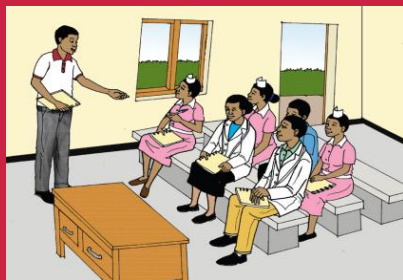


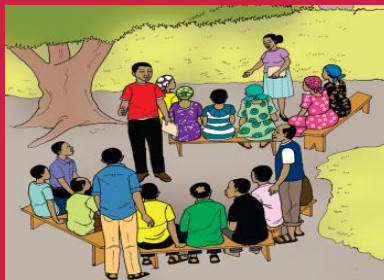
Accountability Can Transform Health (ACT Health)



Health Centre Dialogue

Share Citizen's Report Cards

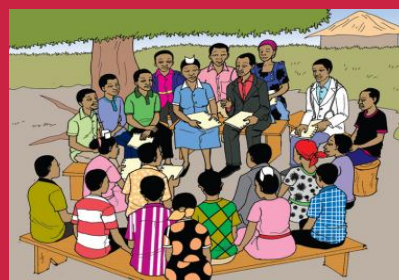
Develop Action Plan



Community Dialogue

Share Citizen's Report Card

Develop Action Plan



Interface

Community representatives +
health centre staff

Develop a Social Contract

Procedure #4 (Full Programme)

Guidelines for Implementation Teams: Officers, Managers & Mentors

Version 11-September-2014 [FINAL - Update 1]

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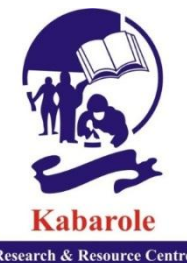
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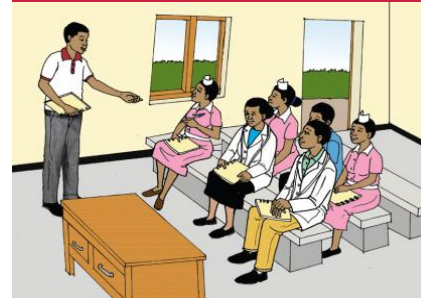
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Contents of Procedure #4 Guidelines

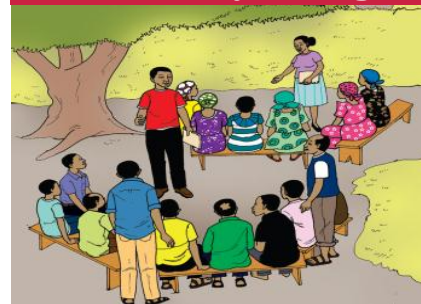
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HC Staff Dialogue



Community Dialogue



Interface Dialogue



Acronyms

ACT Health	Accountability Can Transform Health
ANC	Antenatal care
ART	Anti retroviral therapy
CAO	Chief Administrative Officer
CDO	Community Development Officer
CRC	Citizen's Report Card
DHO	District Health Officer
DPC	District Police Commander
HCIC	Health Centre In-Charge
HCT	HIV Counselling and Testing
HUMC	Health Unit Management Committee
LC	Local Council (I, II, III, etc.)
PMTCT	Prevention of mother-to-child transmission
RCT	Randomised Control Trial
RDC	Resident District Commissioner
UNMHCP	Uganda National Minimum Health Care Package
VHT	Village Health Team

How To Use These Guidelines

ACT Health Procedure #4 (Full Programme) has these main steps

- 1) Mobilise Participants
- 2) Health centre dialogue using Citizen's Report Cards & action plan development
- 3) Community dialogue using Citizen's Report Cards & action plan development
- 4) Interface & social contract development
- 5) Follow-up Interfaces every six (6) months

Roles/Responsibilities

- 1) Accountability Officers will be responsible for the majority of activities described in these Guidelines.
- 2) ACT Health Managers, Mentorship Managers (GOAL), Monitoring and Evaluation Officers (GOAL), and other GOAL and partner staff will support, mentor and monitor activities for quality control and quality assurance.

For each step in the process, Guidelines for Procedure #4 (Full Programme) explains

- **Purpose:** why is this activity being conducted?
- **Target Group(s):** which participants will be involved in the activity?
- **Timing:** when should the activity take place, and how long should it last?
- **Location:** where does this activity take place?
- **Materials:** what materials are needed for conducting this activity?
- **Tips & Action Points:** how should this activity be carried out?

Procedures Table

Procedure	Citizen Report Card (CRC)	Health Centre Dialogue	Community Dialogue	Interface	Final Output Action Plan or Social Contract	Follow-up every six (6) months
1	<u>No intervention</u> (control)	Baseline data will be collected but no activities.	None will be held.	None will be held.	None will be developed.	*Survey at 12 months and 36 months after baseline.
2	Information provided (CRCs) and <u>two separate action plans</u> are developed in community and health centre dialogues. There is <u>no interface</u> between HC staff and community.	The Citizens Report Card will be shared in community <u>dialogue</u> and health centre <u>dialogue</u> .	Health centre staff have a <u>dialogue</u> and develop an action plan.	Community members have a <u>dialogue</u> and develop an action plan.	This will not be held.	<u>Two separate action plans</u> will be developed – one by the health centre staff and one by the community members. Every six months <u>separate follow-up dialogues</u> for community members and health centre staff. *Survey at 12 months and 36 months after baseline.
3	<u>No information</u> (CRC) provided and <u>no health centre or community dialogues</u> are held. Interface between health centre staff and communities yields <u>one social contract</u> .	The Citizens Report Card will <u>not</u> be shared.	This will not be held.	This will not be held.	The <u>interface</u> will bring together community members and health centre staff.	<u>One social contract</u> developed at the interface combining community and HC actions. Every six months follow-up <u>interface</u> with community members and HC staff. *Survey at 12 months and 36 months after baseline.
4	Information (CRC) provided in separate dialogues at health centre and community levels. During these dialogues, each group develops an action plan which is discussed at the interface. The interface yields <u>one social contract</u> .	The Citizens Report Card will be shared at community dialogue and health centre dialogue.	Health centre staff <u>dialogue</u> and develop an action plan.	Community <u>dialogue</u> and develop an action plan.	The <u>interface</u> will bring together health centre staff and <u>representatives</u> of the communities.	<u>One social contract</u> developed combining community and HC actions. Every six months follow-up <u>interface</u> with community members and HC staff jointly. *Survey at 12 months and 36 months after baseline.

Health Centre III (HC III) Standards

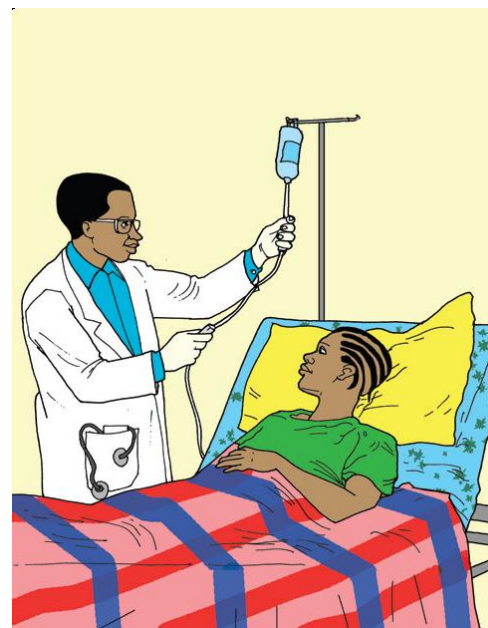
Sub-county level

Services

- Antenatal care (ANC)
- Immunisation
- Family planning education
- Delivery
- Lab services
- Outreach (in villages)
- Outpatient care
- Family planning
- Prevention of mother to child transmission (PMTCT)
- Anti retroviral therapy (ART)
- HIV Counselling and Testing (HCT)
- Health education (at HC)
- Inpatient admissions

Staffing

- In-Charge should be a clinical officer
- **Eleven (11)** medical staff
- **Eight (8)** support staff
- **Nineteen (19)** staff in total



Health Centre II (HC II) Standards



Parish level

Services

- Antenatal care (not delivery)
- Out-patient care (treating common diseases like malaria, diarrhoea, pneumonia, first aid)
- Immunisation
- Simple family planning methods
- Family planning education
- Health outreach (in villages)
- Health education (at HC)

Staffing

- In-Charge should be an enrolled nurse
- **Three (3)** medical staff
- **Six (6)** support staff
- **Nine (9)** staff in total

Village Health Team (HC I)

Definition

A Village Health Team (VHT) is a non-political health community structure and the equivalent of Health Center I (HC I). VHTs are responsible for monitoring the health of community members at the household level. They have been mandated to serve since **2010**. There should be **5** VHTs per village.



Mandate

- Promote good health and hygiene
- Mobilise for vaccination campaigns, National Child Health Days, use of ITNs
- Encourage good breastfeeding practices, new born care, etc.
- Provide integrated community case management for children under 5 – where trained/equipped this is treatment for malaria, pneumonia and diarrhoea
- Bridge information gaps

Membership

- A VHT is selected on popular vote after sensitization and consensus building of all village members from all households
- Selected during a community meeting led by the LC1 to discuss the VHT Programme. All residents present at this meeting decide who they feel would be good candidates
- VHTs are accountable to community

Health Unit Management Committee

Definition

The Health Unit Management Committee (HUMC) is a community structure mandated by the Ministry of Health in Uganda since **2003**.



Mandate

- Serve as a bridge between community members and health centre staff
- Oversee activities in health centres
- Monitor the storage and utilisation of goods and services at the HC
- Ensure Primary Health Care (PHC) and other resources are not diverted
- Monitor performance of approved budgets
- Ensure the HC work plans reflect the priorities of the community, especially in rural areas or marginalised communities

Membership

- Appointed by Government (local government, i.e. the LC III)
- Chairperson (public prominent figure)
- Secretary is the in-charge of the health facility
- Members selected from each parish served by HCIII or village served by HCII

Health Rights & Responsibilities

Health Rights ...

- Medical care
- Non-discrimination
- Participation in decision-making
- Healthy and safe environment
- Proper medical care
- Treatment by named provider
- Training and research
- Safety and security
- Receiving visitors
- Informed consent
- Medical care without consent
- Refusal of treatment
- Be referred for second opinion
- Continuity of care
- Confidentiality and privacy
- Medical information
- Custody of medical records
- Right to redress

Health Responsibilities...

- Provide information to health workers
- Compliance with instructions
- Refusal of treatment
- Respect and consideration



A responsibility to be healthy!

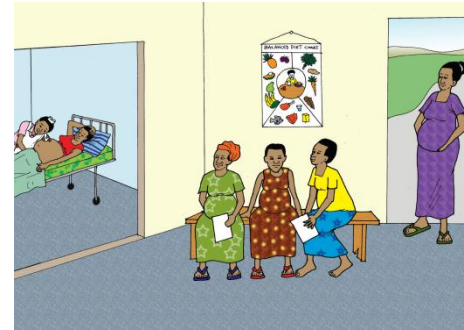
A citizen has a responsibility to become a patient first. This means

- Getting preventative care (immunisations, ANC, VCT, etc.)
- Going for treatment early to reduce complications that make treatment more difficult

The Three R's

■ Responsibility

Individuals and households have good health-seeking behaviour. They seek preventive care (ANC, immunisations, testing, etc.) and go early for treatment of illness to avoid complications.



■ Responsiveness

Health Centre staff use resources effectively and provide care as per Ministry of Health standards in the Uganda National Minimum Health Care Package (UNMHCP).



■ Relationships

Mutual understanding and trust between community members and health centre staff. Includes better understanding of each other's constraints and barriers.



Standard Talking Points

1. Create space and get community more involved

1. We want to hear voices of all social groups in the community.
2. Mobilising diverse social groups (women and men of different ages, income levels and social standing) is very important!
3. We want to make sure communities understand the HCII and HCIII standards and constraints of HC staff so they know what to expect
4. Programme to create opportunity (space) for health centre staff and community members to discuss issues and make constructive plans

2. Contribute to improved health outcomes for women and children through Responsibility, Responsiveness and Relationships

1. **Responsibility** Individuals and households have good health-seeking behaviour. They seek preventive care (ANC, immunisations, testing, etc.) and go early for treatment of illness to avoid complications.
2. **Responsiveness** Health Centre staff use resources effectively and provide care as per Ministry of Health standards in the Uganda National Minimum Health Care Package (UNMHCP).
3. **Relationships** Mutual understanding and trust between community members and health centre staff. Includes better understanding of each other's constraints and barriers.

3. Programme has the following major activities to be implemented in target communities/ villages closest to the health centre. These include:

1. Health centre dialogue using Citizen's Report Cards & action plan development
2. Community dialogue using Citizen's Report Cards & action plan development
3. Interface & social contract development
4. Follow-up Interfaces every six (6) months

Facilitating the ACT Health Process

1. **Building relationships** – Establish trust between facilitator, community and health centre staff.
2. **Identifying concerns** – Provide space for people to discuss issues that affect them deeply and reflect on how to change these.
3. **Exploring concerns** – Probe deeper so community members discuss the values and behaviours that are connected to their concerns.
4. **Making decisions & committing to action** – Help community members to make decisions about what can be done to address these concerns and establish action plans.
5. **Acting responsibly** – Encourage community members to act on these commitments and start to see change.
6. **Reviewing & reflecting** – Support this continuous process of thinking about how everyone is contributing to positive changes.



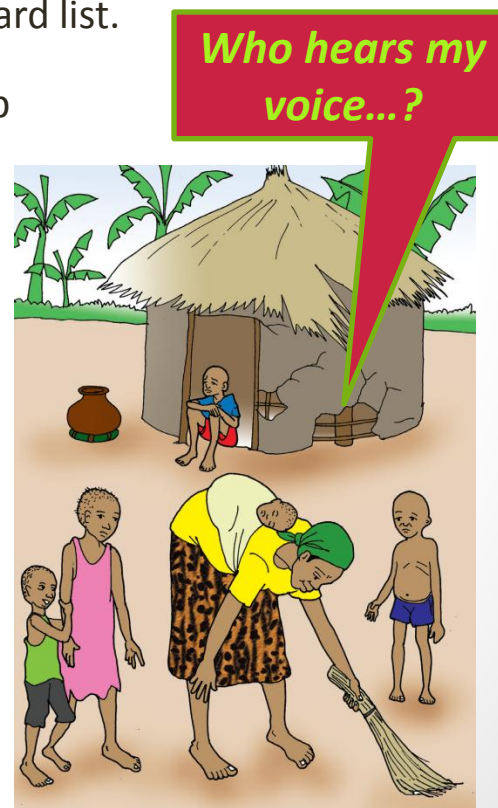
Mobilising Diverse Participants

Mobilising diverse social groups (women and men of different ages, income levels and social standing) is very important!

➤ We want to hear voices of all social groups in the community.

Accountability Officers will share a detailed mobilisation list with the VHTs and LCIs, who will use the guidance to mobilise community members. This is a standard list.

- LCI Chairperson
- LC Women Representative
- LC Youth Representative
- LC Representative with Disability
- Mother
- Male lowest income group
- Female lowest income group
- Male highest income group
- Female highest income group
- Male youth (age 15 – 20)
- Female youth (age 15 – 20)
- Male adult (age 21 – 49)
- Female adult (age 21 – 49)
- Male elder (age 50+)
- Female elder (age 50+)
- VHT Member
- HUMC Member



Reducing Barriers to Participation

For ACT Health, participation means access to the activity and also ability to have your voice heard, and contribute to making decisions while in the community dialogue and interface.

Women and men have unique barriers.

➤ We can reduce some barriers through planning (P) and/or facilitation (F).

Women's Barriers

- Women with children (P)
- Long distance from home (P)
- Household (HH) responsibilities (P + F)
- Limited decision making (F)
- Financial (cost/opportunity cost)
- Youth considered children/no voice (F)
- Men control conversation (F)
- High income women not interested
- Limited time (P + F)
- Low income, less voice (F)
- No social position, less voice (F)
- Comprehension/confidence (F)

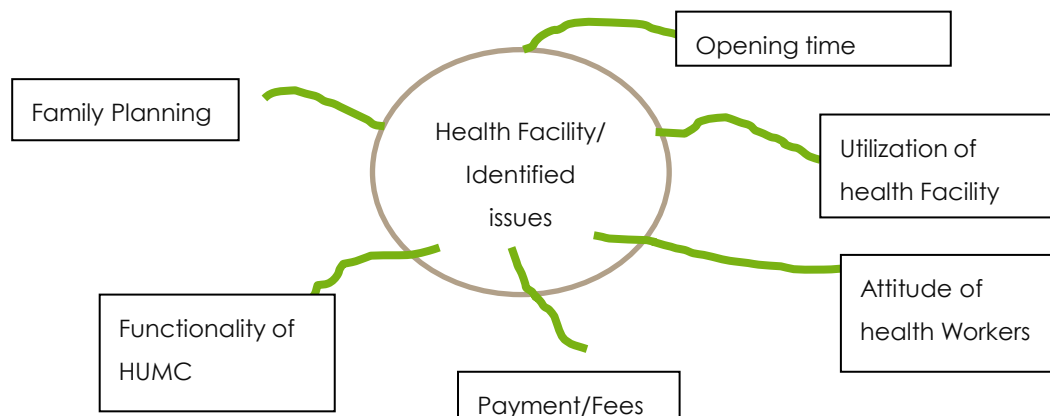
Men's Barriers

- Youth considered children/no voice (F)
- High income not interested
- Limited time (P, F)
- Low income, less voice (F)
- Low position, less voice (F)
- Comprehension/confidence (F)
- Unmarried men, less voice (F)
- Might see health as a woman's issue (P, F)
- Don't like meetings – prefer *malua* or cards

Making Decisions (Priorities)

What happens when people get stuck?

1. Draw spider
2. On each spider leg, put one issue that has been identified
3. Use available resources to count (rocks, beads, beans, etc.)
4. Give each participant three (3) counters to use and vote on their priority issues
5. When all have placed their votes, count all and select top items
 1. Small groups = 4 items
 2. Action plan = 7 items
6. Support all groups by asking probing questions!



Probing Questions

What?

When?

Where?

Who?

How?

Why?

1. What is the situation now?
2. What do we want to change?
3. Who are we targeting to make this change?
4. When do we want this change?
5. What is the current behaviour? Why does this behaviour exist? Who or what influences that behaviour?
6. Where and who are the people who will support us to make the change?
7. How do we get the commitment of other people?
8. What action will support the change?
9. How can we be more responsible?
10. How can we be more responsive?
11. But why....?

Translating Community Documents

*Language
leads
to
ownership.*

*Using
language that
community
understands
is essential.*

1. Always use the local language that participants prefer during all dialogues/interfaces.
2. For writing up the action plans in communities – either in small groups or large groups – use the local language.
3. Health centre action plans should also be in the local language so that community members will be able to easily understand the content and not be intimidated.
4. Social contracts must be in the local language. This is what will stay in community and be used during all follow-up interfaces.
5. Officers should type up all plans in the local language and keep them on file.
6. Officers should work with secretaries to complete the translation of the social contracts into English for keeping in the ACT Health data base. English versions will be used to complete analysis.

Managing Challenges

- High expectations
- Difficult participants
- Conflicting opinions
- Verbal attackers
- Absolute silence
- Inability to reach consensus
- Leaders are dominating
- Health centre staff very defensive
- Community blaming HC staff for all issues
- Community not taking responsibility
- Politicization of dialogue/interface in advance of elections

Strategies to Manage Challenges

1. Always remain neutral and unbiased. Everyone has a unique perspective and as facilitator, you cannot take sides!
2. Keep eye contact
3. Call participants by their name
4. Propose time limits for discussions if no resolution is happening
5. Invite others to comment, share their own (different) opinion or experience
6. Remind members of the ground rules and agenda
7. Put issues in the parking lot if they cannot be resolved; come back to resolve them at the end of the meeting if possible
8. Remind all participants that good health is for people from all political affiliations

Implementing Timeframe

Tips

- This is the longest procedure to implement. Try to complete **Step 1** through **Step 4** in **six (6)** weeks.
- ACT Health Officers should be in communities minimum of **three (3)** days per week until all HCs have completed this cycle.
- Officers will need to simultaneously work with at least **four (4)** health centres to meet our deadlines.
- Between the baseline survey and the 12-month follow-up survey each HC should have had **Step 1** through **Step 4** plus one follow-up interface.
- Follow-up dialogue **six (6)** months after interface.

Step	Steps in Procedure # 4 (Full Programme)	Week						
		1	2	3	4	5	6	7
1	Mobilise Participants							
1.1	Mobilise HC staff to host dialogues and interface	X						
1.2	Mobilise and meet the LCIs and VHTs		X					
1.3	Prepare VHTs/LCIs to mobilise community members			X	X			
2	Health Centre Dialogue							
2.1	Open health centre dialogue				X			
2.2	Discuss the Citizen's Report Card findings				X			
2.3	Develop health centre action plan				X			
2.4	Document the health centre dialogue				X			
3	Community Dialogue							
3.1	Open community dialogue					X		
3.2	Discuss the Citizen's Report Card findings					X		
3.3	Develop small social group action plans					X		
3.4	Report back, make one community action plan					X		
3.5	Prepare community members for interface (includes selecting representatives)					X		
3.6	Document the community dialogue					X		
4	Interface							
4.1	Open interface						X	
4.2	Share & discuss HC & community action plans						X	
4.3	Develop joint social contract with seven (7) issues						X	
4.4	Participants agree to implement social contract						X	
4.5	Beads in Bowls (participant satisfaction)						X	
4.6	Document the interface and report outcomes						X	X
5	Follow-up Interface Every Six (6) Months							

Step 1: Mobilise Participants



Step 1: Mobilise Participants

Accountability Officers will mobilise health centre staff, VHTs and LCIs. The HC staff must agree to host all meetings. The VHTs and LCIs will then mobilise community members from **three (3)** target villages and social groups to attend the community dialogue.

For Step 1: “Mobilise participants” complete the following	Completed?
Meet HC In-Charge. <ul style="list-style-type: none">• Share endorsement letter from District Health Office.• Explain programme and mobilise HC staff to host dialogues and interface.• Obtain contact details of LCIs and VHTs in target villages.	
Meet LCIs and VHTs from three (3) target villages. <ul style="list-style-type: none">• Share endorsement letter from District Health Office.• Explain programme.• Secure their commitment to mobilise participants.	
Prepare VHTs/LCIs to mobilise by explaining the list of three (3) target villages and mobilisation list to them. This is important so they reach the right villages and all social groups.	
Call the LCIs and VHTs once per week to ensure they are proceeding successfully in mobilising community representatives from all targeted social groups.	

Step 1.1: Mobilise HC staff to host dialogues & interface

Purpose

Meet the health centre in-charge and staff of each health centre.

Using standard information, explain the programme and encourage ownership from health centre staff. During this introductory meeting, invite the health centre staff for the upcoming health centre meeting (**Step 2**).

Agree on a day/time for meeting.

Target group(s)

- Health centre in-charge and health centre staff
- **Notes:**
 - If the Health Unit Management Committee (HUMC) chairperson is available to attend the introduction meeting, they are welcome. However, we do not need to specifically mobilise them for this meeting.
 - The HUMC is represented through the in-charge (who is the HUMC secretary).
 - Meeting should be on a weekday in afternoon when there are fewer patients, unless otherwise suggested by HC staff.

Timing

- Meeting will be after the district introduction
- Meeting will last **one (1)** hour

Location

- Health centre

Materials

- Information card for Procedure #4 (Full Programme)
- Letter of endorsement from DHO
- VHT/LC 1 contact information sheet
- List of target villages

Step 1.1: Mobilise HC staff to host dialogues & interface

Tips

Please do **not** mention GOAL or DFID while mobilising HC staff. We do this to manage expectations.

Think about different needs and schedules of different social groups!

For example, many women would not be able to attend meetings scheduled in the morning due to household responsibilities.

Talking Points

1. Accountability Officer goes to health centre to request a meeting with the in-charge and any available health workers. **Please do not mention GOAL/DFID.**
2. Use Information Card for **Procedure #4** and standard talking points (pg.13) to explain the ACT Health programme.
3. Request from the in-charge permission to have all programme meetings at the health centre. Arrange tentative dates and times for the following:
 1. Health centre dialogue (within two (2) weeks)
 2. Community dialogue (within three (3) weeks)
 3. Interface (within four (4) weeks)
 - Activities should be held on a week day in the afternoon when the HC is open, but less busy unless the HC staff suggest a more convenient time.
 - Activities involving community members must be scheduled for day/time when community members are free and can attend. **Especially women!**
4. **Encourage ownership by the health centre in-charge.**
 - Without support from the in-charge, it will be very difficult to have a successful programme.
5. Ask the in-charge for names and phone numbers of VHTs representing the three (3) targeted villages so you can contact them and get them involved in the process. This information will be inserted into the VHT/LC1 contact information sheet.

Step 1.2: Mobilise and meet the LCIs and VHTs

Purpose

In this step, Accountability Officer contacts the VHTs and LCIs from all **three (3)** targeted villages to invite them to a group discussion to learn more about the programme.

Target group(s)

- LCI Chairperson of each village
- VHT members of each village

Timing

- Begin contacting VHTs/LCIs from the **three (3)** targeted villages immediately after mobilising the health centre staff (**step 1.1**)
- It should take about **two (2)** days of calling/visiting villages to make contact with all the LCIs and VHTs and mobilise them for the meeting
- Meeting will last two hours and should occur within **one (1)** week of the mobilisation of health workers (**step 1.1**)

Location

- In **three (3)** targeted villages
- Over the phone

Materials

- Community mobilisation list
- VHT contact list (completed with the HC In-Charge)
- List of **three (3)** targeted villages
- Information Card for Procedure #4 (Full Programme)
- Letter of endorsement from DHO

Step 1.2: Mobilise and meet the LCIs and VHTs

Tips

Try to visit all the **three (3)** target villages and LCIs in the same day.

Remind the health centre in-charge about the plans after you confirm with community.

Please do not mention GOAL or DFID while mobilising HC staff. We do this to manage expectations.

Talking Points

1. **Accountability Officer calls the VHTs from each target village.**
 - Tell them the date and time of the preparation meeting (**step 1.3**) at the health centre, and request them to attend.
 - Follow-up with VHTs over the phone once each week leading up to the introductory meeting to ensure that they will attend.
2. **Accountability Officer visit each target village and meet LCIs.**
 - Explain to the LCIs that you have informed the VHTs over the phone about the preparation meeting (**step 1.3**).
 - Ask the LCIs to confirm with the VHTs to ensure they will attend the preparation meeting (**step 1.3**).
 - While visiting the LCIs, briefly move around the community to check in with any VHTs that are in the village at that time and confirm that they will attend the preparation meeting (**step 1.3**).
3. **Keep the LC/VHT contact information in your files for future use.**

Step 1.3: Prepare VHTs/LCIs to mobilise community members

Purpose

VHTs and LCIs will learn about the programme in some more detail.

VHTs/LCIs commit to support the process.

Explain the mobilisation list to the VHTs.

After this session, VHTs will mobilise community members for the upcoming community dialogue (step 3).

Please do ***not*** mention GOAL or DFID while mobilising HC staff. We do this to manage expectations.

Target group(s)

- LCI Chairperson and VHTs use community mobilisation list (see full list)
- Reach all social groups as per the list: Female youth, male youth, older female, older male, mothers, HUMC members, VHTs, disabled individuals, low income individual, high income individual, etc.
- A total of **25** community members per village should attend (**75 total**)

Timing

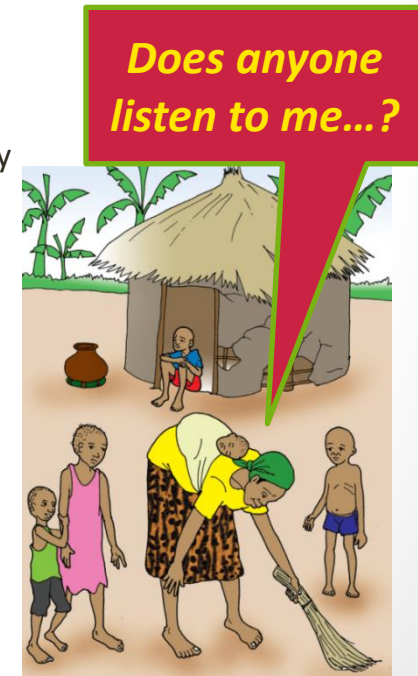
- VHTs/LCIs will have about **five (5)** days to mobilise community members from targeted social groups within **three (3)** target villages to attend the community dialogue (**Step 3**)
- VHTs/LCIs will be mobilising the community in the same week as the health centre dialogue (**Step 2**)

Location

- Health centre

Materials

- Community Mobilisation List
- Endorsement letter
- Information Card for Procedure #4
- Target Village List



Step 1.3: Prepare VHTs/LCIs to mobilise community

Tips

VHTs may ask for facilitation allowances, transport or other incentives to mobilise community participants.

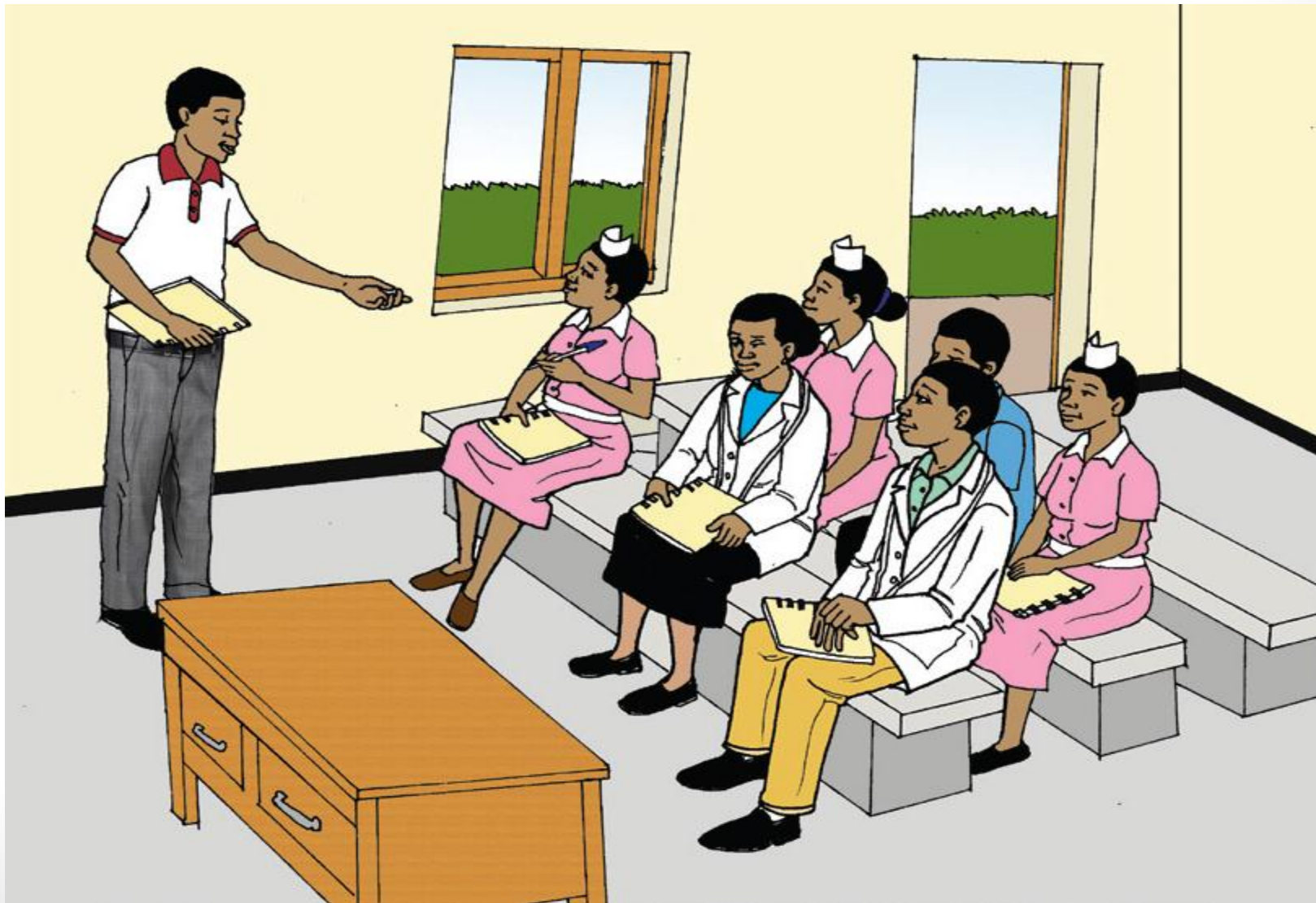
For sustainability, we are relying on assistance from VHTs because of their position in the community and voluntary spirit.

See **Mobilising Diverse Participants (pg. 15)** and review the community mobilisation list carefully so you can explain the categories clearly to VHTs/LCs.

Talking Points

- 1. Share information about the programme with the VHTs and LCIs.**
 - Give the LCI from each targeted village the endorsement letter from the District Officials
 - Share a copy of the **Information Card for Procedure #4** and explain it using the **standard talking points (pg.13)**
- 2. Ask the VHTs and LCIs if the date/time for the community dialogue is convenient to them and organise refreshments.**
 - Ask VHTs and LCIs to identify a person (or people) near the health centre from whom refreshments (soda or water) can be purchased
 - Ask one VHT to volunteer to follow-up and buy refreshments on the day of the meeting.
- 3. Request VHTs to mobilise diverse community members using the mobilisation list in target villages.**
 - Share a copy of the community mobilisation list and explain that we are including a variety of social groups from each.
 - Ask the VHT's/LCs to think of someone in the village, who fits the descriptions, and would be willing and able to participate.
- 4. Make follow-up phone calls to the VHTs before the community dialogue.**

Step 2: Health Centre Dialogue



Step 2: Health Centre Dialogue

Accountability Officer will facilitate the health centre dialogue, which is a space to share and discuss the findings of the Citizen's Report Card with the staff of the health centre. The staff includes medical (midwives, clinical officers and enrolled nurses) and non-medical staff including guard, porters and cleaners) of the health centre. At this dialogue, health centre staff will develop an action plan with low cost/no cost suggestions to address challenges at the health centre and improve relationships with community members.

When	For Step 2: "Facilitate Health Centre Dialogue" complete the following	Completed?
One week before dialogue	One (1) week in advance, study the CRC for the HC. Make copies of the CRC for each HC staff.	
	Using 3Rs, prepare your probing questions based on the CRC for that HC.	
	Move with the correct set of posters for the specific HC you are visiting.	
Before opening dialogue	Ensure that all medical and non-medical staff of the HC are present for the dialogue. If they are not, document explanations. See standard report format for guidance.	
During dialogue	Open the dialogue – explain purpose, agenda, and agree on expectations. Ensure a secretary is selected that can document (and translate if necessary).	
	Present the Citizen's Report Card (CRC) findings.	
	Allow participants to develop the health centre (HC) action plan. Support with probing questions and prioritisation exercises if necessary. Participants agree to next steps.	
After	Document the dialogue and file the report, attendance records and action plan.	

Step 2: Facilitate health centre dialogue

Purpose

To share the Citizen's Report Card (CRC) with health centre staff, using participatory facilitation methods (see pg. 14).

Health centre staff develop a low cost/no cost action plan.

This is a preparatory meeting for the interface (Step 4).

Target group(s)

- Health centre in-charge
- All staff at the facility
- **Notes:**
 - Agree on a time that is most convenient for HC staff.
 - One staff should be assigned to attend to patients during the meeting.
 - Meeting should be on a weekday in afternoon when there are fewer patients, unless otherwise suggested by HC staff.

Timing

- A half-day meeting
- Should take place at most **two (2)** weeks after **step 1.1** "Mobilise the HC staff to host meetings"

Location

- Health centre

Materials

- **One (1)** copy of Citizen Report Card (CRC) per staff
- Attendance lists
- Poster set for the specific HC level (II or III)
- Flip chart (with a blank action plan matrix to be filled in the meeting) – see **step 2.3** for template

Step 2.1: Open health centre dialogue meeting

Tips

Our role is to **facilitate** a participatory process.

See **Facilitating ACT Health Process** (pg. 14).

Talking Points

1. **Introduce yourself and your organisation, but please do not mention GOAL /DFID.**
 - We do this to manage expectations since we do not give additional supplies or inputs under the ACT Health programme.
 - **Note:** The only time GOAL should be mentioned is if GOAL is directly implementing (i.e., Agago district).
2. **Ask one participant to please serve as the secretary for the health centre staff.**
 - Ask the volunteer to take minutes of the dialogue and copy down the action plan developed.
 - Ask the secretary to be sure to bring the notebook to every activity.
 - It is preferable to conduct the dialogue in the local language, but if all HC staff agree and can follow they can proceed in English. If they proceed in English, then the action plan will need to be translated into the local language before the interface (**Step 4**).
3. **Write the agenda items and approximate times on the flip chart for participants.**
 1. Dialogue purpose, rules and expectations (*30 minutes*)
 2. Citizen Report Card Findings (*1 hour 30 minutes*)
 3. Develop action plan (*2 hours*)
 4. Prepare for interface with community members (*30 minutes*)

Step 2.2: Discuss the Citizen's Report Card findings

Tips

You must master the CRC content before you go to this dialogue.

Health centre staff may be sensitive about the information presented. Make them feel at ease by trying to understand their perspective on community behaviour and relationships.

Use **Probing Questions** (pg. 18) as you present:

- **What?**
- **Where?**
- **Who?**
- **How?**
- **Why?**

Talking Points

1. **One (1) week before dialogue, review the specific CRC for the health centre and master content! Set aside at least 2 hours for study.**
2. **One (1) week before dialogue, prepare your probing questions based on the information for the specific HC.**
 1. **Responsibility** = *Are community-members showing responsible health seeking-behaviour?*
 2. **Responsiveness** = *Are health centre staff providing the services as per policy?*
 3. **Relationship** = *Do the community members and HC staff have good relations?*
3. **At least two (2) days before, prepare your materials.**
 - Print one copy of the CRC for each HC staff
 - Move with the correct set of posters for the HC II or HC III
4. **In the health centre dialogue, share and discuss the findings.**
 - Explain the source of the information – CRC findings were compiled from household surveys, interviews with the In-Charge and HMIS.
 - Findings represent the overall picture.
 - Discuss the report card findings section by section.
 - **Explain the boxes clearly. One box = 10 people out of 100 people.**
 - For each section write down the results on the large posters, as participants follow along in their individual report cards.
 - Ask at least one probing question per poster. This may lead to others.
5. **If there are any questions that cannot be resolved, put them in parking lot to raise at the interface.**

Step 2.3: Develop health centre action plan

Action Points

Use **Making Decisions** (pg. 17) and ask **Probing Questions** (pg. 18) to help health centre staff identify issues and actions.

Using the guidance in the action plan matrix to the right, ask probing questions highlighted in this table, support the health centre staff to develop their own low cost/no cost action plan based on their priority issues.

After the health centre staff have their action plan, discuss the next step in the process, which will be the interface with community to agree on social contract.

HC action plan will have a maximum of seven (7) issues. Items are **suggested** until agreed to in interface.

Issue	Reason(s) for the Issue	<u>Suggested</u> Action (low cost/no cost)	<u>Suggested</u> person responsible for Action	<u>Suggested</u> completion date
<p>This is the problem or challenge HC staff have at the health facility.</p> <p>It may also be a challenge they face in encouraging communities to pursue good health-seeking behaviour.</p> <p>Issues should be written in a positive or neutral way, for example “communities need better information” as opposed to “community members are ignorant.”</p> <p>Actively encourage participants to use CRC findings and data!</p>	<p>What are the root causes for this issue?</p> <p>Why do participants feel this issue is important?</p> <p>Use probing questions to explore this:</p> <ul style="list-style-type: none"> ➤ What? ➤ When? ➤ Where? ➤ Who? ➤ How? ➤ Why? <p>Three (3) R's</p> <ul style="list-style-type: none"> ➤ Responsibility ➤ Responsiveness ➤ Relationships 	<p>What low cost/no cost action could address each issue?</p> <p>Like the issues, these actions should be framed in neutral or positive statement that can be done.</p> <p>For example, “health workers report to work on time,” as opposed to “health workers stop coming to work late.”</p>	<p>Who should be responsible for doing each action?</p> <p>The person should have the will and authority to carry out the action.</p>	<p>A deadline for completing the action.</p> <p>Now = Can be done within 6 months and with local resources</p> <p>Soon = Can be done in 12 months and mostly local resources</p> <p>Later = Things we want but that need more time and maybe resources from outside</p> <p>Low cost/no cost actions can usually be done “now” or “soon” 😊</p>

Step 2.4: Document the health centre dialogue

Tips

The report should be prepared immediately after the dialogue to ensure that the information is fresh in your mind.

if a Manager, Mentor or other senior member of staff comes to visit you and see the files.

Officer will use this to complete and submit a full report after the interface.

For procedure #4, you will not submit these to the ACT Health Manager (direct supervisor of the Officer).

They are in the files only. They will be verified during monitoring visits.

1. **Health Centre Dialogue Attendance sheet**
2. **Health Centre Action Plan**
 - This should be typed exactly as health centre staff agreed.
 - If the proceedings went on in English, please ensure that the secretary prepares a translation in the local language as well.
 - This is necessary for the interface dialogue with community members.
3. **Health Centre Dialogue Report (one page)**

Reminder: Always use standard activity report formats for ACT Health! Place in files immediately so that it can be verified

Step 3: Community Dialogue



Step 3: Community Dialogue

Accountability Officer will facilitate the community dialogue. This is a space to share the findings of the Citizen's Report Card, ask probing questions and have a discussion. All targeted social groups must be represented for each of the **three (3)** target villages. In small social groups, participants will prioritise their issues and develop an action plan identifying challenges, discussing their own health-seeking behaviour and suggesting low cost/no cost actions that can contribute to positive change. They will develop an action plan.

When	For Step 3: "Facilitate Community Dialogue" complete the following	Completed?
One week before dialogue	One (1) week in advance, study the CRC for the HC. Master the information for the HC.	
	Using 3Rs, prepare your probing questions based on the CRC for that HC.	
	Organise and move with correct set of posters for the specific HC you are visiting.	
Before opening dialogue	Ensure that all social groups and target villages are sufficiently represented. Carefully review the mobilisation list and the quorum guidelines on page 38 (Step 3) .	
During dialogue	Open the dialogue – explain purpose, agenda, allow for village introductions and agree on expectations. Ensure a secretary is selected that can document /translate.	
	Use posters to present the CRC findings. Ask the probing questions you prepared.	
	Allow participants to develop small group action plans based on social groups.	
	Facilitate merging of small group action plans into one community action plan. Support with probing questions and prioritising (making decisions) exercise .	
After	Document the meeting and file the report, attendance records and action plan.	

Step 3: Facilitate community dialogue

Purpose

Share the Citizen's Report Card (CRC) with community members using **participatory facilitation methods** (pg. 14).

Community will identify issues and develop an action plan containing low cost /no cost actions to improve health service responsiveness and health responsibilities.

This is preparation for the upcoming interface with health centre staff.

No sub-county observers are to be mobilised. They will be invited to interface (**Step 4**).

Target group(s)

- See community mobilisation list shared with VHT/LCIs.
 - Ideally, **25** community members per village should attend (**75 total**)
- *QUORUM = minimum number of members needed to proceed***
- The meetings should continue once at least **35** participants are present. Each village should have at least **five (5)** members in the dialogue. Ideally, you will have a minimum of **one (1)** representative from each of the following **nine (9)** social groups from each target village:
 1. VHT
 2. Female youth (age 15 – 20 years)
 3. Male youth (age 15 – 20 years)
 4. Mother (any age)
 5. Male adult (age 21 – 49 years)
 6. Female adult (age 21 – 49 years)
 7. LC from each village
 8. Health Unit Management Committee (HUMC) member
 9. Disabled individual

Timing/Location

- A half-day meeting at the health centre
- Should take place at most **two (2)** weeks after preparing the VHT/LCI to mobilise meeting (**step 1.3**) and at most **one (1)** week after health centre dialogue (**Step 2**)

Materials

- Poster set for the specific HC level (II or III)
- Attendance lists
- Copy of CRC for the facilitator
- Flip chart (with a blank action plan matrix to be filled in the dialogue) – see **step 3.3** for template

Step 3.1: Open community dialogue

Tips

Use the local language. To ensure the participants understand and own the dialogue and action plan.

Review **pages 13 – 19** of the manual a few days before you facilitate the community dialogue.

Talking Points

1. **Introduce yourself and your organisation, but please do not mention GOAL/DFID.**
 - We do this to manage expectations because this is not a supply-side programme.
 - Our role is to facilitate a participatory process and we will not be providing other inputs.
 - **Note:** GOAL can only be mentioned where GOAL is directly implementing community dialogues (i.e., Agago district).
2. **Ask one participant to please serve as the secretary for the communities.**
 - Ask the volunteer to take minutes of the dialogue and copy down the community action plan developed.
 - Ask the secretary to be sure to bring the notebook to every meeting.
3. **Write the agenda and approximate times on the flip chart.**
 1. Dialogue purpose, rules and expectations (30 minutes)
 2. Citizen Report Card Findings (1 hour 30 minutes)
 3. Small group action plan (1 hour)
 4. Large group action plan (1 hour)
 5. Prepare for interface with health centre staff (30 minutes)
4. **Remind everyone that as Ugandans, we also have the responsibility to act in ways that keep us healthy!!!**

Step 3.2: Discuss the Citizen's Report Card findings

Tips

Make sure that community members understand the purpose of this meeting is to share information gathered from them!

See **Probing Questions (pg. 18)** and ask community members probing questions as you present:

- **What?**
- **Where?**
- **Who?**
- **How?**
- **Why?**

Encourage community to take responsibility for their own health!

Talking Points

1. **One (1) week before dialogue, review the specific CRC for the health centre and master content! Set aside at least 2 hours for study.**
2. **One (1) week before dialogue, prepare your probing questions based on the information for the specific HC.**
 1. **Responsibility** = *Are community-members showing responsible health seeking-behaviour?*
 2. **Responsiveness** = *Are health centre staff providing the services as per policy?*
 3. **Relationship** = *Do the community members and HC staff have good relations?*
3. **At least two (2) days before, prepare your materials.**
 - Move with the correct set of posters for the HC II or HC III
4. **In the community dialogue, share and discuss the findings.**
 - Explain the source of the information – CRC findings were compiled from household surveys, interviews with the In-Charge and HMIS.
 - Findings represent the overall picture.
 - Discuss the report card findings section by section.
 - **Explain the boxes clearly. One box = 10 people out of 100 people.**
 - For each section write down the results on the large posters, as participants follow along in their individual report cards.
 - Ask at least one probing question per poster. This may lead to others.
5. **If there are any questions that cannot be resolved, put them in parking lot to raise at the interface.**

Step 3.3: Develop small social group action plans

Action Points

To ensure that everyone has a voice, participants will develop action plans in small social groups:

- Young women
- Women
- Young men
- Men
- VHT/LCI/HUMC

Each small social group should list their **top four (4) issues**. Then they develop low cost/no cost actions to address those issues.

Use **Making Decisions (pg. 17)** and ask **Probing Questions (pg. 18)** to identify issues and actions.

After **one (1) hour**, groups will come together and share.

Issue	Reason(s) for the Issue	<u>Suggested Action</u> (low cost/no cost)	<u>Suggested person responsible for Action</u>	<u>Suggested completion date</u>
<p>This is the problem or challenge participants have at the health facility, or challenges they face in accessing health-care. Relationship with HC staff can be included here.</p> <p>Issues should be written in a neutral or positive way.</p> <p>For example “attitude of staff,” or “men should go with wives for ANC visits” or “communities need better information.”</p> <p>Actively encourage participants to use CRC findings and data!</p>	<p>What are the root causes for this issue?</p> <p>Why do participants feel this issue is important?</p> <p>Use probing questions to explore this:</p> <ul style="list-style-type: none"> ➤ What? ➤ When? ➤ Where? ➤ Who? ➤ How? ➤ Why? <p>Three (3) Rs</p> <ul style="list-style-type: none"> ➤ Responsibility ➤ Responsiveness ➤ Relationship 	<p>What low cost/no cost action could address each issue?</p> <p>Like the issues, these actions should be written in neutral or positive, language, that can be done as what to do.</p> <p>For example, “health workers report to work on time,” as opposed to “health workers stop coming to work late.”</p>	<p>Who should be responsible for doing each action?</p> <p>The person should have the will and authority to carry out the action.</p>	<p>A deadline for completing the action.</p> <p>Now = Can be done within 6 months and with local resources</p> <p>Soon = Can be done in 12 months and mostly local resources</p> <p>Later = Things we want but that need more time and maybe resources from outside</p>

Step 3.4: Report back, make one community action plan

Tips

Community will develop **one (1)** action plan with maximum of **seven (7)** issues.

Format is same as small groups used, but must be agreed by majority of participants. Consensus is best!

Use **Making Decisions (pg. 17)** and ask **Probing Questions (pg. 18)** to identify issues and actions.

Try to have mostly actions **Now** or **Soon**. Too much focus on **Later** may likely frustrate community.

Items are **suggested** until agreed to in interface.

Talking Points

1. One volunteer from each small social group should present the issues and suggested actions they prioritised in their action plan.
2. Lead the process of prioritizing and making decisions about which **seven (7)** issues should be included in the community action plan.
 - Make sure that at least one issue/action from each small group is included in the community action plan.
 - For each issue, participants should agree to the suggested actions, people responsible, and completion date.
 - Community low cost/no cost action plan will be in the format below:

Issue	Reason(s) for the Issue	<u>Suggested</u> Action (low cost/no cost)	<u>Suggested</u> person responsible for Action	<u>Suggested</u> completion date
This is the problem or challenge participants have.	What are the root causes for this issue? Use probing questions Three (3) Rs Responsibility Responsiveness Relationship	What low cost/no cost action could address each issue?	Who should be responsible for doing each action? The person should have the will and authority to carry out the action.	A deadline for completing the action. Now = Can be done within 6 months and with local resources Soon = Can be done in 12 months and mostly local resources Later = Things we want but that need more time and maybe resources from outside

Step 3.5: Prepare community members for interface

Tips

Manage the expectations of the community and make sure they come prepared to have a constructive and positive discussion with health centre staff at the upcoming interface.

Note: Because there is no interface is procedure #2 and no preliminary community dialogue in procedure #3, the selection of community representatives only happens Procedure #4.

Talking Points

1. Explain the HC staff have developed an action plan and they want to share with community representatives in the interface dialogue.
2. Describe what the interface dialogue will be like, agree on a date that is convenient for representatives.
3. Ask each village to choose at least seven (7) representatives. It is most ideal if one (1) person from each social group below represents each village at the interface:
 1. VHT
 2. LC Chairperson
 3. Female youth (age 15 – 20 years)
 4. Male youth (age 15 – 20 years)
 5. Mother (any age)
 6. Male adult (age 21 – 49 years)
 7. Female adult (age 21 – 49 years)
 8. Health Unit Management Committee (HUMC) member
 9. Disabled individual
4. Ask for a volunteer to come prepared to present the community action plan at the interface. Share the date of meeting!
5. Request the VHT to update the community mobilisation list with the names and contacts of the selected representatives.

Step 3.6: Document the community dialogue

Tips

The report should be prepared immediately after the dialogue to make sure the information is fresh in your mind. Do not submit, but keep in the file for the specific health centre.

Officer will use this to complete and submit a full report after the interface.

For procedure #4, you will not submit these to the ACT Health Manager (direct supervisor of the Officer).

They are in the files only. They will be verified during monitoring visits.

1. **Community Dialogue Attendance sheets**
2. **Community Action Plan**
 - This should be typed exactly as community agreed.
 - Attach an English translation that the community secretary has worked on.
3. **Community Dialogue Report** – one page typed

Reminder: Always use standard activity report formats for ACT Health!

Step 4: Interface



Step 4: Interface

Accountability Officer will facilitate the interface. This is a space for health centre staff and community representatives to discuss the action plans developed in the community dialogue and health centre dialogue. The participants will discuss their individual action plans and agree to one social contract. Participants will also agree on monitoring of the social contract.

When	For Step 4: “Facilitate Interface” complete the following	Completed?
Before the interface	Reconfirm dates and participation by calling health centre in-charge and VHT/LCIs. VHT/LCIs confirms with the nine (9) representatives from each village. Mobilise sub-county observers to attend interface.	
	Review the community action plan and health centre action plan carefully. Contact community representative, remind him/her to prepare to present action plan.	
During the interface	Ensure all target villages and social groups are adequately represented (see quorum on pg. 48).	
	Open the interface – explain purpose, agenda, allow for village introductions and agree on expectations.	
	Allow presentation of HC action plan and community action plan and discussion of both.	
	Allow participants to develop joint social contract with maximum of seven (7) issues. Facilitate the process of prioritizing / making decisions about which seven (7) issues should be included in the social contract.	
	Participants agree on next steps through consensus.	
	Assess satisfaction of participants through beads/bowls voting.	
After interface	Document the interface, submit report to your Manager within 5 (five) working days and include copies of the agreed social contract in English and local language.	

Step 4: Facilitate interface

Purpose

Create space for community representatives and health centre staff to meet and come to a common understanding of issues and low cost/no cost actions to address these issues.

Keep the discussion constructive and positive!

The outcome of this meeting will be a joint social contract that all participants have agreed to.

Target group(s)

- All health centre staff
- VHT/LCI should follow-up with community representatives selected at the community dialogue (**step 3.5**).

QUORUM = minimum number of members needed to proceed

- A minimum of **two (2)** health centre staff
- Each target village should have at least five (5) representatives from different social groups. Ideally, there will be at least one (1) person from each village from each of these social groups:
 1. VHT
 2. Female youth (age 15 – 20 years)
 3. Male youth (age 15 – 20 years)
 4. Mother (any age)
 5. Male adult (age 21 – 49 years)
 6. Female adult (age 21 – 49 years)
 7. LC from each village
 8. Health Unit Management Committee (HUMC) member
 9. Disabled individual
- **Accountability Officer mobilises these sub-county observers to attend interface**
 1. Sub-county chief
 2. Community Development Officer (CDO)
 3. Health assistant

Timing/Location

- A half-day meeting at the health centre
- Should take place at most **two (2)** weeks after the health centre dialogue (**Step 2**) and at most **one (1)** week after the community dialogue (**Step 3**)

Materials

- Copy of both action plans (health centre & community)
- Copy of CRC for reference purposes
- Beads and bowls
- Attendance sheets
- Flip chart with a blank matrices to be filled in the meeting – see **step 4.3** for the template you must prepare. Remember to use local language.

Step 4.1: Open interface

Tips

Interfaces should be very interactive and allow participants to discuss fears and challenges and agree on solutions.

Use participatory facilitation methods (pg. 14) to build trust and strengthen the relationship between HC staff and community members. Use strategies for **Managing Challenges** (pg. 20)!

Sub-County observer(s) mobilised before this interface are present to provide clarification. They should not dominate.

Talking Points

1. Review both action plans closely at least two (2) days before meeting.
2. Review both action plans for evidence of balance of the 3Rs. If these are not balanced, think about what challenges you might face in the interface of the community representatives and health centre staff!
 - **Responsibility** – is community responsibility in both action plans?
 - **Responsiveness** – are requests of HC staff realistic?
 - **Relationship** – is this reflected in direct actions?
3. Introduce villages, VHTs, HC staff and secretaries.
 - One by one, recognise each village and ask representatives to stand
 - Ask all health centre staff to stand
 - Recognise sub-county observers, secretaries, etc.
4. Write the agenda and approximate times on the flip chart.
 1. Interface purpose, rules and expectations (30 minutes)
 2. Community action plan presentation (45 minutes)
 3. Health centre action plan presentation (45 minutes)
 4. Discussion about action plans (1 hour)
 5. Develop joint social contract (1 hour)
 6. Beads in bowls (30 minutes)
5. Remind all the participants that we all have a part to play in improving our health. We should appreciate and respect each other.

Step 4.2: Share & discuss HC & community action plans

Tips

If you can, get in touch with the community representative and remind him/her to review their action plan before the interface.

Sub-county observer should not make comments at this stage, only provide clarification if there are queries that none of the participants can answer.

This very formal sharing and commenting process is only found in procedure **#4**.

Talking Points

- 1. Community representative presents the community action plan.**
 - Hang the community action plan so everyone can see it.
 - The community presenter should read the action plan to the whole group.
 - S/he should read exactly what is written, with no information added or subtracted.
- 2. In-charge presents the health centre action plan.**
 - Hang the health centre action plan so everyone can see it.
 - Health centre in-charge should read the action plan to the whole group.
 - S/he should read exactly what is written, with no information added or subtracted.
- 3. Allow comments on individual action plans.**
 - Explain to participants that you are providing limits on the number and length of comments in the interest of time.
 - Allow **ten (10)** people to make a comment on the action plans just presented.
 - Remember, we want to hear many voices so – make sure representatives from all social groups and villages do make comments.
 - Each comment will be capped at two minutes.

Step 4.3: Develop joint social contract with seven (7) issues

Talking Points

Share the social contract matrix format.

Explain the differences between action plan and social contract.** In action plans, most were “suggested” and here they are confirmed. Compare the columns with **to the action plan. Also, the evidence column is not in the action plan matrix.

Use **Making Decisions (pg. 17)** and ask **Probing Questions (pg. 18)** to identify issues and actions.

Issue	* Action (low cost/no cost)	* Person responsible for the <u>action</u>	* Expected completion date	* Evidence of progress on <u>action</u>	* Person responsible for monitoring progress
This will be transferred from the community or health centre action plans after the participants have agreed.	<p>Proposed way to address the issue.</p> <p>Actions should be framed in neutral or positive language, and something that can be done! For example, “health workers report to work on time,” or “pregnant women go early for ANC.”</p> <p>The group can adopt or improve actions suggested in the HC or community action plans, or come up with new actions for each issue.</p> <p>Low cost/no cost actions can usually be done “now” or “soon”. 😊</p>	<p>This person should have the will and authority to implement the low cost/no cost action.</p> <p>This person could derive these things from a formal role they hold (e.g. HUMC member) or from their status in the community (e.g. someone others to go for advice).</p> <p>The person should confirm during the meeting that they are willing to do this action.</p>	<p>A clear deadline for completing the action.</p> <p>This date should be chosen by the person/people responsible for the action.</p> <p>Now = Can be done within 6 months and with local resources</p> <p>Soon = Can be done in 12 months and mostly local resources</p> <p>Later = Things we want but that need more time and maybe resources from outside</p>	<p>Signs that will show that progress is being made on the action.</p> <p>This is a “means of verification.”</p> <p>It should help us keep track of completeness during future follow-up interfaces.</p>	<p>This person will be responsible for checking in with the person/people responsible for the action between now and the follow-up meeting six months from now.</p> <p>This person should confirm during the meeting that they will monitor and provide feedback to HC staff and community members between follow-up interfaces (Step 5).</p>

Step 4.4: Participants agree to implement social contract

Tips

Ask probing questions to make sure that participants are owning this process and the outcomes!

- *What?*
- *Where?*
- *Who?*
- *How?*
- *Why?*

Remember to say “**THANK YOU**” and wish the participants “**GOOD LUCK**” in local language as the meeting ends. 😊

Talking Points

1. **Participants agree on next steps through consensus.**
 - Ask volunteers from each village and social group to inform others about what happened in the interface.
 - Explain to all participants that there will be a follow-up interface at the health centre after **six (6)** months.
 - Explain that the purpose of the follow-up interface will be to review progress on the social contract, and update it if necessary.
 - Agree on a month for the follow-up interface, and tell participants that the specific date will be confirmed later.
2. **Community and HC staff should jointly own the social contract.**
 - Ask the HUMC chairperson (or another HUMC member if the chairperson is not present) to take the flip chart with the social contract and post it at the health centre.
3. **Community and HC staff are responsible for implementing actions!**
 - The “person responsible” for each action in the social contract must use their will and authority to implement the action.
 - The “person responsible for monitoring progress” also has an obligation to keep track of what is happening.
 - Every participant needs to keep focus on the “evidence or progress” to be fair and objective.

Step 4.5: Beads in bowls (participant satisfaction)

Tips

Make sure everyone votes!

Ensure that people from less powerful social groups are not powered or pressured into voting against their will.

If participants are uncomfortable explain that this exercise allows them to express their level of satisfaction with the meeting (not about satisfaction with community or HC staff). This must be made very clear!

Talking Points

1. Beads and Bowls Voting.

- Arrange the **three (3)** bowls marked with different satisfaction signs in a semicircle.
- Hand out one bead to each participant. Give different colours for
 1. HC staff
 2. Community members
 3. Sub-County observers

2. Levels of satisfaction with interface AND social contract.

- Explain to participants that there are **three (3)** different bowls, and that they are to place their bead in the bowl that best describes their satisfaction with the interface process and outcomes today:
 1. **Very satisfied:** very or extremely happy with the interface and social contract
 2. **Satisfied:** happy with the interface and social contract
 3. **Unsatisfied:** unhappy with the interface and social contract
- First ask the community participants to get up (by village) and place their bead in the bowl that represents their feelings.
- When all villages have voted, ask the HC staff and S/C leaders to vote with their beads.
- Remind participants that each person has his/her own vote. Please do not pressure your neighbours!

Step 4.6: Document the interface & report outcomes

Tips

The report should be prepared immediately after the interface to ensure that the information is fresh in your mind.

It must be submitted to the ACT Health Manager (direct supervisor of the Officer) within **five (5)** working days after the interface.

If you have a different # of attendees and voters, explain reason(s) in your report. Ideally, we want 100% of participants to vote.

Document AND submit these items to ACT Health Manager (direct supervisor of Officer) for review and approval.

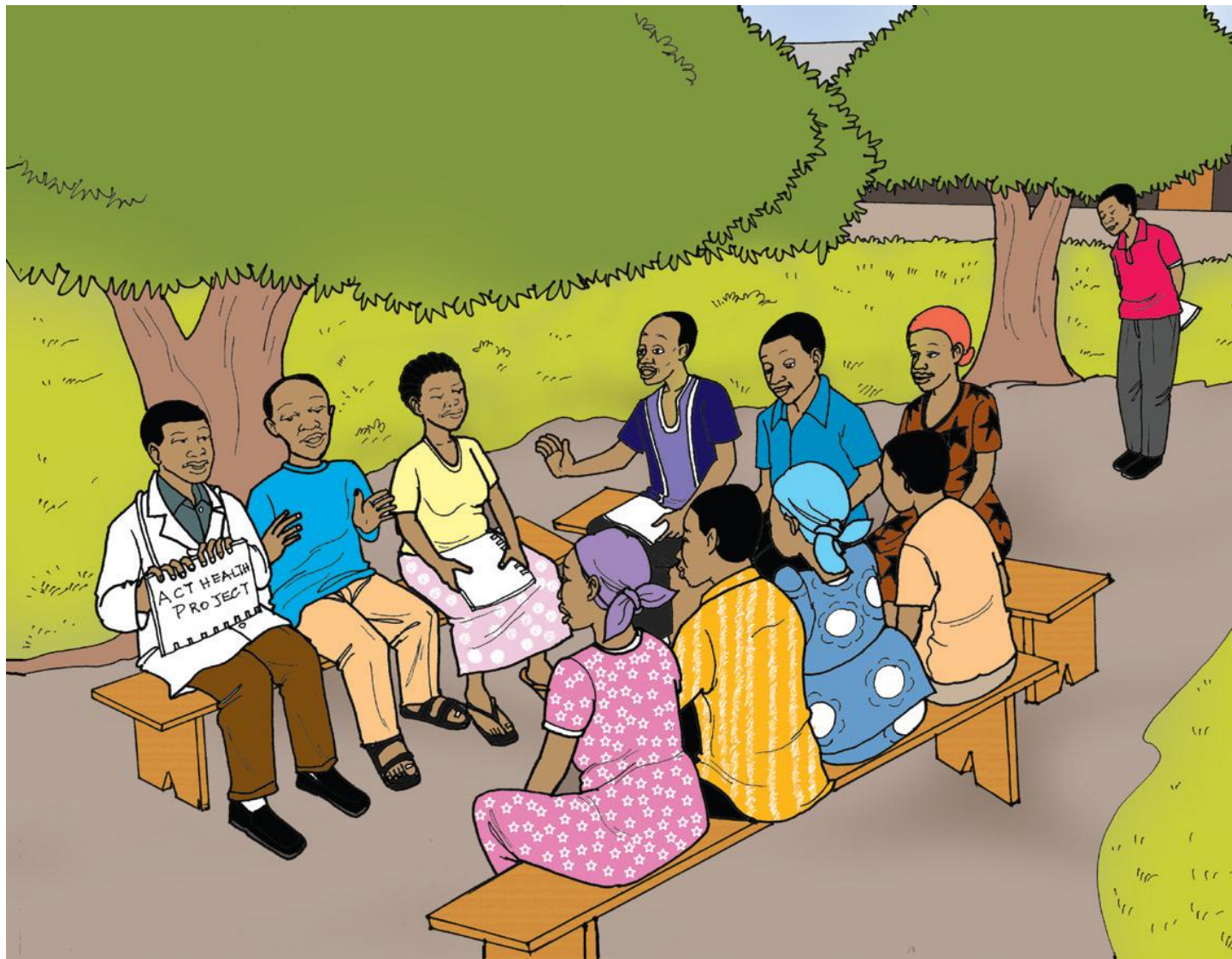
- 1. Attendance sheets from interface dialogue meeting**
- 2. Social Contract**
 - This should be typed exactly as agreed in meeting.
 - Also attach an English translation that secretary has completed.
- 3. Interface Report – one page typed**

Submission process

- 1. Officer submits to ACT Health Manager within five (5) working days of facilitating this activity.**
- 2. ACT Health Manager should review, provide feedback to Officer within three (3) working days.**
- 3. When ACT Health Manager has approved the report, s/he countersigns the Interface Report.**
- 4. Officer keeps the approved report in the HC files.**

Reminder: Always use standard activity report formats for ACT Health!

Step 5: Follow-Up Every Six Months



Step 5: Follow-Up Interfaces

Accountability Officers will facilitate follow-up interfaces for health centre staff and community representatives to review the social contract to help institutionalize the process. The half-day follow-up interfaces are held every six (6) months for community representatives and health centre staff. Participants in interface follow-ups discuss progress on implementation of the actions in the social contract, revise actions and agree on recommendations for improvements to the social contract.

When	For Step 5: “Follow-Up Interfaces” complete the following	Completed?
Before the follow-up interface	Five (5) months after interface (Step 4), visit the health centre in-charge to arrange a date and time within the month for the follow-up interface. Ask in-charge to mobilise the health centre staff.	
	Invite all VHTs and LCIs from three (3) target villages to attend the follow-up interface. Confirm their attendance. Invite the sub-county observers who observed to attend follow-up interface.	
	Ask the VHTs/LCIs to re-mobilise the members of their target villages who attended the interface (Step 4) or previous follow-up interface to attend.	
During the follow-up interface	Ensure that all target villages and social groups are adequately represented before opening the meeting. See quorum guidelines on page 56 (Step 5) .	
	Facilitate discussion about the progress on and updates to the social contract.	
	Assess satisfaction of participants through beads/bowls voting.	
After the follow-up interface	Document the interface, submit report to your Manager within 5 working days and include copies of the updated social contract in English and local language.	

Step 5: Follow-up interface

Purpose

The follow-up dialogue interface is a space for interface participants to review the social contract developed during the interface (Step 4).

Participants discuss the progress that has been made on the social contract and any improvements.

Participants agree on ways to improve the actions or sustain the progress made.

Target group(s)

- All health centre staff
- VHT/LCI should follow-up with community representatives selected at the interface (Step 4).

QUORUM = minimum number of members needed to proceed

- A minimum of **two (2)** health centre staff
- Each target village should have at least **five (5)** representatives from different social groups. Ideally, there will be at least one (1) person from each village from each of these social groups:
 1. VHT
 2. Female youth (age 15 – 20 years)
 3. Male youth (age 15 – 20 years)
 4. Mother (any age)
 5. Male adult (age 21 – 49 years)
 6. Female adult (age 21 – 49 years)
 7. LC from each village
 8. Health Unit Management Committee (HUMC) member
 9. Disabled individual
- Accountability Officer invites these sub-county officials to observe interface/offer clarification
 1. Sub-county chief
 2. Community Development Officer (CDO)
 3. Health assistant

Timing/Location

- A half-day meeting at the health centre.
- Should take place every **six (6)** months marking time from when the previous interface or follow-up was done.

Materials

- Social contract developed/updated at previous interface/follow-up
- Beads/bowls
- Attendance sheets
- Flip chart with blank social contract progress matrix – see **step 5.3** for template

Step 5.1: Mobilise for the follow-up interfaces

Tips

Between the interface (**Step 4**) & follow-up (**Step 5**), maintain contact casual with VHTs for easy mobilisation.

It is very important to hold the follow-up interface **six (6)** months after the interface or follow-up.

For **consistency**, it is also important to ensure the same representatives as attended previous interface dialogue or follow-up meeting.

Target group(s)

- Health centre in-charge
- HUMC Chairperson
- LCIs and the VHT that attended the interface/follow-up from each village

Timing/Location

- **Four (4)** weeks before the follow-up interface date
- In villages and over the phone

Action Points

1. **Accountability Officer will visit the health centre in-charge to arrange a date and time within the month for the follow-up interface.**
2. **Ask in-charge to mobilise the health centre staff.**
3. **Accountability Officer ensures key participants are aware of follow-up interface.**
 - Invite all VHTs, LCIs and sub-county observers to attend the follow-up. Confirm their attendance.
 - Ask the VHTs/LCIs to re-mobilise the members of their community who attended the interface meeting to attend the follow-up interface.
 - VHTs/LCIs mobilise community representatives.
 - Follow-up with VHTs/LCIs over the phone on weekly basis to ensure that they have mobilised the interface participants to attend.

Step 5.2: Open the follow-up interfaces

Tips

Plan ahead to be well-prepared and respect community members time!

Use participatory facilitation methods (pg. 14) to build trust and strengthen the relationship between HC staff and community members. Use strategies for **Managing Challenges** (pg. 20)!

Sub-County observer(s) are present to provide clarification. They should not dominate.

Talking Points

1. **At least one (1) week before the follow-up interface, start a detailed review of your files so you will be very well-prepared:**
 - Citizen's Report Card
 - Social contract - local language and English language versions
 - Report and satisfaction levels from previous interface follow-up
 - Attendance list from previous interfaces
2. **Request the health centre and community secretaries to please take notes.**
 - Secretaries record the reported progress on the social contract.
 - Secretaries record any changes to the social contract.
3. **Write the agenda and approximate times on the flip chart.**
 1. Follow-up interface purpose, rules and expectations (30 minutes)
 2. Discussing progress on social contract (1 hour 30 minutes)
 3. Updating the social contract (1 hour)
 4. Preparing for the next follow-up interface (30 minutes)
 5. Beads in bowls voting (30 minutes)

Step 5.3: Review and discuss social contract progress

Actions

Hang up the social contract so all participants can see it.

Ask for **seven (7)** volunteers – each one will read through one row of the social contract.

Display the “status” matrix and explain each column.

Facilitate discussion for each issue/activity using the guidance and probes in matrix to the right.

Issue	Issue Progress	Action (low cost/no cost)	Action progress based on progress markers or other evidence	Person responsible to implement	Expected completion date	Person responsible to monitor progress
Each issue should be copied exactly from the social contract.	For each issue, ask probing questions about level of progress. When participants reach consensus, record either a + or a – in this row. Options: “+” for yes “-” for no	The action should be copied exactly from the social contract.	Ask participants if the action proposed accurately address the larger issue? Based on progress markers agreed to, have actions been achieved? Why or why not? Options: 1. Achieved 2. Partially achieved 3. Not achieved For each action, participants should discuss and concur. If it is taking too much time to get consensus through debate, you can consider calling for a vote (with beads or show of hands). Record brief comments here.	Did s/he have the will and authority to complete the action? Options 1. Yes 2. No 3. Partly If they did not complete the action, how participants better support this person? Record brief comments here.	Was it possible to complete the action and improve the issue in the suggested time frame? Options 1. Yes 2. No 3. Partly Record brief comments here.	Did s/he monitor progress on the action? Options 1. Yes 2. No 3. Partly Why or why not? Record brief comments here.

Step 5.4: Update social contract & develop next steps

Tips

New “issues” should **not** be included.

If review of progress has highlighted problems with the “actions” (not effective to solve the problem, not achievable, etc.) participants can amend.

Facilitator (Accountability Officer) should **not** suggest any changes to the social contract. All changes must come from participants.

Use **Making Decisions** (pg. 17) and ask **Probing Questions** (pg. 18) to identify updates.

Talking Points

1. **After discussion on progress (step 5.3), update the social contract.**
 - Use this table to guide discussions on the changes to social contract (if any are desired).

Guidelines for updating the social contract	
For issues with no improvements or actions that have not been achieved, participants can	
1.	Develop new actions (i.e., replacing actions which are not effective)
2.	Change the existing actions
3.	Change the person responsible
4.	Change the person monitoring
5.	Change the timeline for the action

 - Record all changes in the social contract matrix and the follow-up interface report.
2. **Develop next steps.**
 - Ask volunteers from each village and social group to inform others about what happened in the follow-up interface.
 - Remind the community secretary and health centre secretary to copy down the social contract updates.
 - Inform the participants that in **six (6)** months there will be another follow-up interface to discuss progress and update the social contract again.

Step 5.5: Beads in bowls (participant satisfaction)

Tips

Make sure everyone votes!

Ensure that people from less powerful social groups are not powered or pressured into voting against their will.

If participants are un-comfortable explain that this exercise allows them to express their level of satisfaction with the meeting (not about satisfaction with community or HC staff). This must be made very clear!

Talking Points

1. Beads and Bowls Voting.

- Arrange the **three (3)** bowls marked with different satisfaction signs in a semicircle.
- Hand out one bead to each participant. Give different colours for
 1. HC staff
 2. Community members
 3. Sub-County leaders

2. Levels of satisfaction with follow-up interface process **AND** social contract progress.

- Explain to participants that there are **three (3)** different bowls, and that they will place their bead in bowl that best describes their satisfaction with the follow-up interface process and social contract progress:
 1. **Very satisfied:** very or extremely happy with the interface and social contract progress
 2. **Satisfied:** happy with the interface and social contract progress
 3. **Unsatisfied:** unhappy with the interface and social contract progress
- First ask the community participants to get up (by village) and place their bead in the bowl that represents their feelings.
- When all villages have voted, ask the HC staff and leaders to vote.
- Remind participants that each person has his/her own vote. Please do not pressure your neighbours!

Step 5.6: Document the follow-up interface & report outcomes

Tips

The report should be prepared immediately after the follow-up interface to ensure that the information is fresh in your mind.

Report must be submitted to the ACT Health Manager (direct supervisor of the Officer) within **five (5)** working days after the activity.

If you have a different # of attendees and voters, explain reason(s) in your report. Ideally, we want 100% of participants to vote.

Document AND submit these items to ACT Health Manager (direct supervisor of the Officer) for review and approval.

1. **Attendance sheets from follow-up interface**
2. **Updated Social Contract**
 - This should be typed exactly as agreed in follow-up interface.
 - Also attach an English translation that secretary has worked on.
3. **Follow-up Interface Report** – one page typed

Submission process

1. **Officer submits to ACT Health Manager within five (5) working days of facilitating the follow-up interface.**
2. **ACT Health Manager should review, provide feedback to Officer within three (3) working days.**
3. **When ACT Health Manager has approved the report, s/he countersigns the Follow-Up Interface Report.**
4. **Officer keeps the approved report in the HC files.**

Reminder: Always use standard activity report formats for ACT Health!

Glossary of ACT Health Key Terms

Many programmes or projects have their own “language” and ACT Health is not an exception. To ensure that all colleagues in the ACT Health consortium are using the same language, please refer to the definitions of our key terms in the ACT Health programme. In case of any questions, please discuss with a Manager or Mentor.

Absenteeism – Absenteeism is the term generally used to refer to unscheduled health worker absences from the workplace/health facility during operational hours.

Accountability – This is when someone has an obligation to meet certain commitments or standards and there are consequences to face if it is found that these have not been met.

Action Plan – A document which includes specific actions (with assigned roles, responsibilities and timeframes) to address priority issues related to health in the community. This is agreed to by participants in the community or health centre dialogue.

(Experimenter) Bias – An error which can lead research findings that are not accurate because of errors in collecting data, or by errors in sampling. e.g. if you choose only well performing health centres as part of the programme and poor performing health centres as part of the control.

Citizen’s Report Card (CRC) – A document containing information from households and health centre staff on perceptions of the status of health service delivery and patterns of health behaviour at a particular health centre II or III.

Control communities/health centres – Randomly selected health centres and their catchment communities that will not intentionally receive any activity offered by the ACT Health programme for purposes of comparison with those that receive the programme.

Counterfactual – Represents the state of the world that programme participants would have experienced without the programme i.e. had they not participated in the programme.

Demand side – Programmes designed to encourage health users to modify their health seeking behaviour and ask for accountability from the health service providers.

Dialogue – A separate meeting of community members or health centre staff. A community dialogue will have several social groups represented. Each dialogue will have an action plan.

District Health Team (DHT) – A group of government officials that participate in planning, budgeting, monitoring of health services in the district. By Ministry of Health policy, the DHT includes these positions: District Health Officer (DHO), District Biostatistician, District Health Inspector (DHI), District Nursing Officer and Maternal New born and Child Health (MNCH) focal person.

Follow-up dialogue or interface – Meetings held every six months to review progress and challenges in implementation of community or health centre action plans (Separate Dialogues) or social contracts (Interface Only and Full Programme). They are also an avenue for providing feedback to the community on District Action Plans and National Advocacy issues.

Health centre – This is a government health facility at the level II (parish) or level III (sub-county).

Health centre staff – These are medical staff (midwives, clinical officers and enrolled nurses) and non-medical staff (including guard, porters and cleaners) that work at a specific health facility.

Glossary of ACT Health Key Terms

Health Unit Management Committee (HUMC) – A community structure for the health sector in Uganda. Members of HUMCs are consumers of health services and are also mandated by the government to play a critical role in community-driven monitoring of health inputs and service delivery standards.

Impact – A comparison between 1) the outcome sometime after the programme has been introduced and 2) the outcome at that same point in time had the programme not been introduced (the ‘counterfactual’).

Implementation Teams – Includes ACT Health Officers employed by all consortium agencies that are responsible for facilitating and reporting on programme activities described in Procedure Manuals.

Inclusiveness – Allowing the participation of people from different backgrounds and interests, taking into account issues of language, ethnicity, culture, gender, age, socio-economic status and disability.

Interface – An activity that includes community members or representatives and health centre staff. Each interface will end with a social contract.

Low cost / no cost – This refers to an action or solution that does not require additional resources from outside sources, but things that do not cost money or are within capacity of people to do within one year (12 months).

Maternal mortality – The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. It is measured on a ratio of 100,000 live births per year.

Mobilisation – The process of assembling and organizing community members and health centre staff to come for dialogue and interface meetings.

Participation – The result and process of empowering people to analyse the health challenges in their community, prioritise needs, raise identified issues, make action plans and take action to improve their health and health care services.

Officer-In-Charge – This is the head of a health centre. S/he is the one who oversees the activities of health centre and is secretary of the HUMC. In a HCII s/he should be an enrolled nurse and in a HCIII s/he should be a clinical officer.

Ownership – This is where communities take responsibility to improve their health behaviour and health centre staff commit to being more responsive to community needs.

Participatory facilitation – Engaging participants in discussion by incorporating their needs and questions, reflection and analysis and focusing on their strategies for change. The facilitator supports the change process by honouring everyone’s contributions and creating an environment that allows people to come to a common understanding.

Quality Assurance (QA) – A set of activities for *ensuring quality in the processes* through which dialogue meetings, action plans/social contracts and MSC stories are developed. QA aims to prevent issues with a focus on the process used to make the ‘product.’ It is a proactive quality process.

Quality Control (QC) – A set of activities for *ensuring quality in ‘products’*. The activities focus on identifying issues in the actual ‘products’ (action plans, summaries, analysis) produced. QC aims to identify (and correct) issues in the finished ‘products’. QC, therefore, is a reactive process. The goal of QC is to identify issues after a product is developed BUT before it is released.

Glossary of ACT Health Key Terms

Randomized Control Trial (RCT) – A research method (used in ACT Health) in which a number of similar HCs are randomly assigned to one of four procedures (one of which is a control group) to test the effectiveness of ACT Health procedures. The HCs are followed up and *outcomes* are measured at specific times and any difference in response between the groups is analysed statistically.

Random sampling – Each HC will be randomly selected so each has an equal chance of being assigned to any ACT Health procedure. When we use random sampling, our research/programme communities better represent the larger group and the results of the research will be more likely to be representative (have more external validity).

Random assignment – Is an experimental technique for assigning communities to different programme procedures. We randomly assign in order to help assure that our intervention groups are similar to each other prior to the intervention. We will randomly assign health centres and their communities to various procedures.

Social contract – Output of a facilitated interface between community members and health centre staff.

Space – Opportunity created for community to meet with health centre staff and leaders to identify health challenges and find solutions to these problems.

State – Also known as duty bearer is the institution that has the obligation to meet basic health needs of citizens; these include health centre staff, policy makers and political leaders.

Stock Out – This is when a pharmacy in a medical store or health centre temporarily lacks one or more of the essential/tracer medicines on the shelf (see tracer drugs below).

Target Villages – These are the **three (3)** villages with centroids (physical centre) closest to the HC. These will be targeted for programme activities.

Tracer Drugs – These are the commonly prescribed drugs for a particular condition based on national guidelines. Uganda has five (5) tracer drugs namely 1st line ACT anti-malarials, measles vaccine, Oral rehydration salts (ORS), cotrimoxazole and depoprovera. The standard GoU requirement is that all six drugs should be available at any one time in all government facilities. *If/when MoH updates, implementation teams will be informed.*

Under five (<5) Mortality – The Probability of a child dying between birth and exactly five years of age expressed per 1,000 live births.

Village Health Team (VHT) – A Village Health Team (VHT) is a non-political health implementing structure and the equivalent of Health Center 1 (HC 1) who are responsible for monitoring the health of community members at the household level. A VHT is selected on popular vote after sensitization and consensus building of all village members from all households, such as following a community meeting lead by the LC1 discussing the VHT Program to all residents present at this meeting who can later decide who they feel would be good candidates.

Sources of Inspiration

Several materials were referenced in developing this Procedure Manual. These include:

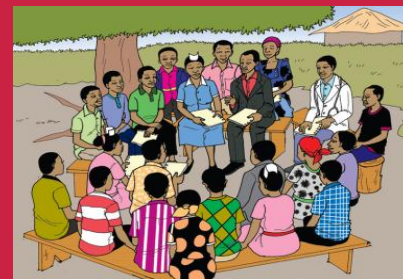
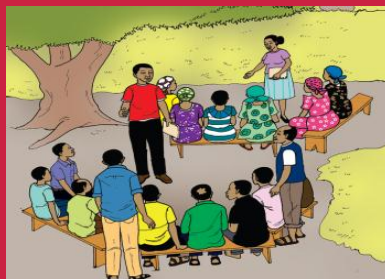
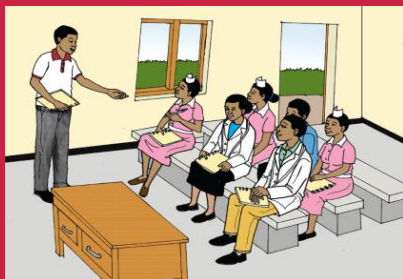
Concern Worldwide, *“Community Conversations: Training of Community Facilitators”*

GOAL and HEPS, *“ACT Health Resource Guide”* (2012)

International HIV/Aids Alliance Frontiers Prevention Project *“Tools Together Now! 100 participatory tools to mobilise communities for HIV/AIDS”* (2006)

Training and Research support centre (TARSC) and Ifakara Health Development centre with EQUINET *“Organising people’s power for health”* (2006)

Ministry of Health Department of Quality Assurance, *“Patient’s Charter”* (2009)



Accountability Can Transform Health

Guidelines for Procedure #4 (Full Programme)