups at different levels in the CAG selection process, including the SSDI program staff, district staff from relevant government departments, partner Non-governmental Organizations (NGOs), traditional leaders, representation from community-based organizations (CBOs), and representatives from each village that comprises the VDC. The sub-contracted NGO staff at the VDC level will by default be part of the CAG.
- Prepare a list of objectives for the meeting.
- Write roles and responsibilities of the CAG on a flip chart.
- Organize the venue and seating arrangement with the participants.
- Choose in advance the person who will lead the session and have him/her rehearse his/her role.

The meeting:

- Step 1:** The CMT chairperson will call the meeting to order and welcome the participants to the meeting.
- Step 2:** Ask participants (including the District SSDI Team and DHPSc) to introduce themselves.
- Step 3:** Ask the GVH to officially welcome members of the meeting, thank them for coming, and give the opening remarks, emphasizing the importance of the meeting and inviting them to participate freely and openly.
- Step 4:** The CMT Chair will hand over the discussion to the person facilitating the CAG formation process.
- Step 5:** The lead facilitator will introduce the objectives (i.e. selecting/electing members for the CAG). The lead facilitator will also brainstorm with the VDC on the expected roles of the CAG and write them on a flip chart.
- Step 6:** Agree with the participants on the qualities of members from the VDC who will make up the CAG. The principles below are provided for guidance, and the meeting should brainstorm about additional criteria:
- 40% of the membership of the CAG should be taken from the VDC.
 - 60% should come from the community (and include membership from vulnerable and marginalized/most affected/interested members of the community. Members should include 50% men and 50% women).
 - It should be left to the community to identify the marginalized.

- Efforts should be made to avoid having members of the community who are already chairing or occupying influential positions in other structures – such the VDCs, VHCs (Village Health Committees), etc. – to be in the CAG.
- Efforts should be made to avoid having community members from other community structures/committees, such as VDCs and VHCs, chair the CAG.
- Chairpersonship of the CAG should be left to those not already holding influential positions in other sectors of society.

Step 7: Discuss with the community and come to an agreement about whether to use old groups or form new groups.

Step 8: Reach an agreement with the participants on the mode that will be used in selecting/electing the CAG. The selection/election may be done through a secret ballot, open voting, self-selection, etc. Putting members in groups according to their villages may also be used to select/elect CAG members in a way that ensures equal distribution within the Group Village Head. Ensure that all villages are represented during the meeting.

Step 9: Facilitate the selection/election process for the CAG using the agreed-upon method.

Step 10: When the CAG membership has been elected/selected, explore with the VDC on the same day whether they are happy with the process and its outcome. Ask them if the team that they have elected/selected is one that they will be committed to working with on community mobilization around health issues in their area.

Step 11: Once the election process has been finalized and the participants are satisfied, inform the participants about an orientation that will be

organized for the CAG. Where appropriate, negotiate the actual date(s) and venue of the orientation (if it has already been set) to ensure that CAG members keep the date(s) free.

Step 12: Ask the participants if they have any questions and answer only those that you have answers for. If the facilitator and team have no immediate answers, they should tell participants that they will provide answers at a later date.

Step 13: If there are no questions, thank the participants for their time and close the meeting.

Tool 2.4: Orienting the Community Action Group (CAG) on members' roles and responsibilities and the roles of Office Bearers

The Community Action Group (CAG) is an important structure for implementing the community mobilization process, especially when it comes to exploring community health issues at the Group Village Headman level. The effectiveness of CAGs in mobilizing members of their communities to tackle health issues largely depends on the capacity and support they acquire from the Community Mobilization Teams (CMTs). Community Mobilization Teams should take a leading role in the capacity building of CAGs supported by local NGO sub-grantees and district community mobilization teams.

Objectives: By the end of the session participants will have:

- Been oriented on their roles and responsibilities as well as CAG norms.
- Evaluated the meeting.

Time needed: 2 hours

Resources required: flip chart, marker, notebooks, refreshments

Preparation

- The Community Mobilization Team should negotiate a date and time for the meeting.
- Arrange the meeting in consultation with the Group Village Head and other stakeholders at the community level. The GVH should facilitate identification of a convenient venue for the orientation meeting and communication to CAG members. Venues at the community level may include churches, schools, or other community structures. It is important that the GVH attend the orientation meeting.
- The CMT should hold a planning meeting prior to the orientation meeting to draw up the agenda of the meeting, solicit resources, and decide how to share responsibilities during the meeting.

The meeting

Step 1: The chairperson of Community Mobilization Team or representative should call the meeting to order and welcome all participants.

Step 2: The chairperson should then ask the GVH to give opening remarks and open the meeting.

- Step 3:** The Chairperson then introduces other members of the CMT and asks CAG members to introduce themselves. Introductions should include the names of the individuals, the villages they are from, and the committees they represent (either the VDC or from the community where necessary).
- Step 4:** Ask participants to mention expectations for the meeting. List each expectation on a flip chart so that all members can easily view them. The facilitator reads aloud each expectation and presents the agenda.
- Step 5:** Once the agenda has been presented, clarify eventual questions and explain whether or not the participants' expectations will be addressed during the meeting, depending on their relevance. Assure participants that they will not be there for the whole day. Ask participants if they have any questions, comments, or adjustments to the agenda.
- Step 6:** Describe the objective(s) of the orientation meeting. They should be clearly written on the flip chart and properly displayed for everyone to see.
- Step 7:** The facilitator should explain the background of the initiative to participants as an introduction to the roles and responsibilities of CAG members. This background includes: the Support for Service Delivery Integration (SSDI) initiative and its components; project goals; stakeholders; implementation structures at the district and community levels; selection and composition of CMT and CAG. Explain to the participants that they were selected by the Village Development Committee to participate as CAG members.
- Step 8:** Divide CAG members into two groups and let them discuss what they perceive their roles to be. Ask CAG members to write the points they agree about on the flip chart.
- Step 9:** Let members present what they have agreed upon in their respective groups on a flip chart during plenary.
- Step 10:** The facilitator should guide discussion on the role of the CAG using the groups' presentations as a basis. At this time the facilitator should add any of the following roles and responsibilities stipulated

in the community mobilization strategy document but not mentioned by the groups:

- Exploring health-related problems in their communities (GVH catchment area) and developing action plans
- Being catalysts for community responses to health-related issues and facilitating awareness-raising activities
- Identifying Community Health Volunteers (CHVs) and agreeing on their tasks in community mobilization
- Developing CAG internal norms and a code of conduct
- Helping to link community initiatives with health facilities and other social services
- Ensuring that the minimum required numbers of CHVs, village discussion facilitators, etc. are identified; providing them with support
- Developing management systems and structures appropriate to their own capacity
- Promoting community traditional coping strategies and avoiding over-dependency on external resources
- Facilitating the identification of resources within the community to address community health problems. (CAG members and the entire community are a great resource.)
- Gathering and documenting information/data on health prevention, promotion, and care activities within the community
- Meeting on a regular basis to monitor, document progress achieved, and make necessary readjustments
- Participating in any training or capacity-building activity
- Identifying and documenting success stories for the project or initiative
- Ensuring that there is community participation in all activities planned by CAGs to achieve community ownership.

Step 11: Entertain participants' questions, provide any needed clarification, and summarize the discussion on the CAG roles and responsibilities. Then announce discussions on CAG norms and a code of conduct.

Step 12: Brainstorm over and agree upon norms for the CAG – e.g. how many times per month they will meet; for how long; what to do about absenteeism; what if any membership fee should be required; replacement and motivation of CAG members, etc.

Step 13: Brainstorm over and agree upon the code of conduct for the CAG. Using the examples below, discuss and reach an agreement with participants concerning a draft code of conduct for the CAG:

Example of Code of Conduct for a Community Action Group¹:

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

Step 14: Divide participants into two groups to discuss the roles and responsibilities of duty bearers for the CAG (Chairman, Secretary, Treasurer), and present the results on a flip chart during plenary.

Roles of Office Bearers

Role	Key responsibilities
Chairperson	Day-to-day running of the group Disciplinary action Attending to community disputes regarding core program issues Liaison with partners Chairing meetings to review progress and activities
Vice Chairperson	Supporting the chairperson in his or her absence
Treasurer	Keeping a record of financial donations, disbursements, and expenditures incurred by group Responsibility for banking and withdrawals (with second signature)
Vice Treasurer (optional)	Supporting treasurer in his or her absence

¹ Adapted from Save the Children, 2009 Draft, “CASP – Mobilising Communities for Education, Health and Social Change”, Malawi.

Secretary	Keeping minutes and resolutions from meetings Keeping records of all group activities Calling for meetings on behalf of chairperson
Vice Secretary	Supporting Secretary in his or her absence Possible additional record-keeping responsibilities
Representative of local government or traditional authority – may be an extension worker (ex-officio)	Acting as focal point for communication between the group and local decision makers
Committee members	Providing support to the chair, secretary, and treasurer in carrying out all activities of the CAG Possibly providing supervision functions for community activities on behalf of the CAG

- Step 15:** Summarize the proposed list of CAG roles and responsibilities. Provide a sample code of conduct/norms for the group and a summary of the roles of office bearers.
- Step 16:** Lead the group in the selection of office bearers. This should be done in a democratic way and should include 50% men and 50% women.
- Step 17:** Conduct an evaluation. Inform the participants that you are at the end of the meeting and ask them to evaluate the workshop by stating what needs to be improved during the next meeting. Explain to the participants how the evaluation will be done. Conduct the evaluation.
- Step 18:** Tell participants that this is the end of the orientation and ask them if they have any questions or comments.
- Step 19:** Thank them for their participation and contributions. Inform participants that they will be invited for another meeting to continue with the process.
- Step 20:** Thank the Group Village Head for participating and ask for his/her closing remarks.



Mobilising Communities for Action on Health and Social Change



Tool Kit 4: Explore Health Issues and Set Priorities

Support for Service Delivery Integration
Ministry of Health, Malawi

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SSDI Community Mobilization Toolkit
Module 3: Explore Health Issues and Set Priorities

Acronyms:

CAC:	Community Action Cycle
CAG:	Community Action Group
CBDA:	Community Based Distribution Agents
CCM:	Community Case Management
CDO:	Community Development Officer
CMT:	Community Mobilization Team
CSC:	Community Scorecard
DEC:	District Executive Committee
DHO:	District Health Office(r)
DHPT:	District Health Promotion Team
EHP:	Essential Health Package
FGD:	Focus Group Discussion
GVH:	Group Village Head (man/woman)
HCC:	Health Centre Committee
HSA:	Health Surveillance Assistant
IDI:	Individual In-Depth Interview
MNCH:	Maternal, Neonatal and Child Health
NGO:	Non-Governmental Organization
PLHIV:	People Living with HIV
SSDI:	Support for Service Delivery Integration
WASH:	Water, Sanitation and Hygiene

ABOUT THIS TOOLKIT

1. Introduction

Active engagement of communities and their leaders in a process of identifying underlying causes of health issues can contribute to sustained change in behavioural and social norms. This will also help to strengthen the capacity of communities to carry out activities on a *participatory* and *sustained* basis to improve their health and meet other needs on their own initiative in the future. Community leaders – particularly Traditional Authorities (TA), Group Village Headmen, Village Headmen, Religious Leaders, and other influential leaders in the community – play a critical role in regulating normative behaviours at both household and community levels.

SSDI, in collaboration with the MoH through CM sub-grantees, will support communities to mobilize themselves on health issues using the Community Action Cycle (CAC) approach. CAC is a multiphase process whereby community leaders, community based organizations, community health workers, and other community members at large collectively identify health problems; set priorities; design interventions consistent with the national guidelines, strategies, and objectives; implement the interventions; and then monitor and evaluate the results. The phases and all the activities of the CAC will be adapted and harmonized to be consistent with the Malawian context. The CAC process will serve to engage communities and their leaders at community level in tackling underlying causes of health issues in their respective areas.

The exploration phase aims at identifying critical behaviours and social factors that contribute to ill health and also act as barriers to effective access and utilization of health services by different segments of the populations, some of whom are socially marginalized.

This document is a guide to facilitating a *participatory* exploration of the underlying social norms and behaviours that cause or contribute to health problems within communities. The success of the facilitation process depends on the efforts that go into logistical and technical preparation.

1.2 Exploration Process

The process of the explore phase takes three to four days and is broken into three steps:

1. Community Mobilization Teams (CMT), a Community Action Group (CAG), and a Health Surveillance Assistant (HSA) for the area meet with the Group Village Headman (GVH) to explore issues together first before engaging the community using a mini-drama, picture cards, and social mapping. This may take one to two days. At the end of this meeting the CAG and CMT members should produce a list of problems identified during this meeting. This meeting is also an opportunity for CAG members to learn how to explore health issues and set priorities using the picture cards, the priority ranking matrix, and the problem tree.

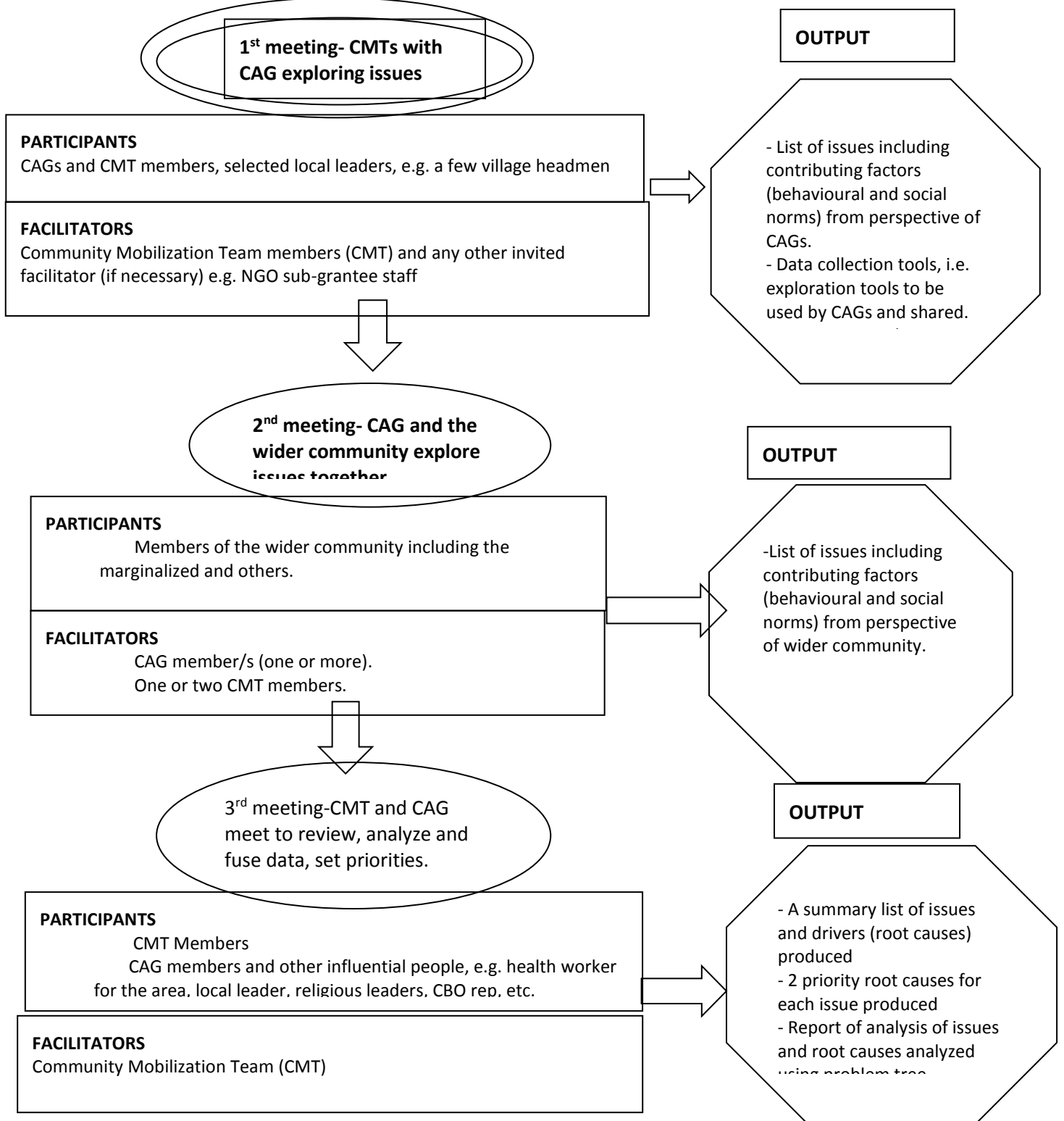
SSDI Community Mobilization Toolkit
Module 3: Explore Health Issues and Set Priorities

2. The CAG and the wider community explore issues together. Mini-dramas, social mapping, and picture cards will be used. This meeting is meant to ensure that the wider community is involved in this critical phase of the CAC. Each CAG member, with support from other members, is expected to do this exercise in his or her community/village; alternately, the villages in the GVH area can be grouped into zones, and the exploring process can take place in each zone. CMTs are encouraged to support CAGs in this step. At the end of this exercise, a list of problems should also be developed. These meetings can take a number of days.

3. The CMT, CAG, and other influential leaders from the community meet to review, analyse and fuse data, and set priorities. During this meeting, CAG members, CMTs, and other selected influential members from the community summarize all the issues together (issues they gathered during their initial meeting and those gathered with the wider community). A single list of issues is produced. Priorities are set using the priority ranking matrix or any other method. Select the top priority problem on each EHP. On each priority problem, select the first two (2) root causes that have been explored and analysed using the problem tree. Work around these in the first planning cycle. Produce a report on the analysis including the exploration methods used. CMTs should facilitate the whole process.

SSDI Community Mobilization Toolkit
Module 3: Explore Health Issues and Set Priorities

Diagrammatically, the Exploration process looks like this:



SESSION 1. FACILITATING THE FIRST MEETING OF THE EXPLORE PHASE

Objectives: By the end of the session, the participants will have:

- Identified some health issues in their community/area
- Familiarized themselves with exploration tools to be used by CAGs with the wider community
- Practiced using exploration tools
- Planned for exploration meetings with the wider community
- Developed the Terms of Reference (ToRs) for the third meeting of the Explore phase.

Duration: 2 days

Method: Presentation, mini-drama, discussions, demonstrations

Participants: CAG, CMT members, NGO staff, Selected Community Leaders

Materials and supplies for the meeting shall include:

- Tables, benches or mats
- Blackboard or flip charts
- Chalk or Markers
- Writing materials for CAGs
- Translated exploration tools, including picture cards
- Snacks and drinks
- Lunch
- Others as relevant

Preparation:

- a) A week before the meeting CMTs and project staff should get together to prepare the meeting's agenda, select the venue, review and translate into the local language the exploration tools they plan to use, and arrange for all needed materials and supplies. Group members should share responsibilities in these preparations.
- b) Prepare scenarios for a mini-drama on problems relating to one focus area of the Essential Health Package (EHP).
- c) Prepare the actors for the mini-drama; make sure they have had ample time to rehearse the drama, and watch them run through it.
- d) Call for the meeting one week in advance. Ensure that all members are informed, including influential people such as local and religious leaders, health workers for the area, etc. Remember to have a manageable group of people.
- e) Verify with the GVH or CAG chair two or three days before the meeting that all of the parties mentioned above are informed about the meeting.
- f) Copy the program and important information translated into the local language on a flip chart.
- g) Prepare icebreakers and energizers.
- h) Arrive at the venue in time and get set.

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- i) Before the meeting, arrange the tables and benches in “U”-shape so that all participants can interact during the meeting. It is critical that participants engage in group discussions.
- j) The meeting schedule should be flexible and can be organized to meet participants’ schedules.

Section 1: Welcome/Introductions and adoption of meeting agenda and objectives

Duration: 15 minutes

Activities:

Step 1: The CMT member should welcome all members of the CMT and CAG, as well as other participants, and thank them for giving their time to this exercise.

Step 2: Introduce yourself, ask your colleagues to do the same, and allow the CAG members and others to introduce themselves as well.

Step 3: Ask the village head or CAG chairperson to say his or her opening remarks and thank him/her for his/her time.

Step 4: Present the meeting’s objectives and the process to be followed in carrying out the explore phase. Emphasize that this meeting will focus on exploring health issues between the CMT and the CAG, including some selected community leaders.

Step 5: Allow participants to ask questions and take time to answer those questions. Introduce the next session.

Section 2: Familiarization with Exploration Tools – Mini-drama

Duration: 1 hour 30 minutes

Activities:

Step 1: Introduce the mini-drama and ask participants to pay attention as discussions will follow on the mini-drama. Inform participants that the mini-drama is part of the exploration phase of the issues to be identified in their community.

Step 2: Invite the already prepared volunteers to perform the first scene of the mini-drama (5 minutes). After the first scene has been presented, invite participants to remain focused for the second scene and call on the mini-drama actors to continue their performance.

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Step 3: At the end of the performance, thank the actors and ask participants to give them a big round of applause. De-brief with participants using the following questions:

Scene 1

- What took place in the play we have just seen?
- What was the problem?
- What are the causes of this problem?
- Does this happen in our area/community? Give or share examples.

Scene 2

- What took place in the play we have just seen?
- How was the problem solved?
- Are there other solutions to the problem?

Step 4: Ask participants to list, based on their own experience, other main health issues in their communities for that EHP area.

Step 5: Tell participants that in addition to the mini-drama, they will also use picture cards and a social map to explore health issues. It will not be enough to just use one tool.

Step 6: Thank participants for their contribution and announce the next session.

Section 3: Familiarization with Exploration Tools – Social Map

Duration: 1 hour 30 minutes

Activities:

Step 1: Tell the participants that you will explore health issues with them using the tool of social mapping.

Step 2: Ask if anyone present is already familiar with this technique and can explain what it is.

Step 3: After someone has explained, emphasize what social mapping is.

Social mapping is a tool used to help in identifying households in a community with specific predefined socioeconomic indicators. The tool can be used to identify which households in a community benefit the most from specific infrastructure or services in that community. It also helps to give an overview of a community in terms of socioeconomic status, available resources and skills (including professional), leadership, and the well-being of community members.

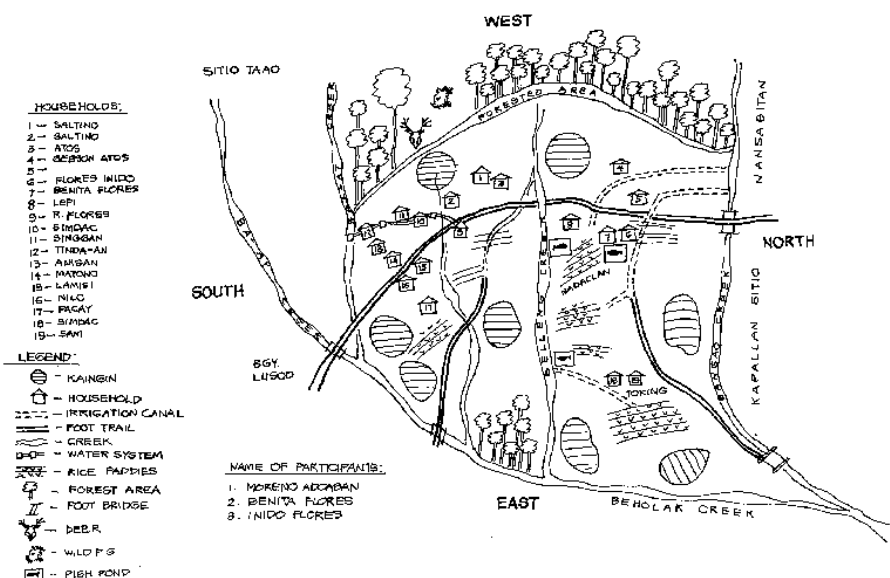
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Step 4: Allow participants to ask questions.

Step 5: Draw a social map for the GVH with CAGs. Follow the process below:

- Divide participants into small groups of 5 people.
- Use a flip chart paper and a permanent marker to draw a sketch map of the GVH. Alternatively, the map can be drawn on the ground using a stick or any drawing object, or on a chalk board in a classroom. A member of the CAG should be the one drawing the sketch map.
- Begin by drawing the key landmarks/features of the GVH that have an impact on the focus EHP areas (such as schools, hospitals, market, mountain, forest, river/lake, football ground, entertainment places, water source, toilets, gardens, CBDA house, Community Case Management [CCM] clinic, youth clubs, trading centre, etc.).
- Afterwards, begin including households using agreed-upon symbols (such as a star, small house symbol, etc.). Concurrently, give the houses numbers that can be recorded on a legend on the side of the map or on a separate piece of paper.
- Identify each household using specific socioeconomic indicators accepted by the community (such as child-headed households, female-headed households, People Living with HIV – PLHIV, newly married couples, etc.).
- When every relevant and important feature has been drawn on the map, summarize and draw a consensus with the drawing team as to whether the map is a true reflection of how the community is.
- After practising, the CAG should come up with a social map for the entire GVH.

Below is an example of a social map developed in Barangay Tawangan, in the Philippines:



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Asset Mapping 2 – Resources, Services & Utilization

There are various types of maps that can be made by community members. Many times maps are made in order to lay out the physical dimensions and resources in a community (identifying, for example, where houses, roads, rivers, and health posts are located). The type of map suggested here can be used to identify and locate the *resources* and *services* available to community members. It will also provide a better understanding of whether or not and why these resources are used. In addition, this mapping process will seek to clarify what new services and resources may be needed.

To undertake asset mapping, draw a child (or beneficiary) in the centre of a piece of paper or in the dirt. If the goal is improved child health, for example, ask community members what services, resources, and assets they already have in the community for child health, and note those things to the left of the child you have drawn. Then ask what services, resources, and assets they have in the community for child health, *but are not yet using*. Note those things to the right of the child. Underneath the child, note what services and resources the community members say that children still need.

Each year revisit this map and see whether there are improvements in the assets it tracks.

Section 4: Familiarization with Exploration Tools – Picture Cards

Duration: 1 hour

Activities

- Step 1:** Inform participants that picture cards will be used to stimulate discussion around an issue and can be used to explore various health issues involving adolescent health; maternal, child, and neonatal issues; malaria; water hygiene and sanitation; etc.
- Step 2:** Invite 5 volunteers to come into the middle of the room and be seated on the floor. In order to simulate the use of this tool, also seat yourself on the floor. *Choose two CMT members to record or write all responses.*
- Step 3:** Introduce this tool by saying that picture cards are a way of exploring the core health issue in a community.
- Step 4:** Lay out all of the cards on the ground and ask participants to choose one problem that they know exists in the community. Ask the one participant who has chosen a card what the card represents and what they call it in their village.
- Step 5:** Then ask the group the questions on the back of the selected picture card.
- Step 6:** Share the responses-capturing matrix.

Example of the matrix:

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EHP area	Problem	Causes/contributing factors	Possible solutions

Step 6: Divide CAG members in two groups. Allow each group to explore health issues using pictures cards for two EHP areas.

Step 7: Call a plenary meeting to share a list of explored issues from each group. All the problems should be summarized on one sheet of paper. Assist CAG members in coming up with clear problems.

Step 8: When you have finished discussing all the identified problems, ask the participants whether they know of any other problems that were not mentioned.

Step 9: After all groups have presented, lead a discussion based on the following questions:

- o How did you feel using the tools?
- o What was difficult and what was easy?
- o Any comments on the role plays? Note that ‘giving constructive feedback is important’.
- o Is there anything that needs more simplification?
- o What can be done to make it simpler?

Section 5: Planning for exploration meetings with the wider community (field work)

Duration: 1hour 30 minutes

Activities:

Step 1: Now that they have used all the exploration tools (picture cards and social mapping tools), ask the participants whether they are comfortable with going out to conduct field work and collect the data.

Step 2: Explain the need to plan before conducting fieldwork. Present the planning template and start planning.

Step 3: Plan how fieldwork will be conducted (exploration meetings with the wider community). Decide whether each village will be visited or whether sampled villages or the catchment area will be divided in clusters

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Table 2: Planning matrix for Mkuta CAG

Activity	Tools to be used	Place	Time and date	Responsible person	Resources needed	Remarks
Exploration meeting with wider community in cluster 1	Picture cards Mini-drama	Bwalo la mpira kwa mfumu Chikho	12 Nov. 2016 9 koloko	Bambo Chavunya	Picture cards Actors for mini-drama Mphasa Kope ndi cholemb era	

Exploration meeting with wider community in cluster 2	Picture cards Mini-drama	Bwalo la a mfumu a Makwakwa				
Exploration meeting with cluster 3	Picture cards Mini-drama					
Exploration meeting with cluster 4	Picture cards Mini-drama					
Refining the social map	Draft social map	CAG meeting place	20 Nov. 2016	Miss Sibande	Draft social map, flip charts, markers	

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Step 4: Developing the Terms of Reference (ToRs) for the third meeting of Explore phase

After Exploring Health issues with the broader community using tools such as mini-drama, picture cards, and social mapping exercises, a team will be formed comprising CAG members, CMTs, and selected community members to further conclude activities in the phase. The team will be expected to analyse and prioritize the health issues using problem trees and pair-wise ranking.

Specific responsibilities of the team will be to:

1. Determine the objectives of the third exploration meeting.
2. Work out the meeting schedule. Agree on the times, venue, and logistics for the meetings.
3. Develop norms for the meeting and agree on leadership roles (this leadership is liquid – i.e. formed for a specific purpose).
4. Discuss members' responsibilities to enable them to bring about the expected results of the process. This should lead them to draw up an action plan for the specific agreed tasks.
5. Identify specific problems under each of the six prioritized health issues targeted by the project.
6. Analyse the health problems using a problem tree to come up with root causes.
7. Develop problem trees for each of the analysed problems as a basis for identifying root causes. The problem trees will act as evidence of how the team helped the community to define its priorities.
8. Prioritize the root causes for each problem using pair-wise ranking. The prioritized root causes will form the basis for developing action plans.
9. Participate in the identification of the planning team since they are already empowered and understand the process.
10. Facilitate the process of sharing the identified problems and root causes with the broader community for their input and ownership during the planning phase.

Section 6: Evaluation and Closure

Duration: 30 Minutes

Activities

Step 1: Inform the participants that you are at the end of the meeting and ask them to evaluate the workshop by stating what needs to be improved during the next meetings.

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Sample Questions for the evaluation:

How was the meeting? Was the meeting helpful?

Do you feel prepared to meet with the wider community?

Are you comfortable with what you are going to do in the community?

Are you comfortable with how you will record information gathered from the community?

Which areas were not clear and which areas would you want repeated?

Step 2: Next Steps: Discuss with participants the date for the next meeting, on the topic of finalizing the exploration phase (after the exploration meetings with the community have been held).

Step 3: Invite an already notified leader to say a word of prayer to close the session, and extend thanks afterwards.

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SESSION 2. FACILITATING THE THIRD MEETING OF THE EXPLORE PHASE

Objectives: By the end of the session participants will have:

- o Analysed the information collected during the field work
- o Identified one priority problem from each EHP area
- o Identified two root causes for each priority problem
- o Developed a calendar for the plan together phase

Duration: 2 days

Participants: CAG members, CMT members, other community members, NGO staff, district representative, HSA for the area, community leaders, other opinion leaders

Method: Presentation, discussion, group work

Materials: Flip charts, markers, masking tape, pens, pieces of paper, lists of explored issues, refreshments, lunch, ToRs written on different flip-chart pages prior to the meeting, problem-capturing matrix, pair-wise ranking

Preparation

- a) Agree on a date and venue for the third meeting.
- b) Use a separate notebook when recording issues generated from each tool.
- c) Identify additional participants for the third meeting.
- d) Remind the participants about the planned meeting one week in advance. Ensure that all members are informed, including influential people (e.g. local leader in the area, religious leaders, health workers for the area, etc.). Remember to have a manageable group of people.
- e) Develop the program in a local language and important information (e.g. meeting agenda) on the flip chart.
- f) Prepare icebreakers and energizers.
- g) Arrive at the venue on time and be prepared.
- h) Before the meeting, arrange the tables and benches in a “U”-shape so that all participants can interact. It is critical that participants engage in group discussions.

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Section 1: Welcome/Introductions and adoption of meeting agenda and objectives

Duration 15 minutes

Activities:

Step 1: Welcome the CAG members and other participants and thank them for giving their time to this exercise.

Step 2: Request all participants to introduce themselves, including members of the CAG and CMT.

Step 3: Remind participants that this meeting is building on the first meeting and exploration meetings with the wider community.

Step 4: Inform participants about the objectives of this meeting as written above.

Step 5: Allow CAG members to share field experiences. Address their concerns and announce the next section.

Section 2: Compiling and Analysing Explored EHP Issues

Duration: 3 hours

Activities:

Step 1: Present the objective of the section and ensure that participants understand them.

Step 2: Ask a participant to read from the already prepared flip chart of ToRs and make sure you answer eventual questions.

Step 3: Form at least 2 groups: the first group will compile the community's issues using picture cards, and the second group will work on the mini-drama and social map issues.

Step 4: Once the groups are formed, indicate to them the places that have been prepared for each group to work in, and invite them to start the work. Share the problem-capturing matrix with each group

Step 5: Join each group from time to time to provide clarification and assistance if necessary. At the end of the allotted time call back the groups for the plenary.

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- Step 6:** Give time to each reporter to present the work of each group. After each presentation give time for questions, comments, and amendments.
- Step 7:** Make a summary of the presentations on a flip chart in such a way that you have a list of key issues.
- Step 8:** Bring back the list of key issues that the CAG developed in the first meeting, and guide the team in reconciling the 2 lists into one.
- Step 9:** Ensure at the end of the compilation that you have answered the questions and/or comments; announce the next section.

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Section 3: Setting Priorities

Duration: 1 hour 30 minutes

Activities:

Step 1: Inform participants that it is time now to identify one top priority problem in each EHP area.

Step 2: Demonstrate to the participants how the identification of priority problems will be conducted using pair-wise ranking.

MNCH problems

	HMD	HND	HMC	SCORE	RANK
High number of maternal deaths	X	HMD	HMD	2	1
High number of neonatal deaths	X	X	HND	1	2
High number of maternal complications	X	X	X	0	3

Note: When there are only two problems, pair-wise ranking is no longer applicable; members can resort to voting to decide between the two.

Step 3: After demonstration and prioritization on MNH, let participants finish prioritizing the remaining EHP problems as part of practising in groups. Form three groups for this exercise. Each group should focus on two EHP areas.

Step 4: 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's 6 EHP priority problems.

Step 5: Thank the participants for their achievements and inform them that it is time to look at the root causes of their 6 EHP priority problems.

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Section 4: Root Cause Identification

Duration: 2 hours 30 minutes

Activities:

- Step 1:** Inform participants that in order to solve their 6 EHP priority problems, it is necessary to identify the root causes; ask a volunteer to start out by recalling the 6 priority problems.
- Step 2:** Tell participants that a tool called ‘the problem tree’ will help in the task of identifying root causes.
- Step 3:** Demonstrate how to identify root causes using a problem tree for one EHP priority problem. The tree should show the three main parts: the trunk, the roots, and the branches.
- Step 4:** Describe the idea of the tree: the trunk stands for the problem, the roots stand for the causes of the problem, and the branches stand for the effects of the problem.

The guide below should be considered when demonstrating the problem tree:

- ***“What are the main causes of this problem?”*** Write each cause separately on the roots. Come up with at least three main root causes at first.
 - Take one main root cause at a time, explaining that people can also look at the secondary root causes of a problem by asking the question “Why?” For example, if the problem on the tree trunk is that many children suffer from malnutrition in the area, ask “Why?” to get the first response; then get a second major reason and a third major reason. And then to the three answers, ask “Why?” for each big root cause again. Continue in this way until community members feel that all the causes have been discussed.
 - The facilitator should ask, ***“What are the main effects of this problem?”*** The effects should then be written on the branches. Take one effect at a time, explaining that people can also look at the secondary effects by asking the question ***“What is the effect of this?”*** Continue in this way until community members feel that all the effects have been discussed.
- Step 5:** Once everyone has understood how the problem tree works, form 3 groups and ask one participant for each group to be the facilitator. Give each group 2 EHP priority problems.
- Step 6:** At the end of the exercise ask each group reporter to give an overall description of the tree with all its roots and branches.

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Step 7: Ask participants to comment on the problem trees presented and make necessary corrections.

Step 8: Guide participants to prioritize the root causes using the pair-wise ranking matrix. Participants should come up with two root causes for each EHP priority problem.

Note: Sometimes the pair-wise ranking matrix is not applicable; in such cases, participants can use voting to identify two priority root causes for each EHP problem.

Step 9: Congratulate participants on identifying the root causes and effects for the 6 EHP priority problems.

Step 10: Explain that in the next meeting participants will look in detail at how they can deal with the identified root causes of the priority problems and plan for solutions.

Step 11: Ask participants to propose new dates for the planning meetings and the formation of the planning team. Members should agree on the composition of the planning team.

Step 12: Inform the participants that the meeting has come to a close and ask them to evaluate it and suggest improvements for the next meetings.

Sample questions:

Did we achieve what we wanted to achieve?

Which areas did not go well?

How can these areas be improved?

What needs to be improved during the next meeting?

Step 13: Invite an already notified leader to say a word of prayer to close the session, and afterwards extend thanks.

HANDOUT # 1: Problem Tree

A problem tree is used to show the ‘root causes’ of an issue along with its consequences or results. For example, to create a problem tree related to *poor maternal health*, the facilitator will ask group members or participants to draw a tree with roots, a trunk, and branches. On the trunk, participants will write “poor maternal health” (the issue/problem being discussed). Participants (with one taking the role of a moderator) will then discuss why there is *poor maternal health* in their community or what causes poor maternal health in their community. Every response they think of is written on a root. For each root cause identified, the moderator will continue to ask, “Why does this happen?” to get deeper and deeper into the roots, until the participants are unable to come up with any more responses. The branches represent the effects of the problem. Follow the same process that was used to identify root causes to identify effects. To do this, ask, “What happens as a result of poor maternal health?” Every response becomes a new branch. For each branch, keep asking “What does that lead to?” Once complete, participants will have painted a full picture of the underlying causes of poor maternal health and their consequences (how poor maternal health affects children’s future, their families, the community, the district, the country, etc.)

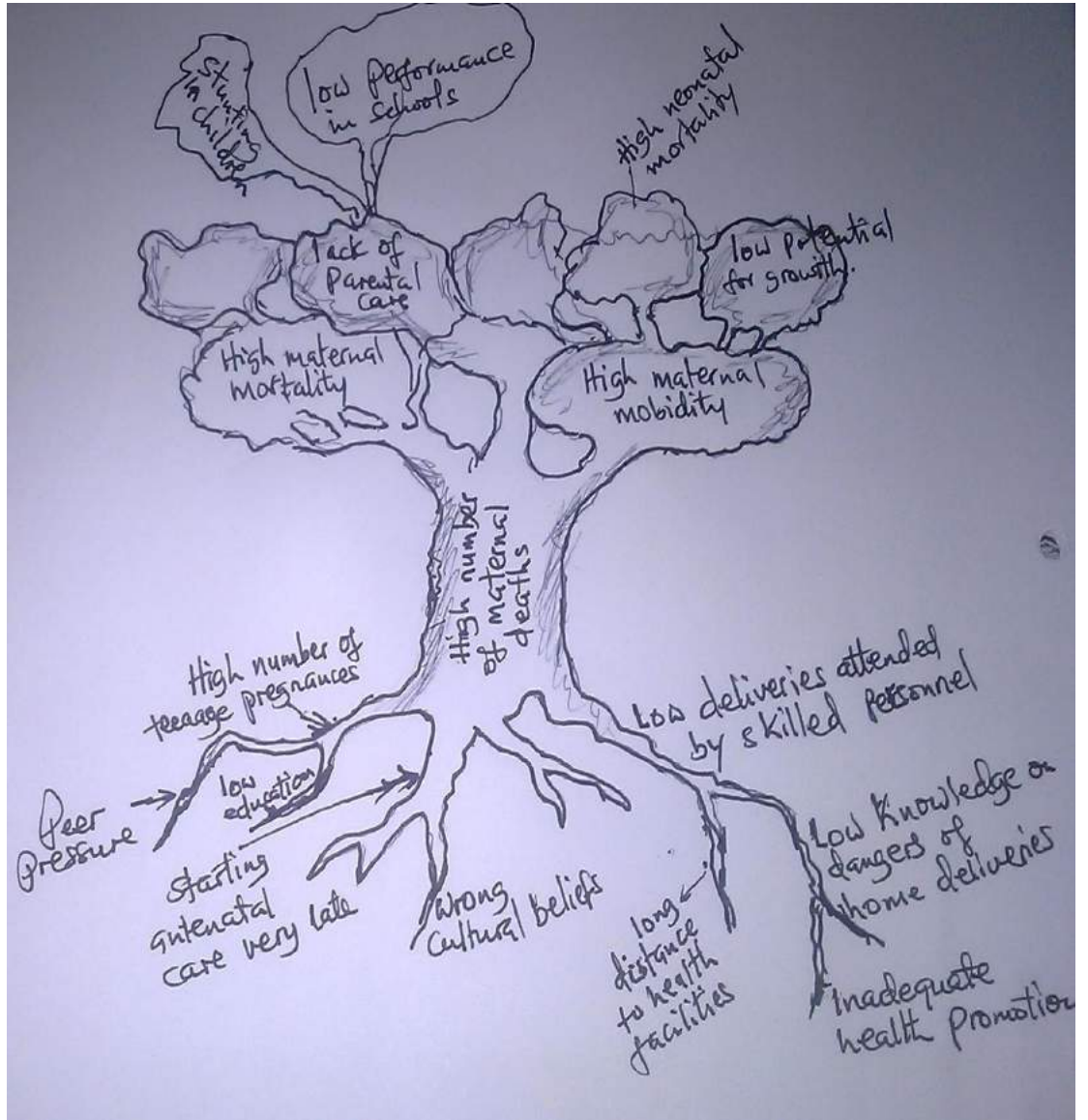
Below is an example of a completed problem tree around the issue of MNCH.

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EFFECTS

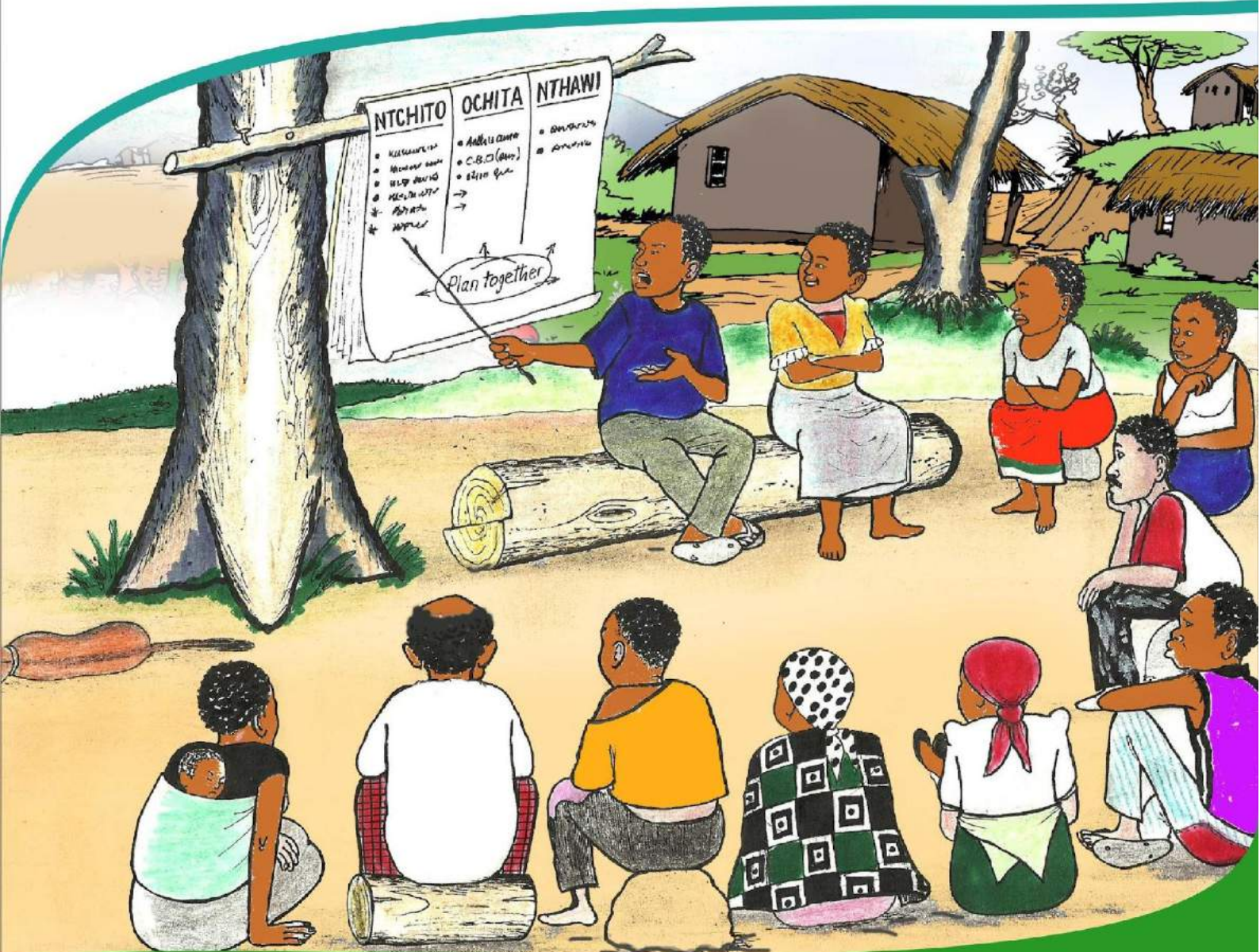
CORE PROBLEM

ROOT CAUSES





Mobilising Communities for Action on Health and Social Change



Tool kit 5: Plan Together

Support for Service Delivery Integration
Ministry of Health, Malawi



USAID
FROM THE AMERICAN PEOPLE



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Module 4: Plan Together

Acronyms:

- AEHO:** Assistant Environmental Health Officer
- CAC:** Community Action Cycle
- CAG:** Community Action Group
- CM:** Community Mobilization
- CMT:** Community Mobilization Team
- DHPT:** District Health Promotion Team
- EHP:** Essential Health Package
- HSA:** Health Surveillance Assistant
- MNCH:** Maternal, Neonatal and Child Health
- NGO:** Non-governmental Organization
- SSDI:** Support for Service Delivery Integration
- TBA:** Traditional Birth Attendant
- VH:** Village Headman

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Introduction

This document is a guide to facilitating the participatory development of community action plans to address health problems and root causes. The success of this process depends on the logistical and technical efforts that go into it.

Since the meetings are intended to run in a very active manner, all necessary measures should be taken:

1. The running of the meeting should be flexible and not necessarily non-stop.
2. The facilitators should keep in mind the availability of the participants and make sure that there is nothing that is preoccupying them during the meetings (group discussions).
3. The program for each meeting should be adopted according to the situation of each group.
4. The planning team/committee should include: CAG members, CMT members, other influential community members, the chief or representative, some NGO representatives, religious leaders, Health Surveillance Assistants (HSAs)/Assistant Environmental Health Officer (AEHO), etc.
5. The maximum number of planning team members should be 25.

The planning guideline should be a constant guide for you. However, it should not be taken as a Bible or Koran. It should not restrict your creativity and your desire to do things more effectively. A guideline is not a solution to all problems and challenges. It does not answer all the questions; therefore be flexible and creative to ensure maximum results.

Session 1: Facilitating the Plan Together Phase

Objective: By the end of the session, participants will have:

1. Developed the objectives, indicators, strategies, activities, resources, and timelines for their community action plan.
2. Defined a co-ordination mechanism for implementing the community action plan.
3. Planned for dissemination of the community action plan.

Material: Masking tape, markers, flip charts/news print, workshop agenda, blackboard, planning matrix tables, benches, mats, pad, chalk, markers, snacks, drinks, etc.

Participants: CAG members, CMT members, other influential community members, the chief or his representative, some NGO representatives, religious leaders, HSAs/AEHO, etc.

Method: Presentation, discussions, group work

Preparation:

For efficient utilization of the facilitation guide, a minimum of preparation is needed prior to the planning workshop/meeting day. To accomplish the basic requirements, the CMT must:

1. Work out the meeting program.
2. Translate the tools and the meeting program into local languages; copy out the program and other pertinent information onto the flip chart.
3. Arrange the tables and benches in U-shape so that all the participants can easily interact.
4. Plan a list of exercises and/or funny stories as ice breakers and energizers.
5. Give adequate notice about the meeting to all participants (i.e. notify a week in advance).
6. Identify a volunteer from among the CAG members the day before and help him/her to prepare a presentation on the problems, prioritized problems, and root causes (from the 6 problem trees); the presentation should also cover the prioritized root causes identified during the explore phase.
7. Help the CAG member to rehearse the presentation in order to feel more comfortable when presenting it to the group

Section 1: Formulating Goals and Objectives

Duration: 1 hour

Activities on the day of the meeting:

- Step 1:** One CMT member leads the session. Welcome the CAG members and all other participants.
- Step 2:** Introduce yourself, ask your colleagues to follow suit, and allow all the participants to do so as well.
- Step 3:** Ask the CAG chairperson to give the opening remarks.
- Step 4:** Explain to the participants that you are here to develop a community action plan for health following the recently conducted exploration of the health issues.
- Step 5:** Present to the participants the purpose and the process involved in the Plan together phase and take time to ask if they have any questions. Once the participants understand the main objectives and process involved in the planning phase, present the specific objectives of the planning phase.
- Step 6:** Take time to answer participants' questions and explain again if necessary the process and the expected outcomes of the planning phase.
- Step 7:** The CAG member who prepared the presentation on the identified problems, priorities, and root causes should present it using the flip chart.
- Step 8:** Ask participants to recall the goal and the objectives of the community mobilization initiative based on the previous meetings and workshop they attended.
- Step 9:** Write on a flip chart all the ideas as the participants list them; at the end of the item, discuss the relevance of the idea in relation to program goals and objectives.
- Step 10:** Make a summary of the discussion at the end and make sure that the following are included:
- **The ultimate goal of the CM** is to facilitate social and behavioural change that supports positive and sustainable changes in social norms, attitudes, and individual and household practices leading to improved health of all Malawians.
 - **The main purpose of the CM** is to empower the communities to play an active role in achieving improved health and to mobilize the support of both human and material resources for health promotion and care activities.
- Step 11:** Inform the participants that the communities are being mobilized and empowered to achieve the following objectives:
- Create demand for comprehensive health services due to increased awareness of health needs among community members.
 - Increase community access to health services. Community participation in service delivery can help expand services (e.g. through community volunteers or care groups), mobilize more resources, and establish linkages.

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- Reach the most vulnerable. Communities themselves are often best placed to identify the most vulnerable & marginalized people in the geographical area.
- Address the underlying causes of health issues, such as gender-related power inequities (unfair treatment), stigma, harmful cultural beliefs, and discrimination. Changing these factors will require a deeper dialogue among community members and health providers.
- Increase community ownership and sustainability (and thus also empowerment).

Step 12: Paste on the wall the flip chart with the list of program objectives. The flip chart should be displayed in such a way that all participants can refer to it throughout the workshop. Thank the participants and move to the next item on the agenda.

Step 13: Ask participants to recall (through brainstorming) the priority problems identified during the explore phase; note all the ideas on a flip chart.

Step 14: Summarize the discussions and call one CAG member up to present a more exhaustive report on the explore phase. The presentation should include the initial list of health problems identified, the priority problems, and their priority root causes.

Step 15: Paste on the wall the priority problems and the root causes.

Step 16: Explain SMART objectives to the participants and demonstrate how to develop a SMART objective using one root cause for one problem.

Step 17: Divide participants into three groups and let them develop objectives from root causes. Each group should focus on two Essential Health Package (EHP) priority problems. Use the table below to formulate objectives.

Priority Problem	Root causes	Objective

Step 18: Make sure that at the end of the presentation there is a consensus on the objectives.

Section 2: Formulate Strategies and Indicators

Duration: 2 hours 30 minutes

Process:

Step 1: Present the objective of the section and ensure it is clear to everybody.

Step 2: Explain what a strategy is and what an indicator is.

Step 3: Demonstrate how to develop a strategy and indicator using one root cause for one problem.

Step 4: Divide participants into three groups and let them develop strategies and indicators from the objectives.

Step 5: Use the table below to develop indicators and strategies for each objective.

Priority	Root causes	Objectives	Indicators	Strategies
1	1			1
				2
				3
	2			1
				2
				3
2	1			1
				2
				3
	2			1
				2
				3

Step 6: Ask the groups to come back for a plenary session at the end of the allocated time.

Step 7: Give time to each group to present their work and allow others to comment and enrich the work.

Step 8: Probe to make sure that the strategies proposed can actually address the problem.

Step 9: At the end of the presentation make a summary of all discussions.

Step 10: Make all necessary additions and announce the next section.

Section 3: Identification of Activities, Resources, and Responsible Persons

Duration: 2 hours

Process:

- Step 1:** Define what an “activity” is in the context of community mobilization for health for the participants. Then explain what is meant in this context by “resources” (both material and human) and responsible persons.
- Step 2:** Demonstrate how to come up with activities, resources, and responsible persons for one strategy. The activities should include targets.
- Step 3:** Divide the participants into three groups and let them come up with activities and resources for the remaining strategies. Each group should focus on two EHP priority problems. Use the table below to come up with activities and resources.

Priority	Root cause	Objectives	Indicator	Strategy	Activities	Target	Resources	Responsible persons	
1	1			1	1				
					2				
					3				
	2			1	2	1			
						2			
						3			
2	1			1	1				
					2				
					3				
	2			2	1	1			
						2			
						3			

- Step 4:** Ask the same participants to go back into their respective groups in order to complete the work. At the end of the allocated time call back the groups for the plenary.
- Step 5:** After the presentation of each reporter, take time to discuss the relevance of each activity, the needed resources, and the responsible persons. Responsible persons can even be identified from among community members.
- Step 6:** In the process of identifying the people responsible for an activity, probe using the following questions:
- Does the proposed person have time to lead the activity?
 - Is this activity better handled by an individual or a group?
 - Do the responsible people have the skills and the competence to lead

Section 4: Determination of Timelines

Duration: 1 hour 30 minutes

Process:

Step 1: Add a column for timelines to the planning matrix, as in the table below:

Priority	Root cause	Objectives	Indicator	Strategy	Activities	Target	Resources	Responsible persons	Timeline	
1	1			1	1					
					2					
					3					
	2				2	1				
						2				
						3				
2	1			1	1					
					2					
					3					
	2				2	1				
						2				
						3				

Step 2: Ask participants to agree on the right timeline for the implementation for each activity if they are to achieve the expected results.

Step 3: Engage participants in a discussion about timelines so that they can come to an agreement about a realistic timeline for the activities.

Step 4: Ensure that planned activities do not overlap, and initiate a discussion with participants about the possible consequences if activities are delayed or not implemented.

Step 5: Summarize the discussions at the end, thank the participants, and announce the next activity.

Note: Each Community Action Group should monitor the actual implementation of the planned activities. Use the table below:

Date	Activity	Planned target	Achieved	Comments

Section 5: Coordination of Activities

Duration: 1 hour 30 minutes

Process:

- Step 1:** Ask participants how they will ensure that the activities are really implemented.
- Step 2:** If participants decide to establish a co-ordinating committee, ask them to clarify its structure and composition, its mandate, the specific tasks of each member, and how the members will be selected.
- Step 3:** Ask participants how the committee will monitor the implementation and progress of the action plan.
- Step 4:** Ask participants what other activities they will carry out to ensure that the wider community gets a chance to input into the action plan.
- Step 5:** Discuss with participants the date for the next meeting, which should focus on sharing the plan with the wider community.
- Step 6:** Identify and plan the next steps (e.g. finalization of the plan after consulting the wider community); start planning for the next meeting.
- Step 7:** Thank the participants and announce the next session.

Section 6: Developing the Agenda and the Facilitation Guide for the Meeting with the Broader Community

Duration: 2 hours

Process

Step 1: Inform participants that as you have all agreed on the necessity of having a meeting with the broader community to seek their inputs in the action plan, you will now take time to develop the agenda, plan, and logistics for such a meeting.

Step 2: Make sure that participants agree at least that the purpose of the meeting is to seek broader community commitment and input into the draft community action plan before the community formally adopts it.

Step 3: Ask participants to brainstorm quickly on some agenda items. Ensure in the summary that participants agree on at least the following minimum agenda:

- Welcome/introduction and discussion of agenda items
- Presentation of the community action plan
- Comments, questions, and answers
- Adoption of the plan and identification of the next steps

Step 4: Thank the participants for their contribution and continue the brainstorming with the following questions:

- Who will present the various topics during the meeting?
- What materials and/or tools will that person need (or will other participants need) in order to present that agenda item?
- How will participant input into the draft plan be requested and given?
- How will new or alternative proposals on objectives, strategies, and activities be handled during the meeting, and what other factors might the team anticipate?
- When and where will the meeting take place? Who should be invited? Who will invite them – and how?
- What materials, supplies, etc. will be needed at the meeting, and how will you get them?

Step 5: Prepare for the meeting with the wider community by carrying out, at a minimum, the following:

- Agree on the date and venue for the meeting.
- Inform the VH/Community at least a week in advance about the meeting.
- Conduct a practice session if necessary.
- Assemble any data/prepare any visual aids that will be needed.
- Set up the meeting room.

Step 6: Thank the participants for their contribution, and move on to the next session.

Session 2: Work plan dissemination meeting

Objectives: By the end of the meeting the participants will have:

- Presented the community action plan to the wider community
- Solicited inputs from the community on the community action plan.

Duration: 2 hours

Method: Presentation, questions and answers

Material: Finalized work plan, markers, flip charts

Process:

- Step 1:** Welcome the community to the meeting and thank them for coming.
- Step 2:** Introduce yourself, ask your colleagues to do so too, and allow the CAG members and planning team to do the same.
- Step 3:** Ask the CAG chairperson to say their opening remarks and thank them for their time.
- Step 4:** If the VH or a representative is present, ask for a few welcoming remarks about the program and a report on the efforts of the CAG and CMT members so far.
- Step 5:** Explain to the community that they were invited to the meeting to contribute to the community action plan for health, which was drafted by the CAG following the exploration of the health issues they conducted in previous days.
- Step 6:** Paste on the wall a list of problems that were identified during the explore phase; list the agreed-upon priorities and root causes and inform the community that the work plan was developed to solve these problems.
- Step 7:** Paste the work plan on the wall.
- Step 8:** Remind participants about the objectives of the community mobilization project.
- Step 9:** Inform participants about the process and people involved in developing the work plan.
- Step 10:** Present the work plan in simple and clear language, laying out the problem, root causes, objective, indicators, strategies, proposed activity, resources, responsible person, and when the activity will be conducted.

SSDI Community Mobilization Toolkit
Module 4: Plan Together

- Step 11:** Invite participants to comment on the presentation and engage in a discussion of each section of the work plan. Make sure any eventual modifications or additions are captured.
- Step 12:** Emphasize the importance of community involvement and stress that it is not the duty of the CAG alone to make the plan work. Encourage participants to volunteer to take part in some of the activities.
- Step 13:** Capture the names of people who are willing to assist in implementing the work in various sections and alert them that the responsible person in each section will call them for a meeting to appreciate the work they will be involved with.
- Step 14:** Summarize the discussions at the end. Thank the participants for attending the meeting. Ask the chief to close the meeting.

Session 3: Evaluation and closure

Objective:

- By the end of the session, the participants will have evaluated the planning workshop.

Duration: 30 Minutes

Method: Plenary discussion

Material:

- Flip chart
- Markers

Process:

Step 1: Inform the participants that you are at the end of the meeting and ask them to evaluate the workshop by stating what needs to be improved during the next meetings. (Give Sample Questions for the evaluation: *How did the planning meeting go? What needs to be improved in the next meetings? etc.*)

Step 2: Discuss with participants the date for the next meeting.

Step 3: Thank them for giving their time, and invite an already notified leader to say a word or a prayer to close the session. Thank him/her at the end.

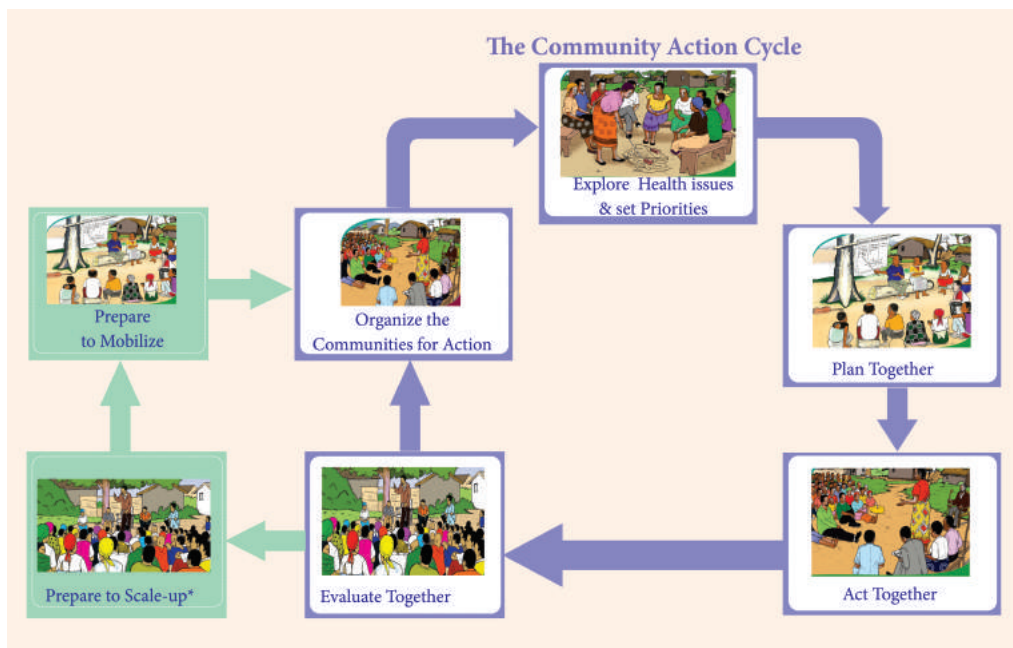
Community Mobilization



Overview

Community Mobilization (CM) is a process that strengthens the capacity of communities to plan, carry out, and evaluate activities in a participatory and sustainable way to improve their health and overall wellbeing. Using the Community Action Cycle (CAC), community mobilization empowers communities to take a leading role in determining problems to be addressed, identifying the root causes of those problems, and coming up with lasting solutions, thereby building a collective problem solving mechanism for sustainable change.

SSDI-Communication used the CAC to mobilize communities to address six Essential Health Package (EHP) areas—malaria; nutrition; MNCH; family planning; HIV/AIDS and TB; and water, sanitation, and hygiene.



The Community Action Cycle for Community Mobilization provides a systematic strategy for engaging communities in positive change.

Activities

SSDI-Communication worked with SSDI Services to provide capacity strengthening support to Community Action Groups (CAGs), comprised of community health volunteers, as they implemented the stages of the CAC. Under the supportive supervision of SSDI-Communication and SSDI Services staff, CAGs worked with communities to identify health problems and their root causes, prioritize health problems for action, and work together to develop solutions to those problems.

Using job aids (Community Health Workers Flipchart, Family Health Booklet) provided by the project, CAG members received training on priority health messages and conducted household visits to engage community members on health topics in their homes. In addition, Health Surveillance Assistants (HSAs) and other volunteers conducted community meetings on health issues that included drama performances, songs, poems, and other health education activities.

CAGs worked diligently to achieve community-level change. They lobbied with local NGOs, community leaders, members of the parliament and their District Health Offices for support to mobilize resources they needed to improve their communities. These included boreholes and shallow wells for safe water, bicycle ambulances to ease transport to a health facility during emergencies, and iron sheets for under-five shelters.



Achievements

- 557 CAGs comprised of 8,000 CAG members established.
- 356 technical supportive supervisory visits to CAGs conducted.
- 2,357,470 people reached with messages during community meetings including drama performances, poems, songs and with integrated messages on the six EHP areas.
- 678,924 households reached with messages on the six EHP areas using the Family Health Booklet; benefiting over three million people in the 13 community mobilization targeted districts.
- 52 Traditional Authorities and 557 Group Village Headmen engaged in community mobilization using the CAC.
- 23 Women's Nutrition Groups formed by CAGs in communities lacking care groups.
- Many CAGs worked with local NGOs to provide integrated services in hard-to-reach areas (e.g. Banja La Mtsogolo, Feed the Future, AMREF, YONECO, YESE).
- CAGs lobbied to receive vital resources for their communities, such as 32 bicycle ambulances to ease emergency transport to health facilities, and 173 boreholes to provide safe water to communities.

Success Story

"Located 65km from Nkhotakota District Hospital, Namakwati CAG now feels empowered with the skills to take action to improve the health of their community. Before the project, members of the CAG never thought people from the village could do anything to improve their health or bring development to their localities," says the Chairman of Namakwati, Yusuf Kambwiri. Since its establishment in 2013, the Namakwati CAG has:

- Facilitated the construction of 43 pit latrines with hand washing facilities in Munthanje village which had only 3 pit latrines and with lots of diarrhoea cases.
- Successfully lobbied with Total Land Care to install two boreholes and to support the protection of four shallow wells.
- Successfully lobbied with Concern Worldwide to provide a bicycle ambulance to carry pregnant mothers due for delivery and other patients to the nearest health facility.
- Formed the Mwana Wa Thanzi women's nutrition group to facilitate nutritional activities in the community. Childhood malnutrition has been reduced in the catchment area since the establishment of the group.



A shallow well lobbied by CAG members.

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