

FACILITATOR'S MANUAL FOR COMMUNITY HEALTH COMMITTEES (COMM)

OVERVIEW FOR THE FACILITATOR



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Cover photo © Paul Bettings/World Vision

Cover photo: Nean Chou (far left) and Onn Kom (far right) are health workers who are part of the Village Health Support Group, organised by World Vision, in Cambodia. Nean and Onn visit pregnant mothers within their community, advising how to properly care for their babies.

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INTRODUCTION TO THE MANUAL

Welcome to the *Facilitator's Manual for Community Health Committees (COMM)*. This manual has been prepared for those who will be responsible for the capacity building and mentoring support of community health groups, referred to as COMMs. (Note that while the generic term COMM is used in this manual, when actually working in the field, any pre-existing title of the community group should be retained.) COMM is the title given to a community health committee that is empowered to coordinate and manage activities, leading to strengthened community-based organisations, structures and networks, and improved community health. This process is known as 'community systems strengthening' or CSS. This manual provides all the information a facilitator will need to successfully contribute to COMM capacity building.

STRUCTURE OF THE FACILITATOR'S MANUAL

This manual is made up of individual sessions, distributed as separate documents. Facilitators may or may not carry out all sessions with a COMM, depending on the unique needs of each group, as explained in this Overview for the Facilitator. The complete manual is made up of the following:

- Overview for the Facilitator
- Appreciative Discovery (Light Assessment)
- Introduction to 7-11 Health Content and 360 Degrees of Support for Behaviour Change
- Session 1: Linkages and Networking
- Session 2: Supporting Community Health Workers (CHWs)
- Session 3a: Root-Cause Analysis (Light Version): Identifying Health Issues for Action
- Session 3b: Root-Cause Analysis of Health Issues in the Community (Robust Version)
- Session 4: Responding to Health Issues and Barriers, and Mobilising for Action
- Session 5: Tracking Community Health Status
- Session 6: Reporting Community Health Status
- Companion Document: *Facilitator's Guide to 7-11 Health Information*

COMPANION RESOURCES

As the Facilitator works through this 'Overview for the Facilitator', he or she will make decisions together with the COMM regarding additional areas of capacity building beyond the sessions available in this manual that the COMM may need, depending on its roles and level of maturity. Reference is made to the following resources for these additional areas, and links to the resources are provided:

- *Organisational Capacity Building in the Development Programme Approach* (includes the Organisational Capacity Self-Assessment – OCSA)
- *Facilitator's Manual and Resources for Timed and Targeted Counselling (ttC)*
- *Facilitator's Manual for Citizen Voice and Action (CVA)*

WORKING WITH EXISTING VERSUS NEWLY MOBILISED GROUPS

In most cases you will be working with an existing community health group. From time to time, however, it will be necessary to mobilise new groups to play the role of the COMM. Instructions are provided in terms of the special considerations that will be made for newly mobilised groups.

FACILITATOR ADAPTATIONS TO THE MANUAL

This manual is meant to support your work as a facilitator in training and preparing COMM members to develop the skills required to carry out their very important tasks. The language and examples used in this manual are general in nature, but the ways in which COMMs are organised and structured will vary from country to country. Therefore, while using this manual to design and prepare activities, ensure that each training is carried out in a way that effectively responds to the context and characteristics of each COMM.

You will need to be certified as a COMM facilitator before utilising this manual, so that you possess the necessary skills to undertake a technically sound and well-organised training for the group.

THE ADMINISTRATIVE LEVEL FOR COMM ACTIVITIES

The COMM will usually be operating at an administrative level *above* the lowest community or village level, and the group members themselves will typically come from the various communities or villages that the COMM oversees. It will be important to decide together with the COMM *where* the activities described in this manual should be carried out. Discuss questions such as, Should the COMM focus only on one representative community and conduct all activities there? Or, should the COMM members split up and conduct activities in their own communities (in small groups) and then reconvene for monthly meetings to share information? You will need to understand the administrative structure of your country and help the COMM to make these decisions as you proceed through these materials.

CONSIDERATIONS REGARDING COMM MEMBERSHIP

Before you begin working with the group, make sure that the COMM comprises persons who will help ensure that health activities move forward in the community. If the group composition is not complete, or not fully representative, you should spend some time with the group helping to complete its membership profile before undertaking anything else. This is so you do not lose time carrying out capacity building support with a group whose membership is not yet complete! The very first section of this Overview for the Facilitator takes you through a process of ensuring a complete membership structure for the COMM.

CONSIDERATIONS REGARDING COMMUNITY

Throughout these materials, reference is made to 'the community'. It will be important for you to help the COMM agree on exactly who the community consists of, and what it means to have the community involved in activities. Broadly, 'community' refers to all sections of society affected by the COMM's work, and therefore the involvement of the community should include representation from all of these parts.

In particular, representation of the most vulnerable segments of society should be ensured, as these groups are often the most likely to be excluded. Their voices must be heard through participation in the COMM's activities, alongside the voices of those in more dominant or visible positions, to help ensure that health activities move forward in ways that will benefit all of these groups. When working together with the community, the COMM will want to consider equal inclusion of representatives from each village within the COMM coverage area; all beneficiaries of CHW programming; women, youth, and disabled members of society; and those involved in arenas other than health (such as education, child protection, food security or livelihoods). This is in addition to traditional community leaders and health practitioners; faith leaders; and local-level government, health facility staff, and other nongovernmental or private-sector community members. Whenever we refer to the community, we are concerned with all of these groups.

TRAINING AND FACILITATION TIPS¹

General

- Discuss the training content with your colleagues before carrying out sessions with COMM members. This practice of consultation beforehand will allow you to make better decisions.
- Follow the activities as suggested in the manual, making adjustments as needed for your context.
- Allow as much opportunity for group discussion as possible, keeping in mind that discussion is a productive learning tool in a group environment.
- Encourage the COMM members to share differences of opinion that arise during the training, as this gives all members an opportunity to exchange ideas and clarify their positions.

¹ Adapted from *Training Community Health Committees in Kenya*, Ministry of Public Health and Sanitation, Kenya.

Before the Training

- Select the site, dates and time.
- Invite participants well in advance.
- Arrange and confirm logistics, such as per diem, lodging, special needs, and so forth.
- Prepare by dividing up tasks, organising all materials (flipcharts, markers, handouts, and so on) and practising.

Upon Arrival of the Participants

- Welcome all members individually and thank them for their participation up front.
- Do individual introductions and an 'icebreaker' to build group rapport.
- Learn participants' names as quickly as possible.
- Review expectations of the training, including work norms and dress code (if appropriate).

During the Training Sessions

- Speak clearly and slowly enough for all to hear, and avoid giving long speeches.
- Practise active listening, remaining attentive to and interested in participants' contributions.
- Conduct the training in a participatory, dynamic manner, attending to different adult learning styles.
- Use visual aids as much as possible.
- Invite participants to read aloud if they are willing, rather than always reading yourself.
- Allow participants sufficient time to answer (at least 7 to 10 seconds), and probe as needed.
- Move around during group work, providing guidance and support.
- When participants have questions, check for relevance to the subject. Answer those that are relevant, but for those that are not, defer by explaining that they will be covered later in the training. This will help to keep time and focus, and avoid going off track.

At the End of the Training

- Ask participants to evaluate the training (use a confidential or anonymous method).
- Allow participants time to reflect collectively through group discussion.
- Specify what follow-up (if any) the participants can expect.
- Thank the members for their participation again, and congratulate them on their accomplishment.

IT'S TIME TO GET STARTED!

You should read through this Overview for the Facilitator before you do anything else. You will see that there are four main phases to your work, as shown in the diagram on the next page, and as follows:

- Phase 1: Getting Started with the COMM
- Phase 2: Preparing for Capacity Building
- Phase 3: Carry Out Capacity Building
- Phase 4: COMM Carries Out Its Roles

You will have very specific responsibilities during each of these phases, and those responsibilities are clearly explained in this document. Make sure you understand all of these responsibilities and then when you are ready, turn the page and get started with your first COMM!

Good luck and have fun!

COMM AT A GLANCE



PHASE I: GETTING STARTED WITH THE COMM

MEETING I: GETTING STARTED

I. INTRODUCTION

FOR THE FACILITATOR

In this first meeting with the COMM you will carry out introductions and orient the COMM to the work you will be doing together, and any other health programming that you and your organisation or ministry are involved with in the area. You will also review the COMM membership, and the roles that the COMM is currently playing and may play in the future.

WITH THE COMM

1. Introduce yourself and your organisation and have the COMM members introduce themselves.
2. Explain the work that is underway or will get underway in the area, including:
 - Your plans for working with the COMM: why are you getting involved with them now?
 - Other health-related programming, such as work with Community Health Workers (CHWs), project models such as PD-Hearth, Citizen Voice and Action (CVA), and so forth.
3. Discuss the work of the Ministry of Health (MoH) and the expectations that the MoH has for the COMM. Are there MoH policies, guidelines, stipulations or curricula for these community health groups? What kind of relationship does the COMM have with the MoH? Review all of this information together.
4. Follow usual protocols for opening and closing the meeting, per your country context
5. Use your creativity to make this first meeting positive, enjoyable and motivational for the COMM!

Tip!



You can do all of this in one meeting, or you can use the first meeting for introductions and set a date for a follow up to review the membership and roles. You know the protocols in your country, and the best way to handle this!

Tip!



Be certain to clarify expectations from the outset! You know what you and your organisation can and cannot do and provide for the COMM. It is important that the members do not have false or unrealistic expectations in terms of material benefits and the like. It is always good to ensure that all of this is clear from the beginning!

2. COMM MEMBERSHIP

FOR THE FACILITATOR

Before you begin working with the group, do a 'membership check'. If the group composition is not complete, or not fully representative, you should spend some time with the group helping to complete its membership profile before undertaking anything else.

The COMM's membership should be broadly representative of community stakeholders and should include those stakeholders directly involved in or affected by the COMM's work. The recommended standards for COMM membership (see box) are based on global experience with community health groups. These standards should be presented to the COMM as strong recommendations, since having a representative group composition will affect how the COMM is perceived in the community and the success of the group's work.

WITH THE COMM

1. Lay out the membership cards where everyone can see them and explain that this is the recommended composition of a community health group, based on global experience with COMM groups.
2. Review the cards and discuss. Ask the members if they agree with the recommendations and if they agree that each of these members are important. Discuss the importance of each member.
3. COMM members may take the cards corresponding to members that the group already has. Write the person's name on the front of each card. The cards may be pasted into the COMM's book (see box) or on flipchart paper to create a visual on the wall.
4. Discuss how the COMM can go about recruiting the missing members. Remember that broad community engagement is always important for this!
5. Agree on the steps and actions the COMM will take to complete its membership profile.

RECOMMENDED COMM MEMBERSHIP

1. At least one representative from **each community** within the COMM coverage area.
2. At least **three women** to represent the beneficiaries of the CHW programming, and to report feedback from female community members.
3. At least **one lead CHW** to represent the CHWs, regardless of who supervises the CHWs .
4. At least **one** representative of the **community leadership**.
5. At least **one** representative of the **Ministry of Health** or local health facility, if possible.
6. In areas with **specialised health programmes**, ensure at least **one representative** from these programmes. Examples include Channels of Hope (CoH) and Community-based Prevention of Mother-to-Child Transmission of HIV (c-PMTCT).
7. Additional recommendations may include **youth, CBO, NGO, FBO** representatives, **private sector** representatives, and **faith leaders**.

TIP!



The COMM may want to develop its own book, entitled Our Community Health Group or a similar title. The first pages can be for COMM membership, pasting in the cards and perhaps even photographs of the members, if possible. Encourage COMM members to be creative with their book and make it their own!

WHAT TO DO IF THERE IS RESISTANCE TO THE RECOMMENDATIONS

It may sometimes happen that the COMM will be resistant to some of the recommendations, such as those regarding women's participation and participation of the more vulnerable or disabled. If that happens, consider the following strategies.

- You may need to mobilise men first and sensitise them to the importance of including women participants.
- Explain that much of the work of the COMM will focus on maternal, newborn and child health, and it is often the women themselves who know most about these things! It is important for them to contribute!
- Consider if it is necessary to meet with community leaders to discuss these issues.
- If the Ministry of Health has protocols regarding group membership, you can make reference to these protocols.
- Do you need to make special arrangements, such as ensuring that men and women will not sit next to each other during meetings? Sometimes a small accommodation such as this can make the recommendations acceptable.

TIP!



You may also want to keep your own books for each COMM that you work with. Start by pasting a copy of the COMM membership cards on page one.

MEMBERSHIP CARDS (to photocopy or print or write on durable, coloured paper)

<p>MEMBERSHIP CARD</p> <p>WOMAN REPRESENTATIVE 1</p> <p>NAME:</p> <hr/>	<p>MEMBERSHIP CARD</p> <p>WOMAN REPRESENTATIVE 2</p> <p>NAME:</p> <hr/>	<p>MEMBERSHIP CARD</p> <p>WOMAN REPRESENTATIVE 3</p> <p>NAME:</p> <hr/>
<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM COMMUNITY # 1</p> <p>NAME:</p> <hr/>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM COMMUNITY # 2</p> <p>NAME:</p> <hr/>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM COMMUNITY # 3</p> <p>NAME:</p> <hr/>
<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM COMMUNITY # 4</p> <p>NAME:</p> <hr/>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM COMMUNITY # 5</p> <p>NAME:</p> <hr/>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM COMMUNITY # 6</p> <p>NAME:</p> <hr/>

MEMBERSHIP CARDS (to photocopy or transfer or write on durable cards)

<p>MEMBERSHIP CARD</p> <p>COMMUNITY HEALTH WORKER (CHW) OR HEALTH VOLUNTEER</p> <p>NAME:</p> <p>_____</p>	<p>MEMBERSHIP CARD</p> <p>COMMUNITY LEADER</p> <p>NAME:</p> <p>_____</p>	<p>MEMBERSHIP CARD</p> <p>HEALTH FACILITY STAFF MEMBER</p> <p>NAME:</p> <p>_____</p>
<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM SPECIALISED PROGRAMMING</p> <p>NAME:</p> <p>_____</p>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM SPECIALISED PROGRAMMING</p> <p>NAME:</p> <p>_____</p>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM SPECIALISED PROGRAMMING</p> <p>NAME:</p> <p>_____</p>
<p>MEMBERSHIP CARD</p> <p>YOUTH REPRESENTATIVE</p> <p>NAME:</p> <p>_____</p>	<p>MEMBERSHIP CARD</p> <p>NGO REPRESENTATIVE</p> <p>NAME:</p> <p>_____</p>	<p>MEMBERSHIP CARD</p> <p>REPRESENTATIVE FROM FAITH COMMUNITY</p> <p>NAME:</p> <p>_____</p>

3. COMM ROLES

FOR THE FACILITATOR

While there are some generally-agreed upon roles that a COMM can play, the things that COMMs will do may not be identical in every country. COMMs' roles may differ because of (a) MoH policies, guidelines and expectations, (b) whether or not there are CHWs or health volunteers in the community, and (c) the availability of the members and time commitments they can make.

It is important to know from the outset what the roles of the COMMs you are working with are or will be. You will carry out an appreciative discovery to determine the areas where the COMMs may need to build its capacity, but this assessment and any subsequent trainings should only address the COMMs' actual roles. If a COMM is not involved in overseeing CHWs, (because there are none in the area) for example, you will neither assess this nor help to build the COMM's capacity in overseeing CHWs.

Training sessions are available that correspond to each of the following six roles. Thus, if a COMM is meant to fulfil a certain role but does not yet have the necessary capacity to do so, you will have the appropriate materials and processes to help the COMM grow.

If you understand the MoH guidelines for such groups and what your organisation's COMM programming is expecting to include, you should already have an understanding of what the COMM's roles are. The purpose of this exercise with the COMM is to verify this understanding.

Role 1: Coordinating Mechanism for Health Stakeholders in the Community

The COMM should be the main link for health issues in the community; connecting community members, CHWs, volunteers, health facilities, NGOs and others. This is a role that *all* COMMs should play.

Relevant resource for building capacity in this role:

- Session 1: Linkages and Networking

Role 2: Support Community Health Workers (CHWs) or other Health Volunteers

If there are CHWs or other health volunteers working in the COMM's area, then the COMM should always be active in supporting these individuals. This is one of the main functions – sometimes the only main function – that Community Health Committees around the world are expected to play. CHWs and other health volunteers need the support of a managing structure at the community level!

Relevant resource for building capacity in this role:

- Session 2: Supporting CHWs

Role 3: Information Management: Tracking and Reporting Community Health Status

This is also a role that most if not all COMMs should play. The COMM should track health indicators based on data collected by CHWs and health facilities in the area (this data will differ by country), monitor for any disease outbreaks, and report this information to all relevant stakeholders. In your programme areas you will want to strongly recommend and ensure that the COMM holds quarterly debriefing meetings in the community with all health stakeholders to report and discuss the community health situation.

Relevant resources for building capacity in this role:

- Session 5: Tracking Community Health Status
- Session 6: Reporting Community Health Status

Role 4: Participatory Learning and Action

This is an additional role that COMMs can play if they have the time available to do so. COMMs normally take on a *management* function in communities: linking stakeholders, supporting CHWs and tracking and reporting on the health situation. In addition, however, COMMs can also *carry out activities themselves* to improve the health of their communities. Not all COMMs will do this, but many will. To do so requires carrying out a situation analysis, planning and mobilising for action, regularly monitoring the results of the action, and learning from experience. COMMs can play a valuable role in responding to community-level barriers that often stand in the way of optimal health behaviours.

Relevant resources for building capacity in this role:

- Session 3a or 3b: Root-cause Analysis of Health Issues
- Session 4: Responding to Health Issues and Barriers, and Mobilising for Action

Role 5: Advocacy

COMMs have an important role to play in monitoring health services at the local level, providing feedback and evaluation of health centre services and policies, guiding clinics on how to be responsive to community needs, and advocating for improvements as needed.

Relevant resource for building capacity in this role:

- Facilitator's Guide to Citizen Voice and Action

Role 6: Supervising CHWs

This is a role that only some COMMs will play, and only in situations where the Ministry of Health is not formally supervising the CHWs. This may happen if the MoH does not have sufficient resources to do so, or if the CHWs or other volunteer health workers are not officially linked to the MoH. The CHW supervision role is different from the support role and requires special training.

Relevant resources for building capacity in this role:


- MoH training curriculum for CHWs, if applicable
- Timed and Targeted Counselling resources, including supervision

WITH THE COMM

1. Begin by asking the COMM members what they understand their roles to be.
2. Review the policies and guidelines that the MoH has with respect to community health committees (or similar name), and ask the COMM what the MoH and health facilities expect of the COMM.
3. If there are new or additional roles that your organisation plans to help the COMM undertake, discuss those now.
4. Lay out the role cards where all can see them. Review the cards one by one, explaining each role clearly and agreeing with the COMM members if each is a role they are expected or have decided to play, or not.
5. Turn the cards over to make the point that there are capacity-building processes and training sessions available to help the COMM perform each of these roles.
6. The COMM members take the cards corresponding to their roles. The cards may be pasted into the COMM's book or on flipchart paper next to the member cards.
7. Explain that you will carry out an assessment with the COMM members to explore their strengths together, and to decide in which areas they might need to build their capacity.

Optional Extra: You may carry out the activities in the embedded document (Practice with COMM Roles) as a fun way of reviewing and 'opening their minds' to the roles that they can play.

Tip!



Remember, if the COMM has decided to create its own book, members can paste the role cards into the book. If they have any photographs where they are performing these roles, those can be included too.



Practice with COMM
Roles.docx

ROLE CARDS (To photocopy or transfer or write on durable cards. Training sessions should be written on the back of the role cards.)

<p style="text-align: center;">ROLE CARD</p> <p style="text-align: center;">LINKAGES AND NETWORKING</p>	<p style="text-align: center;">ROLE CARD</p> <p style="text-align: center;">SUPPORTING CHWs OR OTHER HEALTH VOLUNTEERS</p>	<p style="text-align: center;">ROLE CARD</p> <p style="text-align: center;">SUPERVISING CHWs</p>
<p style="text-align: center;">ROLE CARD</p> <p style="text-align: center;">INFORMATION MANAGEMENT</p> <ol style="list-style-type: none"> 1. TRACKING COMMUNITY HEALTH STATUS 2. REPORTING COMMUNITY HEALTH STATUS 	<p style="text-align: center;">ROLE CARD</p> <p style="text-align: center;">PARTICIPATORY LEARNING AND ACTION FOR HEALTH</p> <ol style="list-style-type: none"> 1. ROOT-CAUSE ANALYSIS OF HEALTH ISSUES 2. RESPONDING TO ISSUES AND MOBILISING FOR ACTION 3. TRACKING COMMUNITY HEALTH STATUS 4. REPORTING COMMUNITY HEALTH STATUS 	<p style="text-align: center;">ROLE CARD</p> <p style="text-align: center;">ADVOCACY</p>

END OF MEETING I

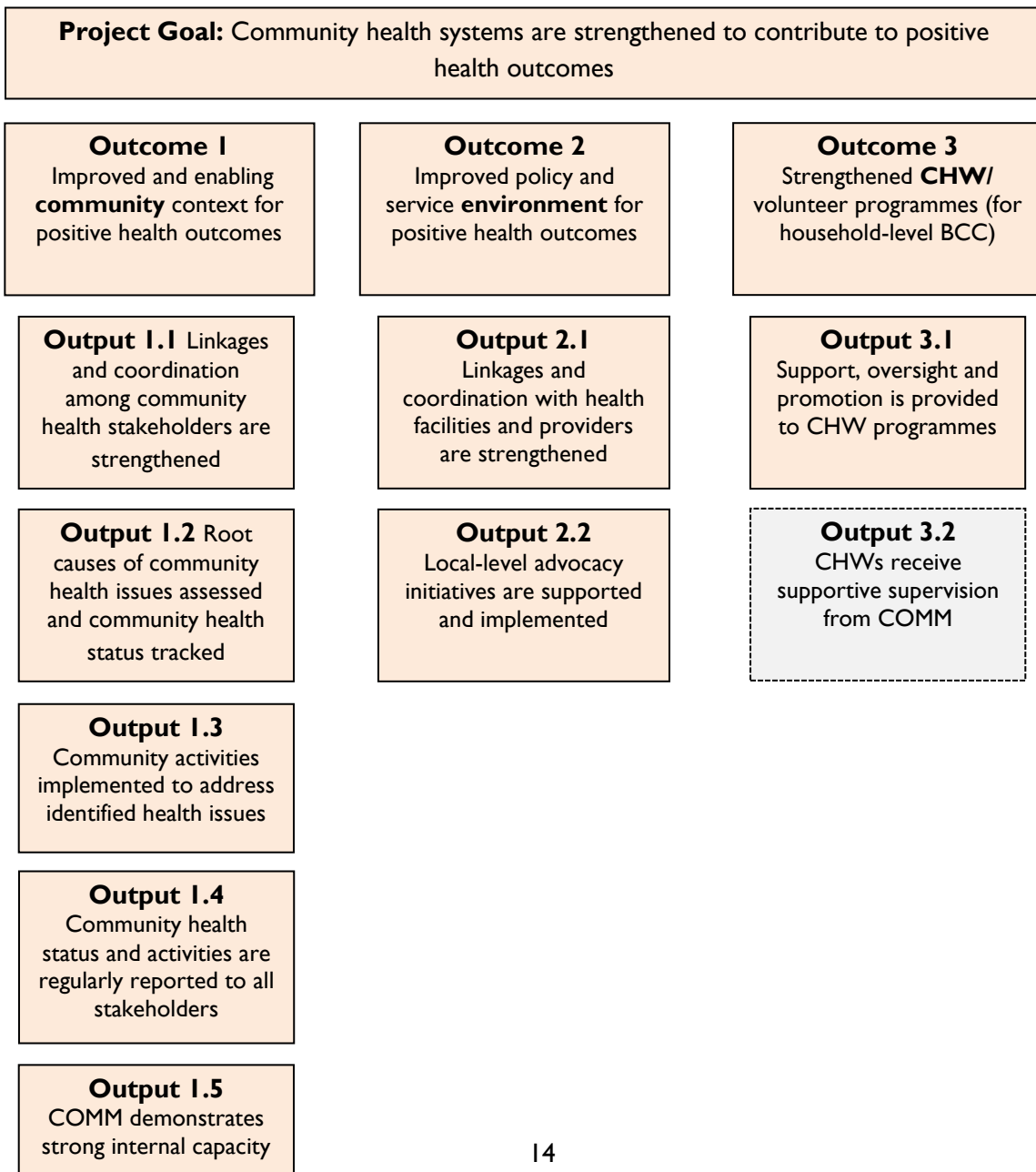
4. LOGICAL FRAMEWORK (FOR FACILITATOR ONLY)

FOR THE FACILITATOR

When you have completed this first meeting with the COMM, you will know what the goal, outcomes and outputs of your work with the group will be. The outputs and outcomes you can expect will depend on the roles that the COMM is playing. If there are some roles the COMM is not playing, then there will be some outputs, and possibly outcomes, that you cannot expect.

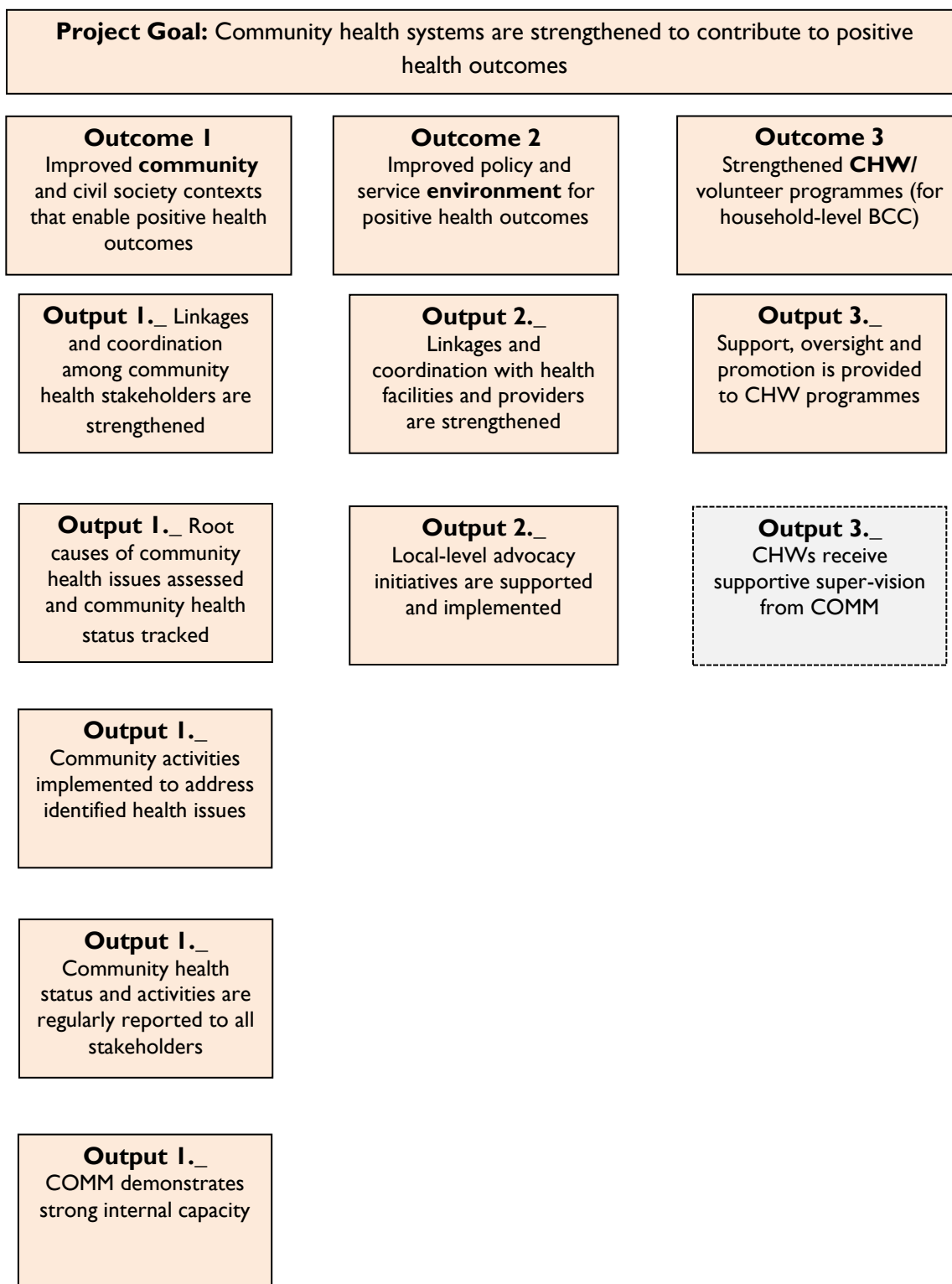
Cut out the cards on the next page. Refer to the chart below which represents all of the *possible* outputs and outcomes, based on the COMM’s roles. On a separate sheet of paper or in your COMM book, paste only those cards corresponding to the outputs and outcomes that your work with the COMM can result in, based on their roles. This will become your project logical framework, or ‘logframe’. Number the outputs as appropriate for your project.

Note: This is for your own use – you do not need to review it with the COMM. However, you can if you would like to.



LOGFRAME CARDS

For facilitator use only. Cut out and paste on a separate paper those cards corresponding to your programme with the COMMs, based on their roles.



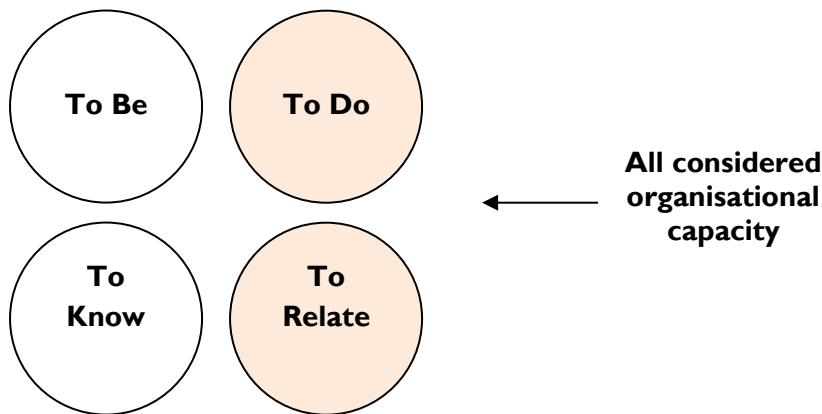
PHASE 2: PREPARING FOR CAPACITY BUILDING

5. COMM CAPACITY OVERVIEW (FOR FACILITATOR ONLY)

FOR THE FACILITATOR

There are various ways of describing the overall capacity of groups such as a COMM. It is common to distinguish between the group’s organisational capacity – the strengths of the group itself, internally – and its technical capacity – the health-related activities the group carries out in the community and the linkages and relationships it creates.

Another way of understanding capacity, however, is to say that all of these areas represent organisational capacity; not only the strengths of the COMM internally as a group, but also the things that it does and the relationships it has with others. In this way of understanding, organisational capacity is observed both internally and in the external environment, and can be described in terms of ‘to know’ and ‘to be’ (internal), and ‘to do’ and ‘to relate’ (external). We will work with this way of understanding capacity.



CAPACITY-BUILDING RESOURCES

Facilitator’s Manual for Community Health Committees (COMM) (‘To Do’, ‘To Relate’)

This *Facilitator’s Manual for Community Health Committees (COMM)* focuses mainly on the ‘to do’ and ‘to relate’ categories of capacity; those which in some definitions would be considered technical capacity. This manual does not focus on the ‘to be’ areas; those areas more traditionally considered as organisational capacity. This is not to say that the ‘to be’ areas are not important – they are! In fact, you helped the COMM to come up with an action plan for putting the minimum ‘to be’ elements in place in meeting 1, when the COMM addressed membership and roles.

Facilitator’s Guide to 7-11 Health Information (‘To Know’)

The supplementary *Facilitator’s Guide to 7-11 Health Information* is the resource you will use to ensure that the COMM has an adequate understanding of maternal, newborn and child health (MNCH) information.

- If the COMMs you are working with are involved in programming outside the MNCH life cycle stages, such as working with adolescents or adult men, then you may need to locate additional resources to ensure the members have an adequate understanding of the health information on those topics.
- In many cases, the MoH will also have a curriculum aimed at improving the health knowledge of community groups, in which case it would be appropriate to use those materials.

Organisational Capacity Building in the Development Programme Approach ('To Be', 'To Do', 'To Relate')

World Vision's *Organisational Capacity Building in the Development Programme Approach* publication (embedded) covers the three categories of 'to be', 'to do' and 'to relate' (considering all of these as organisational capacity areas), and it is a good resource for focusing on all three categories. It is important to understand, however, that while this resource is good for strengthening 'to do' and 'to relate' capacities of a group generally, you will still need to use the COMM materials to address the COMM's health-specific 'to do' and 'to relate' capacities.

As your COMM begins to mature, you may choose to carry out a complete organisational capacity self-assessment (referred to as OCSA) using this supplementary resource. The OCSA is more robust than the lighter Appreciative Discovery found in this *Facilitator's Manual for Community Health Committees (COMM)*. If you carry out an OCSA, you may then choose to work with the COMM in much more detail in any of the prioritised 'to be', 'to do' or 'to relate' areas listed, according to the results of the OCSA.

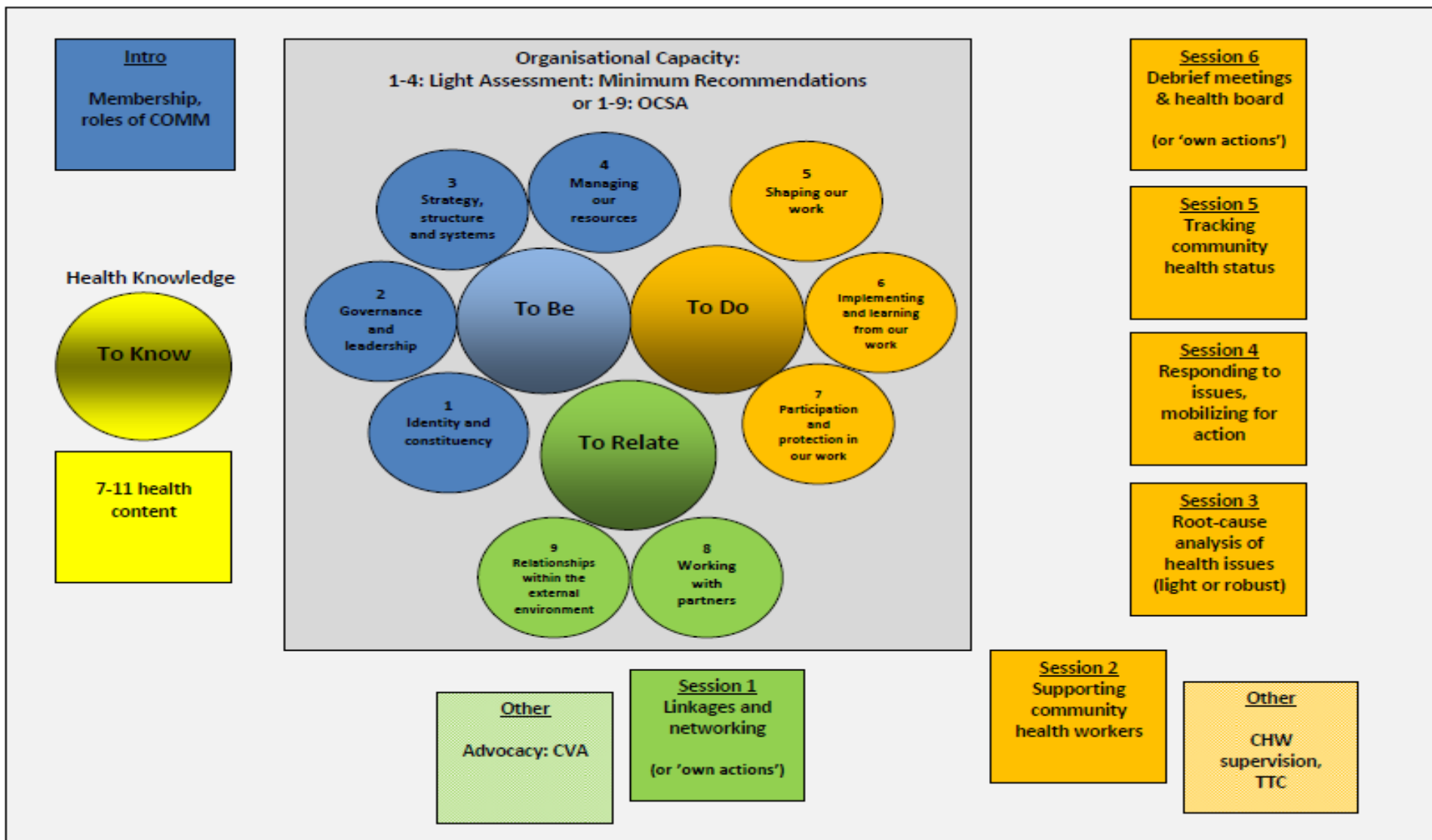
- Capacity Cluster 1: Identity and Constituency ('To Be')
- Capacity Cluster 2: Governance and Leadership ('To Be')
- Capacity Cluster 3: Strategy, Structure and Systems ('To Be')
- Capacity Cluster 4: Managing the Resources ('To Do')
- Capacity Cluster 5: Shaping the Work ('To Do')
- Capacity Cluster 6: Implementing and Learning from the Work ('To Do')
- Capacity Cluster 7: Participation and Protection in our Work ('To Relate')
- Capacity Cluster 8: Working with Partners ('To Relate')
- Capacity Cluster 9: Within the External Environment ('To Relate').

CAPACITY-BUILDING DIAGRAM

Diagram 2 provides an overview of the capacity-building possibilities for the COMM.

1. The central square shows the COMM's general organisational capacities that you may work on using the *Organisational Capacity Building in the Development Programme Approach* resource.
2. In the first meeting with the COMM you already dealt with questions of membership and roles, which are elements of the COMM's internal capacity (to be).
3. You will carry out an appreciative discovery with the COMM: either a 'light' one using the Appreciative Discovery in this *Facilitator's Manual for Community Health Committees (COMM)*, or a full one using the OCSA. As part of the assessment, you will ensure that the group puts the minimum recommendations for group functioning (to be) in place (see later sections).
4. You will ensure that the group has the necessary health knowledge to do its work, using the *Facilitator's Guide for 7-11 Health Information*, a MoH curriculum, or other supplementary materials for different life cycle stages as relevant and as needed (to know).
5. This *Facilitator's Manual for Community Health Committees (COMM)* offers six sessions for building the health-specific capacity of the COMM as needed per their roles ('to do' and 'to relate'). And note! Sometimes it will not be necessary to carry out a training in order to help build the COMM's capacity! Sometimes it is sufficient to simply support the members in their activities as they develop the capacity themselves. You will notice this in the diagram where it says ('or own actions').
6. Other resources are available if the COMM is directly supervising CHWs or involved in advocacy.

Diagram 2: Health-Specific Organisational Capacity



6. CHOOSE ASSESSMENT (FOR FACILITATOR ONLY)

FOR THE FACILITATOR

You may choose one of the following two assessments in order to learn about the group's strengths, general capacity level, and areas that are in need of strengthening.

- The Appreciative Discovery (Light Assessment) in this *Facilitator's Manual for Community Health Committees (COMM)*
- The full, robust, organisational capacity self-assessment (OCSA) in the *Organisational Capacity Building in the Development Programme Approach* resource.

Scenario 1, For a Newly Mobilised Group: Light Assessment, Part 2 Only

- If the COMM has only just been formed through your mobilisation efforts, then there is clearly nothing to assess in terms of their current capacity.
- As such, you will only carry out Part 2 of the light assessment, using a checklist with the group to put the minimum requirements for group functioning into place.

Scenario 2, For a Pre-Existing Group, Low or Medium Maturity Level: Light Assessment

- If the COMM is pre-existing but has not gained a great deal of skills or experience, then the light assessment is appropriate.
- The light assessment first looks at and appreciates the group's existing strengths.
- It then works with a checklist to put the minimum requirements for group functioning into place (to be).
- Then, it has a checklist of indicators to determine if the group needs capacity-building support in the health-specific areas ('to do' and 'to relate').

Scenario 3, For a Mature Pre-Existing Group: OCSA

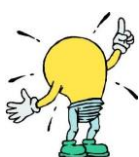
- The OCSA takes the group through a complete 'health check' of all 9 capacity clusters, prioritises two clusters for deeper analysis, and develops a capacity-building plan to address areas that need strengthening.

Tip!



You will find an online training in eCampus that will help prepare you to carry out the OCSA. This training takes about two hours to complete. You can work through it at your own pace, and it is fun!

Tip!



Even if you select the light assessment for the group now, you should plan to carry out the OCSA with the group later on, as it matures. The OCSA will round out the group's capacity, especially in the 'to be' areas that are only lightly touched on in this manual.

Tip!



If you are not sure which assessment to choose, look at the table (embedded document) for an overview of the capacity areas and indicators covered in each.



OCB -DPA How to guide.pdf

MEETING 2: ASSESSMENT AND CAPACITY-BUILDING PLAN

7. CARRY OUT ASSESSMENT WITH THE COMM

WITH THE COMM

FOR A NEWLY FORMED GROUP USING THE APPRECIATIVE DISCOVERY, (LIGHT ASSESSMENT), PART 2 ONLY

1. If you are working with a newly formed group, follow the instructions in Part 2 of the Appreciative Discovery (Light Assessment) tool. The group will look at the checklist for the minimum requirements for group functioning to determine what the group may still need to put into place.
2. At the end of this appreciative discovery process, the group must create an action plan for putting the missing requirements in place.

FOR A PRE-EXISTING GROUP USING THE APPRECIATIVE DISCOVERY, (LIGHT ASSESSMENT)

1. Follow the instructions in the Appreciative Discovery (Light Assessment), Parts 1 to 3.
2. By the end of Part 2, the group must have an action plan for putting the minimum requirements for group functioning into place, if they are not in place already.
3. When you are reviewing the Checklist of Indicators of Health-Specific Capacity per Session (in Part 3) you will only focus on the indicators that correspond to the COMM's roles! You will not assess the group's skills in roles that it is not carrying out.
4. By the end of Part 3, you and the COMM will have a good idea of the health-specific capacity areas that they need support in, and the relevant training sessions.

FOR A PRE-EXISTING GROUP USING THE OCSA

Note that the OCSA normally requires more than one meeting to complete.

1. Follow the instructions in the *Organisational Capacity Building in the Development Programme Approach* materials for the OCSA process.
2. By the end of the process, the COMM will have put together a capacity-building plan for one or two prioritised capacity clusters. The plan will include actions the members can do themselves, actions they can do with others, and possibly actions they can only do with help. This help includes selected trainings.
3. As you and the COMM agree on trainings that the group may require, do not limit yourselves to the resources included in the OCSA materials; rather, remember that you should refer to this *Facilitator's Manual for Community Health Committees (COMM)* as well, as appropriate.

8. EXPLAIN THE CAPACITY-BUILDING PLAN

FOR THE FACILITATOR

Now that you have carried out the assessment, you and the group will make plans for building the group's capacity in identified areas. Remember that capacity building is more than just training! In fact, very often a group can take action on its own to build its capacity, without the need for special trainings. You will help the group distinguish between:

- things they can do themselves (or with others in the community) to build their own capacity
- things they can do with help; usually in the form of training and mentoring.

General Organisational Capacity ('To Be')

In the case of the minimum recommendations for group functioning, the expectation is that the COMM can put most of these in place on its own, following through with the action plan developed during the assessment. For more advanced areas of organisational capacity, the group may request assistance or training from you.

Health-Specific Capacity ('To Do' and 'To Relate')

The same is true for the health-specific capacity areas. In some cases the COMM can build its health-specific capacity on its own through actions it takes, while in other cases the COMM will need your assistance and training.

As you move through these sections with the COMM you will make these decisions together.

You will develop a capacity-building plan with the COMM by selecting cards for the different areas of capacity and putting them in a sequence at the end. Look at the Health-Specific Organisational Capacity Diagram, presented previously, to follow along! You will work in the following order:

- health information
- health-specific capacity
- other specialised trainings the COMM may need
- general organisational capacity.

WITH THE COMM

1. Remind the COMM members that they can build their capacity not only through trainings that you provide, but also through actions that they carry out themselves or with others in the community.
2. Explain that you are going to be looking at each area of capacity one at a time and selecting cards for each area. At the end, you will put all of the cards in a sequence to represent the capacity-building plan

9. SELECT HEALTH INFORMATION CAPACITY CARDS

FOR THE FACILITATOR

This section is represented by the yellow-coded Health Knowledge area on the Health-Specific Organisational Capacity Diagram.

- For COMMs that focus on maternal, newborn and child health (MNCH) issues, it is important to ensure that the groups have sufficient factual information to carry out their roles. The companion *Facilitator's Guide to 7-11 Health Information* is available for this purpose and it is advisable that you carry out this training with all COMMs.
- If the COMM is working on health issues outside the MNCH lifecycle (such as adolescents or men's health), then you will need to identify other resources to ensure that the group has the necessary factual information on those topics.
- Additionally or alternatively, if the MoH or other partners have developed health curricula, decisions will have already been made at the national level to work with these materials. This is something you will have been informed of.

In general, these curricula decisions will have already been made at the national level and it will simply be a matter of explaining to the COMM that you will be training them in the health information accordingly.

WITH THE COMM

1. Lay out the health information cards where all can see them. Explain that each country is different, meaning that different countries may be working with different sets of materials, as these three cards show. Then explain that the health information training needed in your region or country has already been agreed on.
2. Select the card or cards corresponding to the curricula that will be used in your country. If you are working for World Vision, in many if not most contexts this will be the *Facilitator's Guide to 7-11 Health Information*.
3. Save the card or cards that have been selected. You will sequence them later.

HEALTH INFORMATION CARDS (to photocopy or print or write on durable, coloured paper)

<p>HEALTH INFORMATION TRAINING CARD</p> <p>7-11 HEALTH INFORMATION TRAINING</p>	<p>HEALTH INFORMATION TRAINING CARD</p> <p>MINISTRY OF HEALTH HEALTH INFORMATION CURRICULUM (INDICATE)</p> <hr/>	<p>HEALTH INFORMATION TRAINING CARD</p> <p>OTHER HEALTH INFORMATION TRAINING (INDICATE)</p> <hr/>
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10. SELECT HEALTH-SPECIFIC CAPACITY CARDS

FOR THE FACILITATOR

This section refers to the orange and green squares with session titles on the Health-Specific Organisational Capacity Diagram. The potential trainings that will be selected in this section are found in this *Facilitator's Manual for Community Health Committees (COMM)*.

The choices that will be made depend on various factors:

1. The COMM's roles. Refer to the role cards selected in Section 3. The specific training sessions corresponding to the roles are indicated on the backs of the cards.
2. The results of the assessment. It may be that the COMM does not need capacity building in select areas because it has either already received training (through the MoH or other partners, for example) or is already carrying out the role-specific functions effectively.
3. In some cases the COMM may build its capacity through actions it takes on its own rather than through training. This is particularly the case for the Linkages and Networking training, where it may be sufficient for you to assist the COMM in forming linkages with other stakeholders rather than carrying out Session 1, and for the Reporting Community Health Status training, which involves carrying out debriefing meetings and maintaining a community health board. The COMM may not need to go through the Session 6 training to be able to perform these functions.

WITH THE COMM

1. Lay out the health-specific capacity cards where all can see them. Discuss the following training choices one at a time.

Linkages and Networking

This is a role that all COMMs should play. It may be the case that the COMM can build its capacity simply through taking action in this area, perhaps with your assistance. If so, the first card should be selected, and the actions that you agree on should be written on the back of the card. Alternatively, if you and the COMM members would like to go through the activities in Session 1, then you will select the second card.

Important! If the COMM selects the card for its own actions, you should provide them with Tool 1-1, COMM Action Planning and Monitoring Tool: Linkages and Networking, found in your materials for Session 1. This is where they will record and track their actions and the achievement of the goals for this role.

Supporting CHWs

If this is one of the COMM's roles, then the card for Session 2 should be selected. Even if the COMM has already gained experience in this area, Session 2 is less about training the group and more about summarising the respective responsibilities of the COMM, the supervisor and the MoH. It is important to carry this out with all COMMs that have this role.

Root-Cause Analysis of Health Situation

If the COMMs play this role, there is a choice here between a light or a robust Session 3a or 3b respectively. The robust root-cause analysis will enable a very thorough examination of the issues and barriers in the community, through a schedule of carefully-planned focus group discussions. The ability to carry this out will depend on the time commitments and availability of the members. The light root-cause analysis will not take as much time, while still involving and listening to a broad range of community members. Reach agreement on which version of Session 3 you would like to train the COMM in and select the appropriate card.

Responding to Issues and Barriers, and Mobilising for Action

If the COMM will be doing a root-cause analysis, then they will continue with Session 4. The two sessions go together and one cannot be done without the other. If the card for Session 3a or 3b was selected, the COMM should now select the card for Session 4.

Tracking Community Health Status

It is recommended that all COMMs should play this role. Training in this area is normally required – it will not be easy for a COMM to know how to track community health status without training. In most cases you will select the card for Session 5.

Reporting Community Health Status

In Session 6 the COMM is taught to carry out quarterly debriefing meetings and maintain a community health board. It is recommended that all COMMs play this role. However, it may not be necessary to carry out the formal Session 6 training; rather, you can simply assist the COMM to put these mechanisms in place. In that case, select the first card for this topic and write the agreed-upon actions on the back of the card. Session 6 is not terribly time-consuming to carry out, however; so if you and the COMM decide you would like to go through the session, that is fine too, and you should select that card.

Important! If the COMM selects the card for its own actions, you should provide the group with Tool 6-2, COMM Action Planning and Monitoring Tool: Reporting Community Health Status, found in your materials for Session 6. This is where they will record and track their actions, and the achievement of the goals for this role.

2. Save the cards that have been selected. You will sequence them later.

HEALTH-SPECIFIC CAPACITY CARDS (to photocopy or print or write on durable, coloured paper)

<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>LINKAGES AND NETWORKING</p> <p>OUR OWN ACTIONS</p> <p>(LIST ON BACK)</p>	<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>LINKAGES AND NETWORKING</p> <p>SESSION 1 TRAINING</p>	<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>SUPPORTING CHWs</p> <p>SESSION 2 TRAINING</p>
<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>ROOT-CAUSE ANALYSIS</p> <p>SESSION 3A TRAINING (LIGHT VERSION)</p>	<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>ROOT-CAUSE ANALYSIS</p> <p>SESSION 3B TRAINING (ROBUST VERSION)</p>	<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>RESPONDING TO ISSUES, MOBILISING FOR ACTION</p> <p>SESSION 4 TRAINING</p>
<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>TRACKING COMMUNITY HEALTH STATUS</p> <p>SESSION 5 TRAINING</p>	<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>REPORTING COMMUNITY HEALTH STATUS</p> <p>OUR OWN ACTIONS</p> <p>(LIST ON BACK)</p>	<p>HEALTH-SPECIFIC CAPACITY CARD</p> <p>REPORTING COMMUNITY HEALTH STATUS</p> <p>SESSION 6 TRAINING</p>

11. SELECT OTHER CAPACITY CARDS, IF NECESSARY

FOR THE FACILITATOR

This section is represented on the Health-Specific Organisational Capacity Diagram by the light orange and light green squares entitled 'Other'. There are separate resources for these trainings, if needed. The choices that will be made depend on the following factors.

1. Whether or not the COMM is directly supervising CHWs. Note that this is a different role from supporting CHWs, which many COMMs, if not most, will do. Formally supervising CHWs is different, and is a role that the COMM might need to play if the MoH does not have the resources to do so itself, or if the health volunteers are not formally linked to the MoH. Refer back to the role cards selected earlier. If the COMM is playing this role, the following trainings will be required:
 - supervision (see separate resources)
 - the ttC or MoH curriculum in which the CHWs have been trained.
2. If advocacy programming is being carried out in the area and if the COMM will be taking on an advocacy role, then the COMM should be trained in Citizen Voice and Action (CVA). (See separate resources.)

In general, these curricula decisions will have already been made at the national level and it will simply be a matter of explaining to the COMM that you will be training the group in these areas.

WITH THE COMM

You will only select other capacity cards with the COMM if one or both of the above situations applies. If not, skip this section.

1. Lay out the other capacity cards where all can see them.
2. Select the card or cards corresponding to the additional trainings that the COMM will need in order to perform its remaining roles.
3. Save the card or cards that have been selected. You will sequence them later.

OTHER CAPACITY CARDS (to photocopy or print or write on durable, coloured paper)

<p>OTHER CAPACITY CARD</p> <p>SUPERVISING CHWs: TRAINING</p>	<p>OTHER CAPACITY CARD</p> <p>TIMED AND TARGETED COUNSELLING (TTC) TRAINING</p>	<p>OTHER CAPACITY CARD</p> <p>MINISTRY OF HEALTH CURRICULUM FOR CHWs (INDICATE)</p> <hr/>
<p>OTHER CAPACITY CARD</p> <p>CITIZEN VOICE AND ACTION (CVA)</p>	<p>OTHER CAPACITY CARD</p> <p>OTHER LOCAL-LEVEL ADVOCACY TRAINING (INDICATE)</p> <hr/>	

12. SELECT GENERAL ORGANISATIONAL CAPACITY CARDS

FOR THE FACILITATOR

In this section, if the COMM selects only cards for actions that it will take on its own, then your role will simply be to assist and support the group as it carries out these actions.

If you and the COMM feel that additional assistance with general organisational capacity building is needed – either now or sometime later down the road – then additional cards will be selected for that. See the nine capacity areas in the central square of the Health-Specific Organisational Capacity Diagram. In these cases, you will refer to *Organisational Capacity Building in the Development Programme Approach* for instructions and resources.

WITH THE COMM

1. Explain that you will begin by making a plan for building the COMM's general organisational capacity. Remind the group that there are minimum recommendations for group functioning that you looked at together if you did the light assessment. Some COMMs will already have these minimum recommendations in place. Others COMMs will not yet have the recommendations in place but will have developed an action plan for this during the assessment.
2. Besides the minimum recommendations, there are other areas of organisational capacity that you and the COMM may decide are important to build, either in the short term or later in the group's journey.
3. Lay out the general organisational capacity cards where all can see them. Point out that some cards concentrate on actions the COMM can do itself, while other cards are for requesting trainings.
4. If the COMM created an action plan during the assessment for putting the recommended standards for effective group functioning into place, then the first card should be selected, and the actions from the action plan should be written on the back of the card.
5. If you carried out the OCSA, then the COMM may have identified other actions it can take on its own to strengthen other organisational capacity areas. If this is the case, then one or more 'our own actions' cards should be selected. The name of the capacity area should be written on the front of the card, and actions from the COMM's action plan should be written on the back.
6. Then, if there are specific organisational capacity areas that you and the COMM agree need further strengthening through assistance or trainings provided by you, take one or more cards for that purpose, writing the name of the capacity area on the front of the card. Later, you will agree on when you will carry out these trainings.
7. Save all the cards that have been selected. You will sequence them later.

GENERAL ORGANISATIONAL CAPACITY CARDS (to photocopy or print or write on durable coloured paper)

<p style="text-align: center;">GENERAL ORGANISATIONAL CAPACITY CARD</p> <p style="text-align: center;">MINIMUM RECOMMENDATIONS:</p> <p style="text-align: center;">OUR OWN ACTIONS</p> <p>WRITE ACTIONS ON BACK, TAKEN FROM ACTION PLAN DEVELOPED DURING APPRECIATIVE DISCOVERY: (LIGHT ASSESSMENT)</p>	<p style="text-align: center;">GENERAL ORGANISATIONAL CAPACITY CARD</p> <p style="text-align: center;">CAPACITY:</p> <hr style="width: 20%; margin: auto;"/> <p style="text-align: center;">OUR OWN ACTIONS (LIST ON BACK)</p>	<p style="text-align: center;">GENERAL ORGANISATIONAL CAPACITY CARD</p> <p style="text-align: center;">CAPACITY:</p> <hr style="width: 20%; margin: auto;"/> <p style="text-align: center;">OUR OWN ACTIONS (LIST ON BACK)</p>
<p style="text-align: center;">GENERAL ORGANISATIONAL CAPACITY CARD</p> <p style="text-align: center;">CAPACITY:</p> <hr style="width: 20%; margin: auto;"/> <p style="text-align: center;">WE REQUEST TRAINING IN THIS CAPACITY</p>	<p style="text-align: center;">GENERAL ORGANISATIONAL CAPACITY CARD</p> <p style="text-align: center;">CAPACITY:</p> <hr style="width: 20%; margin: auto;"/> <p style="text-align: center;">WE REQUEST TRAINING IN THIS CAPACITY</p>	<p style="text-align: center;">GENERAL ORGANISATIONAL CAPACITY CARD</p> <p style="text-align: center;">CAPACITY:</p> <hr style="width: 20%; margin: auto;"/> <p style="text-align: center;">WE REQUEST TRAINING IN THIS CAPACITY</p>

13. SEQUENCE THE CAPACITY-BUILDING SCHEDULE

FOR THE FACILITATOR

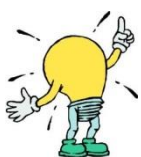
Now all you have to do is agree with the COMM on the sequence in which to carry out the capacity-building plan! It is recommended that these steps happen first:

- Minimum requirements for effective group functioning: COMM's own actions
- Health information training (7-11 or other), carried out over time
- Linkages and Networking: COMM's own actions, or Session 1
- Supporting CHWs: Session 2 for all COMMs playing this role.

After these steps, the remaining cards can be put in whatever sequence is felt to be most logical.

WITH THE COMM

1. Explain that there is a recommended sequence for getting started, listed above. Put the three or four corresponding cards in order. Together with the COMM, decide on the sequence for the remaining cards. Post the cards in the COMM's book or on a wall visual, perhaps designed to look like a road.
2. Decide on the approximate scheduling for the capacity building. Remember, you do not need to carry out all of the trainings and capacity-building actions right away, and you should not feel like you are in a hurry! You may work over a period of 12 to 18 months, for example, building capacity, assisting the COMM as it begins to work, conducting more training, interspersing organisational capacity building with health-specific capacity building, mentoring the COMM, and other activities. Develop a realistic schedule!
3. And one last thing! **Monitoring Tool A**. Once you begin carrying out trainings with the COMM, you will track these trainings using Monitoring Tool A, found in the annex. Take a moment now to write the names of all the members on the front page. Notice that each member is assigned a number which carries over to the second page, enabling you to tick their attendance at the trainings. Now in the row labelled 'date', write N/A in the spaces for all of the trainings that you will not carry out with the group based on the results of the assessment and capacity-building plan. This information is needed in order to have accurate data. It will avoid your supervisor asking why you have not trained the COMM in those sessions! This way, your supervisor will know that the trainings you have not carried out are not applicable for this COMM.



Tip!

You may want to type up a training schedule overview and give one copy to each member. There can be space next to each training for the member to sign his or her name and the date, assuming he or she attends the session. You can sign the form at the end to show that the member has 'graduated'. It is found that this type of learning schedule and graduation can be motivating!

PHASE 3: CARRY OUT CAPACITY BUILDING

14. FACILITATOR ACTIVITIES: TOOLS FOR MONITORING

FOR THE FACILITATOR

Now you can start carrying out capacity-building sessions with the COMM, according to the programme you put together with the group. It is a good idea to refer back to the tips for training and facilitation found in the introduction!

There is a monitoring system that goes along with the COMM programme, made up of four tools, found in the annex. The data from these tools should be entered into a spreadsheet by an identified colleague to provide aggregated results for all the COMMs your programme is working with. Depending on arrangements made at the national level, this monitoring system may or may not be incorporated into MoH systems.

The trainings and support you provide to COMMs represent programme activities. In logical frameworks (logframes), activities lead to outputs which lead to outcomes. This means that the trainings you carry out with the COMMs, and the support you provide to them, will help to enable the COMMs to achieve the outputs that you saw in your logframe in Section 4 of this overview.

Monitoring Tool A

Monitoring Tool A is filled out by you. You will use one Tool A for every COMM you are working with. On the front you will record the names and pertinent information for each COMM member, and on the back you will track the trainings you carry out with the group. This is a way of recording that the project activities are in fact taking place. You will turn in a copy of every Tool A to your supervisor or manager on a quarterly basis. You should ask your supervisor or manager to share the aggregated results with you!

Monitoring Tool B

Monitoring Tool B is filled out by your supervisor or manager. It is meant for quality assurance. Your supervisor should join you for one or more COMM trainings to observe your skills. He or she will use Tool B to record his or her observations. This is a way of ensuring the quality of the programme activities. Your supervisor should support and mentor you as you grow in your skills as a facilitator and trainer! Tool B is helpful for that.

WITH THE COMM

1. Make sure that each COMM member is listed on Tool A.
2. Fill in Tool A every time you carry out a training with the COMM. Write the date of the training, and put a tick for each member who participated (each member has a number). Give this to your supervisor or manager on a quarterly basis. Make sure he or she gives it back to you.
3. Invite your supervisor to come to a COMM training so that he or she may observe you and fill out Tool B. Request that the supervisor provide you with support and mentoring based on his or her observations.

PHASE 4: COMM CARRIES OUT ITS ROLES

15. COMM ACTIONS: TOOLS FOR MONITORING

FOR THE FACILITATOR

As the COMM builds its capacity in the various areas, it will begin to carry out its roles. This is exciting! Depending on what the COMM's roles are, you will begin to see:

- more and stronger links between the COMM, the health facility, CHWs and the community at large
- the COMM supporting CHWs; greater efficiency and effectiveness of CHW programming
- the COMM involved in participatory learning and action, including situation and root-cause analysis, action planning and learning from results
- the COMM involved in tracking and reporting the community health situation
- quarterly debriefing meetings with all stakeholders and a regularly updated community health board
- activities of an advocacy nature.

To the extent that the COMMs are performing these functions, you will be seeing programme outputs.

Monitoring Tool C

Monitoring Tool C is the Action Planning and Monitoring Tool that the COMM will receive for every role that it is performing. Each one of these begins with one or more goals. These goals for the COMM are indicators that logframe outputs have been achieved. The COMM will write its action plans for achieving these goals or indicators, and record its progress in completing the actions in the action plan.

Remember that you should collect these Action Planning and Monitoring Tools (Monitoring Tool C) from the COMM every quarter and give them to the individual responsible for inputting data into the monitoring system. He or she will record every time a 'goal' (indicator) is achieved on any of the tools. You will return these documents to the COMM after you have received them back.

Monitoring Tool D

Monitoring Tool D is filled out by you. It assists the COMMs to ensure the quality of their actions. To put it another way, it is a tool to help you mentor the COMMs. You should join the COMMs from time to time as they are carrying out their roles. You can use Tool D to see if the COMM is working successfully; and you can support and mentor the COMM to continue to grow in these areas.

WITH THE COMM

1. Assist the COMM in completing the Action Planning and Monitoring Tool (Monitoring Tool C) corresponding to each of its roles. Collect these from the COMMs on a quarterly basis and give them to the individual in your programme responsible for data input. Make sure this individual returns the tools to you and that you return them to the COMM. Alternatively, you can arrange to make photocopies of the tools so that you do not have to borrow the originals from the COMM.
2. Find opportunities to accompany the COMM as it carries out its roles. Use these times as mentoring and support opportunities. You may use Tool D to guide you as you observe the COMM's work and provide the group with feedback.

16. MINIMUM STANDARDS FOR COMM IMPLEMENTATION (FOR FACILITATOR ONLY)

FOR THE FACILITATOR

In a logframe, programme activities lead to outputs which lead to outcomes. Programme activities can only be expected to lead to outputs, however, if they are carried out well; with quality! There are some minimum standards with regard to the activities you carry out with COMMs, shown in the matrix below. Review these minimum standards to make sure you are able to meet them. If you have any areas of doubt, consult with your supervisor.

Essential Element 1: COMM Capacity Building			
Level 1 Standards not met	Level 2 Standards partially met	Level 3 Minimum standards	Level 4 Good to have
<ul style="list-style-type: none"> Capacity building of COMMs is carried out by facilitators who may not have received passing scores in the facilitator training. There is no systematic plan for the capacity building of COMMs. 	<ul style="list-style-type: none"> Certified COMM facilitators carry out the capacity building of COMMs. COMM capacity building follows the curriculum in a linear fashion with no prior needs assessment. COMMs receive a limited 7-11 orientation but are not provided with ongoing capacity building with regard to basic health information. COMM general organisational capacity building is disregarded. Long delays between training sessions are common. 	<ul style="list-style-type: none"> Only certified COMM facilitators carry out the capacity building of COMMs. An appreciative discovery is carried out to understand existing roles and responsibilities of the COMM and trainings received to date, and to determine additional capacity-building needs. COMMs receive training to enable them to carry out their roles and responsibilities on an as-needed basis per the assessment results. COMMs receive factual health information (7-11 or other) on an ongoing basis to upgrade their knowledge base. COMMs receive general organisational capacity building (OCB) on an as-needed basis per the assessment results. There is no more than a three-month gap between any successive trainings. COMMs directly supervising CHWs are trained by qualified facilitators in the CHW activities such as ttC and iCCM. 	<ul style="list-style-type: none"> The robust Organisational Capacity Self-Assessment (OCSA) process is carried out with COMMs to determine the full range of their capacity-building needs. COMMs take ownership of their ongoing organisational growth both with support from partners and on their own.

Essential Element 2: Programme Monitoring and Evaluation			
Level 1	Level 2	Level 3	Level 4
Standards not met	Standards partially met	Minimum standards	Good to have
<ul style="list-style-type: none"> • No monitoring or evaluation system is in place. • The tools corresponding to the WV COMM materials are not being used. • There is no information regarding programming results. 	<ul style="list-style-type: none"> • A system is in place to monitor programme activities and COMM outputs. • Tools A and C are submitted but the data may not be aggregated on a regular basis. • It is not common to report aggregated data results to MoH, staff and COMMs. • Outcome and impact evaluations are rare. 	<ul style="list-style-type: none"> • A system is in place to monitor programme activities and COMM outputs. • Facilitators turn in Tool A to their managers on a quarterly basis. • Facilitators request a copy of Tool C from each COMM on a quarterly basis and submit to managers. • One or more WV or MoH staff is identified for data input, inputting the data from Tools A and C into the COMM monitoring spreadsheet on a quarterly basis. • Aggregated data reports are provided to MoH partners and COMM facilitators who in turn will report back to COMMs. • Programme data is used to inform ongoing programming. • Programme outcome and impact evaluations are carried out at pre-determined time points. 	<ul style="list-style-type: none"> • COMMs routinely report aggregated data results to the wider community.

ANNEX: MONITORING TOOLS A, B, C, D

MONITORING TOOL A. COMM CAPACITY BUILDING (print front and back)

Name of Facilitator: _____

Name of COMM/Community: _____

Age Groups: A: <20; B: 20–24; C: 25–29; D: 30–40; E: >40

Instructions: Write the name of each COMM member and the respective information. Note that the number assigned to the member will transfer to the second page so that member attendance at capacity-building events can be tracked. Copy additional pages if needed.

No.	Name of COMM Member	Gender	Age Group	Entity	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					

(Monitoring Tool A continued)

		Start Up			Health-Specific Capacity Building						Other Capacity Building (as relevant)			
		Meeting 1: Roles and Membership	Appreciative Discovery/ Assessment	7-11 Health Information	Session 1: Linkages and Networking	Session 2: Supporting CHWs	Session 3: Root-Cause Analysis	Session 4: Responding to Health Issues	Session 5: Tracking Health Status	Session 6: Reporting Health Status	Other (Indicate)	CVA	ttC	CHW Supervision
Date	No.													
	1													
	2													
	3													
	4													
	5													
	6													
	7													
	8													
	9													
	10													
	11													
	12													
	13													

MONITORING TOOL B. OBSERVATION AND MENTORING OF FACILITATOR

Name of Mentor/Supervisor: _____

Name of Facilitator: _____

Training Session Observed _____

Date: _____

Scoring: **1** – Unsatisfactory and requires further training. **2** – Average and requires some additional training in specific areas. **3** – Good but with room for improvement. **4** – Very good and no further improvement is required. **N/A** – not applicable

Areas	Score	Comments
Content of the Session		
Carries out all activities		
Follows the instructions given for each activity, making modifications as desired but without losing the intent and the message of the activity		
Ensures that the main point of each activity is clear by the end of the activity		
Answers questions satisfactorily		
Transmits technical content accurately		
Summarises the session at the end		
Ensures that COMM members understand the session		

(Monitoring Tool B continued)

Facilitation Skills		
Speaks clearly, slowly and loudly enough for all to hear; avoids giving long speeches		
Practises active listening, remaining attentive to and interested in participants' contributions		
Conducts the training in a participatory and dynamic manner, attending to different adult learning styles		
Uses visual aids as much as possible		
Allows participants sufficient time to answer (at least 7 to 10 seconds), and probes as needed		
Moves around during group work, providing guidance and support		
Checks for relevance of participants' questions to the subject. Answers those that are relevant; defers answering those that are not by explaining that they will be covered later in the training if they become relevant or will not be covered		

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL A-3: GROUP FUNCTIONING

Note: Only the first page of each COMM Action Planning and Monitoring Tool is presented here. See the corresponding sessions for complete tools (two pages) that you can photocopy to give to the COMM.

Name of COMM: _____ Year: _____ Quarter: Q1 _____ Q2 _____ Q3 _____ Q4 _____

Instructions: Fill in the table below with the activities the COMM will undertake to achieve the minimum recommendations for effective group functioning. Tick the boxes under ‘Goals’ only when the activities are complete and the goals have been achieved.

Goals

- COMM membership includes one representative from each community within the COMM coverage area, at least three women, at least one lead CHW, one representative of the community leadership, and at least one representative from the Ministry of Health or local health facility if possible.
- We have a leadership structure in place, and at least one leader is a woman.
- Leaders are elected by secret ballot.
- New leader elections are held periodically, per an agreed-on rotation period.
- We have a set of written rules to guide our internal procedures, drafted with the participation of all members.
- We meet on a regular basis (such as monthly or quarterly).
- At least 75 per cent of our members are present at meetings.

Does the COMM have a health fund or otherwise manage money? Yes _____ No _____ *(if No, no further action is needed)*

- if yes, we have written procedures in place for the use of this money
- if yes, we have a bookkeeping system with a cashbook and supporting documentation.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL I-I: LINKAGES AND NETWORKING

Name of COMM: _____ Year: _____ Quarter: Q1 _____ Q2 _____ Q3 _____ Q4 _____

Instructions: Fill in the table below with the activities the COMM will undertake to achieve the goals of linkages and networking. Tick the boxes under ‘Goals’ only when the activities are complete and the goal has been achieved.

Goals

- Linkages with the local health facility are established and strong.
- Linkages with the supporting organisation and other partners are established and strong.
- In the past six months the COMM organised at least one debriefing meeting where all community members were invited and at least 10 community members attended.
- In the past quarter a COMM representative attended a health facility committee meeting.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL 2-7: SUPPORTING CHWs

Name of COMM: _____ Year: _____ Quarter: Q1 ___ Q2 ___ Q3 ___ Q4 ___

Instructions: Fill in the table below with the activities the COMM will undertake to support CHWs. Tick the boxes under ‘Goals’ only when the activities are complete and the goals have been achieved.

Goals

- We provided support and oversight of the CHW programme this quarter, in the following ways (tick all that apply):
 - mobilised community to review and contribute to CHW recruitment criteria and CHW roles
 - mobilised community participation in selection of new CHWs
 - tracked CHW training attendance
 - mobilised community to ensure CHWs receive locally-appropriate recognition for good performance
 - provided feedback for CHW performance evaluations and supervision
 - supported the referral system in ways agreed locally
 - carried out spot checks in community to ensure CHWs doing work claimed on reporting forms.
- We had a meeting with CHWs this quarter for support, discussion and feedback.
- We carried out at least one activity in the community this quarter that helped the community to better understand the CHW programme.
- Number of CHWs supported: _____

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL 3A-6: ROOT-CAUSE ANALYSIS (LIGHT)

Name of COMM: _____ Year: _____ Quarter: Q1 _____ Q2 _____ Q3 _____ Q4 _____

Instructions: Fill in the table below with the activities the COMM will undertake to achieve the goal of completing a root-cause analysis of health issues in the community. Tick the box under 'Goal' only when the activities are complete and the goal has been achieved.

Goal

- A participatory situation analysis has been carried out and health issues for action have been identified and prioritised together with the community.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL 3B-9: ROOT-CAUSE ANALYSIS (ROBUST)

Name of COMM: _____ Year: _____ Quarter: Q1 _____ Q2 _____ Q3 _____ Q4 _____

Instructions: Fill in the table below with the activities the COMM will undertake to achieve the goal of completing a root-cause analysis of health issues in the community. Tick the box under ‘Goal’ only when the activities are complete and the goal has been achieved.

Goal

- The full Root-Cause Analysis is complete (includes all interview and FGDs, and analysis of the information).

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL 4-3: RESPONDING TO HEALTH ISSUES

Name of COMM: _____ Year: _____ Quarter: Q1 _____ Q2 _____ Q3 _____ Q4 _____

Instructions: Fill in the table below with the activities the COMM will undertake in response to identified health issues in the community. Tick the boxes under 'Goal' only when the activities are complete and the goal has been achieved.

Goals

- We fill out this Action Plan and review it every quarter.
- We have completed the activities we planned for this quarter.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL 5-4: TRACKING COMMUNITY HEALTH

Name of COMM: _____ Year: _____ Quarter: Q1 ____ Q2 ____ Q3 ____ Q4 ____

Instructions: Fill in the table below with the activities the COMM will undertake to track the community health status. Tick the boxes under ‘Goals’ only when the activities are complete and the goal has been achieved.

Goals

We received data from CHWs this quarter and used it to update our Community Data Form.

Were there any adverse events this quarter? Yes _____ No _____

If there were any adverse events this quarter, we investigated their cause and took any necessary action.

Were there any outbreaks of disease this quarter? Yes _____ No _____

If there were any disease outbreaks this quarter, we reported them to the health authorities.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL C. COMM ACTION PLANNING AND MONITORING TOOL 6-2: REPORTING COMMUNITY HEALTH

Name of COMM: _____ Year: _____ Quarter: Q1 _____ Q2 _____ Q3 _____ Q4 _____

Instructions: Fill in the table below with the activities the COMM will undertake to report the results of its work and the health status in the community. Tick the boxes under 'Goals' only when the activities are complete and the goal has been achieved.

Goals

- We held a debriefing meeting this quarter.
- We created or updated a Community Health Board this quarter.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

MONITORING TOOL D. COMM SUPPORTIVE SUPERVISION FORM

Name of Person Providing Supportive Supervision Visit: _____ Date: _____

Instructions: This tool should be used by World Vision or the partner providing supportive supervision to active COMMs at the output level.

Scoring: **1** – Unsatisfactory and requires further training. **2** – Average and requires some additional training in specific areas. **3** – Good but with room for improvement. **4** – Very good and no further improvement is required. **N/A** – not applicable

COMM Group Objectives (add additional sub-sections under each main section if required)	Score	Description/Comments
Linkages and networking among community health stakeholders strengthened		
Links with MoH/clinic committee		
Links with CHWs		
Links with health NGOs, community-based organisations (CBOs) and faith-based organisations (FBOs)		
Links with the community at large		
Links with private stakeholders		
Root-cause analysis of health issues assessed (one time) and community health status tracked (ongoing analysis)		
Understands health statistics		
Conducts focus group discussions		
Conducts key informant interviews with key individuals		
Analyses the information		

(Monitoring Tool D continued)

Community activities are implemented to address identified health issues (action)		
Community mobilisation		
Community sensitisation		
Advocacy		
Activity plans		
Monitors the work (action) plan and activities		
Community health status and activities regularly reported to all stakeholders (reporting)		
Collects data from CHWs		
Tracks/reports disease outbreaks		
Monitors/analyses adverse events		
CVA local-level advocacy initiatives are supported and implemented		
Enables citizen engagement		
Engagement through community gathering		
Improves services and influences policy		
Support, oversight and promotion provided to ttC programmes		
CHW recruitment		
CHW roles and responsibilities		
Monitors CHW equipment/supplies		
CHW support		
Input on individual CHW performance		
CHW recognition and appreciation		
Referral system support		
CHW documentation and information		
Programme performance appraisal input		

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